Care Quality Commission

Royal National Orthopaedic Hospital Trust

Royal National Orthopaedic Hospital (Bolsover Street)

Quality Report

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Date of inspection visit: 08/05/2014
Date of publication: 15/08/2014

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

Ratings

Overall rating for this hospital	Requires improvement
Outpatients	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

The Bolsover Street location is the central London outpatients facility of the Royal National Orthopaedic Hospital NHS Trust. The purpose-built facility was opened in December 2009. It offers modern healthcare facilities for patients, which include clinics, imaging - both X-ray and ultrasound, orthotics, occupational therapy, physiotherapy, pre-operative assessment and plaster services.

The trust was selected for inspection as it is an example of a specialist trust and a 'medium risk' trust.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the trust's key referrer of patients, NHS Trust Development Authority, the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Health and Care Professions Council (HCPC), Parliamentary and Health Service Ombudsman (PHSO), NHS Litigation Authority, the royal colleges and the local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our thinking. We held a publicised listening event on 6 May 2014. This was held before the inspection began and helped inform the thinking of the inspection team. Approximately 13 local residents and service users attended the listening event, and each had the opportunity to tell their story, either in small groups or privately with a member of the inspection team.

We carried out an announced inspection at Bolsover Street on 8 May 2014. At the Stanmore location we held focus groups with a range of staff in the hospital, including senior nurses, junior doctors, consultants, student nurses and healthcare assistants, administrative and clerical staff, physiotherapists, occupational therapists, and pharmacists. We also spoke with staff individually as requested. Most staff worked across both locations.

We talked with patients and staff. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

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

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

The inspection team inspected the following core services:

- Outpatients

What patients say

A total of 20 comments cards were received regarding the outpatients services. The majority of these were positive and related to the good or excellent care that patients received. Patients told us that staff were kind and caring and that staff at all levels and professions had time to listen and help them. However, patients also told us that clinics often did not run on time.

Overall, The Royal National Orthopaedic Hospital NHS Trust – Bolsover Street location was rated as 'requires improvement'. We rated it 'good' for providing caring and safe care and it required improvement for the services to be responsive and well led.

Our key findings were as follows:

Summary of findings

- The service was safely managed and the environment was clean and hygienic. The building was purpose built for outpatients and accommodated a variety of patient needs.
- Some clinics often ran late these were longstanding issues that the trust were working on.
- There was an unnecessary delay in letters being sent to GPs following appointments. The trust did not have a standard timeframe to which the letters should be sent.
- An overwhelming majority of patients told us that staff were caring and kind. Patients felt included in their care and treatment.
- Patient records were available at least 99% of appointments; they were transported and stored securely.

We saw areas of outstanding practice including:

- The environment was designed with the patient at the centre of service.
- Medical records were available for nearly all appointments.
- Some patients were given pagers on arrival so they were free to wait in an area that suited them – children's play areas, the café or different departments within the building – and not miss their appointments.

However, there was also an area of practice where the trust should make improvements.

- The trust should consider carrying out formal proactive audits of cleanliness and infection control in the outpatients clinics.

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?
Outpatients	Requires improvement 	The service was safely managed caring and effective but it required improvement in being responsive and well-led. The building was purpose built for outpatients and accommodated a variety of patient needs. Patient records were available for at least 99% of appointments; they were transported and stored securely. 21% of the clinics started late. There was no key performance indicator for sending out clinic letters following consultation to patients and their GPs. A significant proportion of letters were not sent out for over one month. There was an exception within the trust that letters regarding patients who had cancer would be sent out within 48 hours. The leadership team were aware of the issues but had not addressed them as they were not responsible for the clinical divisions who booked appointments.

Requires improvement

Royal National Orthopaedic Hospital (Bolsover Street)

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Detailed findings

Background to Royal National Orthopaedic Hospital (Bolsover Street)

Royal National Orthopaedic Hospital – Bolsover Street provides outpatients services only.

The purpose built facility was opened in December 2009 and offers modern healthcare facilities for patients, which include clinics, imaging - both X-ray and ultrasound, orthotics, occupational therapy, physiotherapy, pre-operative assessment and plaster services.

Our inspection team

Our inspection team was led by:

Chair: Professor Norman Williams, President, The Royal College of Surgeons

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission

Inspection Lead: Hayley Marle, Inspection Manager, Care Quality Commission

The team included CQC inspectors, senior NHS managers and an Expert by Experience.

How we carried out this inspection

In the planning of this inspection we identified information from local and national data sources. Some of these are widely in the public domain. We developed 98 pages of detailed data analysis which informed the inspection team. The trust had the opportunity to review this data for factual accuracy, and corrections were made to the data pack from their input.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the trust's key referrer of patients, NHS Trust Development Authority, the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Health and Care professions Council (HCPC), Parliamentary & Health Service Ombudsman (PHSO), NHS Litigation Authority, the royal colleges and the local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a publicised listening event on 6 May 2014. This was held before the inspection began and helped inform the thinking of the inspection team. Approximately 13 local residents and service users attended the listening event, and each had the opportunity to tell their story, either in small groups or privately with a member of the inspection team.

During our inspection we spoke with patients and staff from the wards. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

Facts and data about Royal National Orthopaedic Hospital (Bolsover Street)

The trust provides outpatients services only at Bolsover Street. It sees approximately 30,000 patients a year (2,500 patients a month).

The Bolsover Street location had two reviews on NHS Choices website as of June 2014, and was rated as having 5 stars out of 5.

The Bolsover Street location was inspected by CQC in November 2013 and was found to be compliant with the outcomes: respecting and involving people, care and welfare of people, safety and suitability of premises, safety, availability and suitability of equipment, supporting workers and records.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Outpatients

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

Information about the service

Bolsover Street is one of two sites from where the trust provides outpatient services. It is located in central London. It is a dedicated outpatients service that operates out of a purpose-built unit. Treatment is provided Monday to Friday from 11 clinic rooms and is open from 8am to 8pm. It is a three-storey building, with a wheelchair accessible lift to all floors.

The trust's outpatients service sees approximately 90,000 patients in total each month. The Bolsover Street location operates at one third less capacity than the main outpatients department at the Stanmore location and sees about 30,000 patients a year.

Patients present to the department, either by walking into the reception area or arriving by patient transport. All patients report to reception and are booked in for their appointment. A café provides tea, coffee and snacks.

We spoke with four patients, and a further 20 completed our 'tell us about your care' forms that were available in the outpatients department waiting areas throughout our inspection. We spoke with a range of staff at all levels of the trust, observed waiting areas of the clinics, and interactions between staff and patients. We received feedback from our listening event and staff focus groups. We also reviewed performance information about the trust.

Summary of findings

The outpatients service was safely managed and the environment was clean and hygienic. The building was purpose built for outpatients and accommodated a variety of patient needs. Patient records were available for at least 99% of appointments; they were transported and stored securely. Records for staff training showed they were up to date, although staff lacked a working knowledge of consent, capacity and safeguarding. The service was adequately staffed.

21% of the clinics started late. There was no key performance indicator for sending out clinic letters following consultation to patients and their GPs. A significant proportion of letters were not sent out for over one month. There was an exception within the trust that letters regarding patients who had cancer would be sent out within 48 hours.

The service ensured that patient assessments followed trust and national treatment guidelines through integrated booklets for different patient pathways. Appraisals were taking place for all staff, and we found good examples of multidisciplinary working. Services were provided five days a week.

An overwhelming majority of patients told us that staff were caring and kind. Patients felt included in their care and treatment. People's privacy and dignity was also observed.

There were clear lines of accountability and management for front line services within the

Outpatients

outpatients department. The issues of clinics running late and patients not attending had been identified through leadership meetings, and also through the comments and complaints the service received. Waiting times were the responsibility of individual clinical divisions, not the outpatient department itself. This meant that neither the Head of Outpatients, nor the Head of Operations- Support Services Division felt they could influence and effectively improve this aspect of the service.

Are outpatients services safe?

Good

The service had a good system for reporting and investigating incidents. Aspects of safety were suitably monitored and the environment was clean and hygienic. Medicines were checked and stored securely, although the medication case for emergency use was not secured. Patient records were transported and stored securely and were accessible when required. Records for staff training showed they were up to date, although staff lacked a working knowledge of consent, capacity and safeguarding. The department was adequately staffed.

Incidents

- There had been no 'never events' or serious untoward incidents reported.
- Staff had access to an online reporting form and were trained in using it. They demonstrated a good culture of reporting incidents.
- Reported incidents were assigned to an appropriate service lead for investigation. Risk ratings and outcomes were decided by the trust's 'risk team', who reviewed every incident report to ensure that what had been initially reported had been looked into and responded to.
- The completed report was automatically sent back to the person who reported the incident, so that they received feedback.
- The quality and risk direct care meeting (the medical division to which outpatients belonged and the formal structure to monitor quality in outpatients) reviewed incidents that occurred within outpatients, to identify possible themes and review specific issues.
- We were given examples of learning from incidents. Wider learning was cascaded through lead nurses, and issues were also discussed at monthly outpatient team meetings.

Safety thermometer

- The safety thermometer was not used in outpatients although it is recognised that this is not required within national guidelines.
- Monthly staff meetings monitored a number of safety aspects such as falls and rates of infection. There had been neither within the last year.

Outpatients

- Not enough staff being available to run the service was monitored and was mitigated when it occurred.

Cleanliness, infection control and hygiene

- There were hand-washing facilities in every clinical room.
- The service was not undertaking infection control audits as they used the patient-led assessment of the care environment (PLACE) audit that took place on a monthly basis. There had not been any incidents of infection in the department.
- We observed a clean and hygienic environment. We also observed good adherence to hand washing protocols.

Environment and equipment

- The environment was purpose-built specifically for outpatient clinics.
- There were designated waiting areas for different clinics taking place in the 11 clinic rooms.
- The environment was designed to enable an easy flow of patients. Clinic rooms had a door at each end to enable easy access of notes from the staff only side and easy access from the patient waiting area.
- The hand therapy room had two patient treatment tables, both designed to provide appropriate treatment. For instance, at the right height and right positioning. A screen was in position between the two tables for patient privacy and dignity.
- Medical engineers were responsible for the maintenance of equipment. There was an allocated budget to cover the maintenance.

Medicines

- Medicines were stored securely. They were stored in locked medicine cabinets to which nurses had access.
- Monthly medicines audits took place to check the medicines were still appropriate to use if required.
- All medication and equipment was ready for use.
- The emergency / resuscitation trolleys were checked daily.

Records

- Approximately 2,500 files were retrieved for outpatients per month.
- Patients told us their records were available and used during appointments.
- Patient records were stored securely within the records department at the main Stanmore hospital site and transported to Bolsover Street in a secure van, and in sealed and tagged packages prior to appointments.
- Clinical records kept were a combination of electronic records and paper files. When records were in the outpatients department, they were stored securely; locked away or on password-protected computers.
- Nurses told us that many patients had multiple conditions, so notes were essential for their appointment. They told us they rarely could not locate patient records, and were well served by the records department.
- Records showed that the 'key performance indicator' target of 99% had been achieved month on month for the whole of the 2013/14 year. On the rare occasion that a file could not be located a temporary file was produced from the most recent electronic data, such as clinic letters, basic details and test/blood test results.
- The records department was a well-managed department, with staff who were confident and competent in their roles. They spoke highly of the team they worked within, and praised the manager they reported to.

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

- There had been a focus to improve staff awareness and knowledge of safeguarding, consent and capacity, which were all part of mandatory training. The safeguarding lead for the trust was raising the profile and awareness, and was featured in the trusts' staff magazine for spring 2014.
- There had not been any reported safeguarding issues or referrals.
- The safeguarding lead told us that they had identified a gap in staff knowledge, and had been supported to roll out further safeguarding awareness and Mental Capacity Act (MCA) training.

Mandatory training

- Staff cover arrangements were made so staff could attend training courses.
- Online training records showed that 90% of outpatient staff were up to date with their training. Those not at 100% compliance could be accounted for by maternity leave, sick leave and training arranged for future dates.
- Core training topics included information governance, infection control, moving and handling, fire safety, child protection (levels 1,2 &3, although who had completed

what level was not verified), safeguarding, health and safety, conflict resolution, equality and diversity, blood transfusion, dementia awareness, Deprivation of Liberty Safeguards (DoLS) and MCA.
- All new staff had a four day, face-to-face induction prior to beginning duties in a supervised capacity.

Nursing staffing

- The lead nurse based at the main hospital site in Stanmore had overall responsibility for outpatients. A senior sister and sister, both based at Bolsover Street took responsibility for this location.
- The senior sister was responsible for overseeing the staffing rota. We reviewed the staffing establishment in relation to the number of qualified nurses, clinic support workers and administrative staff. We found the outpatients department to be adequately staffed.
- There was good retention of staff.
- Nursing and clinical support workers were allocated to different clinics by senior nurses. Clinic tasks and duties were posted on a whiteboard so that it was clear to identify which staff were allocated to which clinic. The whiteboard also showed staff allocated to other tasks such as checking medication storage.
- The main reception was supported by clinical support staff who were able to respond to patient questions and support needs.

Medical staffing

- There were individual service managers for sarcoma, paediatric and upper limb, pain and rheumatology, nerve injury and spinal, who were responsible for the management of doctors and the staffing of their own clinics.
- A dedicated member of staff attended the quality and risk support services division meeting, the division to which outpatients belonged, and the formal structure to monitor quality in outpatients.

Major incident awareness and training

- Major incident planning was especially pertinent to Bolsover Street because of its central London location, with terrorist attack and lone working for staff being of particular issue. They spoke about the plan from a practical perspective, but major incident planning was the responsibility of senior trust managers.

Are outpatients services effective?

Not sufficient evidence to rate

The service ensured that assessments followed trust assessment and treatment guidelines through integrated booklets for different patient pathways. Appraisals were taking place for all staff, and we found good examples of multidisciplinary working. Services were provided five days a week.

Evidence-based care and treatment

- The service had integrated booklets to support patient pathways that were evidence-based best practice. These included: elective hip, elective knee, short stay (day case), general, foot and ankle, and paediatric. We found these covered all aspects of care and treatment.

Pain relief

- Nurses were able to give pain relief. Although there was no on site pharmacy at Bolsover Street.
- The trust had a dedicated consultant-led pain therapy service and a business plan for a new consultant and two nurses specific to pain management had been submitted to the board and awaited confirmation for approval.

Patient outcomes

- Patient Reported Outcome Measures (PROMs) were recorded in the department, but the records belonged to the surgical department, which meant that we were not able to extrapolate what it meant for outpatients.

Competent staff

- All annual appraisals were completed by the appropriate level of staff. Most staff had had an appraisal in the last 12 months, and those who had not were accounted for; this was due to issues such as maternity leave, sick leave and 'completed but record not updated'.
- Regular supervision or one-to-one operational meetings were less fixed, and took place within the same structure as appraisals. The lead outpatient nurse had one-to-one meetings with the senior sisters.
- There was a competency framework for new staff to the service, completed within first three to six months.

Outpatients

- There was a teaching programme for staff development. The trust supported training, including training for degrees and qualifications, such as in health promotion, management of chronic illness and advanced assessment.
- Clinic support workers had a competency book and worked to its core values.
- Appraisal rates for administrative and clerical staff detailed evidence of this being managed.

Multidisciplinary working

- Multidisciplinary working was well established. Radiographers, nurses, occupational therapists, physiotherapists and doctors all provided services to patients and patient care was coordinated. For instance, pre-assessment and imaging were both able to offer appointments to patients on the day if needed.

Seven-day services

- Outpatient clinics ran from Monday to Friday and scheduled to run from 8am up to 8pm.
- We were told that weekend clinics had happened on an exceptional basis in the past. We were told there were nursing resources to run weekend clinics, although this did not happen.

Are outpatients services caring?

Good

An overwhelming majority of patients told us that staff were caring and kind. Patients felt included in their care and treatment. One patient told us "staff listened to me and were happy to answer all questions". People's privacy and dignity was also observed.

Compassionate care

- We spoke with four patients, and a further 20 completed our 'tell us about your care' during our visit. An overwhelming majority told us that staff were caring and kind. "Always friendly and keen to help", "staff were kind and caring". Were typical of the comments we received.
- There were three methods for patients to provide feedback: patient satisfaction (real time feedback), via the Friends and Family Test, and 'say so' which was a comments card. The real time feedback will eventually be replaced completely by the Friends and Family Test.
- If negative comments could be attributed to an individual because they had attached their contact details, they would receive a call or an email from the head of outpatients.
- Figures for the previous year showed over 500 responses to the outpatients department as a whole, through the Friends and Family Test, with an overwhelming majority being positive about the care and treatment they had received.
- Recurring themes and issues arising from patient feedback were waiting times in clinics.
- The 'patient experience improvement committee' met quarterly. Minutes showed patients, the Patient Advice and Liaison Service (PALS), the director of nursing, consultants and heads of departments attended. Where issues had arisen through patient satisfaction feedback, action had been identified.

Patient understanding and involvement

- Patient understanding of conditions and services was enhanced by patient information leaflets that were readily available throughout the department. There was also a list of online information leaflets and paper leaflets available.
- Patients told us that they felt that both medical and nursing staff were good at explaining what was happening and what different treatments involved.
- Patients felt included in care and treatment. One patient told us "staff listened to me and were happy to answer all questions".

Emotional support

- Patients told us they felt emotionally supported when this was needed, through the kind and compassionate care they had experienced.
- Clinical staff helped out at reception which enabled them to identify and offer support to those who were in need of extra help.

Are outpatients services responsive?

Requires improvement

The environment was designed with the patient at the centre of the care. However the service delivery was not as responsive as it could be to the patients' needs.

Outpatients

21% of the clinics started late. There was no key performance indicator for sending out clinic letters following consultation to patients and their GPs. A significant proportion of letters were not sent out for over one month. There was an exception within the trust that letters regarding patients who had cancer would be sent out within 48 hours

Service planning and delivery to meet the needs of people

- A new centralised booking process had been introduced in the last six months which made it easier for patients to make appointments.
- Waiting areas had comfortable seating which was located in different parts of the building and in close proximity to different clinics.
- The main reception was supported by clinical support staff who were able to respond to patient questions and support needs.
- Staff were able to access interpreters when required. Telephone and face-to-face interpreting services were available, and were booked through the Patient Advice and Liaison Service (PALS).
- There was a dedicated transport service for outpatients, run by a private contractor. The system for booking transport was responsive to patients' needs and was monitored for quality.
- There were no MRI scans available. If this was needed as a matter of urgency, it could be offered by a hospital that was very close by. There was a service level agreement to cover this.

Access and flow

- Overall 79% of clinics started on time or within 15 minutes allowing time for the first patient to visit x-ray.
- Overall DNA rate for this site in April was 6.1%. DNA rates had been high compared to previous years as there was a decision to stop issuing text reminders for outpatient appointments which saw an increase in DNA so the decision was rescinded in February 2014.
- DNA rates were monitored by specialty. Spinal had the highest rate and PHI had the lowest.
- The Outpatients' Transformation Board meeting minutes from March 2014 described the DNA rates as 'appalling', and 'a bad month for cancelled clinics'.
- Waiting times were the responsibility of individual clinical divisions, not the outpatient department itself. This meant that neither the head of outpatients, nor the Head of Operations- Support Services Division could influence and effectively improve this aspect of the service.
- Steps were taken to mitigate this by blocking out spaces in booking diaries. One example of this is in the spinal sarcoma service, where it has had a positive impact on capacity. However, services did not have the capacity to deliver on waiting times consistently.
- Patients consistently told us that they felt they received a good service, but their appointments regularly ran late. No one was managing clinic waiting times. Patients told us that the service was quite good in keeping them informed about late running appointments, but they were not told why their clinic appointment was late.
- There was a supported discharge for patients, which allowed for patients to come back if they needed to after being formally discharged from the trust, although the lead outpatient nurse told us that it remained difficult to encourage patients to be discharged.

Meeting people's individual needs

- Privacy and dignity were maintained in private consultation in rooms with the door closed. There was adequate space in the hand therapy room with screens between the two treatment chairs.
- The service had an electronic pager system which meant that patients could wait in the children's play area, the coffee shop or indeed out of the building and be notified of their appointment. This was also useful for when patients might be attending different clinics such as x-ray or phlebotomy in different parts of the building.
- There was a dedicated pre-operative assessment service. The service offered patients an assessment on the day of their outpatient appointment if they were told of the need for surgery.
- The service offered pre-operative assessments by telephone if appropriate.
- A comprehensive pre assessment took place, carried out by nurses. A pre assessment booklet was completed.
- There was a play area for children. Parents were given electronic pagers to notify them when there appointment was so they were able to wait in the play area. There was also a mini play area on the first floor and a staff rota to make sure toys were clean and in good order.
- We were told that the outpatients department ran a fast-track service for those who needed it. One patient

we spoke with told us that they had had an operation at the main hospital site last year and was attending outpatients' appointments at Bolsover Street. They were told by their doctor to get in touch if they had any problems. They had come in to the outpatients department at Stanmore because of a relapse, but without an appointment. Reception contacted their consultant's secretary, who arranged for him to be seen by the nurse therapist consultant.

- As a national organisation, most patients were not local. Clinical information was shared with patients' local GPs and other hospital consultants. However, records showed there were severe delays in sharing this information following treatment. Transcripts of the consultants were contracted out, and were typically returned after 30 days. We saw that there was then a further delay of up to 52 days for the letters to be approved before being sent out to GPs, consultants and patients.
- A 'This is me' booklet had been introduced, which can be filled out and given to staff when a person with dementia goes into hospital. It provides a snapshot of the person behind the dementia, and helps hospital staff be aware of a person's habits, hobbies, likes and dislikes. This was in the process of being implemented.

Learning from complaints and concerns

- There had been no formal complaints in the last 12 months at Bolsover Street. The trust target was for all complaints to be fully responded to within a 25 day period. People were notified if this was not possible. All complaint responses were reviewed following their investigation, by an executive team member.
- The complaints and the Patient Advice and Liaison Service (PALS) officer attended the quality and risk direct care meeting (the medical division to which outpatients belonged and where quality was monitored) to give brief detail of complaints and timeframes.
- We were given examples of where the department had acted on comments made by patients.
- We were told by the head of outpatients that all negative patient feedback received with contact details attached was responded to.

Are outpatients services well-led?

Requires improvement

There were clear lines of accountability and management for front line services within the outpatients department. There was a senior sister at Bolsover Street who reported to the head of outpatients, who reported to the head of operations for clinical support services.

21% of clinics started late and over ran. These had been identified through leadership meetings, and also through the comments and complaints the service received. Waiting times were the responsibility of individual clinical divisions, not the outpatient department itself. This meant that neither the head of outpatients, nor the head of operations for clinical support services influence and effectively improve this aspect of the service.

Vision and strategy for this service

- The outpatient transformation programme meeting oversaw the vision and development of the department and was attended by the medical director, the head of operations for clinical support services, the head of outpatients and the lead nurses from both Stanmore and Bolsover Street.
- The lead nurse from Bolsover Street had only recently been invited to join this meeting, following intervention by the medical director.

Governance, risk management and quality measurement

- There was a formal structure to monitor quality in outpatients through the quality and risk support services division meeting, the medical division to which outpatients belonged and which quality was monitored.
- The April 2014 minutes showed that although matrons attended, there were no doctors or allied health professionals from outpatients involved in this meeting.
- The risk register was monitored through the quality and risk direct care meeting. The April 2014 minutes showed that from April the deputy head of nursing attended the meeting. Minutes showed that the trust risk register had been reviewed by the trust, and as a result there were now three risk registers, one for each medical division. A newly devised issue logging process was awaiting approval .The intention was that issues were discussed at this meeting to decide their level of risk.

Outpatients

- The outpatients' transformation board meeting minutes from March 2014 showed that the improvement of clinic times and the efficiency of the outpatients' department was a work in progress. The meeting minutes evidenced that this was being discussed, but that it needed further work to effect the desired improvements.
- The patient experience improvement committee met quarterly. Minutes showed that patient representatives, the Patient Advice and Liaison Service (PALS), the director of nursing, consultants and heads of departments attended.

Leadership of service

- There were clear lines of management, up to the chief operating officer.
- There were clear lines of accountability and management for front line services within the outpatients department.
- The roles and responsibilities of each staff member were communicated and displayed for all
- There was a lead nurse and senior sister who reported to the head of outpatients. The head of outpatients was based at Bolsover Street on some weekdays and reported to the head of operations for clinical support services.
- There were weekly visible leadership days, where lead nurses and matrons did patient-based work, and looked at sets of notes to check the quality of records.
- We found examples of some clinics that started late and over ran. These had been identified through leadership meetings, and also through the comments and complaints the service received. Waiting times were the responsibility of individual clinical divisions, not the outpatient department itself. This meant that neither the head of outpatients, nor the Head of Operations-Clinical Support Services could influence and effectively improve this aspect of the service.

Culture within the service

- There was an open door policy for staff to come and speak about issues. We were also told that they let people get on with their work rather than micro manage, but always wanted to be the first to know if anything was a concern.
- Staff felt the leadership were managing instances of bullying as a direct result of responding to the staff survey, and that the culture had changed for the better.
- Staff were happy with staff development opportunities, and we were given examples of educational trips and promotion opportunities.

Public and staff engagement

- Staff survey results for the whole trust were broken down to look at trends. Staff had reported experiencing physical violence at a higher rate than the national average.
- The human resources (HR) department presented the results of the staff survey to the outpatients department. Outpatient sub leads also met with HR to discuss the survey outcomes.
- The head of outpatients told us that all staff were asked if they were willing to express more about experiencing violence, which some did. This was reported to HR anonymously, along with actions taken to address issues raised in the staff survey.
- We were told that in relation to bullying, some staff were spoken to about how to be a less oppressive manager.
- We were told there was some interpretation needed to understand this, as staff were reporting confrontational situations they had experienced as physical violence, when physical violence had not occurred.

Innovation, improvement and sustainability

- There was an innovation fund which had funded the development of a video, for staff about the patient pathway through the hospital, which was accessed through staff computers.
- Clinic support workers also worked some reception sessions for the benefit of informing and supporting patients and to widen their skills.
- Staff expressed enthusiasm and engagement for improving the services.

Outstanding practice and areas for improvement

Outstanding practice

- The environment was designed with the patient at the centre of service.
- Medical records were nearly always available at every appointment.
- Some patients were given pagers on arrival so they were free to wait in an area that suited them - children's play areas, the café or different departments within the building - and not miss their appointments.

Areas for improvement

Action the hospital SHOULD take to improve

- Consider carrying out formal proactive audits of cleanliness and infection control in the outpatients clinics.