West Hertfordshire Hospitals NHS Trust

Hemel Hempstead General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Inadequate
End of life care	Not sufficient evidence to rate
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

This was the second comprehensive inspection of the trust the first taking place in April and May 2015. It was rated as inadequate overall and went into special measures in September 2015.

Part of the inspection was announced taking place between 6 and 9 September 2016 during which time Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital were all inspected. Unannounced inspections were undertaken of Watford General Hospital and Hemel Hempstead Hospital on the 19 September 2016.

We inspected and rated the core services of the urgent care centre, medicine and outpatients and diagnostic imaging. We also inspected the mortuary as part of the end of life core service but did not rate this.

We rated Hemel Hempstead Hospital as inadequate overall. We rated medical care as inadequate. We rated Urgent Care Centre (UCC) as requires improvement. We rated outpatients and diagnostic imaging as good. For the five key questions that we inspect and rate, we rated three (safe, responsive and well-led) as inadequate and caring and effective were requires improvement.

- Whilst most staff were kind and caring in the hospital, we found concerns regarding staff attitude to patients and visitors on Simpson ward.
- During the last inspection, we found that there was no clear streaming or triage process in place in the UCC. This had not improved at this inspection. We escalated this as an urgent concern to the trust, who took a range of actions to address this risk to patient safety.
- There was no process in place in the UCC to monitor and review arrival time to initial assessment. The UCC did not have an effective process in place to ensure that all children under the age of 16 received an initial assessment within 15 minutes in line with The Intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, 2012'.
- There was no clear process in place to ensure that patients who were waiting to see a clinician were assessed as safe to wait in the UCC.
- The premises did not always meet the needs of patients. The designated children's waiting area was not child-friendly and had no appropriate distraction items for children.
- Staff in the UCC had not received all required mandatory training. Staff had received no specific training in sepsis management. Not all staff had had the required safeguarding adults training.
- Staff in UCC had minimal understanding of the duty of candour regulation and its requirements.
- Nurse staffing met patients' needs at the time of the inspection for adult patients, but not for children as there was not always a nurse present in the UCC with the full range of competencies to assess children's needs.
- Staffing levels did not meet patient need and acuity at all times of day at the time of inspection on Simpson ward. Non-clinical staff were used to provide one to one care for patients requiring supervision.
- Learning from incidents was not effectively shared and communicated to all relevant staff to minimise the risk to patient safety in the hospital.
- There was not an effective process in place to monitor and review patient outcomes in the UCC and on Simpson ward.
- There were not robust appraisal and clinical supervision systems in place to support staff in the hospital.
- There were not robust processes in place to manage demand and patient flow in the UCC and on Simpson ward.

Summary of findings

- There was no clear strategy for the UCC and Simpson ward. Staff were not always given the opportunity to have their views reflected when changes to the service were being made.
- Medicines were not always managed safely.
- There was a lack of effective governance measures in place to support the delivery of good quality care. Risks to patient safety in the service had not been identified in the UCC and on Simpson ward.
- Appropriate Deprivation of Liberty Safeguards authorisations were not in place for patients on the ward, and staff did not always understand the impact of this on Simpson ward.
- Fire safety was not sufficient on Simpson ward to ensure patients and staff would be kept safe in the event of a fire.
- There were no activities to engage patients, including those with complex needs and living with dementia on Simpson ward. We did not observe staff engaging patients living with dementia who appeared anxious or distressed.
- There were no formal admission criteria to Simpson ward, which meant that staff could not be assured that appropriate patients were being placed under their care. The ward lacked identity and all staff gave different descriptions of the service provided.
- Referral to treatment performance had been improving since the last inspection, and exceeding the target for some clinics. However, due to poor performance in certain clinics, only 87% of patients met this target from May 2016 to September 2016. This meant performance had declined over the past six months.
- Data for July to September 2016 showed that the trust had fallen below the national 93% target that all suspected cancers should be referred to a consultant and seen within two weeks; only 87% of patients were seen within this timeframe. This meant performance had declined over the past six months.
- The Royal College of Paediatrics and Child Health (RCPCH) Intercollegiate Document 2014 states that clinical staff assessing and treating children and young people should have level three safeguarding children training. Not all medical staff in outpatients had received this training but the trust took actions to address this once we raised it as a concern.
- The UCC was consistently meeting the national target of 95% for four-hour admission to discharge.
- Effective induction and orientation processes were in place for new staff and agency/bank staff on Simpson ward. Staff felt that whilst there was uncertainty about the ward, they tried to maintain the 'family' feel of the ward and work together as a team.
- Staff felt that their local leaders were visible and approachable.
- Standards of cleanliness and hygiene were well maintained in the mortuary. Reliable systems were in place to prevent and protect people from a healthcare-associated infection.
- Facilities were in a good state of repair in the mortuary. The air-change system in the mortuary was being monitored to ensure there were no risks to staff. Equipment was generally well maintained and fit for purpose.
- The recently appointed senior and junior sisters had improved morale and processes in the outpatient department.
- Following their last inspection, many improvements had been made in outpatients and their performance data improved. We have seen evidence of clear action plans as a result of the last inspection. This could partly be contributed to the new leadership appointments made, including the lead nurse and service lead for outpatients. Both services recognised that since the last inspection they needed to improve their systems and process and provide a greater leadership for the nursing team.

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

Importantly, the trust must:

- Ensure that there are effective streaming systems in place in the Urgent Care Centre (UCC) and all staff have had appropriate training to carry out this process.
- Ensure there are processes in place to monitor arrival time to initial clinical assessment for all patients.
- Establish a process so that all children are seen by a clinician within 15 minutes of arrival to the UCC.
- Ensure that there are effective processes in place in the UCC to provide clinical oversight for patients waiting to be seen.

Summary of findings

- Ensure non-clinical staff receive sufficient support or training to provide oversight to recognise a deteriorating patient in the UCC.
- Ensure the UCC has direct access to a registered children's nurse at all times and that paediatric competencies for emergency nurse practitioners are recorded as a part of their continuous professional development (CPD), in line with national recommendations.
- Ensure that effective governance frameworks, standard operating procedures and policies are in place to support service delivery in the UCC.
- Ensure that systems and processes are in place to monitor and review all key aspects of performance to identify areas for improvement and all potential risks in the UCC and on Simpson ward.
- Ensure that staff are given training and support to understand the duty of candour statutory requirements.
- Ensure all staff have had the mandatory training relevant to their roles and that all staff receive an annual appraisal in the UCC and on Simpson ward.
- Ensure that all outpatients administrative staff receive appraisals.
- Maintain medicines at correct temperatures in all areas and ensure appropriate action is taken if outside recommended range on Simpson ward.
- Ensure that all medicines are suitable for use and have not expired on Simpson ward.
- Ensure safe storage and management of controlled drugs on Simpson ward.
- Ensure staffing levels and competency of staff meets patient need at all times on Simpson ward.
- Ensure appropriate assessments and authorisations are in place for Deprivation of Liberty Safeguards on Simpson ward.
- Ensure that the Simpson ward can meet the needs of patients with vulnerabilities, including those living with a dementia and those displaying difficult behaviours and to ensure the provision of activities to engage patients in meaningful stimulation.
- Ensure learning from incidents and feedback is embedded to drive improvements on Simpson ward.
- Review the admission and exclusion criteria for Simpson ward to ensure all referred patients have their needs met.
- Plans must be put into place to ensure referral to treatment (RTT) and cancer treatment times to continue to improve so that they are similar to or better than the England average.
- Ensure all staff understand the duty of candour regulation and its requirements.

In addition the trust should:

- Consider ways to make the UCC environment more child-friendly in line with national recommendations.
- Consider ways of developing an audit process in UCC to monitor key areas of performance and compliance to protocols/pathways in line with other areas of the unscheduled care division.
- Monitor how learning from incidents is effectively shared and communicated to all relevant staff to minimise the risks to patient safety.
- Consider ways to ensure that staff are aware of the strategy for the UCC and continue to develop ways for their views to be heard.
- Establish clear escalation processes to manage the service in the UCC during periods of high demand or excessive waiting times.
- Monitor how pain assessments and management systems are being used in the UCC.
- Review processes for monitoring those patients transferred from the UCC to other services in an emergency.
- Review how staff can be supported via a clinical supervision process.
- Monitor how staff demonstrate compassionate care towards patients at all times on Simpson ward.
- Review discharge pathways to ensure access and flow are improved for Simpson ward.
- Review the process for having medical records available for all clinic appointments.
- Review the provision of advice leaflets in a variety of other languages in outpatients.
- Provide safeguarding children level three training to all required clinical staff in outpatients.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Overall, we rated the Urgent Care Centre (UCC) as requires improvement. We rated caring as good and requires improvement for safe, effective and responsive. We rated well-led as inadequate. Overall, we rated the UCC as requires improvement because: • During the last inspection, we found that there was no clear streaming or triage process in place. This had not improved at this inspection. We escalated this as an urgent concern to the trust, who took a range of actions to address this risk to patient safety. • There was no process in place in the UCC to monitor and review arrival time to initial assessment. The UCC did not have an effective process in place to ensure that all children under the age of 16 received an initial assessment within 15 minutes in line with The Intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, 2012'. • There was no clear process in place to ensure that patients who were waiting to see a clinician were assessed as safe to wait. • The premises did not always meet the needs of patients. The designated children's waiting area was not child-friendly and had no appropriate distraction items for children. • Staff had not received all required mandatory training. Staff had received no specific training in sepsis management. Not all staff had had the required safeguarding adults training. • There were no robust measures in place to provide medical support for the unit if the external provider was unable to provide this cover.

Summary of findings

- Nurse staffing met patients' needs at the time of the inspection for adult patients, but not for children as there was not always a nurse present in the UCC with the full range of competencies to assess children's needs.
- Learning from incidents was not effectively shared and communicated to all relevant staff to minimise the risk to patient safety
- There was no process in place to monitor and review patient outcomes.
- The service was not meeting the trust's 90% target for appraisal rates. There were not robust appraisal and clinical supervision systems in place to support staff.
- There were not robust processes in place to manage demand and patient flow in the UCC. Patients who left before being seen was 5%, which was worse than the England average of 3%.
- There was no clear strategy for the service. Staff were not always given the opportunity to have their views reflected when changes to the service were being made. There was a lack of effective governance measures in place to support the delivery of good quality care. Risks to patient safety in the service had not been identified.

However, we also found that:

- We observed that staff displayed compassion and treated patients and their relatives with respect and kindness. Patients made positive comments about the care they received from staff and their friendly attitudes.
- The UCC was consistently meeting the national target of 95% for four-hour admission to discharge.
- Medicines were stored in line with trust medicines' management policy.
- All staff had the appropriate level of safeguarding training for children in line

Summary of findings

with national guidance. Staff had a good understanding of consent procedures and 93% of nursing staff had received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

- There was clear information on making complaints and we saw that complaints were investigated in a timely manner.
- Staff worked autonomously to provide good quality care and there was a good culture of staff supporting each other. Staff felt that their local leaders were visible and approachable.

Medical care (including older people's care)

Inadequate

Overall, we rated the service as inadequate because:

- There were not appropriate systems in place to identify and monitor risk, and learning from incidents was not shared across multidisciplinary teams. There were not always policies or procedures in place to support staff.
- Staffing levels did not meet patient need and acuity at all times of day at the time of inspection. Non-clinical staff were used to provide one-to-one care for patients requiring supervision.
- Appropriate Deprivation of Liberty Safeguards authorisations were not in place for patients on the ward, and staff did not always understand the impact of this.
- Patients received weekly consultant reviews; however, these were not conducted in conjunction with medical staff caring for patients on a daily basis.
- Medicines were not always managed safely.
- Visiting staff did not always discuss patients in a respectful way and this went unchallenged by ward staff. There were concerns expressed by patients

Summary of findings

and family members regarding staff attitude and care. Staff did not always communicate and involve family members in the progress of discharges.

- There were no activities to engage patients, including those with complex needs and living with dementia. We did not observe staff engaging patients living with dementia who appeared anxious or distressed.
- Patients were not always positioned well or comfortably during meal times.
- There were no formal admission criteria to the ward, which meant that staff could not be assured that appropriate patients were being placed under their care. The ward lacked identity and all staff gave different descriptions of the service provided. There was no clear vision, identity or strategy in place for the ward, resulting in the ward admitting patients from a variety of specialities and with complex conditions.
- There were significant problems with flow out of the ward, due to a lack of ownership of the discharge process.
- Senior staff were not aware of the significant risks to patient safety that we found and raised during our inspection.
- Staff were concerned about the future of the ward and this impacted morale and culture. Staff did not feel engaged in developments and changes relating to the future of the ward. Staff felt there was a significant disconnect between the ward and the rest of their trust, which was affecting the care they could provide.

However, we also found that:

- Evidence-based care was provided to patients on the ward, reflective of national guidance. Patient nursing risk

Summary of findings

assessments and observation records were thoroughly completed for all patients. Medical and nursing records were easily accessible and up to date.

- Infection control procedures were in line with trust policy and audits showed good compliance rates for hand hygiene.
- Mental capacity assessments were carried out appropriately and this was documented clearly in patient records. Staff understood safeguarding vulnerable adults and how to report any concerns. Safeguarding training rates met the trust target.
- Effective induction and orientation processes were in place for new staff and agency/bank staff. Staff felt that whilst there was uncertainty about the ward, they tried to maintain the 'family' feel of the ward and work together as a team.
- Data collected through patient satisfaction audits was generally positive and regularly shared with the team. Patients generally were positive about the care they received whilst on the ward and dignity being maintained during interactions with patients.
- Staff felt well supported by the ward sister and spoke highly of them.

End of life care

Not sufficient evidence to rate

We inspected, but did not rate, elements of the safe key question. We did not inspect the effective, caring, responsive, or well-led key questions on this inspection. Significant improvements had been made since the April 2015 inspection. We found that:

- Staff knew how to report incidents appropriately and incidents were investigated, shared, and lessons learned. Risks in the environment and in the service had been recognised and addressed and the service had a robust risk register in place.

Summary of findings

- Standards of cleanliness and hygiene were well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Facilities were in a good state of repair in the mortuary. The air-change system in the mortuary was being monitored to ensure there were no risks to staff.
- Appropriate checking systems were in place to monitor the temperatures of the body fridges. Equipment was generally well maintained and fit for purpose. Chemicals hazardous to health were generally appropriately stored.
- Appropriate systems were in place to respond to major incidents and emergencies.

Outpatients and diagnostic imaging

Good

Overall, we rated the service as good. Responsive was rated as requires improvement and safe, caring and well-led were rated as good. We found that:

- Staff we spoke to described with confidence how they would recognise and report incidents and there was evidence of learning from incidents and patient complaints. Senior staff had oversight of risks in their areas.
- Outpatients appeared visibly clean and staff used personal protective equipment such as gloves and aprons. Generally, equipment was maintained, appropriately checked and visibly clean.
- Patient records were stored securely, and access was limited to those who needed to use them. This ensured that patient confidentiality was maintained at all times.
- Patients' care and treatment was delivered in line with current national standards and legislation in both services. Policies and procedures

Summary of findings

followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence.

- Patients and their relatives we spoke to told us they were supported by staff that were caring and compassionate.
- Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making.
- There was clear signage displaying clinic waiting times that were updated every 30 minutes, and audited by senior nurses to ensure that this was done.
- There was evidence of multidisciplinary working in the outpatients and diagnostic imaging department.
- The recently appointed senior and junior sisters had improved morale and processes in the outpatient department.
- All staff we spoke with told us that managers of both services were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.

However, we also found:

- Referral to treatment performance had been improving since the last inspection, and exceeding the target for some clinics. However, due to poor performance in certain clinics, only 87% of patients met this target from May 2016 to September 2016. This meant performance had declined over the past six months.
- Data for July to September 2016 showed that the trust had fallen below the national 93% target that all suspected cancers should be referred to a

Summary of findings

consultant and seen within two weeks; only 87% of patients were seen within this timeframe. This meant performance had declined over the past six months.

- The Royal College of Paediatrics and Child Health (RCPCH) Intercollegiate Document 2014 state that clinical staff assessing and treating children and young people should have level three safeguarding children training. Not all medical staff in outpatients had received this training but the trust took action to address this once we raised it as a concern.
- Patient records were not always available for patient appointments.
- Nasal endoscopes were not fully decontaminated in an endoscope washer-disinfector.
- Leaflets were not available in other languages other than English.

Hemel Hempstead General Hospital

Detailed findings

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

Detailed findings

Contents

Background to Hemel Hempstead General Hospital

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

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

Hemel Hempstead General Hospital has an urgent care centre which is open 24 hours a day, seven days a week, a medical ward consisting of 22 beds, outpatients department and diagnostic and imaging services. A local NHS community trust also operates intermediate care beds at this hospital but these were not inspected as they will be included in the inspection of the community trust.

In 2015/16, the trust had revenue of £299.8m and a deficit of £41.2m.

We carried out an announced comprehensive inspection of the Hemel Hempstead Hospital from 6 to 9 September 2016. We undertook an unannounced inspection on 19 September 2016.

This was the second comprehensive inspection of the trust the first taking place in April and May 2015, it was subsequently rated as inadequate overall and went into special measures in September 2015.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers,

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included 15 CQC inspectors, two CQC pharmacy inspectors and a variety of specialists: safeguarding lead, consultants and nurses from accident and emergency departments, medicine and surgical services, senior managers, an anaesthetist, senior paediatric nurses and a neonatal consultant, a consultant obstetrician, midwife, allied health professionals and a palliative care consultant.

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 of people's needs?
- Is it well-led?

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

We carried out this inspection as part of our comprehensive programme of re-visiting trusts which are in special measures. We undertook an announced inspection from 6 to 9 September 2016 2016 and unannounced inspection on 19 September 2016.

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

Facts and data about Hemel Hempstead General Hospital

Hemel Hempstead General Hospital is part of West Hertfordshire Hospitals NHS Trust. It has 22 beds.

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

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

Overall, in 2015/16 the trust had 94,530 inpatient admissions, 454,558 outpatients' attendances and 34,524 attendances at the urgent care centre at Hemel Hempstead General Hospital.

Some of the information used in this report is trust wide data.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

The Urgent Care Centre (UCC) is based at Hemel Hempstead hospital and is open 24 hours a day, seven days a week including Bank Holidays.

The UCC is a nurse-led unit co-located with a 24-hour GP service and provides a service for patients with minor injuries such as sprains, fractures and minor head injuries. The unit has six consultation and treatment rooms and a resuscitation room.

Patients who present to the UCC are streamed at reception to the nurse-led unit or to the GP service.

From July 2015 to June 2016, the UCC had 33,416 attendances. From September 2015 to August 2016, 10,331 attendances were children aged 0 to17, which equates to approximately 30% of all attendances.

Patients who attend the UCC should expect to be assessed and admitted, transferred or discharged within a four-hour period in line with the national target for all accident and emergency and unscheduled care facilities.

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

We conducted an announced inspection on 9 September and unannounced visit on 19 September 2016. During our inspection, we spoke with eight members of staff, four patients and looked at five sets of patient records. We did not inspect the GP service as a part of this inspection as these services were from an external provider commissioned by the local clinical commissioning group and would form part of a separate inspection.

Urgent and emergency services

Summary of findings

Overall, we rated the Urgent Care Centre (UCC) as requires improvement. We rated caring as good and requires improvement for safe, effective and responsive. We rated well-led as inadequate. Overall, we rated the UCC as requires improvement because:

- During the last inspection, we found that there was no clear streaming or triage process in place. This had not improved at this inspection. We escalated this as an urgent concern to the trust, who took a range of actions to address this risk to patient safety.
- There was no process in place in the UCC to monitor and review arrival time to initial assessment. The UCC did not have an effective process in place to ensure that all children under the age of 16 received an initial assessment within 15 minutes in line with The Intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, 2012'.
- There was no clear process in place to ensure that patients who were waiting to see a clinician were assessed as safe to wait.
- There was no clear operational policy or standard operating procedure to support non-clinical staff with streaming decisions.
- There were no clear eligibility criteria to define which patients would be suitable for urgent ambulance transfers.
- The premises did not always meet the needs of patients. The designated children's waiting area was not child-friendly and had no appropriate distraction items for children.
- Staff had not received all required mandatory training. Staff had received no specific training in sepsis management. Not all staff had had the required safeguarding adults training.
- There were no robust measures in place to provide medical support for the unit if the external provider was unable to provide this cover.
- Nurse staffing met patients' needs at the time of the inspection for adult patients, but not for children as there was not always a nurse present in the UCC with the full range of competencies to assess children's needs.
- Whilst the service was generally visibly clean, there was no evidence that regular monthly infection control audits were conducted.
- Learning from incidents was not effectively shared and communicated to all relevant staff to minimise the risk to patient safety.
- Staff were not fully aware of the major incident policy or their actions if a major incident was declared, and had not received specific major incident training.
- During the last inspection in 2015, we found that there was no local clinical audit programme for the UCC. During this inspection, we found this had not improved.
- There was no process in place to monitor and review patient outcomes.
- There was no process in place to monitor and review emergency and ambulance transfers so that opportunities for learning may have been missed.
- The service did not meet the recommendations of the Royal College of Emergency Medicine (RCEM) management of pain in children document (revised 2013).
- The service was not meeting the trust's 90% target for appraisal rates. There were not robust appraisal and clinical supervision systems in place to support staff.
- There were not robust process in place to manage demand and patient flow in the UCC.
- Not all staff were aware of the trust's strategies related to patients with complex needs, such as patients living with dementia.
- There were no clear escalation processes in place to manage the service during periods of high demand or excessive waiting times. This meant that there was a risk that patients could experience delays and staff had no clear guidance on what actions to take to manage an increase in demand.
- Patients who left before being seen was 5%, which was worse than the England average of 3%.
- Whilst local leadership in the UCC was effective, there was inconsistency in leadership and visibility from senior departmental leaders.
- There was no clear strategy for the service. Staff were not always given the opportunity to have their views reflected when changes to the service were being made.

Urgent and emergency services

- There was a lack of effective governance measures in place to support the delivery of good quality care. Risks to patient safety in the service had not been identified.
- Staff did not have access to information about the risks that affected their unit and an overview of the divisional risks.
- There were no effective systems in place to measure quality and consistently identify areas for improvement or best practice.
- There was no clear guidance or standard operating procedure for staff on key areas of service delivery.

However, we also found:

- We observed that staff displayed compassion and treated patients and their relatives with respect and kindness.
- Patients made positive comments about the care they received from staff and their friendly attitudes.
- The UCC was consistently meeting the national target of 95% for four-hour admission to discharge.
- Medicines were stored in line with trust medicines' management policy.
- All staff had the appropriate level of safeguarding training for children in line with national guidance.
- Staff in the UCC worked well with other teams and departments to deliver patient care.
- Staff had a good understanding of consent procedures and 93% of nursing staff had received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
- There was clear information on making complaints and we saw that they were investigated in a timely manner.
- Staff worked autonomously to provide good quality care and there was a good culture of staff supporting each other.
- Staff felt that their local leaders were visible and approachable.

Are urgent and emergency services safe?

Requires improvement

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

- During the last inspection, we found that there was no clear streaming or triage process in place. This had not improved at this inspection. We escalated this as an urgent concern to the trust, who took a range of actions to address this risk to patient safety.
- There was no process in place in the UCC to monitor and review arrival time to initial assessment. The UCC did not have an effective process in place to ensure that all children under the age of 16 received an initial assessment within 15 minutes in line with The Intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, 2012'.
- There was no clear process in place to ensure that patients who were waiting to see a clinician were assessed as safe to wait.
- There was no clear operational policy or standard operating procedure to support non-clinical staff with streaming decisions.
- There were no clear eligibility criteria to define which patients would be suitable for urgent ambulance transfers.
- The premises did not always meet the needs of patients. The designated children's waiting area was not child-friendly and had no appropriate distraction items for children.
- Staff had not received all required mandatory training. Staff had received no specific training in sepsis management. Not all staff had had the required safeguarding adults training.
- There were no robust measures in place to provide medical support for the unit if the external provider was unable to provide this cover.
- Nurse staffing met patients' needs at the time of the inspection for adult patients, but not for children as there was not always a nurse present in the UCC with the full range of competencies to assess children's needs.
- Whilst the service was generally visibly clean, there was no evidence that regular monthly infection control audits were conducted.

- Learning from incidents was not effectively shared and communicated to all relevant staff to minimise the risk to patient safety
- Staff were not fully aware of the major incident policy or their actions if a major incident was declared, and had not received specific major incident training.

However, we also found:

- Staff were aware of their responsibility to record patient safety incidents, both internally and externally.
- Medicines were stored in line with trust medicines' management policy.
- All staff had the appropriate level of safeguarding training for children in line with national guidance.

Incidents

- Staff understood their responsibility to report incidents and raise concerns, both internally and externally using the trust-wide electronic incident reporting system.
- The trust had a comprehensive incident management policy that described the incident grading system and guidance on reporting and escalation. Staff had access to the policy on the trust's internal website.
- Incidents were graded in severity from low or no harm to moderate, severe or death. Near miss incidents were also recorded; these were incidents that had the potential to cause harm but were prevented.
- There had been no never events reported for this service from April 2015 to May 2016. A never event is described as a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- From August 2015 to September 2016, there were no incidents in the Urgent Care Centre (UCC) categorised as serious incidents and reported to the Strategic Executive Information System (STEIS).
- From August 2015 to September 2016, there were 44 incidents recorded for the UCC. The majority of these incidents (20) related to the lack of medical cover in the unit. The UCC operational model was based on having a GP available to the unit 24 hours a day, seven days a week. If a GP was not available from midnight to 7.15am, the unit would be staffed with a registered nurse and non-clinical staff who were unable to safely assess all patients. The issue had been highlighted as a risk on the divisional risk register since October 2015 and we saw that the trust had been liaising with the local clinical commissioning group to resolve the issue; however, there was no clear plan to address the issue at the time of our inspection.
- During our last inspection in 2015, we found that learning from incidents was not always shared across the unscheduled care division and to staff in the UCC. During this inspection, staff told us that they received information about some, but not all incidents through the clinical governance meetings. Minutes from the meetings were kept in staff areas for all staff to access. Therefore, we saw some improvement to shared learning from incidents but there was not a robust system in place for learning from all incidents to be embedded into practice. The service did not have a separate quality and safety performance dashboard, but reported into the divisional dashboard.
- We saw that opportunities for learning from incidents were identified, however, we were not assured that actions put in place to minimise the risk of incidents recurring were always embedded or fully communicated to all relevant staff. For example, nursing staff told us about an incident that occurred within the unscheduled care division in 2014 regarding delayed treatment for a patient on anticoagulant treatment (a type of drug that reduces the body's ability to produce clots) who was bleeding from a head injury. We saw that the trust had developed a flowchart to ensure these patients were treated in line with National Institute of Health and Care Excellence (NICE) guidelines. That included arranging a Computerised Tomography (CT) scan within a specific timeframe. We saw that there was no process in place to alert clinical staff of patients with head injuries and on anticoagulant treatment during the booking in process and reception staff were not aware of the incident or significance of recording this information. This meant that we were not assured that learning from the incident had been effectively actioned or communicated to all staff.
- Staff had minimal understanding of the duty of candour regulation 2014. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of

candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All staff that we spoke to were aware of their responsibility to be open and honest when things went wrong but were not aware that there was a specific process and regulation related to it. Staff were not aware of the trust's duty of candour or 'being open' policy.

Cleanliness, infection control and hygiene

- Safety systems, processes and practices related to infection control were regularly monitored and improvements made when required. We saw that the department was visibly clean and all staff carried out cleaning tasks when required. There were cleaning schedules in place that showed the daily cleaning times. We saw that equipment had 'I am clean' stickers on them that displayed the date the equipment was last cleaned.
- The UCC had a designated infection prevention control nurse (IPCN) lead nurse who conducted infection control audits for the unit. We saw that from June 2015 to August 2016, the UCC average compliance was 89%, which did not meet the trust's target of 95%. We saw that actions implemented to improve compliance included improving staff awareness and training from the IPCN. In April 2016, the UCC had conducted a comprehensive internal IPC audit and overall compliance was 82%. We saw that actions had been taken to remove items of furniture and ensure that staff were made aware of their responsibilities through staff meetings and information on staff notice boards. Staff told us that they were able to contact the IPCN for infection control queries.
- We observed staff using antibacterial hand gel regularly and washing their hands regularly after patient contact. The trust did not provide us with evidence of hand hygiene audits conducted in UCC; staff told us that it was difficult to conduct these audits as they were in enclosed environments and it would be difficult to measure the practice.
- The UCC also conducted monthly 'Test your care' audits which were based on nursing care indicators which included; patient observations, pain management, falls assessment, tissue viability, nutritional assessment, continence assessment, medication administration and infection control and privacy and dignity, the target for each area was 90%. We saw on the trust wide performance dashboard that the UCC achieved 88% overall compliance in May 2016 and during our inspection we saw a display on the wall that stated 97% overall compliance in August 2016.
- 'Arms bare below the elbow' policies were adhered to and staff wore minimal jewellery in line with the trust infection control policy.
- Personal protective equipment such as gloves were used in line with the trust's infection control policy. We saw staff reminding each other to use disposable aprons when carrying out treatments such as changing dressings.
- The UCC had a specific room that could be utilised as an isolation room for patients with suspected infectious diseases.

Environment and equipment

- The premises did not always meet the needs of patients. The waiting area was spacious and we observed that there was adequate seating and no patients were standing whilst waiting to be seen.
- There was a small area partially sectioned off within the waiting area that had some distraction items such as books for children. However, we found that this area was not child-friendly and had no appropriate artwork or distraction items for children of all ages. Staff told us that they had highlighted this to senior staff and some UCC staff had offered to provide appropriate artwork for the area. The Intercollegiate document Standards for Children and Young People in Emergency Care Settings 2012 relate to all urgent and unscheduled care facilities including UCCs and recommend an audio/visual separation for waiting areas for children where possible. We asked the trust for their plans to meet the standards and they told us that it would be considered during their review of the urgent care service in October and November 2016.
- Patients who arrived at reception were signposted to a space behind a line where they could wait to book in. This was some distance from the reception desk and meant that patients' privacy and confidentiality was generally maintained.
- Staff in the reception area sat at an open desk and had access to panic buttons if there was a security alert or threat. Staff told us that on the rare occasion that a patient or visitor to the UCC had displayed aggressive

behaviour they did sometimes feel vulnerable as there was no screen or barrier between them; however, security staff were prompt in their response. We saw that from August 2015 to September 2016, there were three incidents recorded for the UCC which were categorised as 'Inappropriate/Aggressive behaviour towards staff by a patient', on each occasion we saw that security staff had acted promptly; however, this was not highlighted as a risk on the divisional risk register.

- The UCC had a designated resuscitation room. We saw that the room was fully equipped with resuscitation equipment for adults and children. We saw evidence that both the adult and children's equipment was checked on a daily and weekly basis and staff had highlighted equipment and drugs that were nearing expiry date.
- The trust had an on-going equipment replacement programme and had a process in place to identify which items of equipment needed urgent replacement and were classified as 'high risk'. We saw that the trust's clinical engineering department had a schedule in place to replace all high-risk equipment in line with the planned maintenance dates for equipment. All urgent replacements were highlighted to the clinical engineering department through the trust's internal website.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps and bins were not overfilled.

Medicines

- Medicines were stored in line with trust medicines' management policy and we saw that fridge and room temperatures were checked regularly.
- Controlled drugs for children and adults were stored in a locked room with a key code access pad. Staff that accessed this room were then required to access a locked cupboard using a key that was held by a designated Emergency Nurse Practitioners (ENPs). We saw that records for controlled drugs were stored securely and they were accurate and up to date.
- The trust's pharmacy department conducted regular audits in all areas that held controlled drugs to ensure that statutory requirements were being met.
- Nursing staff were aware of the trust's medicines management policy that included administration of controlled drugs and was in line with Nursing and Midwifery Council (NMC) – Standards for Medicine Management. For example, we saw that controlled drugs prescribed for administration had an appropriate countersignature in line with NMC guidance and the trust's policy.
- We looked at five sets of patient records and found that any allergies to medications were clearly documented in patient's notes.
- Nursing staff were not independent prescribers; staff told us there were plans to start training for this in February 2017. Patients who attended the UCC and required medications were given them under PGDs (Patient Group Directions). These directions allowed ENPs to give medicines to patients in certain circumstances, without the need for a prescription. All the PGDs were appropriately authorised and records showed that staff were competent to use them.
- There was a pharmacy on site open Monday to Friday from 9am to 5pm and staff had access to out of hours on call pharmacy support and the main pharmacy at Watford general hospital on weekends from 10am to 4pm. The pharmacist maintained the stock levels at the UCC.

Records

- Records were written and managed in a way that kept people safe, and respected patient's confidentiality. Patient's records were stored on a trust wide electronic system. Staff at all sites used individualised smart cards and personal login details to access the electronic record system. This meant that only authorised personnel could access records and an electronic stamp showed who accessed the patient's record.
- All written assessments were scanned onto the computer system and the originals were stored securely and destroyed on site after a specified period.
- We looked at five sets of patient records and saw that they were clearly written and described the patient's care pathway, observations and discharge summary. We saw that staff had relevant paperwork to complete risk assessments related to pressure sores, venous thrombolytic embolism (VTE) and falls when required.

Safeguarding

- There was a clear system and process in place for identifying and managing patients at risk of abuse in line with the trust's policy for safeguarding adults and

children. Nursing and administrative staff we spoke with explained the process of safeguarding a patient and provided us with specific examples of when they would do this.

- The implementation of safety systems, processes and practices in safeguarding, were regularly monitored and improvements made when required. For example, staff told us about a risk assessment tool for children with head injuries that an Emergency Department (ED) consultant had developed to help establish if the injury was potentially related to physical abuse.
- All nursing and reception staff had received the appropriate level of training for safeguarding children. This included 100% safeguarding level three for children for clinical staff in line with the intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health 2014. The document states 'All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained in safeguarding for children levels one, two and three. Reception staff had all received safeguarding level two training for children.
- At the time of our inspection, 81% of nursing staff had completed safeguarding adults level two and 75% of nursing staff had completed adult safeguarding level one; this did not meet the trust's target of 90%: we saw that further training was planned.
- We saw that staff had access to information on the trust's internal website and on display in the UCC related to identifying suspicious injuries that may be indicative of physical abuse for adults and children.
- We saw in the trust's safeguarding report for 2015, that female genital mutilation was included in safeguarding training at all levels. We also saw that information and flowcharts were available in paper version in all staff areas.
- The UCC had a child protection information sharing system in place that allowed the trust to share and receive information from other authorities responsible for safeguarding children. The system also 'flagged' patients that were at risk or under a child protection plan.
- An external health visitor attended the unit weekly to review children's records and safeguarding referrals.
- Staff told us that they saw the safeguarding lead for the unit regularly and the safeguarding lead provided training. We saw that the details of the safeguarding lead and team were on display in staff areas and staff knew who to contact if they had any safeguarding queries.

Mandatory training

- Mandatory training for staff consisted of a range of topics that included health and safety, information governance, safeguarding children and adults, conflict resolution, equality and diversity and infection prevention and control. Mandatory training courses were delivered online or via face-to-face sessions.
- The trust's target for mandatory training was 90%. At the time of our inspection, nursing and reception staff were not meeting the targets for all mandatory training modules. For example, 75% of nursing staff and 20% of reception staff had completed information governance training. Records showed that 69% of nursing staff had completed infection control training and 63% had completed equality and diversity training and advanced basic life support (ABLS). All staff had completed annual paediatric intermediate life support (PILS) training. We saw that further training was being planned.
- Senior nursing staff at the units held a record of staff completion of mandatory training.

Assessing and responding to patient risk

- During our previous inspection in 2015, we found that there was no clear robust process for streaming patients at reception. Non-clinical staff conducted the streaming role and had not had sufficient training or support to ensure that this was carried out safely. This had not improved at this inspection. At this inspection, the unit was in the process of developing their triage and streaming process based on Royal College of Emergency Medicine (RCEM) guidelines. We escalated this as an urgent concern to the trust, who took a range of actions to address this risk to patient safety.
- Dedicated reception staff booked in all patients that arrived at the UCC and took details of their condition or symptoms. Staff used an electronic booking in system that immediately highlighted 'red flag' symptoms such as chest pains, difficulty breathing and severe bleeding. This was in line with RCEM: triage position statement

(2011) guidance for non-clinical staff. Patients who triggered a 'red flag' were prioritised and seen by an ENP as soon as possible, all other patients were streamed to the GP service or to see the triage nurse.

- During our previous inspection in 2015, we found that reception staff had not received any specific training to stream patients. During this inspection, we found that the situation had not improved. We found there was no clear process or guidance for identifying any other patients without 'red flag symptoms' that may require urgent treatment or assessment. For example, guidance for recognising children with high temperatures or patients who presented with altered levels of consciousness. There was no guidance or training for reception staff on what was appropriate advice to give patients with specific symptoms who were waiting to be assessed by a clinician. This meant that receptionist staff were unable to provide useful advice to patients whilst they were waiting to be seen.
- During our previous inspection in 2015, we found that there was no clear process in place to ensure that patients waiting to see an ENP or triage nurse were safe to wait. During this inspection, we found that the situation had not improved and there was no process in place to ensure that patients waiting to see an ENP, GP or triage nurse (who could wait for up to two hours) were safe to wait. For example, an incident recorded in February 2016 showed that 18 patients were in the UCC waiting to be seen with complaints ranging from chest pains and breathing problems to abdominal pains and febrile convulsions. At the time of the incidents, the average wait to see a decision-making clinician (GP) was three hours and staff described the service as 'unsafe'.
- There was no guidance for reception staff to recognise a deteriorating patient or signs of a more serious condition. The RCEM recommended that 'There should be clear guidance within the operational and governance policies, clearly specifying which patient groups or conditions can be treated in the unit and which patients require transfer to the Emergency Department, or to another specialist unit' and that 'All patients should be assessed in a timely manner. If there are delays in an HP (Healthcare Professional) assessing the patient then some form of initial assessment will be required to detect those at risk of deterioration or potentially serious conditions' (Unscheduled care facilities - Minimum requirements for units which see the less seriously ill or injured, 2009)'. We asked staff for the operational policy for UCC and staff told us that a new one had been distributed the week of our 2016 inspection. We received a copy of the updated policy after our inspection, this clearly stated which groups of patients could be seen and treated in the UCC; it also stated that all patients requiring triage should be seen by the triage nurse within 15 minutes, including children.
- During our inspection in 2015, data provided by the trust showed that 95% of all patients were seen by a clinician in 15 minutes, which was in line with national targets. During this inspection, we found that this standard was no longer monitored or reviewed in the UCC; staff told us that there was no requirement for them to monitor this standard. The trust supplied us with data from April 2016 to July 2016 that showed the average wait to treatment was between one hour and 44 minutes and one hour and 55 minutes against a target of one hour. We asked senior staff about how time to initial clinical assessment was monitored to ensure that patients were safe to wait. We were told that it was reasonable to expect 90% of patients in a UCC environment to be seen by a decision-making clinician (ENP or GP) within one hour; however, there was no effective process in place to support or measure this standard. After our inspection, we received a copy of the UCC operational policy that was updated September 2016. The updated policy included quality indicators related to access and flow, infection control and patient feedback that would be used to monitor the quality of care at the UCC.
- The Intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, 2012' includes guidelines for UCCs and recommends that all children should have an initial clinical assessment within 15 minutes and all children attending emergency care settings are visually assessed by a registered practitioner immediately upon arrival, to identify an unresponsive or critically ill/injured child. There was no clear process in place to ensure this happened. Staff told us that the triage nurse should see all children under the age of 16; however, this did not always happen due to capacity and staffing levels.
- We raised our concerns with the trust during and after our announced and unannounced inspection and the trust immediately put in some actions to mitigate potential risks to patient safety. This included the immediate introduction of an hourly check by an ENP of all patients waiting to be seen to ensure that they were

safe to wait, basic life support (BLS) training for all reception staff and a plan to implement a more robust ' red flags' system in line with RCEM guidance by the middle of October 2016. The trust told us that they also planned to monitor and review time to initial clinical assessment against a standard of 90% of patients assessed by a clinician within one hour.

- Staff told us that arranging ambulance transfers was sometimes problematic as there was no local agreement with the ambulance trust which defined response times and eligibility criteria. Staff told us that the ambulance service considered the UCC as a place of safety for patients, which meant that they would not attend as quickly as for a patient in a public place. UCCs were not deemed a place of safety in specific situations, such as, if they did not have full paediatric facilities and had a sick child that required a higher acuity level of care. Staff told us that if it was urgent to transfer patients they would dial 999.
- Nursing staff were aware of the trust's flowchart relating to sepsis management and the need for timeliness in administration of treatment; however, staff had received no specific training in sepsis management and told us that their actions would be to arrange an immediate ambulance transfer to Watford general hospital. The trust had an action plan to complete the training by January 2017, this would include sepsis screening, sepsis six care pathway (sepsis six is a nationally recognised six step process to screen and treat sepsis within a specified timeframe) and treating neutropenic sepsis.
- The UCC used the National Early Warning System (NEWS) and Paediatric Early Warning System (PEWS) in line with the National Institute for Health and Care Excellence (NICE) guidelines (CG50, 'Acute, illness recognising and responding to the deteriorating patient'). This colour-coded system was used by staff to record routine physiological observations such as blood pressure, temperature and heart rate with clear procedures for escalation if a patient's condition deteriorated. Nursing staff that we spoke to were able to describe the process and explained how they would use the escalation process to manage a deteriorating patient. Records seen demonstrated effective completion of NEWS and PEWS by staff.

Nursing staffing

- Nurse staffing met patients' needs at the time of the inspection for adult patients, but not for children as there was not always a nurse present in the UCC with the full range of competencies to assess children's needs.
- There was no baseline acuity tool for staffing used in the UCC. Nursing staffing in UCC comprised of ENPs, registered nurses (RN) and healthcare assistants (HCA). Rotas were arranged to have four ENPs on staggered shifts on duty from 7.15am to midnight, supported by two band 5 registered nurses and two HCAs. From midnight to 7.15am, a band 5 nurse (who was supported by the GP) staffed the unit.
- During our inspection, we found that the UCC was staffed according to plan and the trust provided data that showed that rotas matched planned staffing from April 2015 to May 2016. However, staff told us that at times they felt that there were not enough staff on duty to ensure patients were seen in a timely manner. We saw that nursing staffing had been highlighted as a potential risk to patient care on the divisional risk register since August 2014 and there had been actions taken to mitigate the risk such as developing a pool of bank staff from other sites within the trust and on-going recruitment. We asked the trust for evidence that the workforce establishment for UCC was planned according to historical demand and increased activity but we did not receive a recent workforce review. The trust told us that the establishment would be considered as part of their urgent care review in October and November 2016.
- The unit did not have direct access to a registered children's nurse on site. Royal College of Nursing (RCN) guidelines (Defining staffing levels for children and young people's services, RCN, 2013) recommend that all children presenting at an UCC should ideally be assessed by a registered children's nurse. If this is not possible children should be assessed by a registered nurse with specific competencies which were: paediatric intermediate life support (PILS), safeguarding children level three training, effective communication with children and parents, pain management and recognition of the sick child. We were provided with evidence that all nursing staff had completed PILS and safeguarding level three; however, the trust was unable to demonstrate that staff had competencies in the other areas. Staff told us that they had completed various sessions with consultants in regards to paediatric

competencies; however, there were no formal records of this. This meant there was a risk that children were assessed by staff that did not possess the required competencies. During our inspection, we asked senior staff how they were assured that nursing staff had the relevant paediatric competencies and they agreed they were unable to evidence this and would consider ways to evidence this in the future. This had not been recognised as a potential risk. Staff said that they had received some consultant-led training sessions in regards to care and treatment for children, but the trust could not confirm that these sessions met the key competency training which is set out in the national recommendations.

- The nursing vacancy rate in May 2016 was 14%. The UCC used bank staff to fill vacant shifts and no agency staff were used. Bank staff were provided through a dedicated specialist service and staff told us that induction was conducted for all bank staff by the specialist service and assurances of competencies provided to the trust. Bank staff were then given a local induction when they arrived at the UCC, staff were able to tell us what this would entail including orientation to the unit and supervision, however, they were unable to show us where this information was recorded.
- Staff told us that bank staff could cover long-term sickness; however, there were no arrangements to cover short notice sickness. Staff told us that most of the time this was not problematic and they managed the workload between them. We saw that staff recorded these incidents on the electronic incident reporting system.
- During our inspection, we found that there was an appropriate skill mix of nursing staff on duty.

Medical staffing

- The trust had an arrangement with an external provider, which was to provide on-site GP support to the UCC 24 hours a day. We saw that there were no robust measures in place to provide medical support for the unit if the external provider was unable to provide this cover. This was highlighted as a risk on the unscheduled care divisional risk register and there were no clear plans to mitigate the risk. We saw that from September 2015 to August 2016, there were 20 incidents recorded for the UCC that related to lack of medical staff support.
- We saw that out of the 20 incidents recorded, six had actions where appropriate cover was sought and actions put in place at the UCC to re-direct patients to appropriate facilities such as out of hours GP and Watford general hospital. On one occasion, the UCC was closed from midnight to 7.15am as it was deemed as unsafe as there was no ENP or GP available.

Major incident awareness and training

- Whilst the trust had systems and processes in place for dealing with major incidents, not all staff were fully aware of these plans.
- During our last inspection, we found that the trust had a comprehensive major incident policy that UCC was included; however, staff were not aware of it and had not received training. During this inspection, we found this had not improved.
- The trust had a comprehensive major incident policy which included the UCC, however, staff were not familiar with the policy or their role should a major incident occur in any part of the trust.
- Nursing and reception staff that we spoke with told us they had not received major incident training. However, the trust provided us with data that showed that as of September 2016, 92% of staff had received major incident training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Overall, we rated the Urgent Care Centre (UCC) as requiring improvement for effectiveness, because:

- During the last inspection in 2015, we found that there was no local clinical audit programme for the UCC. During this inspection, we found this had not improved.
- There was no process in place to monitor and review patient outcomes.
- There was no process in place to monitor and review emergency and ambulance transfers so that opportunities for learning may have been missed.
- The service did not meet the recommendations of the Royal College of Emergency Medicine (RCEM) management of pain in children document (revised 2013).

- The service was not meeting the trust's 90% target for appraisal rates. There were not robust appraisal and clinical supervision systems in place to support staff.

However, we also found:

- Staff in the UCC worked well with other teams and departments to deliver patient care.
- Staff had a good understanding of consent procedures and 93% of nursing staff had received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

Evidence-based care and treatment

- During the last inspection in 2015, we found that there was no local clinical audit programme for the UCC or process to monitor and review compliance to evidence based guidelines. During our recent inspection, we found this had not improved. However, the trust supplied us with their updated UCC policy which stated that the service would conduct regular audits of protocols and processes as part of their clinical review process.
- We saw evidence based guidance on display in treatment rooms this included National Institute for Health and Care Excellence (NICE). For example, we saw a clinical assessment tool for febrile children based on NICE guidelines and initial management of acute coronary syndrome (ACS).
- The UCC had a system in place to identify 'red flag' symptoms based on Royal College of Emergency Medicine (RCEM) guidelines, 2011.
- The UCC met most of the minimum requirements in accordance with those set out by the RCEM document 'Unscheduled care facilities', 2009. This included staffing levels met the minimum guidance and that staff had access to resuscitation equipment and diagnostic tests.
- Staff had an awareness of the Mental Health Act (MHA), 1983 and regard to the MHA code of practice. Staff told us that it was rare for them to see a patient who had been sectioned under the MHA.

Pain relief

- Generally, staff assessed and managed patients' pain needs effectively.
- Nursing staff administered pain relief as and when required using patient group directives (PGDs).
- The ENP or triage nurse assessed patient's pain at the initial assessment. We looked at five sets of patient records and saw that administration of pain relief was clearly recorded and all patients were offered analgesia.
- There were signs in the waiting area advising patients to alert staff if they were in pain whilst they were waiting.
- In the Care Quality Commission 2014 A&E survey, the unscheduled care division scored 7 out of 10 in the question 'How many minutes after you requested pain relief medication did it take before you got it?', which was better than other trusts.
- RCEM management of Pain in Children (revised July 2013) recommends that all children should be offered pain relief within 20 minutes of arrival and those in severe pain be reassessed every hour, also that an annual audit is conducted. We saw that there was no formal process in place to meet these recommendations.

Nutrition and hydration

- Staff told us that patients were generally not in the UCC long enough to require monitoring for nutrition and hydration needs; however, if it were required they would use a specific Malnutrition Universal Screening Tool (MUST) assessment.
- Staff knew how to recognise signs of malnutrition and dehydration.

Patient outcomes

- There was no formal process in place to monitor patient outcomes in the UCC. There was no formal process in place to monitor patient outcomes in the UCC. Staff did not routinely attend any audit meetings. Staff in the unit did not routinely monitor information about the quality and outcomes of patient care. Some staff felt that it would be useful to be more involved in audits and local benchmarking exercises to share best practice and learn new techniques and skills
- Staff were not involved in the national audits that were being conducted in the unscheduled care division.
- Staff told us that they were given some information about the unplanned re-attendance rate for the whole unscheduled care division which was 9% at the time of our inspection and higher than the England average of 7%; however they were not informed of information specific to the UCC. We asked the trust for data specific to the UCC and found that from April 2016 to July 2016, unplanned re-attendance rate at the UCC was higher

than the England average at 8.5%. Staff told us unplanned re-attendances at the UCC was mainly due to patients returning the next day for an x-ray or change of dressings.
- There was no process in place to monitor and review emergency and ambulance transfers, staff told us that it would be useful to understand the complete patient's journey and have the opportunity to identify areas for improvement and best practice.

Competent staff

- Whilst staff generally had the competencies for their role in the UCC, there were not robust appraisal and clinical supervision systems in place to support them. From April 2015 to March 2016, 75% of nursing staff received an appraisal. This was below the trust's target of 90%. At the time of recent inspection, the UCC was on track to meet the target for 2016/17.
- Staff told us that there was no formal process for clinical supervision; however, they received clinical update sessions from consultants at governance meetings. For example, staff told us that they had received a specific session relating to traumatic and non-traumatic back pain and recognising the underlying causes.
- Staff told us that there were some opportunities for one-to-one meetings. A more experienced member of staff was given a limited amount of time per week to assist with appraisals and supervision; however, staff told us that sometimes this was not possible due to clinical duties and the demands of the service.
- Staff were aware of the revalidation process for nursing staff which was introduced in April 2016.
- Staff told us that they were not set any performance goals or targets and variable performance was generally identified through the staff in the unit supporting each other. Staff told us if a member of the team needed help with any aspect of training they would receive peer support and if necessary request additional training through their line manager.
- Staff told us that they could access study days to gain knowledge in specific areas.

Multidisciplinary working

- During our last inspection in 2015, we found that there was limited multidisciplinary working in the unscheduled care division. During this inspection, we found that this had improved. Staff told us that they attended clinical governance meetings on a regular basis that were attended by colleagues from the minor injuries unit (MIU) and Emergency Department (ED).
- Staff told us that they would be rotating though the different departments in the unscheduled care division to encourage multidisciplinary working.
- The UCC was co-located with an external provider and we observed good interactions and working relationships in the teams. We spoke with a member of staff from the external provider, they told us that they worked well with the UCC and there was good communication with all staff at a local level.
- We saw that staff worked well with other teams such as the radiography department that was based at their site.

Seven-day services

- The UCC was open 24 hours a day, seven days a week.
- X-ray facilities were available on site seven days a week from 9am to 10pm. Outside of these hours, if patients required an x-ray, they would be sent to Watford general hospital for treatment, by ambulance if necessary or asked to return to the UCC the next day. Staff also had access to ultrasound and computerised tomography (CT) scanning at Hemel Hempstead hospital on Monday to Friday from 9am to 5pm and out of hours at Watford general hospital.

Access to information

- Information needed to deliver effective care and treatment was available to staff in a timely and accessible way.
- All staff had access to the trust's internal website for information on policies and guidance. Staff used smart cards to access the trust's IT system that also allowed them access to radiology reports.
- Patient's records were stored on an electronic system that was accessible to all staff responsible for the patient's care at UCC; this meant that staff had instant access to test results and previous patient's records.
- Discharge information was sent electronically to patients' GPs at the time of their discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Urgent and emergency services

- Staff that we spoke to were able to describe the relevant consent and decision-making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in place to protect patients.
- Patients' consent was obtained as per trust procedures, staff told us that although they were aware of DoLS, they had not encountered instances where it was necessary to make an application in the UCC environment. Records seen demonstrated consideration of consent and capacity in accordance with trust policy.
- Nursing and reception staff were aware of the Fraser guidelines and Gillick competence in regards to children giving consent to treatment.
- We saw that 93% of nursing staff had received MCA and DoLS training. This was above the trust target of 90%.

Are urgent and emergency services caring?

Good

Overall, we rated the Urgent Care Centre at Hemel Hempstead hospital as good for caring because:

- Staff displayed compassion and treated patients and their relatives with respect and kindness.
- Patients made positive comments about the care they received from staff and their friendly attitudes.
- Patients were kept informed of waiting times.
- Patients spoke positively about the care they had received.
- Patients were offered support to manage their treatment and conditions.
- The friends and family test results were consistently above the England average.

Compassionate care

- We observed that patients were treated with dignity, kindness, respect and compassion.
- All staff took the time to interact with patients using the service and their relatives.
- We saw dignity and privacy was respected and staff knocking on closed treatment doors before entering.
- Patients that we spoke with made positive comments about the caring and respectful nature of staff and told us that staff had introduced themselves.
- We saw that nursing and reception staff responded to distressed patients in a timely manner and offered comforting words and gestures.
- The NHS Friends and Family Test was recorded for the whole unscheduled care division and was not specific to each of the three locations. From March 2016 to June 2017, an average of 90% of patients that took part in the survey said they would recommend the service to friends and family; this was higher than the England average of 85%. The figure was based on an average response rate of 4%, which was lower than the England average of 13%.

Understanding and involvement of patients and those close to them

- We saw that staff treated patients with care and compassion, taking into account the communication needs of individual patients and modified the pace and tone of their speech to calm and reassure patients.
- We saw that staff encouraged patients and their relatives to take information away with them about self-care advice and support groups in the local area.
- Patients were advised of the average waiting time when they booked in and a board was displayed at reception and manually updated by staff.
- Nursing and reception staff recognised when patients and those close to them needed support to help them understand their care and treatment, this included access to translation services and interpreters or relevant support groups.
- Relatives felt welcome and were able to sit with their family member. They were kept informed if the patient consented.

Emotional support

- Staff that we spoke to were aware of the impact that a person's treatment, care or condition could affect them both emotionally and socially.
- We saw that patients who needed extra time for their treatment due to communication needs were supported by staff.
- Staff signposted patients to relevant external organisations for support when required.

Are urgent and emergency services responsive to people's needs?

Urgent and emergency services

(for example, to feedback?)

Requires improvement

Overall, we rated the Urgent Care Centre at Hemel Hempstead hospital as requiring improvement for responsive, because:

- There were not robust process in place to manage demand and patient flow in the UCC.
- Not all staff were aware of the trust's strategies related to patients with complex needs, such as patients living with a dementia.
- There were no clear escalation processes in place to manage the service during periods of high demand or excessive waiting times. This meant that there was a risk that patients could experience delays and staff had no clear guidance on what actions to take to manage an increase in demand.
- There were not robust process in place to manage demand and patient flow in the UCC.
- Patients who left before being seen was 5%, which was worse than the England average of 3%.
- There were unplanned closures of the unit due to the lack of consistent medical cover; this meant that patients sometimes attended and found that the unit was closed.

However, we also found:

- The UCC was consistently meeting the national target of 95% for four-hour admission to discharge.
- The trust was working with local commissioners and other healthcare providers to plan service delivery.
- The UCC was accessible for patients with mobility limitations.
- Staff adjusted their practice and communication styles to meet the needs of individuals.
- The service had access to a virtual fracture clinic to enable patients to receive x-ray results on the same day.
- There was clear information on making complaints and we saw that complaints were investigated in a timely manner.
- The UCC had information leaflets available in a variety of languages and access to translation services.

Service planning and delivery to meet the needs of local people

- Service delivery for the UCC was planned with local commissioners, GPs, other local NHS trusts and other community healthcare services.
- The trust published their 'Your Care, Your Future' report on their public website in July 2015. The report described how local health and social care services planned to work together to deliver a more integrated care service which incorporated the needs of the local population. A section of the report related to the provision of urgent care services at Hemel Hempstead general hospital and the options for future models of care, which included exploring the development of the urgent care centre. The report included views and comments from local residents.
- We saw that the planning took account of key demographics and lifestyles of the local population, including areas such as tackling obesity and substance misuse.
- The UCC had a deep vein thrombosis (DVT) clinic that was available Monday to Friday 9am to 5pm (in line with the pathology services at Hemel Hempstead) for patients with a suspected DVT. Outside of these hours, patients were transferred to Watford general hospital for treatment. Patients were also referred to this service by their own GP. An appropriately trained nurse would conduct a blood test and start the treatment if required. During our inspection, this service was unavailable due to staff shortages.
- The delivery of care at the UCC was based on an operational model which required GP medical cover to be provided 24 hours a day. From August 2015 to September 2016, there were 20 incidents reported relating to lack of sufficient medical cover. This had resulted in a number of occasions where the unit was deemed as potentially unsafe and had unplanned closures overnight.
- We saw in the UCC operational policy that ENPs could also refer patients to other services such as ophthalmology services and ear, nose and throat (ENT) services both internally and externally.

Meeting people's individual needs

- Services were not always delivered in a way that took into account the needs of different people, in relation to age, gender, religion, and disabilities.
- Not all staff were aware of the trust's specific strategies to meet the care needs of people in different groups such as learning disabilities and dementia.

- There were no specific facilities in the UCC for people living with a dementia. There was no specific pathway for patients with learning disabilities or those living with dementia; however, staff told us they had received specific training related to caring for patients living with dementia from the trust's dementia lead. Nursing and reception staff told us that patients with learning disabilities and those living with dementia were prioritised to see an ENP or GP.
- There was adequate seating and space in the waiting areas and we saw that patients waiting to be seen by a clinician did not have to stand. Patients who were waiting to book in with the reception staff did stand whilst waiting. Staff told us that they had made suggestions to introduce a system to allow patients to give their names when they arrived so that patients less able to stand could be seated and then called in order of arrival. This system had not been introduced at the time of our inspection.
- The unit was accessible for wheelchair users and we saw that there was designated disabled parking bays on site.
- There were clear signposts at the front of the hospital and throughout directing patients to the unit and volunteers to assist people.
- Staff at the UCC generally worked autonomously and we observed that staff adapted their practice and communication styles to meet the needs of individuals who attended.
- The UCC had access to translation services via the telephone for patients where English was not their first language.
- We saw a number of information leaflets for patients about services available at the UCC and within the community. There was also information about illnesses and self-treatment advice. Most of the leaflets on display were in English; however, we saw that staff had the facility to print information in different languages when required.
- Patients had access to hot and cold drinks and snacks from vending machines within the UCC waiting area.
- There was a chapel at the hospital site which was open 24 hours a day seven days a week for patients of all faiths. There was also a chaplaincy service available at specific times and when requested by patients and staff.

Access and flow

- The Department of Health target for UCCs is to admit, transfer or discharge 95% of patients within four hours of arrival. From March 2016 to August 2016, we saw that the UCC consistently exceeded this target and the average was 98%.
- There were not robust process in place to manage demand and patient flow in the UCC.
- Staff told us that they were not measured against any other targets or kept informed of performance in any other areas. At this inspection, there were limited systems and processes utilised to measure and monitor any other areas of access and flow in the UCC; this meant that we were not assured that patients had timely access to initial assessment and treatment. There was no formal process in place to measure arrival time to initial assessment to ensure that patients were being seen in a timely manner.
- There were no clear escalation processes in place to manage the service during periods of high demand or excessive waiting times. This meant that there was a risk that patients could experience delays and staff had no clear guidance on what actions to take to manage an increase in demand.
- We highlighted our concerns to the trust and we were supplied with data that showed from April 2016 to July 2016, the average time to assessment and treatment was one hour and 45 minutes.
- In the same period, the percentage of patients who left before being seen was 5% which was in line with the trust's target but worse than the England average of 3%.
- After our inspection, the trust supplied us with the operational policy for UCC that was updated in September 2016; it included a section related to monitoring and reviewing specific quality indicators in regards to time to clinical assessment and described triggers for escalating capacity issues to senior staff during periods of high demand. The triggers for escalation included waiting times exceeding two hours, more than 15 patients in the department and staff shortages affecting service delivery. The trust told us that they would monitor and review this process on a regular basis.

Learning from complaints and concerns

- There was clear guidance on display in the UCC for those using the service to make a complaint or express their concerns. Reception and nursing staff knew what steps to take should a patient or relative ask them how to make a complaint.
- There were leaflets and posters in the waiting area with contact details for the trust's Patient Advisory Liaison Service (PALS) for patients and relatives to raise concerns or make a complaint.
- From July 2015 to June 2016, there were 12 complaints recorded for the UCC. We saw that complaints were investigated in a timely way and opportunities for learning identified. For example, we saw staff had received reflective practice training in regards to complaints about staff attitude or miscommunications.

Are urgent and emergency services well-led?

Inadequate

Overall, we rated the Urgent Care Centre (UCC) as inadequate for well-led, because:

- There was inconsistency in leadership and visibility from senior departmental leaders.
- There was a lack of actions taken to make improvements in key areas highlighted during our previous inspection in 2015 and a failure to meet the conditions of the associated requirement notices.
- There was no clear strategy for the service. Staff were not always given the opportunity to have their views reflected when changes to the service were being made.
- There was a lack of effective governance measures in place to support the delivery of good quality care. Risks to patient safety in the service had not been identified.
- Staff did not have access to information about the risks that affected their unit and an overview of the divisional risks.
- There were no effective systems in place to measure quality and consistently identify areas for improvement or best practice.
- There was no clear guidance or standard operating procedure for staff on key areas of service delivery.
- During the last inspection, we found there were no effective systems in place to measure quality and consistently identify areas for improvement or best practice. This had not improved during this inspection.

However, we also found:

- Staff worked autonomously to provide good quality care and there was a good culture of staff supporting each other.
- Staff felt that their local leaders were visible and approachable.

Leadership of service

- There was inconsistency in leadership and visibility from senior departmental leaders.
- The UCC was a part of the unscheduled care division that also included the emergency department (ED) at the Watford general hospital and the minor injuries unit (MIU) at St Albans Hospital. The overall management of the division included a divisional director, divisional general manager and divisional lead nurse.
- The local management of the UCC and the MIU was the responsibility of the ED matron and a designated senior consultant who was the clinical lead. Both were based at the ED at the Watford site, and generally managed the services remotely. Staff told us that the matron and clinical lead visited the UCC regularly. They also told us that the implementation of the regular clinical governance meetings had given them the opportunity to meet other senior managers within the division.
- The matron had identified specific experienced members of the nursing staff at the UCC to act as lead nurses on a daily basis and to assist with some managerial duties on a daily basis. Staff who acted as lead nurses were allowed a set amount of hours each week to perform these duties such as assisting with appraisals, mandatory training compliance and compiling rotas. Staff told us that this was not protected time and no cover was provided to allow them to perform these duties, which meant that at times they were caring for and treating patients in that allocated time. Staff explained that they fully understood that clinical duties were always a priority when patients were waiting for treatment.

- Staff told us that they felt that the UCC lacked the resource capacity to provide strong effective leadership on site. However, they felt that their local leaders provided the best support they could with the challenges of managing services at three separate sites.

Vision and strategy for this service

- Staff we spoke with were aware of the trust's vision, which was to provide 'The very best care for every patient every day'.
- There was no formal strategy for the UCC; however, we saw that staff at UCC had developed their own local strategy that highlighted the areas that they felt needed strengthening. This included increasing staffing levels and ensuring that staff and the UCC were more integrated with the unscheduled care division and the wider trust.
- The strategy for the urgent care service was being developed at the time of our inspection as a part of the longer-term trust wide plans. We saw that there was an ongoing dialogue between all stakeholders regarding how urgent care provision would be delivered for the future.
- The trust had been open about sharing updates on the various options that were being considered on their public website.

Governance, risk management and quality measurement

- There was a lack of effective governance systems to support the delivery of good quality care. Concerns identified at the last inspection had not been addressed. Actions had not been taken to address the requirement notices we issued following the last inspection.
- There was no formal process in place to monitor and review all aspects of performance to identify areas of good practice and areas for improvement.
- There was a lack of understanding of the risks that could impact on the delivery of good quality care and the delivery of the trust's strategy. Risk that we found on inspection had not been identified by the service. For example, the lack of paediatric competent nurses on duty at all times, and the lack of effective monitoring of the time to initial clinical assessments.
- There had been a lack of actions taken and improvements made in key areas which were highlighted in our previous inspection in 2015.
- During our last inspection in 2015, we issued the trust with a requirement notice relating to Regulation 12 (Safe care and treatment) of the Health and Social Care Act (HSCA), 2008. This was because we were not assured that there was a robust process in place to ensure that patients were seen in a timely manner, this had not improved at our recent inspection.
- We also issued the trust with a requirement notice in 2015 in regards to Regulation 17 (Good governance) HSCA, 2008 as we found that there were no arrangements for auditing and monitoring performance standards or compliance to protocols, this had not improved at our recent inspection. There was no clear guidance or standard operating procedure for staff on key areas of service delivery such as eligibility criteria for ambulance transfers and a flowchart to support reception staff in making streaming decisions.
- During our last inspection in 2015, we found that governance and risk management systems were not effective and not understood by all staff and staff were not included in clinical governance meetings. During this inspection, we found some areas of improvement and staff were now attending regular governance meetings; however; there was still a lack of effective governance to support the delivery of a strategy and good quality care.
- There was no clear guidance or standard operating procedure for staff on key areas of service delivery such as eligibility criteria for ambulance transfers and a flowchart to support reception staff in making streaming decisions.
- There was no systematic programme of internal and clinical audits in place to monitor and review all aspects of performance to identify areas of good practice and areas for improvement.
- Staff told us that the UCC did not have a local risk register. The unscheduled care division had a centralised risk register that contained 49 risks mainly relating to other areas of the division. Senior nursing staff were aware of the two risks on the register specific to the UCC which were in regards to lack of consistent GP cover and nursing staffing levels. Staff were not aware of some of the other risks which were on the divisional risk register which were also relevant to UCC; however, we did see that staff were included in actions that were related to some of the risks identified in the divisional risk register. For example, some staff told us

that they had recently attended training related to recognition of a deteriorating patient and escalation processes, which was in line with one of the risks on the divisional risk register.
- During our last inspection in 2015, we found that staff understood the importance of quality measurements; however, there was no clear process to audit or record specific areas of performance and compliance to protocol. During this inspection, we found this had not improved. After our inspection, the trust provided us with an operational policy for the UCC that described the areas for future performance management.
- During this inspection, we found some areas of improvement and staff were now attending regular governance meetings; however; there was still a lack of effective governance to support the delivery of a strategy and good quality care.

Culture within the service

- Staff in the UCC were proud of the work they did and they respected and valued each other and the work of their colleagues in the other areas of the trust.
- Staff told us that they felt that there was more collaborative working with the other teams in the unscheduled care division since our inspection in 2015. This had improved through the establishment of regular clinical governance meetings.
- Staff were open and honest about patient safety incidents and told us that the culture towards learning from incidents had improved since our inspection in 2015.
- Staff told us that they felt that they could voice any concerns they had to the ED matron or clinical lead; however, they felt that sometimes these concerns were not acted on in a timely manner or given sufficient priority. For example, staff told us that they recorded incidents relating to lack of medical support; however, they felt that there was a lack of actions to mitigate the risk. Staff also told us that they had asked for the children's waiting area to be made more child-friendly and had offered to supply materials to complete artworks; however, this had not been acted upon or considered.

Public engagement

- There were questionnaires in the waiting and reception area of the unit asking patients to provide feedback about their experience at the UCC. Reception staff actively encouraged patients and relatives to give feedback about their experience.
- Patients, carers and relatives were able to leave feedback using the trust's public website.
- We saw that the trust had held joint public events with other healthcare providers and commissioners to engage with the local population about the future of services at the UCC through their 'Your Care, Your Future' plans.

Staff engagement

- Staff were invited to complete the trust's annual staff survey. Staff told us that the clinical governance meetings were an improvement; however, there were still limited opportunities for their views to be reflected in service planning and delivery. Staff felt that this was for a number of factors that included their location and workforce capacity.
- The options detailed in the trust's 'Your Care, Your Future' had not been fully communicated to staff in the UCC; this meant that they were unsure what the implications of future changes might mean to them.
- Staff told us that they were often informed of changes to areas of their work without them having the opportunity to offer their views. For example, we were told that the UCC's recent operational policy had been developed and they knew about it when it was sent to them during our recent inspection. Staff had not been given the opportunity to contribute or make suggestions.

Innovation, improvement and sustainability

- The trust was in the process of developing options for the future models of care for urgent and emergency care services for the population they served. This was in conjunction with other NHS trusts, commissioners, local residents and GPs. We saw that the impact on quality and sustainability had been considered in key areas such as workforce, financial viability and needs of the local population.

Medical care (including older people's care)

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

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

Simpson ward provides specialist inpatient stroke rehabilitation for adults. The ward also provides care for patients discharged from Watford General Hospital who are medically fit for discharge, awaiting care packages or nursing home placements.

We visited Simpson Ward at Hemel Hempstead Hospital on 6 and 9 September, returning for an unannounced inspection on the 19 September 2016.

We spoke with 11 members of staff including nurses, doctors, therapists, volunteers and housekeepers. We spoke with 16 patients and observed interactions between patients and staff, considered the environment and looked at care records of 18 patients.

Summary of findings

Overall, we rated the service as inadequate because:

- There were not appropriate systems in place to identify and monitor risk, and learning from incidents was not shared across multidisciplinary teams. There were not always policies or procedures in place to support staff.
- Staffing levels did not meet patient need and acuity at all times of day at the time of inspection.
- Non-clinical staff were used to provide one to one care for patients requiring supervision.
- Appropriate Deprivation of Liberty Safeguards authorisations were not in place for patients on the ward, and staff did not always understand the impact of this.
- Patients received weekly consultant reviews; however, these were not conducted in conjunction with medical staff caring for patients on a daily basis. Outside normal working hours, nursing staff were dependent on the on-call team at Watford General Hospital for advice, or transferred acutely unwell patients to the emergency department by a 999 call.
- Visiting staff did not always discuss patients in a respectful way and this went unchallenged by ward staff.
- There were concerns expressed by patients and family members regarding staff attitude and care. Staff did not always communicate and involve family members in the progress of discharges.

Medical care (including older people's care)

- There were no activities to engage patients, including those with complex needs and living with dementia. We did not observe staff engaging patients living with dementia who appeared anxious or distressed.
- Patients were not always positioned well or comfortably during meal times.
- There were no formal admission criteria to the ward, which meant that staff could not be assured that appropriate patients were being placed under their care.
- The ward lacked identity and all staff gave different descriptions of the service provided. There was no clear vision, identity or strategy in place for the ward, resulting in the ward admitted patients from a variety of specialities and with complex conditions.
- Patients were admitted to the ward that were deemed unsuitable and staff felt unable to provide the holistic care they required for their complex needs.
- There were significant problems with flow out of the ward, due to a lack of ownership of the discharge process.
- Therapy staff would not be able to provide sufficient care if the ward was at full capacity with stroke rehabilitation patients.
- Senior staff were not aware of the significant risks to patient safety that we found and raised during our inspection.
- Staff were concerned about the future of the ward and this impacted morale and culture.
- Staff did not feel engaged in developments and changes relating to the future of the ward.
- Staff felt there was a significant disconnect between the ward and the rest of their trust, which was affecting the care they could provide.

However, we also found that:

- Evidence based care was provided to patients on the ward, reflective of national guidance.
- Patient nursing risk assessments and observation records were thoroughly completed for all patients. Medical and nursing records were easily accessible and up to date.
- Infection control procedures were in line with trust policy and audits showed good compliant rates for hand hygiene.
- Mental capacity assessments were carried out appropriately and this was documented clearly in patient records. Staff understood safeguarding vulnerable adults and how to report any concerns. Safeguarding training rates met the trust target.
- Multidisciplinary working was a strength of the department and allowed patients to receive holistic care.
- Effective induction and orientation processes were in place for new staff and agency/bank staff. Staff felt that whilst there was uncertainty about the ward, all staff tried to maintain the 'family' feel of the ward and work together as a team.
- Data collected through patient satisfaction audits was generally positive and regularly shared with the team. Patients generally were positive about the care they received whilst on the ward and dignity being maintained during interactions with patients.
- Most patients and those close to them felt involved with decision making and making choices about their care, and felt supported.
- Dietary requirements could be met for all patients, including gluten free, halal and vegetarian. Translation services were available and met the needs of patients on the ward.
- Staff were aware of the trust's values and could relate them to the care they provided.
- Staff felt well supported by the ward sister and spoke highly of them.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Overall, we rated the service as inadequate for safety because:

- Medicine storage and administration was not always safe and in line with trust policy or national guidance.
- Nurse staffing levels did not meet patient need and acuity at all times of day at the time of inspection.
- Staff used for one to one supervision of patients with complex needs did not have the skills or competencies to do so.
- Whilst the service had systems in place to assess and respond to patient risk, these were not followed consistently which meant that risks to patients were not managed effectively.
- The maintenance and use of facilities did not always keep people safe.
- Patients' individual care records were not always written and managed in a way that kept people safe. Records seen were not always complete.
- Not all staff were up to date with all mandatory training topics.
- Infection control audit performance had deteriorated and not all staff had received infection control training.
- Lessons learned from incidents were not shared across multidisciplinary teams.
- Incidents relating to short staffing that impacted on patient care were not always reported.
- There was no system in place to track patients transferred to the acute trust.
- Ward rounds were completed independently by the consultant and not in conjunction with the junior doctor responsible for the daily care of the patients.

However, we also found that:

- Falls, nutrition and pressure ulcer risk assessments were completed for all patients in line with trust policy.
- Staff understood safeguarding vulnerable adults and how to report any concerns. Safeguarding training rates met the trust target.
- Patients received weekly reviews by the consultant, with daily junior doctor reviews.
- National Early Warning Scores were used effectively to recognise deteriorating patients.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and how to report them but did not always do so in all cases. When things did go wrong, thorough and robust reviews were not always carried out. The service was not clearly focused on learning lessons to make sure action was taken to improve safety.
- There had been no never events reported from August 2015 to August 2016 within Simpson Ward. Never events are described as wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There were three serious incidents between August 2015 and August 2016. We reviewed reports relating to these and saw that appropriate actions had been put in place to avoid such incidents reoccurring in future.
- Appropriate systems were in place to allow the reporting of incidents and staff were aware of their roles and responsibilities in the management and reporting of incidents. An electronic reporting system was in place for staff to report any untoward incidents that occurred. Staff told us that they were encouraged to complete incident reports, but did not always report on areas such as short staffing as these were common occurrences and reporting these 'did not change anything'. This meant that there was a risk that the service was not monitoring the impact of staffing shortages on the care provided.
- Clinical managers within Simpson ward reviewed all incidents that occurred and told us they felt confident that all staff were reporting appropriately.
- Between August 2015 and August 2016, there were 131 incidents reported within the ward. The highest amount of incidents related to patient slips/trips/falls (46), insufficient patient monitoring (25) and behavioural/ aggression incidents (13). Not all incidents had appropriate actions to learn lessons recorded. We observed that the number of incidents relating to falls had been investigated and actions plans were being implemented to address causes and reduce incidents. Training in relation to falls reduction had only been rolled out a month prior to our inspection so we were unable to see whether this had any impact on falls reduction.

Medical care (including older people's care)

- Clinical managers told us that incident reports were not always detailed enough to investigate thoroughly; staff were being encouraged to provide as much detail as possible to provide investigating staff with a full background of the incident.
- Incidents were discussed at monthly ward meetings, along with any serious incidents, completed root cause analysis reports and any lessons learnt. We saw evidence of this in meeting minutes.
- Staff we spoke with told us that lessons learnt were not shared across the multidisciplinary team. Two therapy staff told us about an incident that occurred with a ward patient, but outcomes and lessons from the investigation were not shared with nursing or medical staff.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff we spoke with were aware of the duty of candour regulations and what that meant to their practice. All staff spoke of the importance of being open and honest if things went wrong and communicating this with those involved.

Safety thermometer

- The ward used the NHS Safety Thermometer (which is a national improvement tool for measuring, monitoring and analysing harm to patient's and 'harm-free' care). Monthly data was collected and displayed locally on pressure ulcers, falls and catheter associated urinary tract infections and blood clots (venous thromboembolism or VTE). Safety thermometer information was visible to staff, patients and visitors on entrance to the ward.
- NHS Safety Thermometer data showed the ward reported three pressure ulcers (category two to four) from August 2015 to August 2016.
- Six falls were reported between August 2015 and August 2016: one of these with harm caused.

Cleanliness, infection control and hygiene

- Reliable systems were generally in place to prevent and protect people from healthcare associated infections but infection control audit performance had deteriorated and not all staff had had the trust's training for infection control.
- All areas of the ward were visibly clean, with appropriate hand hygiene facilities available to staff and visitors.
- We observed staff utilising personal protective equipment (PPE) in line with trust policy. PPE, including aprons and gloves, was available in all areas of the ward and staff disposed of used items correctly.
- Throughout our inspection, we saw staff adhering to correct hand hygiene techniques including utilising alcohol gel and washing hands after patient contact. All staff were bare below the elbow in line with the trust's policy.
- Clinical waste and sharps were disposed of and then stored in line with guidance until it could be collected for further disposal. There was a trust policy in place for managing clinical waste that was in line with national guidance.
- The ward had dedicated domestic staff from an external agency who maintained cleanliness and hygiene. We saw cleaning schedules for the domestic team, and staff were aware of these and their responsibilities. We observed domestic staff carrying out daily cleaning during both of our inspections. We were informed by them that all equipment for their role was available and cleaning products were restocked as required.
- All equipment, including hoists and commodes, was cleaned following use, and this was demonstrated by 'I am clean' stickers placed onto items. Disinfectant wipes and cleaning fluids were available in the sluice for staff to carry out equipment cleaning.
- Disposable curtains were around each cubicle within the bays. We saw that these were changed regularly in line with the trust's policy; staff knew how to replace these if they became soiled.
- The ward carried out monthly infection control audits, and August 2016 results showed 74% compliance with infection control standards (target of 100%) and 100% for hand hygiene compliance. Whilst hand hygiene compliance had remained the same over a three-month period, infection control standards had decreased to below the trust's 'satisfactory' rating. Action plans were in place to address non-compliance with infection control standards.

- Patients were screened for the carriage of MRSA on admission to the unit. This enabled patients to be isolated if a positive result was found to prevent cross infection between patients.
- Staff training for infection control did not meet the trust target of 90%. Compliance at the time of our inspection was 76.5%. We saw that all staff who had not attended were booked to attend training at a later date.

Environment and equipment

- The maintenance and use of facilities did not always keep people safe. Within the ward, there were three bays, each of which contained six beds, with four side rooms, a gym and storage rooms. The ward had limited storage facilities so large recliner chairs and wheelchairs were stored in the main corridor. This posed a fire evacuation risk and a risk of patients tripping whilst mobilising in this area.
- Fire safety concerns were present in the ward. Doors labelled as fire doors were held open by chairs so that if there was a fire they would not close to protect patients and staff. This concern was immediately raised with the sister on the ward who moved chairs to avoid the doors being blocked. However, they did advise that storage was a significant problem in the ward and required some action. The trust took immediate actions to review the fire system on the ward and confirmed that those doors were not fire doors and that action had been taken to remove any signage that might lead to misinterpretation. The trust also put a door retractor system in place so that they would not need to be wedged open.
- Monthly fire alarm checks were not being carried out in line with trust policy, and there were also obstructions to the rear fire exit, which staff rectified immediately.
- We spoke to the trust regarding these safety concerns and during the unannounced inspection on 10 September 2016; we found that action had been taken. The ward had reduced the number of beds within the ward by one, and changed the use of one side room to a store area. All corridors were clear from equipment and doors were free to close. A fire risk assessment had been completed and necessary actions documented reducing risks where possible, however some actions would take time to implement including training fire marshals.
- Oxygen cylinders were not always stored appropriately, with some being stood upright in storerooms and not in storage brackets. This meant there was a risk of the cylinder falling over and causing injury. Notices to alert staff to compressed gas being stored in the area were not in place.
- A resuscitation trolley was available within the ward. Daily and weekly checks had been carried out in line with the trust's policy between May 2016 and September 2016, and all equipment was within its expiration date and suitable for use.
- The ward was not secured throughout the day; staff told us this was due to doors being old and only having a mechanical locking system which if used would pose a risk as there was only one key available on the ward. The ward sister told us that they would not take patients onto the ward that were at risk of absconding due to this reason. There were no plans in place to fit secure access, for example with a swipe card system to the ward.
- There was a gym available within the ward for patients requiring care from the therapies team. The gym met needs of the patients cared for on the ward and equipment was well maintained. The therapy gym was fully equipped with all the equipment therapists required. Staff told us that if they required specialist equipment that this could be sourced whilst patients were cared for on the ward.
- Nursing and occupational therapy staff said that equipment was readily available to assist with the care and treatment of patients. This included pressure relieving mattresses, bariatric equipment and transfer aids, such as hoists.
- We checked portable equipment, such as diagnostic devices, to ensure it had been serviced, maintained and electrically tested (portable appliance testing) as appropriate. Regular tests were completed to ensure portable equipment was safe and fit for use. There was a database containing information of all items of equipment and when they were next due for servicing.

Medicines

- The management, storage and administration of medicines did not always keep people safe.
- The temperatures of the treatment room, where medicines were stored, was consistently above the recommended storage temperature of 25°C and the service was not following trust policy of reducing the expiry dates of medicines in line with the increased temperatures.

- The monitoring of the refrigerator on the ward used to store medicines requiring cold storage was not accurate. On the day of our inspection, the minimum temperature was 10C and the maximum was 150C but the records did not reflect this.
- We observed one nurse leaving the medication trolley open and unattended during a drug round. The nurse attended a patient whom had called for assistance, however, made no attempt to secure the medication prior to leaving. This meant there was a risk of theft or tampering of medication.
- We observed that nursing staff did not check patients' identity prior to administering medication, although all other recommended checks were observed (right medication, right time, expiry, right route).
- Liquid medicines in the trolley had no date of opening on them and some of these had short expiry dates once opened. There was no indication whether these medicines were safe to use.
- The controlled drugs cupboard was not secured to the wall and was loose inside a larger cupboard. This was not in line with the trust policy for safe storage of controlled drugs.
- Controlled drugs (CDs) that had been brought in by visitors or patients were not handled in a way to ensure they were safe and secure until they needed them again. There was not a balance check completed each time CDs were given and the ward was not following trust policy for the handling of CDs. Staff were not always following procedures and there were inadequate controls in place to prevent misuse. We raised this concern with the trust's chief pharmacist during the inspection. Actions were taken immediately to address concerns relating to management of patients own CDs. This included amendments to policies and a memo being produced to ensure staff knew their responsibilities.
- If patients were allergic to any medicines, this was recorded on their prescription chart. We looked at five prescription charts during our visit.
- The ward doctor reviewed patients placed on antibiotic medication at regular intervals. The prescription chart required routine checks after 72 hours of therapy.
- There was no process or chart in place to assist nursing staff to correctly administer medicines that were applied by patches to the skin, some of these medicines must be rotated across sites on the body to avoid side effects.
- Resources used to access information about medicines were out of date. The BNF (British National Formulary) that was in use was dated 2010, not the most recent 2016 version.
- Staff told us that the last two medicines errors that had occurred on the ward were by agency staff. These were reported as incidents and actions had been taken to avoid similar incidents occurring in future, including staff education and extra checks by senior staff.
- One patient was being administered their medicines covertly (hidden in food so they were unaware of administration). This was carried out in line with trust policy.
- Medicines were either brought in from home or supplied by the pharmacy department. The pharmacy department on site was open five days a week, 9am to 5pm. Out of hours and at weekends, staff had to request medicines from Watford General hospital. An out of hour's cupboard containing medicines that may be required in an emergency was provided or medicines could be obtained through the on-call pharmacist service.
- During the week, a clinical pharmacist monitored the prescribing of medicines and visited the ward three times a week and was available for advice about medicines when required. All patients seen had had a medicines' reconciliation done, which is where a check is completed to ensure that people receive the correct medicines on admission to hospital.
- We saw when a medicine was unavailable that an alternative had been prescribed until a supply of that person's medicine could be ordered.

Records

- Patients' individual care records were not always written and managed in a way that kept people safe. Records seen were not always complete. Patient records were maintained in accordance with trust policy.
- Records were all paper based within the ward. Each patient had a medical record file and a nursing record file. Each record seen was arranged consistently and relevant areas were easy to navigate and locate.
- Medical and nursing notes were legible. Most staff identified their role or grade when completing data entries.

- The nursing records folders had been redesigned and had been in use for a month prior to our inspection. Staff told us that whilst they felt they were too bulky and contained too much paper work they were clear to complete and helped to track patient's care.
- We observed that although patient risk assessments were completed, there were limited nursing notes detailing interactions and treatments provided to patients. For example, there were few records relating to patients being assisted to sit up for the meal, mobilising to the toilet, or assisted with a wash. Intentional rounding charts provided evidence that these interactions had been completed, however this was as a "tick" and signature record. This meant that there was not always a complete record of all nursing interventions provided for all patients.
- Medical records were stored within locked trolley within the doctor's office on the ward, meaning that only authorised staff could access these records.
- Therapy notes were consistent, containing details of patient consent and therapies completed.
- All computers were password protected, however, during our inspection we saw computers were not always screen locked meaning unauthorised people could access the computer system. No patient information was accessible or visible during these times.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There were clear systems, processes and practises in place to keep patients safe, and staff were able to describe examples of when they had made referrals to the safeguarding team.
- We found that nursing staff were aware of their responsibilities regarding safeguarding and demonstrated that they were able to access the trust policy on the intranet. They were able to give examples of escalating safeguarding concerns.
- Staff informed us they had completed safeguarding training. We saw that 100% of staff had completed level 1 and 2 safeguarding adults training and 100% had completed level 2 safeguarding children training.
- There was a trust wide lead for safeguarding, however due to the location of the hospital site they were not always visible to staff. A link nurse was in place on the ward for safeguarding whom staff could access for advice where necessary.

Mandatory training

- The service had a mandatory training programme that included basic life support, information governance, infection control, health and safety, fire safety, safeguarding children and adults, mental health act and mental capacity act, equality and diversity and manual handling. Not all staff were up to date on their mandatory training.
- Data provided by the trust showed that staff mandatory training met the trust target of 90% in six out of 10 subjects including basic life support (92%), conflict resolution (100%), moving and handling (94%) and health and safety (90%). The areas that did not meet the trust target were fire evacuation (68%), hand hygiene (68%), information governance (63%) and infection control (76.5%).
- Training was a combination of face-to-face and e-learning. Staff told us that training was accessible and would only usually be cancelled due to demand and staffing constraints.
- We saw that all staff who had not completed training we booked onto a course to attend at a later date.

Assessing and responding to patient risk

- Whilst the service had systems in place to assess and respond to patient risk, these were not followed consistently which meant that risks to patients were not managed effectively.
- The service carried out VTE assessments, which should be completed on admission and repeated after 24 hours. We saw that out of 236 patients, 27 did not have a VTE assessment between August 2015 and August 2016. This had not been recognised by ward managers and no actions were in place to improve compliance.
- Care plans were not always completed was in relation to 'caring for confused patients'. Whilst risk assessments were present where necessary for patients that were confused, there were insufficient actions documented in relation to how to communicate with the patient, what

their triggers for adverse behaviour were or any techniques that may help the patient remain calm. We raised this with the ward sister who told us they would address this for all patients by updating the care plans

- Consultants reviewed all patients on the ward every Tuesday. Medical cover for patient reviews was provided by junior doctors during weekdays from 9am to5pm. Out of hours, any patient concerns would be raised through the Watford hospital or an out of hours GP could be contacted.
- National Early Warning Scores (NEWS) were completed in line with clinical condition or specified timescales, with evidence of patients' risks or clinical deterioration being escalated as necessary. In accordance with the trust's deteriorating patient policy, staff used NEWS to record routine physiological observations. Examples included blood pressure, temperature and heart rate, and the monitoring of a patient's clinical condition. If there was any deterioration in the patients' NEWS score this would be escalated through the lead clinician on the ward and then to further medical staff on Watford general hospital as necessary.
- We saw an example of one patient where there was a delay in transfer despite staff escalating a deteriorating NEWS score. Following initial escalation, there was a 12-hour delay in the decision being made to transport the patient to Watford General hospital. This delay was due to staff being unable to make a decision over who should have responsibility for the patient, there was no patient harm relating to this delay.
- Patients' observation and daily monitoring charts were located in the nursing records located by the patient's bedside. Patients generally had appropriate risk assessments in place, which included skin integrity assessments, risk of falls and risk of malnutrition assessments. Nursing risk assessments were completed on admission to hospital to identify the patient's baseline condition.
- Patients' skin integrity was reviewed on admission to the ward using a national skin integrity assessment tool (the Surface, Skin inspection, Keep moving, Incontinence and Nutrition (SSKIN) care bundle). This care bundle provided guidance to use five interventions to promote effective skin care.
- The service used intentional rounding charts for patients at risk of pressure tissue damage or dehydration. The charts were fully-completed and included records of patient interactions, such as changing position and offering oral hygiene. Patients identified as at risk of tissue damage were placed on repositioning regimes and if necessary, provided with pressure relieving equipment. Repositioning charts were completed, with evidence of patients being assisted to turn or transfer as necessary.
- Patients who were at risk of falling out of bed, or who may fall if leaving their bed without assistance, had bed rails raised. We noted that 10 patients had bed rails in place. Risk assessments were completed during admission to assess whether bed rails were appropriate. However, these risk assessments were not reviewed at any point to ensure they were still suitable.
- Staff told us that if a patient became critically unwell they would call 999 for a blue light transfer to Watford General hospital. There were no medical staff during evenings and weekends to respond to a cardiac arrest across the Hemel Hempstead hospital site.
- Staff told us that patients who were transferred back to Watford general hospital were not tracked. This meant that any learning from the reasons why patients had been transferred was not available for the service. All patients were re-reviewed prior to readmission to ensure they were still suitable to be cared for on the ward.

Nursing staffing

- Staffing levels, skill mix and caseloads were not planned and reviewed so that patients could receive safe care and treatment at all times, in line with relevant tools and guidance.
- Actual staffing levels did not meet the planned levels at the time of the inspection and not all patients' needs were met.
- The ward rota was for three registered nurses and three healthcare assistants (HCAs) to staff the ward during day shifts. This reduced to two nurses and three HCAs during night shifts. This equated to one nurse for between six and eight patients and this staffing level was appropriate to meet the of patients' care needs, however, it was not sufficient for the enablement or rehabilitation of patients, which was one the main functions of the ward. Staff were unable to assist with therapies or assist with normal daily activities to promote patients' independence such as sitting out in chairs, due to the increased workload of managing dependant patients' needs.

Medical care (including older people's care)

- On both days of our inspection, the ward was short staffed due to the need of a patient requiring one to one supervision. On the first day, the ward was short of one HCA and the second day by two HCAs. The need for HCAs had increased due to the level of patients living with dementia and other complex needs being admitted to the ward.
- Actions had been taken to source staff to assist from Watford general hospital. We were told that it could take up to two hours for a staff member to arrive due to the geographical distance between the two sites and arranging transport.
- Nursing staff reported using one to one supervision for all patients who were at risk of harm if left unattended. However, we observed on both of our visits to the ward that short staffing impacted on being able to provide a balance of one to one supervision and general nursing care to other patients. We observed a reliance on family members to provided one to one observation during visiting hours to allow clinical staff to carry out care of other patients. We also saw a member of the housekeeping team providing one to one supervision whilst the ward was short staffed. Housekeeping staff were not provided with the relevant training or possessed appropriate level of knowledge of the patients to allow them to carry out this role.
- We spoke to the ward sister regarding the ward staffing levels and how the rota was planned to meet patients' needs. We were told the trust's workforce department had carried this out. The ward had not had a staffing review since it began taking alternative patients to stroke rehabilitation over 12 months ago.
- Staffing levels were shared with the trust management team daily. This enabled senior nursing staff to identify areas of pressure and request further allocation of staff where necessary. When staff moves were not possible, additional bank or agency staff were sought to fill rota gaps. Agency and bank staff worked within the ward to cover vacant shifts. Agency staff were observed being inducted to the ward area. This included a tour and orientation of the ward, introduction to staff and details of the equipment used. A checklist was used for this process. Agency staff confirmed that this always happened during their first shift on the ward. We spoke with two members of agency staff who told us they had received an induction and thorough orientation of the ward. Both staff felt supported and that they were provided with the necessary information to care for patients on the ward proficiently. A folder was maintained with a record of all agency staff inductions
- There were six registered nurse vacant posts within the ward. These posts were not currently being recruited into due to uncertainty around whether stroke rehabilitation services would move to Watford general hospital. The impact of increased activity and nurse vacancies meant that ward based senior nursing staff were regularly working clinically. During inspection we observed ward sisters working clinically, which reduced time for ward management duties.
- We observed nursing handovers and found these to be thorough and informative, with other staff including therapies attending to provide a holistic background of each patient.
- A volunteer worked on the ward and assisted with providing tea/coffee and food to patients. they were positive about their role and enjoyed being on the ward.

Medical staffing

- Patients admitted to the ward had been assessed as medically fit for discharge. A junior doctor was on site on the ward Monday to Friday from 9am to 5pm. Any concerns could be escalated to the registrar on call at Watford general hospital.
- Consultant led-ward rounds took place once a week on a Tuesday. Medical records seen detailed the consultant weekly ward rounds. We were told that only the consultants carried out ward rounds weekly, and that these were not attended by the junior doctor covering the ward. This meant that they had to rely on information documented in notes and were not fully involved in the care process for each patient.
- Out of hours, staff could contact medical staff at Watford general hospital, speak to a local out of hours' GP, or in urgent cases, staff would call the emergency services via 999.
- Junior doctors told us that their consultants offered them support where required and were easily accessed.

Major incident awareness and training

- The trust had a major incident policy in place and most staff were able to tell us where this was located on the trust intranet. The trust had appropriate plans in place to respond to emergencies, business continuity (for adverse weather) and major incidents.

Medical care (including older people's care)

- Some staff within the ward were unclear as to what role the ward would take if a major incident occurred.
- Most staff we spoke with were aware of the trust's fire safety policy and their individual responsibilities. We observed fire alarm tests being carried out whilst we were on the ward.
- Evacuation plans were in place should there be a fire and fire escape signs were visible.

Are medical care services effective?

Requires improvement

Overall, we rated the service as requires improvement for effective because:

- Appropriate Deprivation of Liberty Safeguards authorisations were not in place for patients on the ward. We escalated this as an urgent concern to the trust. Staff did not understand DoLS and the impact it had for patient care.
- Staff understanding of the need for patient consent to treatment was not always robust.
- Length of stay for patients was longer than the England average for all specialties, mainly due to delays in social care availability.
- Apart from therapy interventions, the service was not monitoring patient outcomes to understand and drive improvements in patient care.
- There was not a formal clinical supervision process in place.
- There was not direct access to mental health services from the ward.

However, we also found that:

- Mental capacity assessments were carried out appropriately and this was documented clearly in patient records.
- Multidisciplinary working was a strength of the department and allowed patients to receive holistic care.
- Evidence based care was provided to patients on the ward, reflective of national guidance.
- Effective induction and orientation processes were in place for new staff and agency/bank staff.

Evidence-based care and treatment

- Generally, assessments for patients were comprehensive, covering all health needs (clinical, mental health, physical health, and nutrition and hydration needs) and social care needs with the exception of effective care planning for people living with a dementia. Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- The service provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal Colleges. Local policies reflected current best practice and guidance.
- The ward provided evidence based care for stroke rehabilitation patients. In line with the NICE guidance, patients were provided with 45 minutes of daily intervention from the therapies team.
- Patients that did not require stroke rehabilitation did not have set therapy guidance and would receive therapy input when staff capacity allowed. This meant there was little focus on preserving their independence whilst awaiting discharge.
- Trust policies and guidelines were available on the intranet. We observed ward nurses locating guidelines and policies within the trust intranet.

Pain relief

- Effective systems were in place for the assessment and management of patients' pain.
- We saw patients' pain assessed regularly and recorded on National Early Warning Score (NEWS) charts. Nursing staff recorded a pain score at each contact for completion of observations and administered analgesia in line with medicine prescriptions.
- During our inspection, all patients we spoke with told us they received analgesia in a timely way. Nursing staff told us that if a patient pain was not being controlled by prescribed medication they would request for this to be reviewed by a doctor.

Nutrition and hydration

- Whilst systems were in place for the assessment of patients, nutritional and hydration statuses, staff did not always followed the recommended care plans.
- Patients were not routinely sat up or repositioned to eat or take drinks: this resulted in some patients not completing meals or fluids and increased their risk of aspiration.

- Patients with special dietary requirements who had fluid texture meals recommended or who required assistance with eating were highlighted on a board above their bed.
- Patients were screened for risk of malnutrition on admission to the ward using a recognised assessment tool, the Malnutrition Universal Screening Tool (MUST) risk assessment tool. Screening was repeated at weekly intervals, unless the patient's clinical condition changed.

Patient outcomes

- In the national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) between April 2015 and March 2016, the trust was rated as band C (A being the best and E the worst). The audit looks at several domains, which includes scanning, implementation of treatments, provision of therapy services and discharge planning. The service score for discharge advice had deteriorated from A to C over this time. Speech and language therapy had scored C and multidisciplinary working had scored D. There were no action plans in place relating to SSNAP; however, SSNAP data was discussed within trust wide meetings.
- The trust held bi-monthly Mortality Review Group meetings chaired by the medical director which oversaw a range of performance measures relating to mortality, including HSMR, patient safety indicators and SHMI. The trust also had a validation process of clinical coding and undertakes targeted audits to investigate alerts or concerns relating to care provided to patients. Senior staff from the ward did not attend any of these meetings.
- Therapy services measured their outcomes against quality of life audits, SSNAP and Barthel assessment tools. Patient outcomes and goals were discussed at daily handovers to ensure all staff were aware of a patient's progress.
- At Hemel Hempstead hospital, the average length of stay for stroke patients was 56 days longer than the England average; 92 days longer than the England average for general medicine patients; and 38 days longer than the England average for geriatric medicine patients. Senior staff told us this was mainly in relation to the unavailability of social care services. Poor discharge planning also played a role in longer length of stays.

Competent staff

- Nursing revalidation was supported by the trust and nursing staff were given assistance and support to complete the appropriate reflective accounts and training to complete this. A revalidation policy had been established and this was discussed in trust wide meetings.
- The induction programme for new permanent staff and students included mandatory training and competency based ward skills.
- We saw that the ward had link roles with specialist subjects such as infection control, dementia and falls. There was a clear notice to inform staff who the link staff were.
- Within the ward, 100% of clinical/ non-clinical/ administrative staff had received an appraisal within the last 12 months; this was above the trust target. The trust appraisal policy stated that all staff were required to have annual appraisal using the job description and person specification for their post. Staff that had received an annual appraisal told us it was a useful process for identifying any training and development needs.
- At the time of our inspection, formal clinical supervision was not carried out. The ward sister told us that plans were in place to introduce and plan clinical supervision for all staff. We were told that informal clinical supervision was carried out, which included one to one meetings between the ward sister and nursing staff if they felt they needed clinical support. Managers told us staff often had de-brief discussions if they had been involved in a difficult care incident.

Multidisciplinary working

- All necessary staff were involved with the assessing, planning and implementation of patient care. Medical records detailed treatment and discharge plans and were amended according to clinical findings and patient condition.
- We observed that handovers were multidisciplinary. These handovers were thorough and discussed all aspects of care being provided to each patient.
- We saw therapy staff and social workers regularly liaising with nursing staff to discuss any changes in discharge progress and any further needs they had. These conversations were recorded in patient records.

- The ward did not have direct access to mental health services. For mental health input, patients had to be discussed with a community liaison nurse who would then review the referral. Staff felt that mental health input was slow due to no input on site and relied on staff attending the ward from another site or community service.

Seven-day services

- Therapies (physiotherapy and occupational therapy) were not provided seven days a week. Cover for these services was Monday to Friday with the exclusion of bank holidays for eight hours a day.
- On site pharmacy, provision was provided Monday to Friday from 9am to 5pm.
- All other specialist advice was arranged via a referral process. This meant that patients were at risk of delays in review from specialists such as speech and language therapy, as a result of being on this hospital site.

Access to information

- Nursing and therapy staff reported that they had access to all information necessary to ensure safe delivery of effective care and treatment.
- Patient records were stored in a consistent way across the ward. This meant that staff were able to access information required to assist with clinical decisions, care and treatments.
- Due to patients' records being a mixture of electronic at some of the trust sites and paper within Simpson ward, there were some problems with tracking areas of patient care that had occurred prior to admission to the ward.
- There was no tracking system for patients who were under a Deprivation of Liberty Safeguards authorisation meaning that unless this was handed over on arrival at the ward, staff would have to rely on reading the entirety of the patient record.
- Trust policies and guidance were available on the trust intranet and staff demonstrated how to access them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Not all staff fully understood the Deprivation of Liberty Safeguards (DoLS) and what this meant for patient care. DoLS are a set of checks that are designed to ensure that a person who is deprived of their liberty is protected and that this course of action is both appropriate and in the person's best interests.
- Patients were appropriately referred to the deprivation of liberty safeguards team for assessment, which enabled an initial urgent authorisation whilst awaiting external assessment. The applications were not tracked to identify expiry dates and not reapplied for when the initial assessment period expired.
- Whilst on the ward, we identified five patients who had an expired DoLS urgent authorisation, which had not been reassessed. Hospitals and care homes can apply for an urgent DoLS authorisation for up to seven days, whilst awaiting the local supervisory body to consider whether a longer term, standard authorisation would be required. This meant that there was a risk patients were being unlawfully deprived of their liberty, as staff were caring for patients as though an active DoLS authorisation was still in place. We escalated this immediately to the ward sister who clarified which patients should have either an urgent or standard DoLS authorisation in place. The ward sister reapplied for DoLS authorisations for three patients whilst awaiting further input from the local supervisory body. The remaining two patients were deemed to no longer require a DoLS authorisation and it was clearly documented in their notes that this was the case.
- Most staff had an understanding of the Mental Capacity Act 2005 and we saw evidence of appropriate mental capacity assessments within patient records.
- Doctors completed mental capacity assessments when there were concerns that the patient was unable to make an informed decision.
- We observed two examples in patient records where staff had documented that a patient had not consented to therapy, but this had continued anyway. There was not clear documentation as to whether this was in the patients' best interests or whether they had capacity to consent. We raised this with the ward senior nurse, who confirmed that treatment had been provided in the patients' best interests, but that this had not been clearly documented in the patients' records.

Are medical care services caring?

Requires improvement

Overall, we rated the service as requires improvement for being caring because:

- Visiting staff did not always discuss patients in a respectful way and this went unchallenged by ward staff.
- There were concerns expressed by patients and family members regarding staff attitude and care.
- Staff did not always communicate and involve family members on the progress of discharges.
- We did not observe staff engaging patients living with dementia who appeared anxious or distressed. There were minimal activity opportunities provided for these patients.

However, we also found that:

- We observed dignity being maintained during staff interactions with patients.
- Data collected through patient satisfaction audits was positive and regularly shared with the team.
- Patients generally were happy about the care they received whilst on the ward.
- Most patients and those close to them felt supported, involved with decision making and making choices about their care.
- Staff had invested time in ensuring visiting hours were suitable for patients' needs and to allow them to have routine and feel relaxed in the ward environment.

Compassionate care

- Staff were observed being polite and respectful during contacts with patients and relatives. This included when patients and relatives attended the ward, during telephone calls and in public areas. The majority of patients we spoke with were very complimentary of the care they were being provided whilst on the ward.
- However, we observed a visiting professional discussing a patient with a doctor in a derogatory way and making disrespectful comments; this was not challenged by the doctor.
- We received two patient and relative complaints during the inspection, which related to the care and compassion provided by staff. We raised these concerns immediately with the trust, who took prompt action to investigate these complaints.
- We observed nursing staff closing doors and screens when discussing patients or completing tasks to promote privacy and confidentiality.
- Call bells were generally answered in a timely way and patients told us that staff responded promptly if they required something.
- NHS Friends and Family Test recommendation results varied between June 2015 and May 2016. The average response rate was 71% and monthly recommendation results varied from 62% (January 2016) to 100% (May 2016).
- Thank you cards from families were visible on the ward, expressing gratitude and appreciation for the care provided to their loved ones.

Understanding and involvement of patients and those close to them

- We saw evidence of discussions regarding treatments and plans with patients and family members documented in patient records. This included discussions relating to resuscitation and further treatment options.
- Most patients told us they felt involved in planning their care, in making choices and informed decisions about their care and treatment.
- Staff communicated in a way that patients could understand and was appropriate and respectful. We observed staff involving patients and those close to them in discussions and offering opportunities to discuss treatments and plans.
- We observed therapists supporting and involving patients appropriately with their therapy assessments on all wards.
- Relatives were spoke with were complimentary of the care provided to those close to them, however some felt communication on their relatives' progress was not always satisfactory. Many were aware there would be long waits for discharge but felt that they were not updated by all members of the multidisciplinary team as to the current progress.

Emotional support

- Staff on the ward had trialled different visiting times for relatives to try and improve patient and visitor experience. When visitors could attend at any time of day, the ward staff felt this caused unnecessary stress to patients who were in unfamiliar surroundings. Staff had changed the visiting times therefore to 2pm to 8pm to allow patients to have some stability in a routine and help them remain relaxed and feel secure in the environment.

Medical care (including older people's care)

- We did not observe staff engaging patients living with dementia who appeared anxious or distressed. There were minimal activity opportunities provided for these patients.
- There was signposting to local advisory groups to offer both practical advice and emotional support to patients and carers, staff told us.

Are medical care services responsive?

Inadequate

Overall, we rated the service as inadequate for being responsive because:

- Service planning to meet the needs of the local community was not robust.
- There was no clear admission criteria to the ward for non-stroke patients and this meant that the service did not always have the ability to care for all patients referred, especially those with vulnerabilities and complex conditions.
- There were significant problems with flow out of the ward due to a lack of ownership of the discharge process.
- There was no clear focus on promoting patients' independence from the nursing staff.
- There were no activities to engage patients, including those with complex needs and living with dementia.
- There were not appropriate facilities or staff skills to assist in caring for patients living with dementia.
- Whilst the number of complaints were very low, the service had not met the trust target for responding to them.

However, we also found that:

- Dietary requirements could be met for all patients, including gluten free, halal and vegetarian.
- Translation services were available and met the needs of patients on the ward.

Service planning and delivery to meet the needs of local people

- We saw some evidence that the trust was working with external agencies in an attempt to reduce medically fit patients remaining in hospital. However, this was not always effective to reduce length of stays for patients within Simpson ward.
- The ward had 14 patients that did not require stroke rehabilitation and were medically fit for discharge awaiting social care packages, care home placements or rehabilitation beds with another provider. Staff told us that patients could wait over eight weeks on the ward before being transferred or discharged appropriately. We saw evidence of the trust working with the local authority to try and expedite discharges where patients were medically fit to return to the community, but this was not solely focussed on patients within Simpson ward. This impacted care for patients who required stroke rehabilitation based at the Watford General Hospital site, as access to beds was reduced because of the change in focus of the ward.
- The 12 stroke rehabilitation beds were not ring-fenced to prevent non-stroke patients admitted into them: this meant that the number of stroke patients being cared for in the ward flexed according to the needs. On occasions where there were reduced stroke inpatients on the ward, therapists transferred their clinical hours to the Watford general Hospital site. Likewise, when there were increased numbers of stroke patients on the ward, staff increased their hours on the ward. There appeared to be no assessment tool in place to determine how time should be split between the two sites.

Access and flow

- The ward recognised that there were some significant delays in discharges and poor flow. We did not see any action plans in place to attempt to improve the speed or efficiency of discharges.
- Since the ward begun taking non-stroke patients, the standard operating policy relating to Simpson Ward had not been updated. There was admission criteria for stroke rehabilitation patients to be admitted to the ward; however, there was not criteria for non-stroke patients. This meant that patients with varying, complex needs, and conditions were admitted. The ward sister told us that prior to admission, a conversation would be had with the Watford hospital site management team to discuss the patient and assess their suitability. We were told that patients at risk of absconding or likely to wander would not be admitted to the ward, however this was not supported by a formal admission pathway and not all staff we spoke with were aware of this. There were no plans in place to amend the admission criteria.
- There were difficulties with obtaining care packages, care home placements and beds within other

community sites due to difficulties in arranging assessment and provision of social care packages. This led to patients remaining on the ward for prolonged periods.

- There was confusion over who led discharges within the ward, and no clear policy or procedure for staff to follow. There was no clear pathway for who would begin the process of advising a patient was fit for discharge, or who was facilitating rapid discharges. There were no plans in place to address the lack of clear pathway for discharge.
- Therapy staff told us that within the trust discharges were not therapy-led and that on occasion there were problems getting assistive equipment to patients' homes to allow discharge.
- Between December 2015 and May 2016, there were on average two out of hours' bed moves per month. This meant patients being moved onto the ward or out of the ward after 10pm.
- Therapy staff described being moved from Hemel Hempstead hospital regularly to meet demand of stroke patients at Watford general hospital. Staff told us that this still allowed them time to provide necessary therapy to patients on Simpson ward whilst there were only a small number of stroke rehabilitation patients on the ward. However, all therapy staff we spoke with felt that is the ward was at capacity with stroke patients the workload would be unachievable.
- Therapy staff we spoke with told us that referrals were not consistently appropriate and that patients are not being considered for the ward based on their clinical condition.

Meeting people's individual needs

- Not all staff were aware of how to support people living with dementia and some had accessed the trust training programme in order to understand the condition and how to be able to help patients living with a dementia. During our inspection, there were six patients being cared for on the ward that had a diagnosis of dementia and were displaying difficult behaviours. Staff had attended dementia awareness training but did not know of techniques or tools to improve the service experience of a patient living with dementia. This meant that staff were not able to effectively manage the needs of those patients at all times. There were not effective care plans in place to provide staff with clear guidance as how to manage the needs of these patients.
- There were no distraction aids, memory boxes or other tools to calm and relax patients living with dementia who may struggle with new surroundings.
- Staff we spoke with told us they did not always feel skilled to deal with aggressive or distressed patients. We saw that one patient had been deemed unsuitable for the ward by a consultant due to their complex dementia and mental health conditions but was not able to be transferred back to the acute site at Watford general hospital due to a lack of beds. This meant that this patient was not in the right environment to ensure that their needs were being met Staff told us that they often tried to advise senior staff that patients were unsuitable but they were sent to the ward anyway.
- Prior to the increase in bed capacity of the ward, there was a day room available for patients to use for activities and to spend meal times. The day room had been turned into a six-bedded bay meaning that there was now no common area for patients to use. This affected patients who had complex needs and required daily routines and familiarity.
- We observed that there were minimal activities to engage patients whilst on the ward and that the only stimulation provided to patient was the ability to watch television. Several patients were agitated and told us they felt demotivated due to mainly sitting in bed or in a chair all day unless family members bought in any activities such as crossword puzzles. This was an area of concern raised during our last inspection but there had been no action to improve activity provision.
- Rehabilitation facilities within the ward were dependent on therapy intervention, and nursing staff did not facilitate continued therapy through activities or assisted practice. For example, patients were not routinely sat out for meals or encouraged to complete their own tasks such as recording meal preferences and oral intake. In preference, nursing staff completed tasks to decrease the time taken for the activity. This meant that there was no clear focus on promoting patients' independence.
- A translation service was available for non-English speaking patients. Staff reported that this service was effective. We were provided with an example of where a face-to-face Japanese interpreter was sourced to assist in communicating with a patient, which was done in a timely way.

- Patients had a choice of meals. Meals to meet cultural and clinical requirements were available, such as Halal or gluten free food. Cold snacks were available for patients outside of meal times and relatives were able to bring food in for patients.

Learning from complaints and concerns

- Patients and relatives we spoke with were aware of what to do and who to contact if they had a complaint.
- The ward provided patients with the opportunity to provide feedback positive or negative.
- The service rarely had complaints and between June 2015 and June 2016, there had been three complaints received. One from another trust that was closed with no necessary action and two regarding substandard care, which were upheld and partially upheld.
- The sister told us that if there was a complaint this would be discussed openly with any staff members involved and that they welcomed feedback about the service.
- The average time to respond to a complaint was 41 days, which was worse that the trust's target of 25 days.
- We saw many compliment letters and thank you cards displayed in the ward.

Are medical care services well-led?

Inadequate

Overall, we rated the service as inadequate for well-led because:

- The lack of effective day to day ward leadership meant that staff did not know the function of the ward or what improvements needed to be made to keep patients safe.
- The service did not have robust systems in place to identify and monitor risks.
- Senior staff were not aware of the significant risks to patient safety that we found and raised during our inspection.
- There was not a clear understanding or definition of what care the ward provided and all staff gave different descriptions of the service.
- There was no clear vision, identity or strategy in place for the ward, resulting in the ward admitting patients from a variety of specialities and with complex conditions without having the required staff capacity and competency to meet their needs.
- There were not always policies or procedures in place to support staff when providing patient care.
- Staff were concerned about the future of the ward and this impacted on moral and culture
- Staff did not feel engaged in developments and changes relating to the future of the ward.
- Staff felt there was a significant divide between the ward and the rest of the trust, which was affecting the care they could provide.

However, we also found that:

- Staff felt that whilst there was uncertainty about the future of the ward, they all tried to maintain the 'family' feel of the ward and work together as a team.
- Staff were aware of the trust's values and could relate them to the care they provided.
- Staff felt well supported by the ward sister.

Vision and strategy for this service

- Staff were aware of the trust's values, which were 'commitment, care and quality', but were unsure of the vision and strategy going forward for Simpson ward. Staff told us they felt the trust's values were relatable and could apply them to their day-to-day patient care.
- The identity of the ward was unclear to most staff. Nursing staff told us that they felt the ward was a rehabilitation ward, whereas therapy staff told us they told patient and visitors it was no longer a rehabilitation ward and more of an acute step down from Watford hospital. Staff from Watford general hospital told patients who were being admitted to Simpson ward that it was rehabilitation service for all conditions. The confusion was due to the change in patient profile on the ward from solely stroke patient to a mixture of medically fit patients awaiting discharge. This reconfiguration of the service the ward provided had not been effectively communicated to all staff.
- Staff told us there were difficulties in managing patient and family expectations of the ward as therapies did not provide rehabilitation for non-stroke patients.

Governance, risk management and quality measurement

- The service did not have robust systems in place to identify and monitor risks. The ward did not have its own risk register. Managers told us that if a risk were present it would be placed onto the trust wide unscheduled care risk register. Managers within the ward were not aware of any risks on this register relating to Simpson ward.
- There was one risk on the unscheduled care risk register relating to Simpson ward. This risk related to patients being unsuitable for one consultant round per week being cared for on the ward. The risks to the safety and quality of patient care and treatment that we found on inspection, such as the lack of understanding of DoLS and medicines' administration risks, had not been recognised, assessed or addressed by the service. There was no clear understanding and ownership of risks in the service.
- There were not always supporting policies and procedures in place within the ward. The admission criteria had not been updated to reflect the change in the service and use for the ward and there was no formal discharge pathway or procedure. Staff we spoke with felt improvements in governance and management were not occurring due to the uncertainty of the ward, and therefore it was not a priority.
- The ward lacked a cyclical audit programme and did not have clear oversight and measurement of patient outcomes, so that improvements needed for the service were not identified and addressed.
- Learning from incidents was not embedded in the ward practice so opportunities to minimise risks to patients were not taken.

Leadership of service

- The ward had been without a sister or senior manager for four months prior to our inspection due to the relocation of a sister temporarily to Watford general hospital. This meant that senior staff were not aware of the significant risks to patient safety that we found and raised during our inspection. The lack of effective day to day ward leadership meant that staff did not know the function of the ward or what improvements needed to be made to keep patients safe. However, the ward sister was back in the permanent position and was keen to improve and make changes.
- Staff were exceptionally positive about the leadership provided by the sister and told us they felt well supported by them on a day-to-day basis and could approach them with any concerns or problems.
- Senior managers told us they were proud of the ward, the staff and the retention of staff. They felt that communication was a strong positive of the ward and allowed staff to provide the best care to patients. Senior managers recognised the hard work carried out by staff and the demands that the ward could have but were not visible on the ward and lacked a detailed understanding of the risks to the safety and quality of patient care and treatment,
- The ward sister was meant to work in a supervisory manner but due to staff shortages, this did not always occur. This then had an impact on local leadership and administrative time.
- Staff told us that the most senior manager they saw on a regular basis was the ward sister. Some staff had met the new chief executive but were unaware of who the wider executive team were and their roles within the trust.

Culture within the service

- Staff told us that the ward was family orientated and that all staff groups supported each other.
- Staff told us they enjoyed working within the ward, but felt anxious about the possible relocation of services and what that meant for their role.
- Some members of the therapies' team were considering leaving the trust due to the current service not meeting the professional goals they aspire too or meet their clinical interests.
- Staff voiced concerns that as Simpson ward was at the Hemel Hempstead site that it was deemed a less important part of the trust and it felt like they were 'out of sight, out of mind'.
- Staff commented on the lack of senior leadership presence in the ward having a significant impact on decision-making.
- Some administrative and housekeeping staff told us that they were expected and asked to work outside of their job description, which was sometimes uncomfortable for them, especially if it involved patient facing care.

Public engagement

- Staff recognised the importance of gathering the views of patients and the public. The trust used surveys and comment cards to gather information from patients and the public to enable service improvement.
- Patient experience was reported and shared with staff to help them make necessary improvements.

Staff engagement

- Staff we spoke with did not feel involved in service planning or delivery. Staff did not feel they were given opportunities to contribute to the longer term plans for the ward. We were told that staff working on the ward did not have the opportunity to share their views or opinions on changes, and that these were implemented without their input.
- Staff did not feel engaged in developments and changes relating to the future of the ward.
- Staff felt there was a significant divide between the ward and the rest of the trust, which was affecting the care they could provide.
- Monthly meetings were carried out within the ward, which were generally well attended.
- We spoke to two agency staff who said they felt that changes needed to be made on the ward but that as external staff they could not have any input in putting forward views or ideas.

Innovation, improvement and sustainability

- We did not see evidence of innovation during our inspection.
- There were concerns raised by all staff we spoke with about the sustainability of the service. There were plans to relocate all stroke rehabilitation services to Watford and therefore ongoing improvements and sustainability were not prioritised.

End of life care

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

Information about the service

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

We carried out this inspection to check whether improvements had been made since the last comprehensive inspection of April 2015. We undertook an announced inspection of Hemel Hempstead Hospital on 7 September 2016. We inspected, but did not rate, parts of the end of life care service. We visited the mortuary at Hemel Hempstead Hospital. The mortuary is the county mortuary for the area.

We visited the mortuary, spoke with five staff, and reviewed a sample of documentation in the service.

Summary of findings

We inspected, but did not rate, elements of the safe key question. We did not inspect the effective, caring, responsive, or well-led key questions on this inspection. Significant improvements had been made in the mortuary since the April 2015 inspection. We found that:

- Staff knew how to report incidents appropriately and incidents were investigated, shared, and lessons learned.
- Risks in the environment and in the service had been recognized and addressed and the service had a robust risk register in place.
- Standards of cleanliness and hygiene were well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Facilities were in a good state of repair in the mortuary.
- The air-change system in the mortuary was being monitored to ensure there were no risks to staff.
- Appropriate checking systems were in place to monitor the temperatures of the body fridges.
- Equipment was generally well maintained and fit for purpose.
- Chemicals hazardous to health were generally appropriately stored.
- Appropriate systems were in place to respond to major incidents and emergencies.

End of life care

Are end of life care services safe?

Not sufficient evidence to rate

We inspected, but did not rate, elements of the key question for safety. Significant improvements had been made since the April 2015 inspection. We found that:

- Staff knew how to report incidents appropriately and incidents were investigated, shared, and lessons learned.
- Risks in the environment and in the service had been recognized and addressed and the service had a robust risk register in place.
- Standards of cleanliness and hygiene were well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Facilities were in a good state of repair in the mortuary.
- The air-change system in the mortuary was being monitored to ensure there were no risks to staff.
- Appropriate checking systems were put into place to monitor the temperatures of the body fridges.
- Equipment was generally well maintained and fit for purpose.
- Chemicals hazardous to health were generally appropriately stored.
- Appropriate systems were in place to respond to major incidents and emergencies.

Incidents

- At the last inspection, we found that appropriate actions had not always been taken to implement the learning from incidents. The service had taken a number of steps to address these concerns and we found that significant improvements had been made. New flooring had been laid in the mortuary to address the historical risks of slips and falls. The back door to the mortuary had been repaired and made secure.
- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and how to report them. When things did go wrong, thorough and robust reviews were carried out. The service was focused on learning lessons to make sure action was taken to improve safety. An appropriate range of safety information was being monitored by the service.
- The trust had an incident reporting system in place and standard reporting forms for staff to complete when something went wrong. Records seen demonstrated staff had acted upon incidents that had occurred. Staff told us that reported incidents were sent to the trust head office and discussed at staff meetings when necessary. Staff received feedback on any incidents and action taken via staff meetings, team briefings and information on staff noticeboards.
- There had been no never events reported for this service in the past year. A never event is described as wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- One incident relating specifically to the mortuary had been reported in March 2016 and prompt actions had been taken, which including training for the bed management on site team to have an oversight of the temperature monitoring system for body fridges, as well as new monitoring alarm systems being ordered.
- Since the last inspection, the service had introduced guidance notes for staff regarding the body fridge temperature monitoring systems. A checking system where the fridges were checked every two hours by porters during hours that staff were not working in the mortuary was also maintained.
- Staff meetings were held monthly and learning from incidents was a regular agenda item. This was where the wider learning points from an incident were disseminated and any necessary change in protocol discussed and passed to all staff. There were processes in place for the team to review all of the deaths in the hospital at morbidity and mortality review meetings.
- Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been no accidents or incidents which had required notification under the RIDDOR guidance in the last 12 months.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person.
- Staff described a working environment whereby they would investigate and discuss any duty of candour issues with the patient and their family and/or representative and an apology given whether or not there had been any harm. We saw that appropriate guidance was in place for staff.
- Staff at all levels were able to explain the changes in regulations to Duty of Candour and their responsibility to deliver a timely apology when there was a defined notifiable patient safety incident.

Cleanliness, infection control and hygiene

- The mortuary generally had effective systems in place to minimise the spread of infections. Appropriate guidance was in place for maintaining a clean environment and reducing the risk of infection.
- Standards of cleanliness and hygiene were well maintained. Reliable systems, such as clear programmes of cleaning and decontamination were in place to prevent and protect people from a healthcare associated infection. Cleaning records viewed were complete and up to date.
- The viewing room, waiting area, and clinical areas visited all appeared to be visibly clean, tidy and free from clutter.
- Hand sanitising gel dispensers were available in waiting areas and all clinical areas. Staff were observed using hand sanitisers and personal protective equipment as appropriate.
- We saw that staff wore clean uniforms with arms bare below the elbow and personal protective equipment (PPE) was available for use by staff in all clinical areas. Supplies of PPE were readily available in all clinical areas to aid effective infection control.
- The segregation and storage of waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and this was in accordance with current guidelines.
- Clinical waste bins were appropriate and securely maintained including those stored externally in the mortuary car park,
- The air-change system in the mortuary was being monitored to ensure there were no risks to staff and to ensure compliance with the meeting the Human Tissue Authority requirement for airflow and falling within accepted design parameters.
- 'I am Clean' stickers were placed on equipment including toilet seats so equipment viewed on the inspection was safe for use.
- Staff training for infection control showed 100% compliance.

Environment and equipment

- At the last inspection, we found concerns about the security of the rear door and also the flooring was not appropriate to keep people safe.
- At this inspection, we found significant improvements had been made. The design, maintenance and use of facilities and premises were well maintained. The maintenance and use of equipment kept people safe. Risks, such as security and accident prevention had been identified by the service and actioned.
- We saw that all areas of the mortuary were visibly clean, bright and well maintained. Surfaces and floors in all areas were covered in easy to clean materials, which allowed high levels of hygiene to be maintained throughout the working day. We saw throughout the mortuary that the general and clinical waste bins were covered with foot opening controls and the appropriate signage was used.
- There were arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances, which are hazardous to health. Cleaning materials used by the cleaners were stored in locked rooms.
- The arrangements for managing waste and clinical specimens were appropriate. This included the classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.
- There were systems in place to check and record equipment was in working order. These included annual checks of electrical appliance testing of electrical equipment. The trust had contracts in place with external companies to carry out annual servicing and

routine maintenance work of other equipment in the premises in a timely manner. This helped to ensure there was no disruption in the safe delivery of care and treatment to patients.

- Electrical safety checks had been carried out on mobile electrical equipment and labels were attached which recorded the date of the last check.
- There were clear guidelines for staff about how to respond to a sharps injury (needles and sharp instruments). The service used dental safety syringes, which meant needles were disposed of safely. This complied with the Safe Sharps Act 2013.
- The mortuary had been purpose built and had appropriate office space and a staff room. Appropriate changing room facilities were available. A lockable archive store for records was also provided.
- The mortuary had a viewing suite where families could visit their relatives. A separate entrance was available to this area. We visited this area and saw that the viewing suite had a separate waiting and viewing room.
- The mortuary waiting room was visibly clean, modern and provided facilities for relatives, such as comfortable seating, tissues and information booklets about bereavement and the trust's bereavement service. The suite contained no religious symbols, which allowed it to accommodate people of all religions.
- Staff said the trust's estates team were very responsive to all referrals for repairs or maintenance issues. A single equipment quality management system was now in place across the trust for all sites.
- The mortuary had appropriate facilities to store 50 deceased patients' bodies. The body stores had an appropriate alarm system that would alert staff when the temperatures were too high via the trust's telephone system. Alarms were tested weekly. The service had a checking system where the fridges were checked every two hours by porters during hours that staff are not working in the mortuary. We saw these records of temperature checks and they had been fully completed for the two weeks that we viewed. A new alarm monitoring system had been ordered and was due to be installed in the next three months.
- The mortuary's external car park for staff had a CCTV camera system in place for extra security.
- No bariatric storage facilities were available, but an appropriate agreement was in place with a nearby local acute trust.

Medicines

- We did not gather evidence for this as part of the inspection

Records

- We did not gather evidence for this as part of the inspection

Safeguarding

- We did not gather evidence for this as part of the inspection

Mandatory training

- We did not gather evidence for this as part of the inspection

Assessing and responding to patient risk

- We did not gather evidence for this as part of the inspection

Nursing staffing

- We did not gather evidence for this as part of the inspection

Medical staffing

- We did not gather evidence for this as part of the inspection

Major incident awareness and training

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.
- Arrangements were in place to respond to emergencies and major incidents. A business continuity plan was in place.
- There was good understanding amongst staff about their roles and responsibilities during a major incident. Staff were able to signpost us to the trust wide policy which was located on the trust intranet.
- Staff we spoke to were aware of the trust's policy and procedures for fire safety and said that regular fire drills were carried out as well as what to do should a major incident arise.
- For fire safety, 100% of staff had completed the trust's training within the past year.
- Checks of fire extinguishers and emergency lighting had taken place at regular intervals.

End of life care

- The mortuary technicians told us they had a contingency plan and agreement with another local trust in the event that the mortuary became full.
- Mortuary staff told us that porters in the trust received training in the use of the fridges and the alarm systems and they followed a procedure to alert mortuary staff if there was storage or other issues relating to the mortuary.

Are end of life care services effective?

We have not rated the service for effective. This key question was not inspected.

Evidence-based care and treatment

- We did not gather evidence for this as part of the inspection.

Pain relief

- We did not gather evidence for this as part of the inspection.

Nutrition and hydration

- We did not gather evidence for this as part of the inspection.

Patient outcomes

- We did not gather evidence for this as part of the inspection.

Competent staff

- We did not gather evidence for this as part of the inspection.

Multidisciplinary working

- We did not gather evidence for this as part of the inspection.

Seven-day services

- We did not gather evidence for this as part of the inspection.

Access to information

- We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not gather evidence for this as part of the inspection.

Are end of life care services caring?

We have not rated the service for caring. This key question was not inspected.

Compassionate care

- We did not gather evidence for this as part of the inspection.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

Are end of life care services responsive?

We have not rated the service for responsive. This key question was not inspected.

Service planning and delivery to meet the needs of local people

- We did not gather evidence for this as part of the inspection.

Meeting people's individual needs

- We did not gather evidence for this as part of the inspection.

Access and flow

- We did not gather evidence for this as part of the inspection.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Are end of life care services well-led?

We have not rated the service for well-led. This key question was not inspected.

End of life care

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- We did not gather evidence for this as part of the inspection.

Leadership of service

- We did not gather evidence for this as part of the inspection.

Culture within the service

- We did not gather evidence for this as part of the inspection.

Public engagement

- We did not gather evidence for this as part of the inspection.

Staff engagement

- We did not gather evidence for this as part of the inspection.

Innovation, improvement and sustainability

- We did not gather evidence for this as part of the inspection.

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

West Hertfordshire Hospitals NHS Trust has outpatients departments at three hospital sites, Watford General Hospital, Hemel Hempstead Hospital and St Albans City Hospital. They provide outpatient services across a wide range of specialities: for example, cardiology, gynaecology, respiratory, urology, dermatology and rheumatology.

The trust had approximately 475,634 appointments across the three hospitals from March 2015 to February 2016, with 124,747 appointments at Hemel Hempstead Hospital.

Outpatients includes all areas where people undergo physiological measurements, diagnostic testing, receive diagnostic test results, are given advice or receive care and treatment without being admitted as an inpatient or day case.

We visited the outpatient area in Hemel Hempstead Hospital and diagnostic imaging. The imaging departments include x-ray, ultrasound scanning, fluoroscopy, magnetic resonance imaging (MRI), computed tomography (CT) and nuclear medicine.

There was a separate children's outpatients department, and they saw children from 0 to 17 years of age.

The outpatients department was under the medicine division. The divisional manager for medicine having overall accountability with the support if the head nurse for medicine. There was a deputy divisional manager who was also the service lead for outpatients.

The outpatients department had 14 consulting rooms and three treatment rooms. There was a large reception desk and three electronic booking in stands.

The children's outpatients department was a separate building within the grounds of Hemel Hempstead hospital. It was run by 10 consultants that worked across the Watford and Hemel Hempstead hospital sites.

We carried out an inspection at Hemel Hempstead Hospital on the 7 September 2016. As part of our inspection, we observed patients' care and treatment and spoke with six patients, two relatives and 12 members of staff. These included senior and junior medical staff, nursing staff (registered and non-registered), managers, matrons, radiographers and support staff. We looked at 10 sets of patient records and reviewed performance information provided by the hospital.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the service as good. One key question, responsive was rated as requires improvement and safe, caring and well-led were rated as good. We found that:

- Staff we spoke to described with confidence how they would recognise and report incidents and there was evidence of learning from incidents and patient complaints.
- Senior staff had oversight of risks in their areas.
- Outpatients appeared visibly clean and staff used personal protective equipment such as gloves and aprons.
- From observations, we saw that equipment was maintained, appropriately checked and visibly clean.
- Patient records were stored securely, and access was limited to those who needed to use them. This ensured that patient confidentiality was maintained at all times.
- Patients' care and treatment was delivered in line with current national standards and legislation in both services. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence.
- The diagnostic imaging department had three ARAC (administration of radioactive substances committee) certificate holders; they ensure good clinical practice is carried out in nuclear medicine.
- There were some areas that provided a proactive service to patients which included several one-stop clinics which provided efficient co-ordinated care.
- Patients and their relatives we spoke to told us they were supported by staff that were caring and compassionate.
- We found staff to be approachable and witnessed them being polite, welcoming and friendly.
- Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making.
- There was clear signage displaying clinic waiting times that were updated every 30 minutes, and audited by senior nurses to ensure that this was done.
- There was evidence of multidisciplinary working in the outpatients and diagnostic imaging department.
- Clinical governance knowledge was shared amongst staff at team meetings.
- Risk management and quality measures were now proactive.
- Patients were treated with dignity and respect and spoke highly of the staff. Patient input and feedback was actively sought.
- The recently appointed senior and junior sisters had improved morale and processes in the outpatient department.
- All staff we spoke with told us that managers of both services were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.

However, we also found:

- Referral to treatment performance had been improving since the last inspection, and exceeding the target for some clinics. However, due to poor performance in certain clinics, only 87% of patients met this target from May 2016 to September 2016. This meant performance had declined over the past six months.
- Data for July to September 2016 showed that the trust had fallen below the national 93% target that all suspected cancers should be referred to a consultant and seen within two weeks; only 87% of patients were seen within this timeframe. This meant performance had declined over the past six months.
- The Royal College of Paediatrics and Child Health (RCPCH) Intercollegiate Document 2014 state that clinical staff assessing and treating children and young people should have level three safeguarding children training. Not all medical staff in outpatients had received this training but the trust took action to address this once we raised it as a concern. In addition, it was recognised that, outpatients at this location, is an area where treatments would rarely be carried out, the risk had been considered, a risk assessment undertaken and that there were arrangements are in place for clinical staff to gain advice and support.

Outpatients and diagnostic imaging

- Patient records were not always available for patient appointments.
- Nasal endoscopes were not fully decontaminated in an endoscope washer-disinfector.
- Leaflets were not available in other languages other than English.

Are outpatient and diagnostic imaging services safe?

Good

Overall, we rated safety as good because:

- Staff were confident in reporting incidents and could describe the requirements of the duty of candour.
- Staff were encouraged to report incidents and report any safeguarding concerns.
- Equipment was maintained and checked to a standard to ensure both the safety of the patients and staff.
- The outpatients department had a dedicated staff member from the estates department to contact for equipment issues.
- People were cared for in a clean, hygienic environment. There were effective systems in place to reduce the risk and spread of infection.
- Medicines were correctly stored, administered and managed in order to maintain the safety of patients.
- The diagnostic imaging department had three ARAC (administration of radioactive substances committee) certificate holders; they ensure good clinical practice is carried out in nuclear medicine.
- Accurate and appropriate patient records were maintained and stored securely.
- Equipment was maintained in line with the manufacturers' recommendations.
- Clinical staff in the separate children's outpatient department were trained to level three in children's safeguarding.

However we also found:

- The Royal College of Paediatrics and Child Health (RCPCH) Intercollegiate Document 2014 state that clinical staff assessing and treating children and young people should have level three safeguarding children training. Not all medical staff in outpatients had received this training but the trust took action to address this once we raised it as a concern.
- Patient records were not always available for patient appointments.

Incidents

- Staff we spoke with described with confidence how they would recognise and report incidents, and explained

they would receive feedback on the outcome in order to undertake any learning. Incident management and response was reported through the trusts online reporting system. There was evidence of learning from incidents; investigations took place and appropriate changes were implemented. For example, had incidents where equipment would not be fixed efficiently or brought back to the department in a timely manner, so the department now has their own designated engineer. The staff spoke positively of this changed, saying the service works well, and there are no issues relating to reporting faulty equipment, and it is a quick turnaround for faulty equipment to be returned.

- The managers told us they encouraged staff to openly report incidents, and the staff reiterated this.
- Findings from incidents were shared at team meetings and a department daily 'huddle' at the start of each day. The managers of outpatients also explained that information from incidents were shared in emails. Staff we spoke with confirmed incidents and any lessons learnt were discussed at staff meetings. We saw evidence of incidents being communicated to staff in the imaging departments, through a radiology newsletter. It described the most recent incidents and what had been learnt, as well as encouraging the staff to report incidents and how to access the electronic reporting homepage on the trust's intranet.
- The diagnostic imaging service reported one serious incident from July 2015 to June 2016, which affected the three hospital sites. The radiology Information System (CRIS) became unusable, which resulted in a backlog of around 2000 patient images which had to be manually matched on the system. We reviewed the root cause analysis report for this incident which identified the cause. Lessons learnt were shared with the department, and the duty of candour had been implemented. The action plan for this incident had been completed and signed off.
- The service had reported 328 incidents from March 2015 to April 2016. All of these had been categorised as either low or no harm, two were categorised as moderate. There was evidence of learning from incidents shown in the clinical governance and quality meetings. These incidents were reported from outpatient and diagnostic imaging departments across all three hospital sites, we were not given a breakdown of incidents for the separate sites.
- There were no 'never events' reported in the past 12 months. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- The ionizing radiation (medical exposure) regulations, or IR(ME)R, provide a framework to protect patients and staff from the risks associated with radiation used in healthcare. Radiology errors, including when the wrong dose had been given to a patient or a patient had received the wrong type of diagnostic test, are reported to CQC in line with the regulations. The CT department had a 'much greater than intended' (MGTI) dose incident under regulation 4(5) of IR(ME)R in August 2016. A CT was taken of a patient's abdomen, when the request was for a chest CT. This was escalated immediately to all relevant parties, including the CQC and electronically reported. There was a good local incident management approach, including a route cause analysis and outcomes and learning was discussed with all staff at their daily meeting. Support and training was given to the member of staff involved. The incident had been closed by the CQC IR(ME)R inspectors. In radiology, the clinical, scientific and nursing directors worked together with the matron, directorate and governance managers all of which had attended directorate monthly clinical governance committee meetings. We saw from the meeting minutes that the committee had routinely reviewed all incidents to identify trends. Mortality and morbidity was also discussed within these meetings, and how these findings would feed into service improvement. From the minutes, we read there was nothing relevant to the outpatients department.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

- Staff we spoke to about the duty of candour were well informed about legal requirements and local procedures. Staff had access to information through their managers and on the internal website. We saw information in folders in the senior sister's office, which was accessible to staff.
- Managers and the senior sister were aware of their responsibilities under the duty of candour legislation. The majority of staff we spoke with were also aware of their responsibilities under the legislation. Duty of candour was part of the trust's induction programme and was included as part of the electronic incident reporting system for completion by staff. On reviewing the incidents reported, we saw evidence that Duty of Candour had been followed and this was evidenced in the patients' medical records.
- Staff told us if they were unclear, they would always inform their line manager for guidance and support.

Cleanliness, infection control and hygiene

- Reliable systems were mostly in place to prevent and protect patients from healthcare associated infections
- The outpatient and diagnostic imaging clinical areas we visited were visibly clean, tidy and well organised.
- Cleaning schedules were completed and on display in each room. Sharp boxes for the disposal of items such as needles were used in accordance to local guidelines.
- We inspected 10 out of the 14 consulting rooms. These all had appropriate hand washing facilities, disposable paper towels and personal protective equipment (PPE) such as gloves, aprons and facemasks available to assist in the prevention of a spread of infection.
- We observed staff washing their hands and wearing PPE appropriately.
- Clinical staff were observed to consistently meet the 'bare below the elbow' guidance, and felt confident in challenging any staff visiting their departments who did not comply.
- An infection control lead was available and a link nurse in outpatients, who were responsible for coordinating audits.
- The nursing staff could explain clearly and correctly the decontamination process they carried out for nasal endoscopes (a thin tube with fibre optic cables for light which is passed down the nasal passageway) and showed us the patient record register. This was essential in showing the patient's details, which nasal endoscope was used and the batch number of the decontamination wipes in case the patient did contract an infection post procedure.
- We observed the department's nasal endoscopes were decontaminated with the 'three part' wipe system. These were wipes specifically designed for cleaning medical devices, with a high-level disinfectant, sporicidal wipe and a rinsing wipe. The manufacturer of the wipes states that this process is clinically proven to effectively clean all scopes used for invasive procedures. This met the guidance outlined in the Department of Health: Health Technical Memorandum 01-06 decontamination of flexible endoscopes. We saw evidence of staff completion of decontamination training in their training records, and regular training sessions were given on how to decontaminate the nasal endoscopes with the 'three part' wipe process.
- Infrequently used water outlets were flushed weekly to help reduce the risk of Legionella bacteria, which can cause a potentially fatal type of pneumonia. We saw evidence from signed checklists that this was carried out.
- Posters were on display reminding staff and visitors about hand hygiene. We also observed infection control notices and information on display, for example, recent hand hygiene audit scores.
- Clinical and domestic waste was disposed of correctly, and sharps boxes were not overfilled. Appropriate containers for disposing of waste including clinical waste were available and in use across the imaging departments and outpatients, and these were not stored by patient areas.
- Regular hand hygiene audits demonstrated high compliance rates throughout the department and these results were displayed on a whiteboard in the waiting area. The recent figures showed 100% compliance for hand hygiene for August 2016.
- The radiology waiting and recovery areas appeared clean, tidy and uncluttered. Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities also appeared clean and tidy.
- Staff in radiology were responsible for maintaining the cleanliness of the radiology equipment in accordance with infection prevention and control standards. Imaging and examination room cleaning schedules were available in all areas and were up to date.

- Staff received an infection prevention module in the mandatory training, 96% of outpatient clerical staff were compliant, and 99% of nursing staff had completed the infection prevention module. This was compliant with the trust's target of 90%.

Environment and equipment

- The maintenance and use of facilities and equipment kept patients safe. Patients and their relatives were complimentary about the appearance of the outpatients department. They told us it was a, 'pleasant, clean environment', 'bright and airy'.
- Clinic and diagnostic imaging rooms were well organised and well lit. All electrical equipment we examined was tested appropriately.
- From observations, we saw equipment was maintained, appropriately checked and visibly clean. There was a dedicated staff member from the hospital estates team who regularly checked the equipment and took reported broken equipment to be fixed on site. Staff we spoke to told us this was a great service, which meant the turnaround for broken equipment was efficient. If equipment needed to leave the site, they would replace that piece of equipment until it was returned.
- We saw sterilised instruments were checked and monitored in accordance with local and national guidance. We saw that all the single-use instruments were all within their expiry dates.
- We observed treatment carried out in consulting rooms, which were well equipped with couches and relevant equipment.
- The couches had recently been upgraded in outpatients. One patient told us they could have gone to sleep; they were so comfortable, and continued to tell us they thought 'the environment at Hemel Hempstead was fantastic'.
- All consulting rooms had a checklist for staff to go through every morning to ensure the room was cleaned and all equipment present and checked.
- There was emergency resuscitation equipment in outpatients and diagnostic imaging departments, which included equipment for the resuscitation of children. The resuscitation trolleys were checked weekly, and then secured with a tag. Daily checks were carried out of the oxygen, suction and bag valve masks (a hand held device, commonly used to provide positive pressure ventilation to patients who are not breathing, or not breathing adequately). We examined the equipment and found all items were present and in date and ready for use in an emergency situation.
- The diagnostics imaging department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were available for staff to refer to. It was the responsibility of the radiation protection supervisor (RPS) to supervise work and observe practices to ensure compliance with these regulations.
- We observed staff wore radiation detection badges that were monitored according to legislation, to ensure that staff were not exposed to unsafe levels of ionising radiation. We also observed safety guidance such as, 'stop and check' posters, designed to make sure that staff maintained an awareness of their own safety within the diagnostic imaging areas.
- All radiation premises had secure access. Radiation warning signs were displayed, explaining that radiation was occurring and there were illuminated 'do not enter' signs within all areas using radiation.
- During our inspection, we observed specialised personal protective equipment was available to staff for use within radiation areas, such as a variety of lead aprons to reduce risk of ionising radiation exposure to certain body parts.
- There were children's play areas available in both services.

Medicines

- The management, storage and administration of medicines kept patients safe. We saw that the service had current medicines management policies and procedures available in order that staff could be guided in the correct processes to manage medicines safely. Staff we spoke with informed us that any changes to policy would be communicated from the clinical governance meetings to the daily staff huddles.
- Medicines were stored securely in locked cupboards in outpatients and diagnostic imaging. We randomly checked medicines, which were all in date. No controlled drugs were kept in the outpatient department.
- Medicines that required refrigeration were stored in a locked fridge. The outpatients department had three medicine fridges, all were locked, with daily

temperature checks monitored and recorded appropriately. This meant that the services were following the appropriate guidance on the safe handling and storage of medicine.

- The senior nurses were responsible for checking medicines. Keys to the medicine cupboards and fridges were held by a senior nurse.
- There was a pharmacy on site, and provided an outpatient dispensing service. This service was available Monday to Friday from 8.30am to 5pm. Pharmacy also provided clinical pharmacists who covered all three sites, and were available for any dispensing queries.
- For certain diagnostic tests injections were carried out, for example, certain CT's and MRI's needed a contrast medication injected; this is a dye to help assess certain organs. These should only be undertaken through appropriately authorised and documented local rules. In order to supply and administer these agents safely, there should be prescriptions (often called patient group directions) that direct staff in delivering an appropriate dose. We saw evidence of compliance, authorisation and a log of training for the radiographers. This was an improvement since the last inspection as there were appropriate patient group directions, and all were signed and authorised. This ensured no medications were given without authorisation or an untrained member of staff.
- We observed the checklist used in CT prior to administrating contrast, and found that all patients' details were recorded, including allergies, and the cautions and contraindications with using this medicine. The patient signed the form along with two radiographers. We saw evidence of these filled out appropriately.
- There was a dedicated radio-pharmaceutical fridge in nuclear medicine. This meant it was suitably designed to the expected level for the safe storage of these types of medicines, in accordance with the Ionising Radiations Regulations 1999 (IRR99) and the Medicines Act regarding safety of radiopharmaceuticals. However, during our inspection we observed their designated fridge had broken, and they were waiting for a replacement. There were no radio-pharmaceuticals needing to be stored at this time, however, they were due a delivery in a weeks' time and had no risk assessment or plan for the safe storage of these drugs, if the fridge had not been delivered. During the unannounced inspection we went back to see if they had risk assessed and had a plan in place, and we were shown that the new fridge had been delivered in time, so there was no risk of radio-pharmaceuticals being incorrectly stored.
- In radiology, the CD registers and order book were all checked and signed correctly. Staff checked the drug fridge temperatures in the x-ray department; records of these checks were up to date. We saw that medical gases and contrast media were stored safely.
- The diagnostic imaging department had three ARAC (administration of radioactive substances committee) certificate holders; they ensure good clinical practice is carried out in nuclear medicine. The certificates were checked during inspection and were in date.
- Radio-pharmaceuticals were delivered by a special courier service, who were registered, and they would sign over to two radiographers and taken to the radio-pharmaceutical fridge in a compliant box. This process was monitored by the environment agency every three months, and they were found to be compliant. They were also inspected every two years by the environment agency for a full inspection.
- We observed that prescription pads were kept securely. Records reflected that each prescription was logged with its individual number when requested by a consultant.
- We saw that staff competences for medicines management training updates were done by the service and a record kept on completion. We looked at 10 training records for staff and saw that their medicine management had been completed and was up to date.

Records

- Patients' individual care records were written and managed in a way that kept them safe. Patient records were stored securely in lockable trolleys, and access was limited to those who needed them. We checked three of these trolleys during the inspection and all were locked. This was an improvement made to the department's information governance since the last inspection.
- We reviewed 10 sets of patient's records. All records were legible, signed and dated, and contained all relevant information, including risks and benefits of treatment explained.
- Medical records were prepared ahead of clinics and delivered to the suites the day before by medical records staff. A computer tracking system logged patient records into and out of the medical records department.

- Patient records were checked and set up by health care assistants in advance of clinics.
- In radiology, we found staff managed and handed over inpatient case notes safely. We reviewed four electronic patient records to check whether radiology staff had completed the safety checks for pregnancy, and they had all been appropriately checked and recorded in the notes.
- The diagnostic imaging department kept radiological images electronically; this allowed shared access throughout the hospital and other hospital trusts.

Safeguarding

- Safeguarding policies and procedures were accessible to staff, which included both vulnerable adults and children guidance.
- Arrangements were in place to safeguard adults from abuse that reflected relevant legislation and local requirements: however, not all medical staff were trained to the appropriate level regarding safeguarding children. Mandatory training courses included adult and children safeguarding. Safeguarding training for all clinical staff was completed to level two and level one for administrative staff. 90% of nursing staff had completed level one and two adult safeguarding and 97% of administration staff had completed level one. In diagnostic imaging, 95% of radiographers had completed both level one and level two adult safeguarding training. Not all clinical staff were trained to level three in safeguarding children. Seven out of 10 consultants in working in the clinics where children were seen had had level three training. The trust put plans in place to address this concern once we raised it. Further training was to be completed by the end of January 2017.
- Children attended adult outpatient clinics, such as dermatology and ear, nose and throat. The safeguarding children and young people intercollegiate document (2014), which was published by the Royal College of Paediatrics and Child Health, states that all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding or child protection concerns. As children attended the outpatient department, it was not possible to ensure adequately trained staff were on duty when a child attended.
- However, staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for a child or an adult. Staff were aware of the trust's safeguarding policies, and the directorate safeguarding lead they could contact for advice and support if they had any concerns. Safeguarding policies included female genital mutilation, raising concerns, domestic abuse and safeguarding children.
- Staff said they were aware of how to identify child related safeguarding cases and told us of the process and pathways they would use if they were concerned.
- Safeguarding issues were highlighted on the electronic patient health record, and staff documented this on the patient's care pathway.
- The 'pause and stop' procedure was used in the diagnostic imaging departments. This ensured the right patients were getting the right scan, at the right time. We saw evidence of this used in practice.
- In diagnostic imaging, we saw the World Health Organisation (WHO) surgical safety checklist (five steps to safer surgery) for non-surgical interventional radiology used. They were adapted from the WHO surgical safety checklist and made specifically for radiologists.

Mandatory training

- Staff received effective and timely mandatory training in the safety systems process and practices. Mandatory training was completed by attending face to face sessions, which were primarily held at Watford General Hospital and on-line electronic learning packages. The training included basic life support, equality and diversity, fire, health and safety, information governance, infection control, manual handling, conflict, resuscitation and safeguarding.
- Trust data showed that 96% of the administrative and clerical staff and 99% of nursing staff were up to date with mandatory training in the outpatients department. The trust target for staff to be trained was 90%.
- Staff reported that they were aware of what training was available and when they needed to complete it by. They told us they were encouraged and supported to complete the on-line training and to remain up to date with their training needs.
- Staff we spoke with told us the introduction on the on-line electronic learning made training more accessible and meant they did not always have to travel to Watford.

- Staff we spoke with in radiology confirmed they were up to date with their mandatory training. We were not provided with a breakdown of staff having completed mandatory training from the trust for diagnostic imaging, but all the staff spoken to during the inspection had completed their training, and we were shown individual competencies and training that proved this.

Assessing and responding to patient risk

- Generally risks to patients were assessed, and their safety monitored and maintained. The outpatient and radiology services completed risk assessments and responded appropriately in order to maintain patient safety. This had improved since the last inspection in 2015.
- From April 2015 to March 2016, 96% of patients were seen with their full medical records. This was the same as St Albans City Hospital. A manual audit was undertaken, and was made available to us by the management team. This had been done since the last inspection, due to staff raising concerns of medical records frequently not being available. A further audit undertaken in March 2016 showed that 83 medical records were required and 11 were unavailable. The two main reasons for the unavailability were, the records were not at the last tracked location and due to late additions to the clinic they had not arrived in time from other departments. The senior management team were discussing having a storage facility for medical records at the Hemel Hempstead site, as well as at St Albans, to help eliminate the unavailability of records for clinics.
- If records were not available 24 hours before the clinic, a set of paperwork (including the last clinic letters, any results, patient labels and a clinic outcome form) were created and sent to the clinic in the absence of the full record. If it then became available on the day of the clinic, the full record would be sent and provided to the clinician for the consultation and the paperwork set destroyed appropriately.
- Outpatient nurses worked closely with the clinic preparation teams to keep them informed of missing records and completed incident reports where notes were not provided.
- The patient's records we reviewed included an assessment of risks, including falls, moving and handling and Malnutrition Universal Screening Tool (MUST) score. The MUST score would only be used if the patient needed surgery.
- Staff had clear protocols and referral systems to support them in assessing and managing patients who became unwell. When someone's health deteriorated staff took observations and used the National Early Warning Score (NEWS) system to determine appropriate actions. If necessary, medical staff liaised with the medial assessment unit and arranged for admission to an inpatient ward through the assessment unit. If the assessment unit was full, patients were transferred to the emergency department as a 'medically expected' patient. For children who attended the separate children's outpatients department who needed urgent admission, the consultant would speak with their colleagues at the Watford General paediatric ward and arrange a bed, if no beds available then they would too be transferred to the emergency department. The staff in the children's outpatients used the Paediatric Early Warning Score (PEWS) to determine if a child's health was deteriorating.
- There were emergency procedures in place in the outpatient department including call bells to alert other staff in the case of a deteriorating patient or any other emergency. The reception desk also had an emergency call bell.
- The staff in outpatients told us of a recent emergency situation. A patient had collapsed and had a cardiac arrest. The staff raised the alarm by using the call bell and staff came immediately with the resuscitation trolley. An emergency call was out through switchboard and they were supported from staff from the minor injury department on site and other staff. The patient was transferred to Watford, where they made a full recovery, and had since sent a letter of thanks and gratitude to the staff in outpatients.
- Each diagnostic area had a radiation protection supervisor. Staff were knowledgeable about safety procedures because of the good liaison with the radiation protection team.
- There was electronic signage in the diagnostic imaging areas to inform patients and staff that radiation was taking place. We observed that the electronic signage was in working order.

Outpatients and diagnostic imaging

- The Royal College of Radiologists guidelines state that all females aged 12 to 50 who were to undergo radiography to areas between the knees and the diaphragm should be asked about the possibility of being pregnant. This was to ensure that the unborn foetus does not receive doses of radiation. In radiology, we looked at four patient electronic records on the reporting information system (RIS) to ensure pregnancy safety checks were completed prior to exposures being undertaken. We saw that pregnancy checks were completed in all records that we looked at. We also observed radiographers verbally asking female patients, and documenting this.
- We observed radiographers following the IR(ME)R regulations that require radiographers to routinely check previous images before continuing with a scan or an x-ray.
- The IR(ME)R regulations require an employer to set diagnostic reference levels (DRLs) and provide staff with procedures on how they are to be used. DRLs are a dose optimisation tool used to help manage the radiation dose to patients. This ensures patients are exposed to as little radiation as is clinically necessary. We observed the DRLs being checked on knees, pelvis, chest, thoracic and lumbar spines during our inspection.
- The diagnostic imaging service audited the DRLs monthly, including for fluoroscopic procedures. Fluoroscopy is the study of moving body structures. A continuous x-ray beam is passed through the body being examined, and the beam is transmitted to a television monitor so that the body part and its motion can be examined. The results of the audit showed that they were in line with the national DRLs and in some examinations including chest fluoroscopy, they were comparably less than the NDRLs, which was a positive result for patients.
- Radiation protection advisors (RPAs) were employed within the radiology service. They undertook annual risk assessment inspections of the radiology services. The results of these were conveyed to the staff.
- The diagnostic imaging departments had local rules for the protection of persons against ionising radiations arising from the use of diagnostic x-ray equipment; these were in accordance with the Ionising Radiation Regulations 1999. We saw evidence of these local rules and they had been reviewed in August 2016.
- We observed the 'pause and check' system used in CT, x-ray and ultrasound. This is a clinical imaging examination IR(ME)R operator checklist. They checked the patient, was the test justified, is the anatomical area correct, user checks, system and equipment settings and that the radiation dose had been recorded with reference to DRLs.
- We observed that staff were available to observe patients in waiting areas, which meant that if a patient's condition deteriorated it would be escalated appropriately.
- Patients that were given radio-pharmaceuticals were 'radioactive' for a certain period of time. The service provided a separate shower and toilet for these patients, which had a dedicated cleaner, who was trained in the cleaning process and would be provided with protective equipment to carry this out.

Nurse staffing

- Staffing establishments for the outpatient department were based on clinic volumes and clinic capacity. There was no official staffing acuity tool for use in outpatients departments. Skill mix was determined by clinic speciality and complexity**.** Nursing staff generally worked from Monday to Friday, but would cover any ad hoc evening or weekend clinics.
- A business plan had been submitted for an increase to the trained nursing establishment, for all outpatients' services across the three sites. However, Hemel Hempstead had no registered nurse vacancies at the time of inspection. We saw in the department meeting minutes for June 2016, that the senior sister had had a meeting with finance regarding Hemel Hempstead's budget for increasing their nursing establishment. This was still ongoing during our inspection
- The outpatient department used agency staff, however during our inspection there were no agency staff working. However, we were shown the agency staff induction checklist, and the temporary staff information folder. From May 2015 to April 2016 the outpatients department only used 0.5% of agency nurses.
- Radiation protection advisors (RPA's) and radiation protection supervisors (RPS's) were employed within the department. There was one whole time equivalent RPA and one whole time equivalent RPS.
- Agency and bank radiographers completed local induction and equipment training which was signed off before they were allowed to work unsupervised.

Outpatients and diagnostic imaging

- There was an escalation process the senior staff followed if the service had staffing difficulties. Staff told us that they were confident in escalating difficulties to the senior team.
- The staff we spoke with told us that even though they were a busy department, they felt they provided good and safe patient care.

Medical staffing

- Many outpatient clinics were consultant led, with nurses accompanying patients. Locum consultants were appointed to maintain clinic activity and medical recruitment was in progress across the teams for the whole trust.
- The individual specialities arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics.
- There were consultant radiologists employed by the directorate who covered the range of specialisms and supported the multidisciplinary teams (MDT). Arrangements for on call and out of hours cover were in place, and they covered the three hospital sites.

Major incident awareness and training

- Potential risks to the service were anticipated and planned for in advance. There were business continuity plans in place to ensure the delivery of the service was maintained. These were seen in a clearly marked folder in the sister's office.
- Staff in outpatients and diagnostic imaging had received no formal training on major incidents; however, mandatory training covers fire safety and fire evacuation.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate this service for effective. We found:

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence.
- Both services monitored patient outcomes through surveys to ensure that patients were satisfied with the service they received.
- Staff were supported in their development using the appraisal process, 91% of nursing staff had received an appraisal from April 2015 to March 2016.
- Care was provided by a range of skilled staff who had access to further training if required.
- Good multidisciplinary team working was evident throughout both services, with effective verbal and written communication between staff.
- Staff took part in a number of local and national audits.

However, we also found that:

- The outpatients department did not operate seven day a week services, although staff did hold evening and weekend clinics to reduce any increased waiting lists.
- The diagnostic imaging department did not participate in the Imaging Services Accreditation Scheme (ISAS) or the Improving Quality in Physiological Services (IQIPS).

Evidence-based care and treatment

- Clinics were usually well-organised and delivered effective assessment and treatment. Staff delivered evidence based care and followed National Institute for Health and Care Excellence (NICE) guidelines where relevant. For example, we saw guidance on Aseptic Non Touch Technique (ANTT). This was a standardised approach developed by University College Hospital, London in the 1990s, and has shown to significantly improve the aseptic technique of healthcare workers, by providing a framework to both standardise and raise clinical standards using a consistent and reliable approach whilst undertaking aseptic clinical procedures. This guidance was in line with the trusts infection control policy.
- Management staff attended regular clinical team meetings where they learnt about new and updated guidance. This was seen to be discussed in the minutes, where clinical guidelines were looked at for ratification.
- Nursing and medical staff told us that policies and procedures reflected current guidelines and were easily accessible via the hospital's internal website, which we observed.

Outpatients and diagnostic imaging

- We saw integrated care pathways for cardiac devices, day case angiograms, and colo-rectal. These followed NICE guidelines on best practice.
- Protocols were in place for radiology examinations such as orthopaedic x-rays.
- We saw guidelines in place to ensure fast tracking where there were significant image findings for known or unknown cancers, as well as severe abnormalities relating to benign or malignant growths. These findings were reported to the referrer and passed immediately to the multidisciplinary team for review and action. This process followed the NICE guideline, 'suspected cancer: recognition and referral', 2015.
- Dose levels were recorded in a dose record book in each diagnostic imaging room for patients and staff, in line with IRR (ionising radiations regulations) 99. These were audited and reported on annually in the radiation protection advisor's report; the last report was October 2015.

Nutrition and hydration

- Nutrition and hydration needs were not formally assessed as part of the outpatient process, unless they were going to be booked for surgery. Then staff would use the Malnutrition Universal Screening Tool (MUST).
- If patients required food or drink for clinical reasons, for example if the patient was diabetic and had not eaten, or they were waiting in the department for transport, there were provisions for staff to order food from the hospital restaurant.

Pain relief

- There were processes in place to assess patient's pain levels and act appropriately. We saw evidence in patient's records that pain levels had been discussed as part of their consultation, and the nationally recognised number scoring tool was used. The patient would use a scale from zero-10, zero being 'no pain' and 10 being 'worse pain possible'.
- Pain relief could be prescribed if needed, by the consultants and subsequently dispensed by the pharmacy department.
- Patients could be referred to the pain management clinic if assessed as needing this by their consultant. This was held at St Albans City Hospital.

Patient outcomes

- There was a local audit programme for outpatients and diagnostic imaging. Audits included hand hygiene, GP referrals, two week wait pathway for gynaecology and service provision for fertility services and environment and infection control audits. These were due for completion at the end of October 2016.
- Evidence was seen in the minutes from the divisional governance and quality group that local and national audits for 2016/2017 were reviewed, and they were either compliant or still awaiting data. Some of the national audits that had been registered for the financial year 2016/2017 were the national diabetic foot audit, chronic obstructive pulmonary disease audit, adult asthma audit and the cardiac rhythm management audit. These were due for submission November 2016 and March 2017.
- The follow up to new rate for Hemel Hempstead was consistent, ranging between 1.7 and 2.0 follow-up appointments for every new appointment; this was slightly below the England average of 2.3, meaning they were doing well on this standard.
- In June 2016 the trust cancelled 4% of clinics, compared to the national standard of 8%. There had been a significant reduction in cancellation rates since the last inspection. Staff said this was due to setting up ad-hoc clinics and clinics on a Saturday. Analysis of hospital initiated single appointment cancellations was underway to identify themes and reasons for these cancellations. We were not supplied with data broken down for the individual hospital sites.
- The hospital monitored patient outcomes through surveys to ensure patients were satisfied with the service they received. Data showed that on average 71% of patients who visited the OPD were satisfied with the service and would recommend it to family and friends.
- The diagnostic imaging department did not participate in the Imaging Services Accreditation Scheme (ISAS) or the Improving Quality in Physiological Services (IQIPS). These help imaging services manage the quality of their services and make continuous improvements. There are currently 24 services that hold the ISAS accreditation across England. The staff at Hemel Hempstead were aware of the schemes and thought it may be due to financial pressures as to why they had not yet applied. However, it is something they would be interested in, in the future.

Competent Staff

- Staff were supported in their development using the appraisal process, an annual performance appraisal helps to deliver individual professional development and service improvement. The trust target was for 90% of staff to have received an annual appraisal. Outpatients did not meet this target for the administration staff. Trust figures showed that 91% of nursing staff and 67% of administration staff had received an appraisal from April 2015 to March 2016. The reason for the shortfall in administration staff receiving an appraisal was due to retirement and sickness.
- Diagnostic imaging staff were compliant, with 96% of their staff receiving appraisals within the same period. All qualified staff within the diagnostic imaging department were registered with the Health and Care Professions Council (HPC) and maintained their registration with regular continuing professional development. A record of all professional development activities for each radiographer was kept on their personal file; we saw evidence of training and annual assessment records.
- The staff who had received an up to date appraisal told us they were useful, carried out by their line manager, constructive, and had plans for further training.
- Staff we spoke with had received suitable induction on starting work. They received a corporate and local induction that welcomed them to the trust and introduced them to their respective departments. Agency radiographers were well supported in the department; their competences were checked and they all signed the local rules. The diagnostic imaging departments had local rules for the protection of persons against ionising radiations arising from the use of diagnostic x-ray equipment, these were in accordance with the Ionising Radiation Regulations 1999, and was standard practice for imaging departments.
- There was a clear process and induction checklist. There was a good process to check professional registration for nursing staff and radiographers.
- We saw evidence that staff competency was checked on recruitment, and all had individual learning logs. Revalidation for nurses was discussed in the outpatient sisters meetings.
- Staff we spoke to were knowledgeable about their area of work and felt supported by their line managers to develop further skills. For example, health care assistants were given the opportunity to do their nurse training.
- If staff required supervised practice this could have been arranged. We saw from minutes from the radiation protection panel meeting, that as part of lessons learnt from incidents, staff were given the opportunity to work supervised, this was the case for Hemel Hempstead and St Albans hospital sites.
- The outpatients department had clinical nurse specialists holding clinics, including colo-rectal oncology. They were all trained to level two in a psychology module.
- For registered nurses there was a new revalidation system, which started in April 2016. There was evidence seen in minutes from department meetings that revalidation process was discussed. We spoke to two nurses who told us that they had been supported through this new process and felt confident with the paperwork that needed to be submitted.

Multidisciplinary working

- We observed good evidence of multidisciplinary (MDT) working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together. Staff confirmed that there were good working relationships between nurses, diagnostic imaging staff and the consultants.
- There was some involvement with other departments, such as therapies and the surgical team, and we saw evidence in the patient records that they had added to the notes to provide information to consultants about treatment plans.
- The services also held multidisciplinary meetings to discuss new cancer diagnoses. These were attended by four surgical oncologists, two oncologists, two radiologists, one histopathologist and a gastroenterologist for colo-rectal cases. There was no dietician, however this was being looked at, and a dietician was planned to be invited when available.
- Various clinical nurse specialists (CNS) held clinics within the outpatients department. We spoke with the colo-rectal CNS during our inspection. They saw patients following surgical procedures, and liaised closely with the oncologists and colo-rectal consultants regarding care and treatment plans.
- Referrals to specialist nurses in the community could be made if required.
- The diagnostic imaging staff had access to any scans and x-rays from other hospitals, and they would

communicate with the staff from Watford General hospital and St Albans if needed, to discuss a patient's previous images. This ensured that patients did not receive unnecessary scanning and radiation.
- The children's outpatients department held one-stop allergy clinics, which were run by a nurse specialist with input from the paediatric consultants when needed.

Seven day services

- The outpatient department was open from 8.30am to 5.30pm, Monday to Friday. However, extra clinics were also scheduled in the evening and at weekends to meet the needs of the population. These were staffed by current trust staff working additional hours.
- The diagnostic imaging department was open 8.30am to 5.00pm, Monday to Friday, and at weekends 9.00am to 10pm, for plain film x-rays, via the minor injury department. If inpatients required urgent x-rays over the weekend, there was an on-call radiographer over the weekend.
- There were extra MRI lists in the evenings set up until 8pm. This was to meet the demand.

Access to information

- Records were available 96% of the time for clinics from March 2015 to April 2016. The reason for records not being available were short notice referrals, and records not in the location, which was last recorded on the notes tracker system.
- Diagnostic imaging results were scanned onto the electronic patient system so that they could be accessed by staff throughout the trust as required. Diagnostic imaging staff could access test results from other providers immediately through an electronic system.
- All the consulting rooms had access to a computer terminal to allow staff to access patient information, such as test results, imaging and electronic paper records.
- Policies and procedures were available on the hospital internal website and staff were aware of how to access them.
- Patient information was protected, records were kept secure in all areas of both departments, and all computers were password protected.
- Information from team meetings was emailed to staff, communicated through the daily morning 'huddles' and displayed on relevant notice boards, this ensured that staff had access to the latest information
- Following an outpatient appointment, the clinic sent a letter to the patient's GP. Senior staff told us that this always happened and had had no incidents of GPs not receiving these letters.
- Information on the hospital website provided information about services and clinics available for patients and relatives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at six consent forms in outpatients and diagnostic imaging departments and found that they were used appropriately to record patients' valid consent. We looked at the radiology policy on consent. Radiographers told us that they followed the policy to ensure that patient consent was gained for each scan or procedure. We observed staff following this policy as they gained consent from patients.
- Staff received training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and told us they were confident in seeking consent from patients. They were aware of the legal requirements and how to make decisions in the best interest of patients who were unable to make decisions about their care themselves, however, we were unable to observe this in practice.
- We saw that consent form four was used for procedures in line with the MCA 2005. This consent form was specifically for patients who lack the capacity to consent to investigations or treatment in accordance with the MCA 2005.
- We were shown the department's MCA folder. This contained all evidence of patient's mental capacity assessments and best interests, a DOLs process flowchart, mental capacity policy, phone numbers of who to contact with queries and concerns, and who had had their training for MCA and DOLs.
- Figures provided by the trust showed us that 90% of outpatient nurses and 100% of administrative staff had attended MCA and DoLS training, and 89% of staff in diagnostic imaging had completed training. In response to these figures the management told us, that with the introduction of increase electronic learning modules these figures would increase.

Outpatients and diagnostic imaging

- The divisional manager for surgery and the surgical consultants had redesigned the generic consent form, to make bespoke forms for specific surgeries. They were to be colour coded so would be easily identifiable in the patients records, with all the risks to patient listed with tick boxes for the doctors, which would make it easier for the patient to read.
- Four out of five nurses knew what Gillick competency was, and how it involved gaining consent from children. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. In the children's outpatient department there was only one nurse and one health care assistant to ask, both could explain Gillick competency.

Are outpatient and diagnostic imaging services caring?

Good

Overall, we rated caring as good because:

- Patients and their relatives told us they were supported by staff who were caring and treated them with compassion, dignity and respect.
- Staff were approachable, kind polite and friendly, and patients were positive about their experience of care given.
- Staff in a range of roles spent time with patients to make sure they understood procedures and to put them at ease.
- Staff explained the consultation and information fully in a manner patients could understand.
- To provide privacy and dignity, there was a separate room for weighing and carrying out patients observations, before they were seen by the consultant.

Compassionate care

- We spoke with six patients and two relatives who all told us that they were treated with dignity and respect by all members of staff they had contact with.
- Patients told us they found staff to be polite, friendly and approachable. Comments included, 'staff are very caring and welcoming; I am treated like a human being and listened to' and 'staff are friendly and calm in their approach'.
- We observed staff greeting patients on their arrival and introducing themselves.
- We observed staff establishing a rapport with patients and relatives to help put them at ease.
- Both services offered patients the support of a chaperone. This person acted as a safeguard and a witness for patients and staff during examinations or procedures. We observed posters in outpatients, and diagnostic imaging, informing patients of the chaperone policy and how to ask for one. We also observed patients being asked by staff before their consultations or procedures.
- Staff told us for clinics that involved examinations that were more intimate; a nurse was always assigned to support patients throughout.
- Staff provided assistance as needed and spoke with patients clearly and discreetly.
- We observed that staff respected patient confidentiality and ensured discussions took place in treatment or consulting rooms for privacy, conversations held within clinic rooms could not be overheard externally.
- We observed that reception staff were welcoming to patients checking in, and were friendly and efficient during busy times.
- There was a separate room to assess weight, height and blood pressure before patients had their consultation. This provided patients with privacy and dignity.
- The outpatient department took part in the 'I want great care' patient survey, data showed that 71% of patients were satisfied with their care and treatment at the OPD.

Understanding and involvement of patients and those close to them

- All of the patients and relatives we spoke with in the outpatients department and diagnostic imaging told us that care and treatments were explained to them and their relatives. Patients told us they felt involved in their care and their appointments were not rushed.
- We observed opportunities for patients to ask staff further questions if they did not understand anything they had been told.
- We observed staff supporting one patient to understand an investigation they were going to have in the

cardiology clinic. This involved a health care assistant explaining that they needed an electrocardiogram (ECG), the patient did not know what this was, so the staff member showed them the machine, how it worked and what it was used for. Afterwards, the patient told us that this had put them at ease, and informed them of the investigation in a way that they understood.

- Four patients we spoke with were aware of why they were attending the outpatients' department.
- Staff recognised if patients needed additional support, if a patient was in the waiting area with a friend or relative, we observed that the patient was asked if they wanted them to accompany them in the consultation room. Staff also told us that when they are informed in advance on patient's referrals that they need an interpreter or translator, this would be arranged.
- Staff gave patients sufficient information regarding their next appointments and any further tests they may need to return for, and this was documented in a letter for the GP. Patients we spoke with were well informed about what was happening and where they had to go next. They were given clear directions to the imaging departments or pharmacy if needed.

Emotional support

- We observed staff speaking to patients about their condition and giving appropriate information. Patient's comments to us included, 'staff really care', they are discreet, and they did not leave me until I was ready'.
- Staff we spoke with were aware of the impact a treatment or diagnosis could have on a patient, and would ensure that time and appropriate information was shared with these patients before they left the department.
- A nurse told us of a patient who had been given a new diagnosis of cancer. The nurses contacted the Macmillan team to come and see the patient, and no one was available, so they called the support line for the patient to make sure that they had support, and a contact. The nurses kept in contact with the patient to ensure they were being emotionally supported. The patient later phoned the department to thank the staff for going the extra mile.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Overall, we rated responsive as requires improvement because:

- Referral to treatment performance had been improving since the last inspection, and exceeding the target for some clinics. However, due to poor performance in certain clinics, only 87% of patients met this target from May 2016 to September 2016. This meant performance had declined over the past six months.
- Data for July to September 2016 showed that the trust had fallen below the national 93% target that all suspected cancers should be referred to a consultant and seen within two weeks; only 87% of patients were seen within this timeframe. This meant performance had declined over the past six months.
- Leaflets were not available in other languages other than English.

However, we also found that:

- Staff provided visible information for patients on how long they might have to wait.
- Several one-stop clinics provided holistic care to patients. The one stop breast clinic would on average see their patients within one week of referral.
- Staff ran evening and weekend clinics to reduce any increased waiting lists.
- All patients who were newly diagnosed with a cancer waited no longer than the national standard of 31 days from the date of diagnosis to receiving definitive treatment from April 2015 to May 2016.
- The diagnostic waiting time was consistently better than the England average.
- Clinic non-attendance was in line with the national average.
- Patients told us they received appropriate instructions with their appointment letters and were given written information as needed.
- There was a trust policy for the care of patients with learning disabilities who attended the outpatients and diagnostic imaging departments.
- Patients living with a dementia could wait in a quieter area of the outpatients department if required.

Outpatients and diagnostic imaging

- The introduction of a SMS test messaging service, to inform patients of their appointment, had helped reduce the non-attendance rate.
- Information leaflets were widely available on a range of subject matter, including diagnoses and explanations of investigations and tests. Patients were given information leaflets and phone numbers to call if they required any further information, and we observed this during our inspection.

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

- Hemel Hempstead General Hospital provided a range of outpatient and diagnostic imaging services to meet patient's needs. Routine and more specialist scans, such as magnetic resonance imaging (MRI) were available.
- Seating in the waiting areas was comfortable and sufficient. There was a water drinks dispenser and a separate area for children to play in both services. Also, reading material in the form of books.
- Patients received their appointment times via a paper format letter, which included directions to the hospital and where to find the departments. They also included any information on tests, such as blood tests and x-rays that may be needed and which consultant they would be seeing. If appropriate, information on nil by mouth instructions was provided too.
- There was wheelchair access throughout both services, and waiting areas had access to toilets and toilets adapted for people who were disabled.
- There was sufficient signposting for all departments, with a staff welcome board, with all staff members' picture, name and role.
- Information regarding patient's needs was captured using patient satisfaction questionnaires.
- On the information board in the waiting room, it said that patients had mentioned in the feedback survey, that car parking fees were unclear and they were not informed of waiting times. The department put feedback on the board to show that they had listened, including whiteboards outside the consulting rooms giving up to date times and information leaflets were available about the car park.
- Ambulance patients were offered a drink and a snack if they were waiting for transport. We saw one patient in a wheelchair waiting for ambulance transport services, they were given a cup of tea and sandwiches, and staff frequently spoke with the patient and mobilised them.
- The audiology service ran drop in clinics for hearing aid issues, improving patient experiences and reducing visits to the clinic.
- Walk in services for x-ray plain film examinations were provided Monday to Sunday, 9am to 10pm.
- Extra clinics were arranged to prevent patients waiting for longer than recommended. This meant that the matrons and sisters had good oversight of any impact to patients care and treatment.

Access and flow

- Patients were referred to outpatient services by their GPs, hospital consultants and other practitioners, for example opticians.
- The department had recently introduced an electronic booking in system within the waiting room. Staff told us that since the introduction of this system, queuing time was alleviated at the reception; however, we were given no audit data to evidence this. We spoke with two patients who were using this system, and they found it easy to use. Reception staff we spoke to told us it had alleviated the pressure of seeing long queues of patients waiting to book in.
- The children's outpatient department received referrals from GPs or direct from the paediatric wards at Watford General hospital. They would look at clinical need and where the patient lived to decide if their appointment would be on the Watford or Hemel Hempstead site. They also delivered a range of sub-specialities, such as, endoscopy and chemotherapy. This reduced the need for the children and their families to attend larger tertiary hospitals further away.
- Some patients were seen within 18 weeks of their referral reaching the hospital. The national standard for NHS trusts is that 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral, was withdrawn in June 2015. The trust performed better than the England average in certain speciality clinics, for example, for dermatology 97%, and geriatric medicine 98%. However, they were slightly below the England average for gynaecology at 94% and urology at 91%. Non-admitted pathways meant those patients who started treatment and did not need admission to hospital.
- The trust did not meet the national standard that 92% of patients waiting to start treatment or 'incomplete pathways' should start consultant led treatment within 18 weeks of referral, from June 2015 to May 2016. In

certain clinics, they exceeded the England average, meeting the target at, for example, dermatology at 99% and general medicine reaching the target at 96%. However, due to poor performance in other clinics, the trust's overall performance was 88%, against the national target of 92%. The trust's performance had declined further for September 2016 to 86%. This meant performance had declined over the past six months.

- The trust told us that ongoing referral demand has been highlighted to the clinical commissioning group (CCG) on a number of occasions, particularly in relation to cardiology. The CCG had been asked to add referral and demand management to the monthly planned care system resilience group (SRG), and further meetings were planned to discuss referral analysis.
- Services that were achieving 92% or above had been given a stretch target to the next percentage point to support services where compliance was an issue. Local actions were being implemented to increase activity to reduce the backlog and achieve a sustainable compliant position.
- The national cancer waiting standard was that at least 93% of patients urgently referred by their GP with a suspicion of cancer should wait no longer than two weeks to be seen. The trust met this target for the period from April 2015 to March 2016 being between 93% and 95%. However, the data for September 2016 showed that they had fallen to just 91% of patients being seen within two weeks of diagnosis. Data for July to September 2016 showed that the trust had fallen below the national 93% target that all suspected cancers should be referred to a consultant and seen within two weeks; only 87% of patients were seen within this timeframe. This meant performance had declined over the past six months.
- The national standard is that 85% of patients should wait no longer than 62 days from urgent GP referral to first definitive treatment for all diagnosed cancers. The trust performed better than the 85% national standard from April 2015 to April 2016, with consistently more than 85% of patients waiting less than 62 days. The trust's figures were between 85% and 89%, this was also significantly better than the England average which was between 82% and 83%.
- From March 2015 to April 2016, the percentage of patients diagnosed with a cancer waiting no more than 31 days for definitive treatment was consistently higher than the national standard of 96% and generally better than the England average.
- Since April 2015, the trust had performed well in providing patients with appointments for diagnostic services. The diagnostic waiting time standard was that 99% of patients referred for diagnostic tests/procedures, should wait no longer than six weeks. This standard had been delivered consistently since April 2015 and was better than the national position of 98%.
- The radiology department reported on diagnostic images efficiently, on the same day for inpatients, four days for routine and two days for urgent referrals. These figures were from data audited from December 2015 to April 2016.
- The average waiting time once patients had arrived in the department for an outpatient appointment in outpatients across all three sites, was 34 minutes, according to the audit carried out from December 2015 to June 2016. The patients that we spoke with during the inspection told us they had waited no more than 20 minutes.
- Waiting times were communicated to patients via whiteboards outside each consulting room. The times were updated regularly by the nursing staff, and this was observed during the inspection. This process had been implemented since the last inspection, and patients told us that this was a significant improvement. They felt communicated with and they told us that the staff updated the boards regularly. During our inspection we did not see waiting times displayed longer than a 20 minute wait to see the consultant.
- We observed two patients booking in with reception and once sat in the relevant waiting room they were immediately called through for the necessary tests to be carried out before their consultation.
- From March 2015 to February 2016, the percentage of appointments which patients failed to attend was around 6 to 8%. This was similar to the England average of approximately 7%. If patients failed to attend urgent referrals for cancer, administration rang them to find out the reason and re-arrange the appointment if necessary. Other patients were sent another appointment in the post, and then if they did not attend the second appointment, they would be referred back to their GP. This system was the same across all three hospital sites.

Outpatients and diagnostic imaging

- An improvement in clinic attendance had been since the trust introduced a text messaging service to patients, reminding them of their appointment time and date. An audit carried since this started, showed that the amount of patients not attending for their clinic appointments had reduced by 10%.
- On the outpatient improvement plan was a plan to implement a clinic room availability schedule, which would identify available rooms to hold ad-hoc clinics. Plans were also in place to analyse hospital-initiated cancellations under 6 weeks and to identify hot spots, and ensure that they take the required actions to meet the 18 week referral to treatment national target. This was a quality improvement plan (QIP) 'must do'. These actions were ongoing and trust wide.
- One patient we spoke with had their first outpatient's appointment at Watford General Hospital, they asked the consultant if they could have the next appointment at Hemel Hempstead Hospital and this was able to be accommodated. When this was discussed with the staff, they told us this was common practice.

Meeting people's individual needs

- The outpatients and diagnostic imaging departments had patient information on display, including large whiteboards with waiting times and clinics running for that day, and how many staff on duty.
- The layout of the reception desks meant that conversations could be heard, however, we were informed by the reception staff that they did not ask confidential information and we observed this to be the case. Patients could write down any confidential information that was required to avoid discussing at this point.
- Information, such as leaflets were not readily available in other languages other than English. When we asked staff, they could tell us ways in which they would be able to gain the information in other languages, or braille, however, this was not needed often. The trust planned to order all leaflets in five other languages, and we saw this on the outpatient improvement plan. However, we saw stop smoking services leaflets in both English and Arabic.
- None of the departments we visited used a hearing loop to improve the quality of communication for people wearing hearing aids; however, they had not received any complaints regarding this.
- Staff were aware of interpreter and translation services available. They could be booked via the telephone, and would either accompany the patient or translate over the telephone. Sign language interpreters were also available. One of the nurses we spoke with had used this service and it worked well and benefited the patient's consultation.
- Patients and relatives were given information on how to book translator services on the main hospital website.
- Patients were given information leaflets and phone numbers to call if they required any further information, and we observed this during our inspection.
- There was support given to service users who needed hospital transport, this could be booked by the GP or patients prior to their appointments. Information was available on the trust website for patients. If patients did not meet the criteria for hospital transport, a voluntary care service could be booked by the GP or hospital.
- There was a link nurse for dementia who supported staff when caring for people with additional needs. There was also a learning disability nurse for the trust, who the staff could contact for advice and support.
- Hemel Hempstead town centre had a dementia café, and the opening times and contact details were displayed on designated dementia noticeboards in the outpatients department.
- Patients living with dementia or learning disabilities were given earlier appointment times, to avoid patients becoming distressed in an unknown environment. Their relatives or carers were always encouraged to come in to the consultations with them.
- The trust had a policy for the care of adult patients with learning disabilities, and guidance for carers and service users when they attend the outpatient or diagnostic imaging departments.
- We saw in the outpatient's department meeting minutes, that they had a spokesperson from the transgender community to come and speak to staff, to explain what it was like to be transgender and a patient in the outpatient department. This took place at the three hospital sites.
- We were told that bariatric equipment was available if needed; this included a bed and a wheelchair. If a bariatric hoist was needed, this could be arranged and delivered from Watford General hospital.
- Consultation rooms were private. This assisted in maintain patient's dignity but also allowed for space and time if the patient required it.

Outpatients and diagnostic imaging

- There was an onsite chapel at Hemel Hempstead hospital, which could be used by staff, patients and relatives. The spiritual and pastoral care department could be contacted via the hospital switchboard and they provided support in a range of areas, including, bereavement, patients facing distressing news and care of the dying and of their relatives.

Learning from complaints and concerns

- There was a complaints policy in place. Staff and managers were aware of the policy and where to find it on the hospitals internal website, and the senior sister had a copy in their office.
- Both departments we visited provided visible information and guidance on how to make a complaint. Staff we spoke with were able to describe the trust's complaints process.
- Information leaflets contained details of who to contact with concerns and details of how to contact the Patient Advice and Liaison service (PALS).
- Initial complaints were dealt with by the senior sister in outpatients and the chief radiographer in diagnostic imaging. However, if this could not be resolved at this level, it would be escalated to the lead nurse for their help and support in driving it forward to be resolved within a timely manner.
- The divisional manager was responsible for overseeing all formal complaints and supported the lead nurse and senior sister in investigating complaints in both services trust wide. Staff told us they tried to resolve complaints and concerns at the time wherever possible, with the support of the senior sister or matron. Staff told us the main theme for verbal complaints was clinic waiting times, however, we were told that these had reduced since the introduction of the whiteboards, informing patients of up to date waiting times and reasons for any delays. This had been an improvement the trust had learned from previous complaints. However, we had no audit data to evidence that complaints had reduced in regard to waiting times, due to it being a new service set up.
- We saw from clinical governance and departmental meeting minutes that complaints were an agenda item and were discussed.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Staff were aware of the hospital vision and told us they wanted to deliver the best possible patient care and treatment.
- Clinical leadership was good at local and corporate level, with the introduction of the lead nurse and divisional director, and a new senior and junior sister in outpatients.
- Both services held regular governance meetings and shared information.
- We saw that risks had been identified and actions taken to mitigate the risks in a number of areas that included leadership and workforce, patient safety and infection control risks.
- There was commitment from the managers to learn from feedback, complaints and incidents.
- We saw good, positive, and friendly interactions between staff, managers and the senior management team.
- Staff in both outpatients and diagnostic imaging felt listened to and well supported by their immediate line managers. There was an open and transparent culture.
- Staff were aware of the trust's vision and values.
- There was a clear improvement plan in place for the service that was being followed.

Vision and strategy for this service

- Staff we spoke with were aware of, and understood, the vision and values of the trust. Staff identified the "very best care for every patient, every day" initiative to look after patients. Nursing staff were clear about their role and behaviours that would achieve these values, using the trust's four aims. These were to deliver the best quality care for patients, to be a great place to work and learn, improve financial stability and to develop a strategy for the future.
- We saw that the vision for the hospital was posted on the walls of the departments.
- There was not a joint strategy or vision to take the directorate forward specifically for outpatients or diagnostic imaging; however they had made many improvements since the last inspection.

Outpatients and diagnostic imaging

Governance, risk management and quality measurement

- The accountability for the management and performance of outpatients was delegated to the divisional director. The divisional director and their management teams had responsibility for oversight and management of performance for outpatient services within their clinical remit.
- The governance structure was defined within the clinical specialist services division. The lead nurse we spoke with explained local clinical governance processes and how they shared governance information at their team meetings.
- We saw evidence that risk assessments were completed for the services and were RAG rated (a project management method of rating issues or status reports, based on red, amber and green colours) from red to green, such as risk of sharps injury, slips, trips and falls, lone working, ligature points, and radiation risk assessments for radiographic examinations.
- We saw that there was an ionising radiation safety policy in place that had been reviewed. The policy set out governance arrangements and the roles and responsibilities of those involved in radiological interventions.
- We reviewed three sets of minutes for the medical division governance meetings, radiation protection panel and the medical exposures committee. Various subjects and issues, were discussed, and actions allocated to staff to complete, for example, review of the radiation safety policy, IR(ME)R audits to be collated, quality and clinical audit, patient safety and risk and complaints.
- Both services assessed the need for a 'local safety standards for invasive procedures' plan. They used the national safety standards for invasive procedures (NatSSIPs) 2015 to do this.
- The senior staff in outpatients and diagnostic imaging knew about the governance structure and which divisions their departments were managed by.
- The diagnostic imaging departments held radiation protection and medical exposure meetings, where incidents, audits and policies were discussed and reviewed, with actions set. The diagnostic imaging department at Hemel Hempstead held monthly clinical governance meetings, and senior team meetings and they rotated the day so all staff got a chance to attend.
- The risk register was seen to be discussed in the divisional governance meetings and plans drawn up on the improvement plan against the risks. There were 14 risks specific to outpatients on the medicine division risk register and the main three were reflected in the corporate risk register. It showed how the risks were managed at department level and managed at a trust wide level.
- Main risks were to do with clinic capacity, management of medical records, and poor ventilation in the departments which lead to poor patient experience and staff working conditions. The trust told us that issues relating to clinics and waiting times were discussed weekly at access meetings.
- The lead nurse had ownership of risk management within outpatients across the three hospital sites. Staff working within their areas could tell us of risks within the service. For example, they told us that the design of OPD and staffing were high on the risk register.
- The lead nurse had monthly meetings with the sisters from all three outpatient departments and discussed headings such as cancellations, patient non-attendance, additional clinics, incidents, complaints, risks, vacancy, sickness, appraisals, and staff training. This gave the matrons oversight of good practice and improvements that needed to be made. Matrons would then escalate and discuss at their one to ones with the deputy divisional manager for outpatients.
- Department waiting areas displayed information for staff and patients, which included patient satisfaction, waiting times, cleanliness, the number of patients that did not attend and the cost of this to the service, as well as their monthly performance against core standards.

Leadership of service

- Outpatients and diagnostic imaging were managed by a divisional director. They worked closely alongside the chief radiographers and the lead nurse for outpatients. They covered all three hospital sites.
- The divisional director and lead nurse were new appointments since the last inspection. At local level a new senior and junior sister had been appointed at Hemel Hempstead outpatients.
- Staff we spoke with told us that their management leads provided clear clinical and nursing leadership. Staff felt supported by the management leads.

Outpatients and diagnostic imaging

- The 12 members of staff we spoke with told us that the department had benefitted from the new leaders both corporately and at local level. They all said that they saw the lead nurse regularly, and they were supportive and positive about the service they delivered.
- Staff told us in all departments that there had been a change of culture since the last inspection, and felt that the senior team listened to their concerns.
- The senior team at local and corporate level were seen to be approachable and supportive. We observed managers to be present in the departments providing advice and guidance to staff and interactions were positive and encouraging.
- We saw good, positive and friendly interactions between all staff members and their managers.
- Locally, managers led their services and had plans in place for improving services for patients.
- There were clear lines of accountability in place and staff were aware of who they could go to for help or to escalate a problem.
- The divisional director and lead nurse were well known and seen to be supportive to staff. Staff said there had been many improvements and morale had increased since they had been in post.
- Staff in both departments said they worked well together and shared the responsibility to deliver good quality care.

Culture within the service

- The managers of the outpatients, and diagnostic imaging departments were visible and we observed a supportive management culture.
- Staff described the culture of the departments as being open and honest and they felt they were listened to by their line managers and senior management.
- During our inspection staff were friendly, welcoming and helpful. They demonstrated commitment to providing a good service for patients.
- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges of the service.
- Senior and junior sisters provided hands on support during times of increased activity. We saw during the inspection that they covered clinics to ensure the continuity of services.
- Staff told us they were happy and felt supported in their roles. They also told us team working was good within the multidisciplinary team.
- We observed staff in outpatients, and imaging services working well together as a team and valuing each other.
- The majority of the staff we spoke with had a positive, optimistic and confident view about the future of the outpatients, and imaging services.

Public Engagement and staff engagement

- The views of patients were actively sought within outpatients and diagnostic imaging using the 'I want great care' patient survey. These were available in locations throughout the department, and posters advertised this. The results and patients comments were displayed on the information board in the waiting room.
- The hospital website provided patients with a forum to leave feedback about their care and treatment. For example, two patients left comments that they had received 'excellent care' in Hemel Hempstead outpatients department.
- In the minutes from the outpatient's department meeting, we saw that staff from the 'patient information department', were holding training sessions in 'the patient experience'. This was for all outpatients departments across the three hospital sites. These included topics, such as, what it was like to be a patient, and videos 'through the eyes of a patient'.
- Staff felt more involved in the trust's processes and decisions since our last inspection, and the recruitment of the new senior sister. They told us they would be able to voice ideas for improvement of the service and said they would be listened to.

Innovation, improvement and sustainability

- There had been improvements made for both outpatients and diagnostic imaging services since the last inspection.
- The outpatient's improvement committee had drawn up an improvement plan detailing all improvements to be made within outpatients trust wide, with deadlines against them and who was responsible for driving each action.
- The main improvements that had been made were improving patient appointment letters, improved telephony in central booking, SMS text reminders for appointments, lockable medical record trolleys,

improved lighting, couches, ventilation and whiteboards displaying patient information and waiting times for current clinics. These improvements had been made at the Hemel Hempstead department.

- There were planned improvements for the future, including providing patients with a central email contact for appointment queries. They were also looking at other trusts, to see how they managed consulting room availability, and were considering using an electronic room booking system. This meant that full use of rooms could be maximised for clinics and seeing when they had availability to add on extra clinics.
- The lead nurse had received a 'gold award', for demonstrating her commitment to the five gold standards of service. These were 'the patient is the priority', 'I smile and introduce myself and listen', 'a 'ringing' phone is my responsibility' and 'I create a calm environment'. This award was displayed in the waiting room.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- To ensure that there are effective streaming systems in place in the Urgent Care Centre (UCC) and all staff have had appropriate training to carry out this process.
- Ensure there are processes in place to monitor arrival time to initial clinical assessment for all patients.
- To establish a process so that all children are seen by a clinician within 15 minutes of arrival to the UCC.
- To ensure that there are effective processes in place in the UCC to provide clinical oversight for patients waiting to be seen.
- To ensure non-clinical staff receive sufficient support or training to provide oversight to recognise a deteriorating patient in the UCC.
- To ensure the UCC had direct access to a registered children's nurse at all items and that paediatric competencies for emergency nurse practitioners are recorded as a part of their continuous professional development (CPD) in line with national recommendations.
- To ensure that effective governance frameworks, standard operating procedures and policies are in place to support service delivery in the UCC.
- To ensure that systems and processes are in place to monitor and review all key aspects of performance to identify areas for improvement and all potential risks in the UCC and on Simpson ward.
- To ensure that staff are given training and support to understand the duty of candour statutory requirements.
- To ensure all staff have had the mandatory training relevant to their roles and that all staff receive an annual appraisal in the UCC and on Simpson ward.
- To ensure that all outpatients' administrative staff receive appraisals.
- To maintain medicines at correct temperatures in all areas and ensure appropriate action is taken if outside recommended range on Simpson ward.
- To ensure that all medicines are suitable for use and have not expired on Simpson ward.

To ensure safe storage and management of controlled drugs on Simpson ward.

- To ensure staff levels and competency of staff meets patient need at all times on Simpson ward.
- To ensure appropriate assessments and authorisations are in place for Deprivation of Liberty Safeguards on Simpson ward.
- To ensure that the Simpson ward can meet the needs of patients with vulnerabilities, including those living with a dementia and those displaying difficult behaviours and to ensure the provision of activities to engage patients in meaningful stimulation.
- To ensure learning from incidents and feedback is embedded to drive improvements on Simpson ward.
- To review the admission and exclusion criteria for Simpson ward to ensure all referred patients have their needs met.
- Plans must be put into place to ensure referral to treatment (RTT) and cancer treatment times to continue to improve so that they are similar to or better than the England average.
- Ensure all staff understand the duty of candour regulation and its requirements.

Action the hospital SHOULD take to improve

- To consider ways to make the UCC environment more child-friendly in line with national recommendations.
- To consider ways of developing an audit process in UCC to monitor key areas of performance and compliance to protocols/pathways in line with other areas of the unscheduled care division.
- To monitor how learning from incidents is effectively shared and communicated to all relevant staff to minimise the risks to patient safety.
- To consider ways to ensure that staff are aware of the strategy for the UCC and continue to develop ways for their views to be heard.
- To establish clear escalation processes to manage the service in the UCC during periods of high demand or excessive waiting times.
- To monitor how pain assessments and management systems being used in the UCC.
- To review processes for monitoring those patients transferred from the UCC to other services in an emergency.

Outstanding practice and areas for improvement

- To review how staff can be supported via a clinical supervision process.
- To monitor how staff demonstrate compassionate care towards patients at all times on Simpson ward.
- To review discharge pathways to ensure access and flow are improved for Simpson ward.
- To review process for having medical records available for all clinic appointments.
- To review the provision of advice leaflets in a variety of other languages in outpatients.
- To provide safeguarding children level three training to all required clinical staff in outpatients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:-** • There were not effective streaming systems in place in the UCC and not all staff had appropriate training to carry out this process. • There were not robust processes in place to monitor arrival time to initial clinical assessment for all patients. • There was not a process so that all children were seen by a clinician within 15 minutes of arrival. • The UCC did not have robust processes and systems in place to ensure that all patients who were waiting to see a clinician were safe to do so. • Non-clinical staff had not received sufficient support or training to provide oversight or recognise a deteriorating patient. • The UCC service was not able to evidence that clinical staff treating children had appropriate competencies in line with national guidance. • In Simpson ward, medications were stored in rooms where temperatures exceeded recommended levels. Controlled drug storage was not in line with trust policy. Patient identification was not confirmed prior to administration of medicines. Staff did not follow safe administration procedures and did not maintain security of medicines during medicine rounds. • The percentage of patients to be seen within 18 weeks of referral from a GP for an outpatient appointment was below the national target. • The percentage of patients waiting to see a consultant with a suspected cancer did meet the national target of 93%.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:-** • The UCC did not have effective systems, processes and policies in place to monitor and improve the quality and safety of services provided. • There were no processes in place to monitor compliance to protocols and to ensure that changes made from learning from incidents were effective. • Risks to patient safety in the UCC had not been identified. • There was no a robust audit programme in place within the UCC. • On Simpson ward, not all incidents had appropriate actions to learn lessons recorded and there were no plans in place to reduce the incidents of falls within the ward. • On Simpson ward, action plans were not in place to address non-compliance with infection control standards. • On Simpson ward, intentional rounding charts provided evidence that these interactions had been completed, however this was as a "tick" and signature record. This meant that there was not always a complete record of all nursing interventions provided for all patients. • Simpson ward's admission criteria had not been updated since the use of the ward had changed meaning it was not suitable. • Simpson ward did not have a local risk register. There were no risks associated with Simpson ward on trust risk registers meaning that risk present were not being identified or responded to.
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The service was not meeting this regulation because:** • The UCC did not have direct access to a registered children's nurse at all items and that paediatric

This section is primarily information for the provider

Requirement notices

competencies for emergency nurse practitioners were not recorded as a part of their continuous professional development (CPD) in line with national recommendations.
- Medical staff cover was not always provided when required for the UCC.
- Not all staff had had the mandatory training relevant to their roles. Not all staff had had the required safeguarding adults training.
- Not all staff had received an annual appraisal.
- Whilst there were sufficient staff to provide general nursing care for the allocated number of patients on Simpson ward, staffing levels did not allow for one to one care, rehabilitation or assistance with therapies and activities.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** • On Simpson ward, whilst patients were appropriately referred to the deprivation of liberty safeguards team for assessment, which enabled an initial urgent authorisation whilst awaiting external assessment, the applications were not tracked to identify expiry dates and not reapplied for when the initial assessment period expired. • Staff lacked understanding of DoLS. • Staff in the main outpatients department did not have safeguarding children level three training in line with national guidance.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:**

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Requirement notices

- Staff in the UCC had minimal understanding of the duty of candour regulation and its requirements.