West Hertfordshire Hospitals NHS Trust

St Albans City Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Minor injuries unit	Requires improvement
Surgery	Requires improvement
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 Hospital and Hemel Hempstead Hospital on the 19 September 2016 but we did not visit St Albans at this time.

We inspected and rated the core services of urgent and emergency care, surgery and outpatients and diagnostic imaging.

We rated St Albans City Hospital as requires improvement overall. We rated the Minor Injuries Unit (MIU) and surgery as requires improvement. We rated outpatients and diagnostics services as good. For the five key questions that we inspect and rate, we rated three (safe, effective and responsive) as requires improvement and caring was rated as good. Well-led was rated as inadequate overall.

- During the last inspection, we found that there was no clear streaming or triage process in place in the MIU. 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 clear process in place to ensure that patients who were waiting to see a clinician were assessed as safe to wait in the MIU.
- There was no clear operational policy or standard operating procedure to support non-clinical staff with streaming decisions in the MIU.
- There was no clear eligibility criteria set out and agreed to define which patients would be suitable for urgent ambulance transfers.
- There was no process in place in the MIU to monitor and review arrival time to initial assessment.
- 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 MIU with the full range of competencies to assess children's needs.
- Learning from incidents was not effectively shared and communicated to all relevant staff in the MIU to minimise the risk to patient safety.
- Staff in MIU had minimal understanding of the duty of candour regulation and its requirements.
- Not all staff had had the mandatory training relevant to their roles. Not all staff had had the required safeguarding adults training.
- In the MIU, only 43% of nursing staff and 0% of administrative and clerical staff had received an appraisal from April 2015 to March 2016, which was significantly below the trust's target of 90%. There were not robust appraisal and clinical supervision systems in place to support staff.
- Staff in the MIU were not 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 in the MIU to manage the service during periods of high demand or excessive waiting times.
- During the last inspection, it was reported that here was no local clinical audit programme for the MIU. During this inspection we founds there was still no local clinical audit programme in place.

Summary of findings

- Whilst local leadership in the MIU 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.
- There was a lack of effective governance measures in place to support the delivery of good quality care in the MIU. Risks to patient safety in the service had not been identified.
- In surgery, sufficient improvements to the governance and risk management systems, to demonstrate full compliance with the requirement notice that was issued after the last inspection, had not been made.
- Theatre teams were not consistently using the five steps to safer surgery checklist.
- Operations were carried out on high risk patients and there were no critical care beds on site. Critically ill patients were transferred to Watford General Hospital.
- Staff did not always observe infection control guidelines in surgery.
- Medicines were not being stored safely as they were stored above the recommended temperatures in surgery.
- Referral to treatment times were consistently below the England average in surgery.
- Venous thromboembolism (VTE) assessments were initially completed but not consistently repeated in line with best practice.
- Staff were unaware of the trust mission, vision, and strategic objectives.
- One of the junior doctors had not received a trust induction and had been working in the service for eight months in surgery.
- Not all staff received feedback after reporting incidents and some staff said they did not report all incidents.
- 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 actions to address this once we raised it as a concern.
- Patient records were not always available for their appointments.
- We saw that patients were treated with kindness and respect. We saw staff taking the time to interact with patients and those accompanying them.
- The MIU was consistently performing above the national target of 95% for four hour admission to discharge.
- There were good processes in place for medicines management at the MIU.
- The environment was visibly clean in surgery.
- Patient notes had documented risk assessments undertaken in surgery.
- There were competency frameworks for staff in all surgical areas.
- Ward sisters had access to leadership programmes in surgery.
- Patients told us staff requested their consent prior to any procedure and records seen demonstrated clear evidence of informed consent.
- The hospital had a nurse led pre-assessment clinic, which provided choice to patients regarding their appointments.
- 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.

Summary of findings

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

Importantly, the trust must:

- To ensure that there are effective streaming systems in place in the unit 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 in the MIU.
- To ensure that there are effective processes in place in the MIU to provide clinical oversight for patients waiting to be seen.
- To ensure non-clinical staff in the MIU receive sufficient support or training to provide oversight to recognise a deteriorating patient.
- To ensure the MIU has 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.
- 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 MIU and surgery.
- To ensure that staff in the MIU are given training and support to understand the duty of candour statutory requirements.
- To ensure all staff in the MIU, surgery and outpatients have had the mandatory training relevant to their roles and that all staff receive an annual appraisal.
- To ensure medicines are stored at correct temperatures in all areas and ensure appropriate action is taken if temperatures are outside the recommended range in surgery.
- To ensure the surgery service is compliant with recommendations for the safe management of controlled drugs.
- 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.
- To ensure all resident medical officers (RMOs) staff receive a trust induction.
- To ensure all staff received feedback after reporting incidents.
- To ensure all staff in surgery report any issues, concerns and incidents using the trust's electronic incident reporting mechanism.
- Actions on fire risk assessments in surgery are should be completed urgently and areas are regularly monitored for future compliance.

In addition the trust should:

- To consider ways to make the MIU environment more child-friendly in line with national recommendations.
- To consider ways of developing an audit process in MIU 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 review the environment and facilities to enhance privacy and dignity in the MIU reception area.
- To consider ways to ensure that staff are aware of the strategy for the MIU and continue to develop ways for their views to be heard.
- To establish clear escalation processes to manage the service during periods of high demand or excessive waiting times.
- To monitor how pain assessments and management systems being used in the service.
- To review processes for monitoring those patients transferred from the MIU to other services in an emergency.

Summary of findings

- All patients should have a venous thrombus embolism (VTE) assessment within 24 hours of admission and follow the National Institute of Health and Clinical Excellence (NICE) guidelines on VTE assessment and treatment.
- Action should be taken reduce the number of cancelled surgery operations and benchmarking should be undertaken against other similar hospitals.
- Pre-assessment documentation should include an assessment for patients living with dementia or a learning disability.
- The five steps to safer surgery checklists should be incorporated into all services and the three step checklist should be removed from use.
- All patients transferred, because of complications; from St Albans hospital should be fully reviewed. This should include an audit of any delay in this transfer.
- To review delays for patients receiving take home medicines and a plan put into place to minimise these delays.
- All complaints should be responded to within the agreed timescales.
- To review ways in which all staff are made aware of the trust's mission, vision, and strategic objectives.
- To improve the availability of medical records for clinic appointments more than 96% of
- To provide safeguarding children level three training to all required clinical staff in outpatients.

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?
Minor injuries unit	Requires improvement 	Overall, we rated the Minor Injuries Unit (MIU) as good for caring and responsive and requires improvement for safe, effective and well-led. Overall, we rated the MIU 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 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 was no clear eligibility criteria set out and agreed to define which patients would be suitable for urgent ambulance transfers.
- There was no process in place in the MIU to monitor and review arrival time to initial assessment.
- 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 MIU with the full range of competencies to assess children's needs.
- Learning from incidents was not effectively shared and communicated to all relevant staff in the MIU to minimise the risk to patient safety.
- Staff had a minimal understanding of the duty of candour regulation and it's requirements.
- Not all staff had had the mandatory training relevant to their roles. Not all staff had had the required safeguarding adults training.
- Only 43% of nursing staff and 0% of administrative and clerical staff had received an appraisal from April 2015 to March 2016, which was significantly below the trust's target of 90%. There were not robust appraisal and clinical supervision systems in place to support staff.

Summary of findings

- Staff in the MIU were not 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 in the MIU to manage the service during periods of high demand or excessive waiting times.
- During the last inspection, it was reported that here was no local clinical audit programme for the MIU. During this inspection we founds there was still no local clinical audit programme in place.
- Whilst local leadership in the MIU 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.
- 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:

- We saw that patients were treated with kindness and respect. We saw staff taking the time to interact with patients and those accompanying them.
- The MIU was consistently performing above the national target of 95% for four hour admission to discharge.
- There were good processes in place for medicines management at the MIU.
- Staff who worked autonomously in the MIU used their skills, knowledge, and abilities to adapt to the needs of their patients.

Surgery **Requires improvement**

We rated the service as requires improvement for safe and responsive and good for effective and caring. We rated well-led as inadequate. We rated this service overall as requires improvement because:

Summary of findings

- Sufficient improvements to the governance and risk management systems, to demonstrate full compliance with the requirement notice that was issued after the last inspection, had not been made.
- Theatre teams were not consistently using the five steps to safer surgery checklist.
- Operations were carried out on high risk patients and there were no critical care beds on site. Critically ill patients were transferred to Watford General Hospital.
- Staff did not always observe infection control guidelines.
- Medicines were not being stored safely as they were stored above the recommended temperatures.
- Referral to treatment times were consistently below the England average.
- Venous thromboembolism (VTE) assessments were initially completed but not consistently repeated in line with best practice.
- Staff were unaware of the trust mission, vision, and strategic objectives.
- One of the junior doctors had not received a trust induction and had been working in the service for eight months.
- Not all staff received feedback after reporting incidents and some staff said they did not report all incidents.

However, we also found that:

- All policies were current and followed the appropriate guidelines, such as National Institute for Health and Care Excellence (NICE).
- The hospital utilised enhanced recovery programmes for surgery pathways.
- The ward team meeting minutes identified shared learning from incidents.
- The environment was visibly clean.
- Patient notes had documented risk assessments undertaken.
- There were competency frameworks for staff in all surgical areas.
- Ward sisters had access to leadership programmes.

Summary of findings

- Patients told us staff requested their consent prior to any procedure and records seen demonstrated clear evidence of informed consent.
- The hospital had a nurse led pre-assessment clinic which provided choice to patients regarding their appointments.
- There was a sense of pride amongst staff working in the hospital.
- The hospital recognised the views of patients and carers.
- Staff working within the service felt supported.
- Patients told us that the care they received was good and that they felt safe.

Outpatients and diagnostic imaging

Good

Overall, we rated outpatients and diagnostic imaging as good because:

- Staff reported patient safety incidents and there was evidence of learning from incidents and patient complaints. Staff were confident in how they would recognise and report incidents.
- Senior staff had oversight of risks in their areas.
- Patient records were stored securely in locked records trolleys.
- Outpatients appeared visibly clean and staff used personal protective equipment, such as gloves and aprons.
- Patients' care and treatment was delivered in line with current national standards and legislation. Staff demonstrated a commitment to patient-centred care.
- There were some areas that provided a proactive service to patients which included several one-stop clinics which provided efficient co-ordinated care.
- Services were caring and patients spoke positively about the care and treatment they received.
- Staff were approachable and we 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.
- The outpatient's service was meeting the two week urgent referral target.

Summary of findings

- The service had made an improvement to the telephony service in the central booking office. This mean that they had a reduction in the amount of abandoned calls and the average wait for a call to be answered had reduced.
- The service had introduced an SMS text messaging service to remind patients of their upcoming appointment. This had reduced the amount of patients not attending appointments by 10%
- 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.
- Staff felt supported by immediate line managers and clinicians. They said they were listened to and able to raise concerns.
- Following their last inspection, many improvements had been made 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, we also found that:

- 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 their appointments.

St Albans City Hospital

Detailed findings

Services we looked at
Minor Injuries Unit; Surgery; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to St Albans City 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.

St Albans City Hospital has a minor injury unit which is open from 9am to 8pm, seven days a week, two surgical wards with a total of 40 beds and an outpatients department and diagnostic and imaging services.

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 at 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.

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 St Albans City Hospital

St Albans City Hospital is part of West Hertfordshire Hospitals NHS Trust. It has 40 beds.

St Albans has a population of over 130,000. It is ranked 320 out of 326 in the English Indices of Deprivation Rankings so is one of the least deprived areas in the country. However about 8.2% (2,400) children live in poverty. Overall life expectancy for both men and women is higher than the England average but in the most derived areas of St Albans the life expectancy is 6.9 years lower for men and 5.8 years lower for women than in the least deprived areas.

Overall, in 2015/16 the trust had 94,530 inpatient admissions, 454,558 outpatients attendances and 14,683 attendance at the minor injury unit at St Albans City Hospital.

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

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Detailed findings

Notes

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

Minor injuries unit

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

Information about the service

The Minor Injuries Unit (MIU) at St Albans City hospital is open every day (except Christmas Day) from 9am to 8pm.

The MIU is staffed by emergency nurse practitioners (ENPs) and administrative support staff. It provides a service for children, aged two and above, and adults with minor injuries such as lower limb injuries and minor head injuries. The unit has five treatment rooms, a resuscitation room, and access to on-site x-ray facilities Monday to Friday from 9am to 5pm.

From July 2015 to June 2016, the MIU had 14,350 attendances for adults and from September 2015 to August 2016, 4,481 attendances were for children aged 2 to17, which equates to approximately 30% of all attendances.

Patients who attend the MIU should be expected 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 MIU forms a part of the trust's unscheduled care division, which includes the emergency department at Watford general hospital site and the Urgent Care Centre at Hemel Hempstead hospital. All three services are managed by the same division and have the same overall manager, so for this reason there may be some duplication of data in the three reports.

We carried out an announced inspection of the MIU on 8 September 2016. During our inspection, we spoke with four members of staff and four patients, and we looked at six sets of patients' records.

Summary of findings

Overall, we rated the Minor Injuries Unit (MIU) as good for caring and responsive and requires improvement for safe, effective and well led. Overall, we rated the MIU 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 MIU to monitor and review arrival time to initial assessment. The MIU did not meet the 'Standards for Children and Young People in Emergency Care Settings, 2012' intercollegiate document as there was not a process in place for all children to be seen by a clinician within 15 minutes of arrival.
- 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 was no clear eligibility criteria set out and agreed to define which patients would be suitable for urgent ambulance transfers.

Minor injuries unit

- 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 MIU with the full range of competencies to assess children's needs.
- Learning from incidents was not effectively shared and communicated to all relevant staff in the MIU to minimise the risk to patient safety.
- Staff had a minimal understanding of the duty of candour regulation and its requirements.
- Not all staff had had the mandatory training relevant to their roles. Not all staff had had the required safeguarding adults training.
- Only 43% of nursing staff and 0% of administrative and clerical staff had received an appraisal, which was significantly below the trust's target of 90%. There were not robust appraisal and clinical supervision systems in place to support staff.
- Staff in the MIU were not 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 in the MIU to manage the service during periods of high demand or excessive waiting times.
- During the last inspection, it was reported that here was no local clinical audit programme for the MIU. During this inspection we founds there was still no local clinical audit programme in place.
- Whilst local leadership in the MIU 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.
- 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:

- We saw that patients were treated with kindness and respect. We saw staff taking the time to interact with patients and those accompanying them.
- The MIU was consistently performing above the national target of 95% for four-hour admission to discharge.
- There were good processes in place for medicines management at the MIU.
- Staff who worked autonomously in the MIU used their skills, knowledge, and abilities to adapt to the needs of their patients.

Minor injuries unit

Are minor injuries unit services safe?

Requires improvement

Overall, we rated the MIU 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 changed 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 MIU to monitor and review arrival time to initial assessment. The MIU did not meet the 'Standards for Children and Young People in Emergency Care Settings, 2012' intercollegiate document as there was not a process in place for all children to be seen by a clinician within 15 minutes of arrival.
- 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 was no clear eligibility criteria set out and agreed to define which patients would be suitable for urgent ambulance transfers.
- The premises did not always meet the needs of patients. The environment was not child-friendly due to limited space and lack of suitable distraction items such as toys.
- Learning from incidents was not effectively shared and communicated to all relevant staff to minimise the risk to patient safety.
- Staff had a minimal understanding of the duty of candour regulation and its requirements.
- Staff were not aware of the major incident policy or their actions if a major incident was declared.
- Not all staff had had the mandatory training relevant to their roles. Not all staff had had the required safeguarding adults training.
- 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.

However, we also found:

- There were good processes in place for medicines management at the MIU.

Incidents

- Whilst staff understood their responsibility to report patient safety incidents, near misses, and raise concerns both externally and internally, learning from incidents was not embedded to drive improvements.
- Staff in the MIU reported incidents on the trust's electronic incident reporting system. Incidents were graded in severity from low or no harm to moderate, severe or death. The trust had a comprehensive incident reporting policy, which described the process for grading and reporting incidents. Staff were able to access this on the trust's internal website.
- There had been no never events reported for this service between April 2015 and May 2016. A never event is a serious incident that is 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.
- From April 2015 to May 2016, there were no serious incidents reported to the Strategic Executive Information System (STEIS) for the MIU.
- From January 2016 to September 2016, there were four incidents recorded for the MIU. These incidents were all categorised as 'no harm': two related to the environment and security, one was related to a transfer for a patient who required an x-ray and one was related to communicating with other departments. There was evidence that these incidents had been investigated and opportunities for learning identified.
- Staff told us that the culture of learning from incidents was continuously improving across the whole unscheduled care division. Previously staff had felt that there was a 'blame culture' attached with reporting incidents, but now the emphasis was about learning from incidents and identifying areas for improvements. Staff told us that after the last inspection, there had been some improvement to the way the MIU was

included in learning from incidents across the whole unscheduled care division. We saw evidence that staff attended cross-divisional clinical governance meetings and the minutes were displayed in staff areas.

- We saw that whilst learning from incidents had been identified, however actions put in place to minimise the risk of incidents recurring were not always embedded or fully understood. For example, nursing staff told us about an incident that occurred regarding the 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 seen and treated in line with National Institute of Health and Care Excellence (NICE) guidelines (CG176, 2014) which included arranging a computerised tomography (CT) scan within a specific timeframe. During our inspection, there was no process in place to ensure that patients on anticoagulant treatment were identified during the booking in process to alert clinical staff. Reception staff, who booked patients in, were not aware of the incident or the significance of recording that specific information. This meant that we were not assured that learning from the incident had been effectively 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.
- Staff that we spoke with were not aware of the trust's duty of candour or 'being open' policy. When prompted by an inspector, staff told us that they would always offer an apology if something went wrong; however, they were not aware of the statutory requirement.

Cleanliness, infection control and hygiene

- We saw that the department was visibly clean and all staff carried out cleaning tasks when required. There were cleaning schedules in place, which showed the daily cleaning times. We saw that equipment had 'I am clean' stickers on them, which displayed the date the equipment was last cleaned. There was inconsistent evidence that safety systems, processes, and practices related to infection control were monitored and improved when required.
- The trust provided us with evidence that comprehensive infection control audits were conducted in October 2015 and June 2016. We saw that an action plan had been developed following the audit in June 2016 and it included the replacement of damaged furniture and storing equipment properly.
- There was no evidence that regular monthly infection control audits were conducted. We asked the trust for evidence that infection control audits had been conducted for the MIU in line with the rest of the unscheduled care division but this was not provided.
- The MIU 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 MIU achieved 92% overall compliance for infection control in May 2016. During our inspection, we saw a display on the wall that stated 94% overall compliance with infection control in August 2016; however, this did not include hand hygiene audits or quality checks.
- 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 MIU; 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.
- '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 and disposable aprons were used as per the trust's infection control policy.
- We saw that the MIU had a specific room that could be used for isolating patients with suspected infectious illnesses such as measles.

Minor injuries unit

Environment and equipment

- The premises did not always meet the needs of patients. Patients who arrived at the MIU were booked in at the reception. There was limited space in this area and no signs asking patients to stand back; this meant that there was no privacy for patients giving personal details whilst others were waiting to see the receptionist. Staff were aware of the issue and we saw that this had been discussed at departmental meetings and highlighted to senior managers by staff and patients. Staff in the MIU had requested that appropriate signage be placed in the area in September 2015. Alternative options such as allowing patients to give their names at reception, then take a seat and wait to be called to be booked in had been discussed by MIU staff, however, during our inspection there was no process in place and no time frame for when appropriate signage would be displayed.
- The Intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, 2012' related to all urgent and unscheduled care facilities including MIUs, recommended that waiting areas for children should be audio and visually separated from adult patients where possible. Staff told us that due to the layout and design of the MIU, there was limited space to have a separate waiting area for children and there was a small area for children within the main waiting area, which had some distraction items such as books. We asked the trust about their plans to meet the standards and they told us that they would review that as part of their review of urgent care services at MIU in October and November 2016.
- Staff in reception sat behind a screened area and had access to panic buttons to raise an alert if required. Staff were aware of how to raise a security alert and said that they felt safe and security staff were readily available if required.
- There was adequate space and seating in the waiting area of the MIU and during our inspection we saw no patients standing whilst waiting to be seen.
- We saw that 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'. At the time of our inspection, there were no high-risk items of equipment in MIU that needed urgent replacement.
- Staff had access to a resuscitation trolley, which was appropriately stocked with equipment for adults and children. Adults and children's resuscitation equipment had been checked on a daily and weekly basis and staff had highlighted equipment and drugs that were nearing expiry date.
- 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 fridge and room temperatures were regularly checked and temperatures recorded.
- There were no controlled drugs kept at the MIU and all medications were stored in a locked cupboard in a room with a keypad access. The keys to the medication cupboard were held by the nurse in charge on the day and stored overnight in a keypad locked safe.
- At the time of our inspection in 2016, emergency nurse practitioners (ENPs) were not independent prescribers. Staff told us training for this was planned for February 2017.
- All patients who attended the MIU and required treatment were administered or supplied medicines under PGDs (Patient Group Directions). These directions allowed ENPs to give medicines to people 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.
- We looked at six sets of patient records and saw that any allergies to medications had been highlighted in patient's records in an area detailing which medicines had been prescribed under the PGD.
- Pharmacy services were available at St Albans hospital from Monday to Friday 9am to 5pm. Outside of these hours nursing staff had access to on-call support if they required medication advice or information.

Records

- Records were written and managed in a way that kept people safe, and respected patient's confidentiality. Patient's records were a mixture of paper and electronic notes. Paper records were used in the unit for assessment and treatment and scanned on to the electronic system.

- We looked at six sets of records and found that information regarding the patient's care and treatment was well documented, with appropriate information to understand the treatment delivered.
- Paper records were stored behind a locked door in secured cabinets in the reception area after patients were discharged.

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 were able to explain 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 were monitored and improved when required. Staff told us about a risk assessment tool for children with head injuries that had been developed by an emergency department (ED) consultant to help establish if the injury was related to physical abuse.
- All nursing staff had received the appropriate level of training for safeguarding children. This included safeguarding levels one, two and three for children 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. This guidance 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/child protection concerns' should be trained in safeguarding for children levels one, two and three. All reception staff had received safeguarding level one and two training for children in line with trust policy.
- All nursing staff had received level two training for safeguarding adults. Current compliance at the time of inspection was that 67% of nursing staff and 75% of reception staff had received level one training in safeguarding adults. 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 related to identifying suspicious injuries that may be indicative of physical abuse for adults and children. The trust's safeguarding report for 2015 showed 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 MIU had an electronic child protection information sharing system in place, which allowed the trust to share and receive information from other authorities responsible for safeguarding children.
- An external health visitor attended the unit weekly to review children's records and safeguarding referrals.
- The MIU had a designated safeguarding lead and staff told us that they saw them regularly for training and updates. 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, which included health and safety, information governance, safeguarding children and adults, conflict resolution, equality and diversity and infection prevention and control. Courses for mandatory training were delivered online or via face-to-face sessions.
- The trust's target for mandatory training completion was 90% for all modules. All nursing staff had completed the majority of modules at the time of our inspection, with the exception of equality and diversity training, which showed staff compliance at 67%. All staff were sent reminders regarding mandatory training and the service was on track to deliver all mandatory training within the year. There were four administrative and clerical staff who covered the reception area and 100% of these staff had completed mandatory training modules in non-patient moving and handling and conflict resolution. For these reception area staff, however, only 25% had completed information governance, hand hygiene and fire evacuation training and 75% had completed modules in health and safety and equality and diversity. We saw that further training was being planned.
- Senior nursing staff at the units held a record of staff completion of mandatory training.
- All nursing staff had undertaken advanced basic life support (ABLS) and 86% of nursing staff had received paediatric intermediate life support (PILS): that equated to six out of seven ENPs had had this training in line with national guidance as part of their mandatory training.

Minor injuries unit

Assessing and responding to patient risk

- During the last inspection, we found that there was no clear streaming or triage process in place. This had not changed 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.
- Patients who arrived at the MIU were initially seen by the unit's reception staff who took a brief description of the patient's condition or symptoms. Reception staff that we spoke to were aware of the 'red flag' conditions such as chest pains, difficulty breathing, and severe bleeding in line with the RCEM: triage position statement (2011) guidance for non-clinical staff. Reception staff told us that any patient presenting with these symptoms would be immediately highlighted to the nursing staff and they would be seen immediately and transferred to Watford general hospital by calling 999 for an ambulance, if necessary. Staff told us that they could also seek medical support from the external GP provider at St Albans hospital.
- 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, children with high temperatures or patients who presented with altered levels of consciousness. There was no process in place to ensure that patients waiting to see a clinician (ENP) were safe to wait. For example, during our inspection, we observed several patients waiting for over 60 minutes to be seen by an ENP or receive an initial clinical assessment; this included a two-year-old child with a head injury who waited for two hours.
- We raised our concerns with the trust during and after our announced inspection and the trust immediately put actions in place to mitigate any 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.
- There was no guidance or specific training delivered for reception staff for monitoring patients, who were waiting to be seen by a clinician, to recognise a deteriorating patient or signs of a more serious condition.
- 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 receptionists could give advice that was not based on clinical judgement and could cause confusion or potential harm. We were informed of an example where a patient on warfarin was given incorrect advice about bleeding from an injury by the reception team.
- There are no nationally set targets for the time to a clinical assessment in an MIU facility. National guidance ('Transforming urgent and emergency care services in England', NHS England, 2015) recommends that a 'see and treat' model (patients are seen and treated by the clinician at first point of contact with the clinician) is best suited to these environments, however, there should still be a process in place to ensure that patients are seen in a timely manner. The Intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, 2012' includes guidelines for MIUs and recommends that all children should have an initial clinical assessment within 15 minutes of arrival. All children attending emergency care settings should be visually assessed by a registered practitioner immediately upon arrival, to identify an unresponsive or critically ill/injured child. For the MIU, there were no processes in place to ensure these standards were being met. The trust told us that they would review these standards as part of the urgent care review in October and November 2016.
- The RCEM guidance (Unscheduled care facilities - Minimum requirements for units which see the less seriously ill or injured, 2009) recommends 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 'All patients should be assessed in a timely manner'. This guidance also recommends that an assessment process be in place to detect patients at risk of deterioration. There were no processes in place to meet these standards during this inspection. Staff were aware that

this was a concern as this had been highlighted during our previous inspection in 2015. At the time of this inspection, we were told by senior managers that the service was developing a triage protocol, which was not yet completed.

- After our inspection, we asked the trust for evidence of monitoring time to initial clinical assessment. The trust provided us with data that showed from April 2016 to July 2016, the average time to treatment was 31 minutes against a target of one hour. The national recommended target is for patients to be seen within 15 minutes.
- We saw that during the same time-period, the percentage of people who left the MIU before being seen was 2%, which was better than the England average of 3%.
- The MIU did not meet the 'Standards for Children and Young People in Emergency Care Settings, 2012' intercollegiate document. For example, they did not have a process in place to ensure that children received an initial clinical assessment within 15 minutes or that they were visually assessed by a registered practitioner upon arrival. The trust told us that they would review these standards as part of the urgent care review in October and November 2016.
- There was no paediatric team at the St Albans hospital site and the unit was designed to see patients two years and older. Staff told us that if a child under the age of two years old presented at the MIU they would be assessed by an ENP and then directed to an appropriate urgent care facility, their GP or transferred by ambulance to Watford general hospital, if necessary. During our inspection, we requested a copy of the operational policy/guidance for the MIU which defined how to manage these transfers and we were told that a new one had been developed but not all staff had seen it. After our inspection, the trust provided us with an operational policy for the MIU, which described pathways for children; however, this did not include the pathways for patients under two years old.
- 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 MIU as a place of safety for patients, which meant that they would not attend as quickly as for a patient in a public place. MIUs 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 therefore dial 999.
- There was no clear escalation process to manage the service during periods of high demand to ensure that patients with more urgent needs were prioritised. The updated MIU operational policy included 'triggers' for escalation to the senior management team which included.
- The MIU 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, 2007). This was a colour-coded system staff used 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.
- We saw evidence that staff were aware of the process for managing sepsis and had appropriate risk assessments and guidance, which was on display in all areas. Staff told us that all children who had been treated at the MIU for burns returned to the unit after two days for sepsis screening. Staff told us that they had attended specific sepsis training courses and we saw that staff had a dedicated sepsis flowchart and sepsis information board in the department.

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 MIU with the full range of competencies to assess children's needs.
- There was no baseline acuity tool used for staffing in the MIU. Staff told us that rotas were planned based on historical demand and national guidelines for MIUs (which stated that a minimum of two ENPs should be on duty at a time) and skill levels. The MIU had funding for 9.3 whole time equivalent (WTE) ENPs. At the time of our inspection, there were six WTE ENPs in post and two of the vacancies were in the process of being filled.

Minor injuries unit

- Staff told us that the rota was devised to have three ENPs on duty on Mondays, which was their busiest time, and two ENPs at all other times.
- There was minimal use of bank staff in MIU and no agency staff 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 MIU, 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.
- 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 MIU 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.
- Staff felt that the staffing levels were not reviewed regularly to take into account increased attendances and felt that a more robust process should be in place to establish the changing levels of care hours required per day. The trust told us that a workforce review had been conducted for the MIU in 2014 and would form part of the urgent care review in November 2016.

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.
- The trust had a comprehensive major incident policy which included the MIU, however, staff were not familiar with the policy or their role should a major incident occur in any part of the trust.
- During our last inspection in 2015, we highlighted this to the trust and the major incident policy had been updated, however, this had not been fully communicated to staff.
- The trust told us that they had conducted a major incident exercise, which included the MIU in May 2016. Staff told us that the exercise had been conducted with the St Albans site as the mock scene of a major incident, with operations being managed from the main Watford general hospital. Staff told us that they had had no meaningful roles in the exercise and it had been 'business as usual' in the MIU and they had limited opportunity to learn from the exercise.
- During our inspection, staff that we spoke with told us they had not received major incident training. The trust provided us with updated information after our inspection that showed that as of September 2016 all staff had received major incident training.
- We saw that the unit had a CBRN (chemical, biological, radiological, and nuclear) box; however, no staff had received any specific CBRN training.

Are minor injuries unit services effective? (for example, treatment is effective)

Requires improvement

Overall, we rated the Minor Injuries Unit (MIU) as requires improvement for effectiveness because:

- During the last inspection, it was reported that here was no local clinical audit programme for the MIU. At this inspection, we found there was still no local clinical audit programme in place.

- Nursing staff were not recording pain assessments.
- 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).
- Only 43% of nursing staff and 0% of administrative and clerical staff had received an appraisal from April 2015 to March 2016, which was significantly below the trust's target of 90%. There were not robust appraisal and clinical supervision systems in place to support staff.

However, we also found:

- Staff had a good understanding of consent procedures for adults and children.
- Improvements had been made in multidisciplinary working across the service.

Evidence-based care and treatment

- We saw some evidence that the MIU had evidence based care pathways in line with national guidance. For example, we saw that the department had a flow chart for treating patients on warfarin with head injuries and children with head injuries, which were based on National Institute for Health and Care Excellence (NICE) guidelines; however, there was no audit process in place to monitor and review compliance to the guidelines.
- During the last inspection, we found there was no local clinical audit programme for the MIU. During this inspection, we found there was still no local clinical audit programme in place. Staff were aware of audits being conducted in other areas of the unscheduled care division and told us that the introduction of the cross-divisional clinical governance meetings meant that they would be able to learn more. We saw that the operational policy for MIU, which was updated in September 2016, included a number of audits that would be conducted which included compliance to protocol and records documentation.
- The MIU met some of the minimum requirements in accordance with those set out by the RCEM document 'Unscheduled care facilities', 2009. These related to staffing levels meeting the minimum guidance and staff having access to resuscitation equipment and diagnostics. We asked the trust for their plans to meet all the minimum requirements and they told us that that would form a part of their review of the urgent care services in October and November 2016.
- Staff told us that care and treatment was delivered based on the 'see and treat' model as defined in national guidelines 'Transforming urgent and emergency care services – Urgent care review' NHS England, 2015 and recommended as best practice in minor injuries units. The guidance also recommends that the service should aim to provide the 'see and treat' model within two hours of the patient's arrival; there was no audit process in place to monitor compliance to that standard, identify good practice or opportunities for improvement.
- 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 but these were not always recorded.
- Nursing staff administered pain relief as and when required using patient Group Directives (PGDs).
- Pain was assessed by the ENP on initial assessment of the patient. Pain assessments were not routinely recorded on patient's records.
- 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 not in the unit 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 MIU. 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 said that they were given some information about the unplanned re-attendance rate for the unscheduled care division, which was 9% at the time of our inspection and higher than the England average of 7%. We asked the trust for data specific to the MIU and found that from April 2016 to July 2016, the unplanned re-attendance rate at the MIU was in line with the England average at 7.2%. Staff told us unplanned re-attendances at the MIU were mainly due to patients returning the next day for an x-ray or to change 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 MIU, there were not robust appraisal and clinical supervision systems in place to support them. From April 2015 to March 2016, 43% of nursing staff and 0% of administrative and clerical staff had received an appraisal. This was significantly below the trust's target of 90%. At the time of our recent inspection, the MIU was on track to exceed the trust's target for 2016/17.
- During our last inspection in 2015, staff told us that they did not undertake regular supervision from a senior clinician or manager as they worked autonomously. During our recent inspection in 2016, staff told us that there was still no formal process for supervision; however, they now had regular meetings at the St Albans hospital where a consultant would attend and deliver clinical training specific to their roles. For example, staff had told us about a new screening tool for children with head injuries as the result of suspected physical abuse. Nursing staff told us that a consultant had attended the MIU and delivered a session to them, which explained the theoretical and practical aspects of the tool.
- Staff told us that there were still limited opportunities for one-to-one meetings due to the logistics of having one overall line manager for all three of the sites in the unscheduled care division. 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. We saw that the trust had sent information to nursing staff in July 2016 to help support them with the process and that there was on-going support available through nursing staff educational leads.
- 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 and courses; however, sometimes attendance would have to be in their own time to meet the needs of the service.
- Nursing staff told us they had received some training in the recognition and management of sepsis through a face-to-face training session delivered by one of the trust's ED consultants. The trust told us that they had an action plan to deliver bespoke training in sepsis screening and management for all nursing staff in the MIU by January 2016.

Multidisciplinary working

- Staff told us that prior to our inspection in 2015, there had been limited multidisciplinary working within the unscheduled care division. Staff said that improvements

had been made which included the monthly clinical governance meetings at the St Albans and Hemel Hempstead hospitals where representatives from each of the services in the division attended.
- We saw that staff worked well with other teams such as the radiography department, which was based at their site.
- The service interacted with the external out of hours' GP service which was co-located at St Albans hospital and staff told us that they were able to receive medical support from staff there if required.

Seven-day services

- The MIU was open seven days a week (except for Christmas Day) from 9am to 8pm.
- X-ray facilities were available at St Albans hospital Monday to Friday 9am to 5pm. Patients who required-rays outside of these hours would be directed to alternate sites or asked to return the next day, if safe to do so.
- There was an on-site pharmacy available at St Albans hospital from Monday to Friday 9am to 5pm and staff had access to a weekend pharmacy at the Watford general hospital from 10am to 4pm. Outside of these hours staff had access to an on-call pharmacist for advice.

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 which also allowed them access to radiology reports.
- Patient's notes were a mixture of paper and electronic records, staff had access to paper records which were stored behind a locked door in reception. If patients were transferred to another site or admitted, receiving teams had access to the patient's electronic records.
- Staff could access the child protection information sharing system which allowed them to share concerns with other providers and see if patients were on the 'at risk' register.
- Patients who were discharged from the service were given written information to share with their GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 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 MIU environment. In July 2016, five out of six ENPs had received MCA and DoLS training. Records seen demonstrated consideration of consent and capacity in accordance with trust policy.
- Staff were aware of the Fraser guidelines and Gillick competence in regards to children giving consent to treatment. Staff told us that they had recently had a training session delivered in the MIU in regards to parental responsibilities for children presenting unaccompanied to the MIU.
- Staff had not received any specific restraint training; however, 81% of nursing staff and all reception staff had received conflict resolution training. Staff told us that it was rare in their environment to physically restrain a patient to deliver necessary care and treatment: if a patient displayed challenging behaviour, they would ask the hospital's security staff for assistance.

Are minor injuries unit services caring?

Good

Overall, we rated the Minor injuries Unit (MIU) as good for caring because:

- We saw that patients were treated with kindness and respect.
- We saw staff taking the time to interact with patients and those accompanying them.
- 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

Minor injuries unit

- Patients that we spoke with told us that the staff were caring and always introduced themselves by name. We saw positive and respectful interactions between patients and staff. All interactions were observed to be caring and respectful.
- Privacy and dignity was maintained during interactions and assessment with patients in all clinical areas. We saw that treatment doors were always kept closed when patients were being seen to ensure privacy and dignity.
- The 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%.
- We saw that staff took into account patient's cultural and religious needs.

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 positively encouraged patients and their relatives to take information away with them about self-care advice and support groups in the local area.
- Patients were kept informed of waiting times and told what the average waiting time was when they booked in.
- 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 minor injuries unit services responsive to people's needs?

(for example, to feedback?)

Good

Overall, we rated the Minor Injuries Unit (MIU) as good for responsive because:

- The MIU was consistently meeting the national target of 95% for four-hour admission to discharge.
- The average time to treatment for patients was half an hour.
- There was evidence that the trust was working with local commissioners and other healthcare providers to plan service delivery.
- Staff adjusted their practice and communication styles to meet the needs of individuals.
- The service had 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 unit had information leaflets available in a variety of languages and access to translation services.

However, we also found:

- Staff were not aware of the trust's strategies related to patients with complex needs, such as patients living with a dementia.
- There were limited processes in place to monitor all aspects of access and flow. The service was only required to report on the four-hour admission to discharge target, there were no processes in place to monitor and review initial time to assessment or treatment.
- 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.

Service planning and delivery to meet the needs of local people

- Service delivery for the MIU 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 were planning 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 St Albans hospital and the options for future models of care, which included exploring the development of an urgent care centre. The report included views and comments from local residents.
- We saw that planning for the service took account of key demographics and lifestyles of the local population, including areas such as tackling obesity and substance abuse.
- We saw good evidence of staff at a local level exploring ways to meet the needs of the local population. For example, a member of staff had suggested having a banner at the front of the hospital which described their services to help publicise the service for the local population which was in line with recommendations in the trust's 'Your Care, Your Future' report. Another suggestion was to place a bench outside the unit so patients waiting for x-rays or results could sit outside if they chose to.
- All patients that we spoke to were aware of the opening times at the unit and this included the provision of x-ray facilities. We saw in the 'Your Care, Your Future' report and other patient feedback items that members of the local population felt that provisions at the unit should be increased such as x-ray services in line with the opening times. The unit had introduced a process to direct patients whose injuries were indicative of a suspected fracture, to the Hemel Hempstead urgent care centre where x-ray facilities were available until 10pm. The trust had also introduced a virtual fracture clinic; this meant that patients for whom x-rays were carried out between 5pm and 8pm could have their results without having to return the next day.
- The trust had highlighted in their own report that the space and facilities on the St Albans site were not utilised to full capacity due to ongoing estate issues such as ageing buildings. The MIU facilities and premises were generally appropriate for the service that were being delivered at the time of our inspection. It was recognised by the trust that further development of services and increasing attendances would require redesigning facilities and workforce structure.

Meeting people's individual needs

- Services were not consistently delivered in a way that took into account the needs of different people, in relation to age, gender, religion, and disabilities.
- Staff were not aware of any 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 MIU for people living with a dementia. There was no specific pathway for patients with learning disabilities or those living with dementia and staff had not received related training; however, reception and nursing staff told us that they would prioritise patients and adapt their practice to suit their needs. For example, a member of staff told us of an occasion when an emergency nurse practitioner (ENP) had gone out to the car park and encouraged a child with autism to enter the unit. Staff told us that they had access to a learning disabilities lead nurse at the main Watford site if they needed any advice.
- Staff at the unit generally worked autonomously and we observed that staff adapted their practice and communication styles to meet the needs of individuals who attended the unit.
- Staff had access to translation services and we saw that the unit had cards and diagrams with pictures to use to assist with communication. Staff gave examples of a variety of ways in which these cards were used such as when English was not the patient's first language. Staff were able to contact translation services for people who did not speak English to enable them to understand their care and treatment.
- We saw a number of information leaflets for patients about services available at the unit 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 reception staff had a number of the leaflets printed in different languages available to give to patients. They also had the facility to print information in different languages when required.
- We saw information leaflets given to patients that clearly stated who they should contact if they had any

concerns or worrying symptoms after treatment. There was information throughout the department relating to support groups for patients with specific conditions to access local support networks.

- The MIU 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.
- There was a canteen available at the St Albans hospital and patients who were waiting in the MIU had access to refreshments, which were provided twice daily.
- During our inspection, we saw that patients who were distressed were not always able to receive adequate support such as a quiet space or confidential area. Staff told us that at those times they would try to find a room or an area to accommodate patients, however, this was not always possible due to the layout of the environment.
- We saw that there was a quiet room at the hospital site for patients of all faiths.

Access and flow

- The Department of Health target for minor injuries units is to admit, transfer or discharge 95% of patients within four hours of arrival at the unit. From March 2016 to August 2016, the unit consistently exceeded this target and achieved an average of 99% overall for that period.
- The average time to treatment for patients was half an hour.
- There were minimal systems and processes used to measure and monitor any other areas of access and flow in the MIU such as initial time to assessment or treatment.
- There were no clear escalation processes in place to manage the service during periods of high demand or excessive waiting times and ensure that patients with more urgent needs were prioritised. NHS England recommend that there should be clear 'triggers' and actions defined for escalation in all healthcare organisations providing urgent and emergency care 'Transforming urgent and emergency care services in England, NHS England, 2015'.
- The unit operated a 'see and treat' model in line with recommendations for MIUs published in 'Transforming urgent and emergency care services in England' NHS England, 2015; however; there was no process in place to monitor or work towards the two hour treatment time frame associated with the 'see and treat' model.
- After our inspection the trust supplied us with the operational policy for the MIU which 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 triggers for escalating capacity issues to senior staff during periods of high demand.

Learning from complaints and concerns

- There was clear guidance on display in the MIU 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.
- Staff told us that the main reason that people complained was due to the x-ray facilities closing three hours before the MIU and the lack of privacy at the reception area.
- Staff told us that if a patient made a verbal complaint to them they would try and resolve the concern at the time and record the details on the electronic system if there were opportunities for learning.
- From July 2015 to June 2016, there were three formal complaints recorded for the MIU. We saw that complaints were investigated and opportunities for learning identified and actioned when required. For example, we saw that arrangements had been made for medical colleagues from the orthopaedics and physiotherapy department to attend the MIU and discuss complex hand injuries after a complaint was made regarding treatment of a hand fracture.

Are minor injuries unit services well-led?

Requires improvement

Overall, we rated the Minor Injuries Unit (MIU) as requires improvement for well-led because:

Minor injuries unit

- There was inconsistency in leadership and visibility from senior departmental leaders.
- There was a lack of improvements from the last inspection.
- 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.

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. There was a lack of improvements from the last inspection, as areas identified as concerns had not all been actioned.
- The MIU was a part of the unscheduled care division which also included the emergency department (ED) at the Watford general hospital and the urgent care centre (UCC) at Hemel Hempstead. The overall management of the division included a divisional director, divisional general manager, and divisional lead nurse.
- The local management of the MIU and the UCC was the responsibility of the ED matron and a designated senior consultant who was the clinical lead and both were based at the ED at the Watford site. Staff told us that the matron and clinical lead generally managed the unit remotely and visited the MIU at least once a month. 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 MIU to act as lead nurses on a daily basis and also 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 often they were caring and treating patients in that allocated time. Staff explained that they fully understood that clinical duties were always a priority when patients were waiting to be seen.
- Staff told us that they felt that the unit lacked the 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 were aware of the trust's vision which was to provide 'The very best care for every patient every day'.
- The strategy for the urgent care service was being developed at the time of our inspection as a part of the long-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.
- There was no clear strategy for the MIU and we were advised that posters relating to the trust's strategy had only recently been put on display.
- The unscheduled care division had a comprehensive strategy and improvement plan; however, there was no strategy for MIU included in this.
- 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.
- 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 affect 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.

- The unit was only required to measure the four-hour admission to discharge target, there was no formal process in place to monitor other elements of performance, such as compliance to protocols or time to initial assessment. This meant that the unit was not consistently identifying areas for improvement or best practice and staff were not aware of how they were performing in some other areas.
- Staff told us that the MIU 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. Staff were not aware of any that were relevant to the MIU. For example, one of the risks recorded for the division was in regards to increasing staff awareness in the recognition of the deteriorating patient and escalation processes; however, staff at MIU were not aware that this was a risk for their department or the actions that were being implemented to mitigate the risk.
- Staff told us that the only risks that they were aware of and conducted assessments for were in regards to patient safety during care and treatment and also staffing levels.
- There was no formal process in place at the MIU to audit the accuracy of patients' records. Failure to complete patient's records according to Nursing and Midwifery Council (NMC) guidelines and the potential impact on continuity of care when patient's move between teams and services was also highlighted on the divisional risk register. The actions put in place to mitigate the risk had not been implemented or effectively communicated to staff in the MIU.
- 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 formal programme for clinical or internal audits to measure patient outcomes and performance.
- During our last inspection in 2015, we found that staff at the MIU did not have regular clinical governance meetings. During this inspection, staff told us that this had improved and we saw that staff from the MIU had been attending regular local joint clinical governance meetings at the Hemel Hempstead site. We saw minutes of meetings from September 2015 to April 2016 in staff areas that showed that these were attended by senior nursing and medical staff from each area of the unscheduled care division. Staff told us that they welcomed the development of the local clinical governance meetings as an opportunity to learn and develop their service.

Culture within the service

- Staff in the unit 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 been improved through the establishment of regular clinical governance meetings.
- Staff told us that they felt that they could voice any concerns they had to the ED senior management team by liaising with the ED matron; 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 had requested signage to be placed asking patients to stand back at the reception area to allow privacy after our inspection in 2015; this was still not in place during our recent inspection.
- 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 and was less of a 'blame culture'.
- Staff at all levels were not aware of the duty of candour regulation and the principles or legal requirements related to it. When prompted by an inspector, staff told us that they would always offer an apology to a patient or a relative if something went wrong; however, they were not aware of any policy or statutory requirements related to it.
- Staff told us that if they witnessed another member of staff displaying behaviours that were not in line with the trust's vision and values: they would challenge this or bring it to the attention of a senior manager.

Public engagement

- There were questionnaires in the waiting and reception area of the unit asking patients to provide feedback about their experience at the MIU.

- 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 MIU 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 which 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 MIU; 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 unit'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

- Staff at a local level were exploring ways to improve service delivery through developing plans to make small changes that could improve the patient's experience and potentially low financial implications for the service.
- The virtual fracture clinic was developed and offered patients more flexibility and choice.
- 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.

Surgery

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

Information about the service

Surgical services provided by West Hertfordshire Hospitals NHS Trust are located on two hospital sites, Watford General Hospital and St Albans City Hospital. Services at Watford General Hospital are reported on separately.

St Albans City Hospital provides a wide range of surgical, diagnostic, outpatient and ophthalmology facilities to approximately 500,000 people living in West Hertfordshire and the surrounding areas.

The surgical service provision at St Albans covers low risk, elective procedures. This includes orthopaedics, ophthalmology, vascular, ear nose and throat (ENT), urology, endocrine and breast surgery. The hospital performance summaries between March 2015 and February 2016 showed there were 11,378 elective spells at St Albans. The trust identified that 80% of surgical patients were day case and 20% were elective in the year ending 29 February 2016. Surgical services at St Albans City Hospital are located within the surgery, anaesthetics and cancer division. The division has been recently reconfigured and the structure includes a divisional director, head of nursing and service manager. There are six theatres and 40 elective surgery beds on two wards as well as a pre-assessment unit and day case surgery department.

During our announced inspection on 7 and 8 September 2016 and our unannounced visit on 20 September 2016, we visited all surgical services, spoke with 17 patients, observed patient care and treatment and looked at 13 patient care records. We spoke with 22 staff including nurses, healthcare assistants, clinical nurse specialists, doctors, consultants, theatre staff, ward managers and matrons. We received comments from our focus group listening events and from people who contacted us to tell us about their experiences at the hospital. We acknowledged the views expressed by patients on Care Quality Commission (CQC) comment cards and those expressed at the CQC stand.

Surgery

Summary of findings

We rated the service as requires improvement for safe, responsive and good for effective and caring. We rated well-led as inadequate. We rated this service overall as requires improvement because:

- Sufficient improvements to the governance and risk management systems, to demonstrate full compliance with the requirement notice that was issued after the last inspection, had not been made.
- Theatre teams were not consistently using the five steps to safer surgery checklist.
- Operations were carried out on high-risk patients and there were no critical care beds on site. Critically ill patients were transferred to Watford General Hospital.
- Staff did not always observe infection control guidelines.
- Medicines were not being stored safely as they were stored above the recommended temperatures.
- Referral to treatment times were consistently below the England average.
- Venous thromboembolism (VTE) assessments were initially completed but not consistently repeated in line with best practice.
- Staff were unaware of the trust mission, vision, and strategic objectives.
- One of the junior doctors had not received a trust induction and had been working in the service for eight months.
- Not all staff received feedback after reporting incidents and some staff said they did not report all incidents.

However, we also found that :

- All policies were current and followed the appropriate guidelines, such as National Institute for Health and Care Excellence.
- The hospital utilised enhanced recovery programmes for surgery pathways.
- The ward team meeting minutes identified shared learning from incidents.
- The environment was visibly clean.
- Patient notes had documented risk assessments undertaken.
- There were competency frameworks for staff in all surgical areas.
- Ward sisters had access to leadership programmes.
- Patients told us staff requested their consent prior to any procedure and records seen demonstrated clear evidence of informed consent.
- The hospital had a nurse led pre-assessment clinic, which provided choice to patients regarding their appointments.
- There was a sense of pride amongst staff working in the hospital.
- The hospital recognised the views of patients and carers.
- Staff working within the service felt supported.

Patients told us that the care they received was good and that they felt safe.

Surgery

Are surgery services safe?

Requires improvement

We rated surgical services as requires improvement for safe because:

- Operations were carried out on patients who were classified as higher risk using the American Society of Anaesthesiologists (ASA) scale. This included ASA level three patients and there were no critical care beds on site.
- The World Health Organisation (WHO) 'five steps to safer surgery' was not consistently recorded. The hospital used a three-step process.
- Some staff told us they did not record all incidents on the trust's incident reporting system and did not receive feedback from incident reports they had completed.
- Fridge temperatures had not been recorded in some areas and intra-venous fluids were stored above recommended temperatures.
- Out of hours senior medical cover was not based on site and some staff reported concerns over adequate support during the night and at weekends.
- One of the F1/F2 junior doctors, who were known as resident medical officers, (RMO) had been working in the division for eight months and had not received a trust induction.
- Infection control practices did not follow trust guidance including cleaning and storage of patient equipment and safe disposal of water. Water used for assisting patients with personal hygiene (washing) was disposed of in hand hygiene sinks.
- Patient equipment was not being monitored and checked in a way that ensured patients were kept free from avoidable harm.
- A fire assessment had identified several high risks, which were not addressed until the fire officer's annual fire inspection.

However, we also found that:

- There were sufficient nurses on duty to care for patients.
- Staff were observed washing their hands before and after patient contact.
- Staff with whom we spoke with had a good understanding of safeguarding children and adults.
- Nursing notes were comprehensively completed, including appropriate care plans and risk assessments.
- The environment was visibly clean and tidy.
- Safety thermometer data collected by the trust was better than the England average for falls, pressure ulcers and catheter associated urinary tract infections (CAUTI).

Incidents

- Staff understood their responsibility to raise concerns, to record safety incidents and near misses and to report them internally and externally. The trust had an electronic incident reporting system in place. Staff were able to tell us what constituted an incident and knew how to correctly report one. Staff told us that they were reporting more incidents since our last visit and records we looked at confirmed this. However, three staff told us they did not always record incidents, although they could not give us a reason for this. Incidents not reported included failing to report inadequate qualified nursing staff on duty to care for the number of patients on the ward or if there had been a delay in obtaining authorisation to transfer deteriorating patients to Watford General Hospital. This meant that although staff understood their responsibility to report safety concerns, this was not embedded into their everyday practice. Additionally four staff we spoke with said they did not always receive feedback for the incidents they reported.
- Staff told us about incidents where learning had been shared and what actions to improve care had been implemented. For example staff told us about an incident where an eye drop was administered into the wrong eye of a patient. This resulted in adding a further checking stage prior to administration.
- Between September 2015 and September 2016 the surgical service reported two serious incidents (SI) requiring investigation. An SI in healthcare is an adverse event where the consequences to patients, families or staff are so significant that a higher level of response is justified. Staff told us about the process of investigating serious incidents. The explained that lessons learnt were analysed and shared by senior staff and cascaded to the team. Staff told us they were informed about incidents and lessons learnt via team meetings. The minutes of these meetings confirmed this.
- De la Mare and Beckett wards provided 40 beds for patients undergoing elective surgery. Staff within these wards provided an example of a recent SI and identified

the learning that had taken place since. Following the investigation staff received extra training from the learning disabilities team and by the diabetes clinical nurse specialist.

- There were 647 clinical incidents between October 2015 and October 2016. The majority (607) resulted in no harm however there were 12 moderate harms and one death or catastrophic injury.
- The trust reported no 'never events' between July 2015 and June 2016. 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
- 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 give reasonable support to the person. Staff were aware of the duty of candour regulation and ensuring patients received a timely apology when there had been a defined notifiable safety incident. Staff told us about a medication error, and how the patient had been informed immediately. The trust showed us documentation where they had applied the duty of candour following another two serious incidents.
- The trust had recently introduced 'Swartz rounds' where staff reflected and learnt from clinical situations and incidents. 87% of staff who attended had rated the sessions as excellent or exceptional. The confidential rounds were run by a mixed panel of staff and had been shown to have a positive impact on individuals and teams. For example in August 2016, there had been a reflection about a patient death that had been particularly traumatic. Staff reported they had benefitted emotionally from learning about the incident.
- Mortality review meetings, which were trust wide took place every two months and were chaired by the medical director. The meetings reviewed performance data relating to mortality, including the Hospital Standardised Mortality Ratio (HSMR), clinical coding and patient safety indicators. Consultants reported that the meetings were well attended. The data was shared in the integrated performance report.

Safety thermometer

- The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing patient harm and 'harm free care'. Data was collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter associated urinary tract infections (CAUTI) and falls.
- NHS Safety Thermometer information was displayed in each ward to provide staff, patients and visitors information on service performance.
- The trust told us they were unable to provide separate NHS Safety Thermometer data for surgical services at St Albans. In the period April 2016 to August 2016, the trust reported 14 new trust wide venous thromboembolism (VTE) over both its hospital sites. This gave a VTE rate of 0.47 which was higher than the national average of 0.38. This meant that more patients had acquired a VTE while receiving treatment at the trust on average, than at other hospitals.
- The surgical nursing services used a monthly performance dashboard to monitor quality of care. Standards were measured, using a collection of nursing care indicators, called 'Test Your Care'. Indicators of care included missed medication doses, nutritional assessments, and pressure ulcers. The checks resulted in an overall compliance to nursing standards score, which were then displayed on the board of each surgical area. We saw that in August 2016 compliance on De La Mare ward was 95%, which exceeded the trust target of 80%.

Cleanliness, infection control and hygiene

- Infection control policies were available on the trust intranet system and staff told us they knew how to access them. However, we observed practice which did not always follow the trust's own policies. This meant good practice was not always embedded into the service.
- We found clean equipment, ready for patient use, stored in the dirty utility room alongside used commodes and sluice hoppers (waste disposal sinks) on De La Mare

ward. This equipment included a clean dressing trolley, a drip stand, five intravenous (IV) therapy pumps and a nebuliser machine. This meant there was a risk of clean items being contaminated by organisms from waste products. This was raised with senior staff on our announced inspection and we were told this would be rectified immediately. On our unannounced visit, we saw an IV pump and a nebuliser machine were still stored in the dirty utility room.

- We observed staff removing some of these items from the dirty utility without cleaning them first. One member of staff told us the items would be cleaned once they arrived back in the theatre. The trust infection control policy stated that 'all items must be cleaned by the user following each procedure and prior to re-use' and that: 'the user must sign and date the appropriate labels to confirm cleaning has taken place'. The equipment that we saw did not have a cleaning label attached.
- Shared and open patient toiletries, for example talcum powder were stored in the dirty utility room. Patient consumables should be stored in a clean supply room (Health Building Note 04-01)(HBN00-04). Shared toiletries can become a reservoir for bacteria and pose an increased risk of transmitting an infection from one patient to another therefore it is recommended that patients do not share toiletries.
- In the ward area, healthcare staff were observed disposing of patient waste washing water in hand hygiene sinks. There is a risk this practice will allow the transfer of new bacteria from the patient to become colonised in the water supply which may in turn cause harm to patients (Health Building Note 00-09)(HBN 00-09). The trusts water safety policy puts a duty on all staff to prevent contamination of the water supply. This meant that although the trust had policies in place to keep patients safe, staff were not always following them.
- We saw on De La Mare ward the linen cupboard was not a dedicated linen store and several other items were stored alongside clean bedlinen. This included patient warming machines and occupational therapy equipment. Some of this equipment was dusty. This meant that bedlinen could become contaminated with organisms which could cause harm to patients.
- The clinical room on De La Mare ward did not have a dedicated hand hygiene sink compliant with HBN 00-09. Dedicated hand hygiene sinks should not have a plug or an overflow and taps should not be aligned to run directly into the drain aperture.
- The surgical areas visited were visibly clean. We saw clean equipment was labelled with 'I am clean' stickers so staff knew the items were ready for use.
- All empty beds on Beckett ward had completed cleaning checklists indicating they were ready for patient use. Appropriate cleaning products were available and safely stored in a locked room.
- We observed personal protective equipment (PPE) such as gloves and aprons being used appropriately and were available in sufficient quantities. We saw that the trust infection prevention team carried out a PPE audit on De La Mare ward in April 2016 and a score of 92% was recorded. The trust sets itself a minimum standard of 90%.
- We saw a daily cleaning checklist in the operating theatres, which was 100% compliant with cleaning for July and August 2016.
- Hand hygiene gel was available at the entrance to the wards, in bays and side rooms and at the end of patient beds. Hand-wash basins were also available in bays and side rooms. We observed staff washing their hands before and after patient contact during our inspection. The service reported handwashing compliance of 100% for all audits carried out between February 2016 and May 2016.
- We observed all staff were bare below their elbows in the clinical environment meaning they could carry out effective hand hygiene when required.
- De La Mare ward carried out environmental audits each month. These audits followed recognised best practice and looked at the environment and equipment. Results displayed on the notice boards showed above 95% compliance each month between January 2016 and May 2016.
- There were no cases of MRSA recorded between December 2015 and June 2016. All patients having elective surgery or attending pre assessment clinic were swabbed for MRSA and appropriate treatment provided if results were positive.
- There had no reportable cases of Clostridium difficile (C. difficile) in surgical services between December 2015 and June 2016. C. difficile is a potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patients who have been exposed to antibiotic therapy.
- All surgical wards had isolation rooms where patients with infections could be source isolated to prevent the spread of infection.

- Between April 2015 and March 2016, the trust reported that 310 total hip replacements had taken place and there had been zero surgical site infections (SSI). There was one SSI reported for total knee replacements between April 2015 and March 2016 equating to a rolling average of 0.2% which is below the national average. The trust had an SSI prevention nurse and lead surgeon who discussed, classified and agreed all SSIs, completed incident reports and conducted root cause analysis of reported SSI incidents. Learning was shared through SSI and divisional governance meetings.
- The hospital had a lead nurse for infection prevention and control. The infection control committee met monthly and monitored the services performance.

Environment and equipment

- The maintenance and use of facilities did not always reduce the risk of patient harm. Resuscitation trolleys, for use in an emergency, were regularly checked, and documented as complete and ready for use. We saw the trolleys we checked had the correct equipment available for adult resuscitation.
- One of the operating theatres, which had been closed for 11 months, had undergone a refurbishment. This included a new floor, doors and ventilation hood and had been reopened.
- Theatre five was a 13-year-old modular theatre with a ten-year lifespan. Modular theatres are mobile theatres set up usually for a defined temporary period to provide extra operating space. The theatre had undergone a structural survey at ten years, which identified the flooring and drainage system required repairing. We saw that this work had been carried out. The theatre was working and continually monitored.
- There were three theatres with laminar flow air systems suitable for orthopaedic surgery. Staff told us the airflow systems serviced and revalidated every six months by an external organisation and met standards set out in the national guidance, HTM03-01: Specialised Ventilation for Healthcare Premises. Evidence provided by the trust showed all five theatres' air ventilation systems had been verified as fit to use but all had recommendations for improvement, including two urgent recommendations. We were not provided with evidence that the recommendations were carried out, however all theatres were revalidated in October 2016 and reports from the external validation company were being prepared at the time of our inspection.
- Theatres were deep cleaned on a rolling three-month programme. We saw theatres one to four had undergone a deep clean between June 2016 and July 2016. A snagging list of all small repairs, for example replacing worn equipment was created and the estates department carried out any repairs during one of the rolling half-day closures.
- There was a large section of wall on De La Mere ward near the fire exit, which had been recently plastered, but had not been painted. Staff told us that the estates department were aware and that the plaster was drying out. During our unannounced visit, the plaster was noted to be covered in a white powder residue which came off when touched. Equipment was stored leaning against this wall including the emergency spinal board and an air mattress. This was raised with staff at the time and the equipment was moved.
- Staff on De La Mare ward said there was only one clean dressing trolley available for wound dressing changes. On our unannounced visit, we saw that three more had been ordered.
- Most equipment we saw had undergone electrical equipment testing. The trust policy on medical devices states staff must ensure equipment has an appropriate asset label and an in-date 'tested' label affixed before use. However, the continuous passive motion (CPM) machines and the ultrasound bladder scanner had not undergone testing.
- We saw details of an incident when a drug infusion pump was required but the only one available had an out of date electrical testing certificate. The pump had not been used in this instance, but the patient did not get their medication because there was not another pump available.
- We saw a damaged hoist that had its electrical control box held together with white sticky tape. The item had a safety equipment sticker, which indicated testing was due in September 2016. The hoist was stored on the public corridor outside the ward. Staff on duty did not know why the hoist was in the corridor or notice that it had been temporarily repaired with tape. On our unannounced visit, staff told us the hoist was always stored in the area outside the ward and the damaged box had now been reported to the manual handling team. The trust equipment policy states that devices

should not be used once they have been reported as faulty and a yellow defective label must be attached to the item. The hoist did not have a defective label and staff could not confirm when it had last been used.

- We saw procedures were in place to ensure that maintenance of equipment was carried out in order to keep patients safe from harm. However, these procedures were not always followed, which meant that patient harm could have occurred.
- Dirty utility rooms were observed to be clean and tidy with appropriate storage for clinical waste and chemicals. One sluice had paper notices on the walls, which were torn and could not be wiped clean.
- Appropriate coloured disposal bags were used for the disposal of waste in the clinical areas. General waste and recycling facilities were available to staff, patients and visitors.
- Sharps boxes for the disposal of needles were found to be appropriate to each clinical area and detailed the date, time, and person responsible for assembling them. All were assembled correctly, were clean and not filled above the recommended level.
- Clinical rooms were found to be well organised and with adequate storage for consumables such as wound dressings and patient toiletries. Staff on De La Mere ward told us they had problems finding suitable places to store large equipment, for example, drip stands and hoists and were looking to utilise extra storage rooms off the main ward area.
- Staff told us they could access bariatric equipment when required, for example larger patient beds and wheelchairs.
- At the Care Quality Commission focus group, a member of staff told us they had concerns about fire safety. They told us not all staff took ownership of fire safety issues and said problems were left for the fire officer's annual check. They also told us that maintenance and fire safety databases were not kept up to date meaning planned preventative maintenance was not being carried out. We were told these issues had been raised with the senior management team. We looked at a fire risk assessment for theatres, which was carried out on 27 July 2016. We saw several high risks had been identified including blocked escape routes, evacuation equipment which staff had not been trained to use, a build-up of combustible waste and fire call bells blocked by equipment. We saw that following a fire officer's inspection, this area was added to the trust risk register and an immediate action plan was drawn up to address the safety risks.

Medicines

- Arrangements were in place for managing medicines. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- There were processes and procedures in place to complete weekly checks and reconciliation of medicines as well as monthly audits to check stock and utilisation.
- The temperatures in the treatment rooms were consistently above the recommended storage temperature of 25°C on both De La Mare ward and the operating theatres. The trust's policy of reducing the expiry dates of medicines in line with the increased temperatures was not being followed. We raised our concerns regarding the room temperature with senior trust management at the time. Following our inspection the chief nurse provided us with an action plan to address and monitor the medication room temperatures.
- The refrigerator on the ward used to store medicines requiring cold storage had been recorded as being out of range for seven days. There was no evidence of the action taken to ensure that medicines were still suitable for use.
- Controlled drugs (CDs) (medicines that require extra checks and special storage arrangements because of their potential for misuse) that were not used or partially used were not denatured (rendered irretrievable) at ward level before being placed into pharmaceutical waste containers. CDs were not disposed of in line with Home Office advice and the Safer Management of Controlled Drugs: a guide to good practice in secondary care 2007 (Department of Health). Following our inspection the chief nurse provided us with an action plan to address and monitor the disposal of CDs.
- CDs were reconciled correctly in the register, in line with ward policy.
- We looked at 17 prescription charts and found that all were clearly labelled with the patient's details. All medicines had been signed for either as administered, or a reason was documented if the patient did not have the medication.

- Medicines were either brought in from home by individual patients, or supplied by the pharmacy department. The pharmacy department on site was open Monday to Friday between 9.00am and 5pm. At weekends staff had to request medicines from the Watford site. An out of hours' cupboard containing emergency medicine was available or medicines could be obtained through the on-call pharmacist service.
- Medicines that were required for patients, who were being discharged during the week, were obtained from the on-site pharmacy. At weekends, staff told us there were long delays in getting medicines for patients prior to discharge as they had to come from the Watford General Hospital site. The tracker system informing staff of where the prescription was in the dispensing process was not operational at the St Albans site. There was no option for patients living close to Watford to collect from the Watford site.
- Staff said there was good communication with the pharmacy team during the week and that pharmacy staff were responsive if they required medication urgently.
- During the week, a clinical pharmacist monitored the prescribing of medicines, visited the wards daily, and was readily available for advice about medicines. We looked at a sample of four prescription charts and found that medicines reconciliation was complete for each patient. Medicines reconciliation is when a check is done to ensure that patients receive the correct medicines on admission to hospital.
- A pharmacist was available as part of the surgical preadmission process to ensure patients received the correct medicines once they were admitted to hospital and to ensure they stopped other medicines, as necessary, before their surgery. In addition, the pharmacist answered any other questions patients had about their medicines, including pain relief.
- All medicines on the ward and in theatre were stored safely behind locked doors or in restricted areas which were only accessible to appropriate staff.
- If patients were allergic to any medicines, this was recorded on their prescription chart.
- Resources used to access information about medicines were available on line via the British National Formulary, which is a pharmaceutical reference book.
- We found patients were not offered the opportunity to self-administer their medicines although there was a policy in place to allow this. In addition, there were lockers suitable for patients who were capable to self-medicate. Patients admitted to De La Mare ward were usually responsible for their own medicines at home.
- Staff told us that they had received medicine training on induction and had their competency assessed but they had not received any further training or competency checks.
- Staff reported incidents related to medicines on the trust's reporting system. Feedback and any learning was discussed as part of handover.
- Emergency medicines were available for use and were checked regularly.

Records

- Patients individual care records were written and managed in a way that kept them safe.
- In the surgical wards and operating theatres, we reviewed 13 sets of patients' notes, which included appropriate assessments for patients undergoing surgery. Within the patient's' notes, we saw detailed and comprehensive records documented in a pre-assessment pathway booklet. This was completed prior to admission. Care plans were in place, which identified care that patients' should be given. This meant that staff had access to information on how to care for a patient.
- Care bundles and pathways were used for patients when appropriate. Care bundles are a set of evidence based interventions that when used together significantly improve patient outcomes. Examples included orthopaedic pathways, breast care and ear nose and throat pathways.
- We observed patients' medical notes were in locked notes trolleys to ensure patients' details were kept confidentiality. End of bed folders were used to store daily assessment records and medicine charts. These were easily accessible and enabled staff to record ongoing care in a timely manner.

Safeguarding

- There were clear systems, processes and practices in place to keep patients safe. The hospital had safeguarding policies and procedures available to staff on the intranet.
- Staff had received safeguarding training through an electronic learning tool and those we spoke with had a

good understanding of their responsibilities in relation to safeguarding adults who used the service. In addition, staff knew when to report issues to protect the safety of patients.

- Training records showed that over 94% of nursing staff had undergone adults level 1 and level two safeguarding training and 95% of them had received level 1 and level 2 child safeguarding training. This was above the trust's target of 90%. All patients were 18 or over. 92% of doctors had undergone adult safeguarding levels 1 and 2 and 94% of them had received level 1 and 2 children's safeguarding training.
- Staff reported that the trust's safeguarding lead was accessible. We saw posters on the walls by the nursing station providing contact details for any safeguarding concern.

Mandatory training

- All new employees received a corporate and a local induction to enable them to become familiar with the organisation and their area of work.
- All staff within the surgical service had access to mandatory training. This included infection control, information governance and manual handling. A training needs analysis had been undertaken to ascertain what extra mandatory training staff required which was based on whether they were registered professionals or health care support staff. This role specific training included other subjects, for example, the level of safeguarding and level of resuscitation training required.
- Trust records showed that 93% of nursing staff and 82% of doctors had in date training for adult basic life support. The trust target was 90%.
- Data provided by the trust showed that compliance with infection control training was 88% in theatres, (29 out of 33 staff) and 68% in De La Mere (19 out of 28 staff). This led to an overall rate 79% of nursing staff had up to date training in infection control. This meant that some staff may have not been aware of the most up to date guidance on how to protect patients from infections.
- Trust data showed the overall compliance of mandatory training for nursing staff working at ST Albans City Hospital was 81%. We saw that the trust had recently introduced an electronic e-learning system for many training modules and staff were accessing these from computers at work and at home. Local senior nurses kept good records of staff training needs and sent reminders via e-mail for any outstanding training. Staff told us that there were procedures in place to release them from clinical duties in order to attend training or complete on line modules as required.
- All staff had access to the electronic e-learning facility.
- Staff told us additional training had been completed following the implementation of a trust wide sepsis bundle. Junior doctors confirmed they had received sepsis training both on induction and in junior doctor teaching sessions. We saw that the sepsis screening tool had been incorporated into the patient observation chart which staff could reference if required.

Assessing and responding to patient risk

- Staff were aware of how to escalate risks that could impact on patient safety, such as staffing, bed capacity and the deteriorating health of patients. There was daily involvement of ward managers and matrons to address these risks. A lower grade doctor was on site 24hours seven days per week. A speciality consultant could be contacted from the Watford site when required.
- Theatre teams were not consistently using the 'five steps to safer surgery' checklist to prevent avoidable mistakes. We observed a mixture of three step and five step processes being used. This meant that step one; team brief and step five; debrief, were not always carried out. The World Health Organisation (WHO) state there was a greater impact on team performance and safety when these two steps were incorporated into the checklist. Briefings are an opportunity to share vital information about patients and actual safety issues both before and after procedures. During our inspection, we raised this issue with the senior management team who told us that the hospital would be shortly moving to a five-step process. When we returned on our unannounced visit, we saw that mixtures of three and five step processes were still being used. The trust told us that they are trialling a new form using the five-step process and have plans to roll it out across the hospital once the trial results have been reviewed, later in 2016. Staff told us the new day surgery care plan would contain all five checks.
- We saw that surgical patients attended a preoperative assessment clinic prior to any planned surgery, where risk assessments for complications were undertaken. This clinic was nurse led with the support of an

anaesthetist in some clinics. In addition, there was support from healthcare assistants, pharmacists and reception staff. The clinic was open Monday to Friday, 9am to 6pm.

- Pre-operative investigations were carried out during the assessment clinic and followed NICE guidance: Preoperative tests for elective surgery, Clinical Guideline CG3 (2003). Patients who had added risk factors, for example, high blood pressure were referred to the anaesthetist or the consultant for further risk assessments and investigations. Nursing staff had undergone training in pre- operative assessments and could explain when they would refer a patient.
- The trust assessed the appropriateness of patients for surgery using the American Society of Anaesthesiologists scale (ASA) physical status classification. For example ASA1 meant the patient was healthy and ASA2 for mild systemic disease. Only patients with a status of ASA1 or ASA2 were initially considered safe for surgery at St Albans City Hospital. However, a doctor told us that ASA3 (severe systemic disease) category patients were accepted for surgery and this was due to capacity issues at Watford General Hospital. ASA3 patients were more likely to experience post-operative complications and require a critical care bed. Critical care beds were unavailable at St Albans. This meant that there was a potential risk to patient safety because St Albans Hospital did not have the facilities to care for ASA3 category patients should they deteriorate. During the period April 2016 to September 2016, 167 ASA3 patients underwent surgery at St Albans. In order to minimise risks to patients, an anaesthetist reviewed ASA3 patients on the morning of surgery.
- The trust told us all unplanned transfers of patients from St Albans were recorded on the trust's incident reporting system and reviewed at monthly transfer and incident meetings. We saw evidence that these meetings had occurred in March, April and June 2016. Trust data showed 11 transfers were recorded for January, seven in February and seven in June 2016. Data supplied for March was incomplete. We were not supplied any data for transfers in April, May, July and August 2016. Of the 29 transfers discussed at these meetings, we saw incident reports had been completed for 11 transfers.
- Staff told us they were concerned about the number of transfers back to Watford and that patients were not being assessed properly and cared for appropriately whilst awaiting transport. There were often delays in getting transport because there was no formal agreement with the ambulance service to transfer non-critical patients within a given timeframe. We saw this had been highlighted in an in incident report recorded on 07January 2016. We looked at 11 incident reports completed for patient transfers between January 2016 and July 2016. Two of these had documented delays in waiting for non-emergency ambulance transfers, one had a delay documented in obtaining authorisation from the on call manager at Watford due a faulty paging system and five transfers had taken place using the emergency services (i.e. via a 999 emergency call).
- A doctor told us of an incident which they did not report and in which it took two hours to obtain authorisation to transfer a patient they suspected of having a pulmonary embolism (PE). A PE is a blockage in one of the pulmonary arteries in the lungs, which is usually caused by a blood clot. Clots which block blood flow to the lungs can be life-threatening however prompt treatment greatly reduces any risks.
- The service had developed a draft document in September 2016 to guide actions following the transfer of a patient back to Watford hospital. This included a plan to complete a route cause analysis, although this had not been done at the time of our inspection.
- Critical care outreach was available from the Watford site between 8am and 9pm each day. They provided clinical support to staff caring for deteriorating patients. Between 9pm and 8am, the critical care outreach team calls were triaged by the hospital at night team, who were based at Watford.
- Staff were able to assess and respond to a deteriorating patient in line with the trust policy and guidelines. The surgical wards used the National Early Warning Score (NEWS) to monitor patients. We reviewed seven NEWS charts and saw that appropriate escalation had taken place in line with the patients' scores.
- Clinical risk assessments were undertaken, for example, falls, malnutrition and pressure ulcers. Actions to mitigate risks were identified and documented in patient records. We saw, for example that pressure relieving mattresses was ordered appropriately. A tall patient was assessed as requiring a longer mattress to prevent skin damage and this had been requested. In addition, the staff also highlighted the patient's height to theatre staff.
- Venous thromboembolism (VTE) assessments were completed on admission, but not consistently repeated

and recorded after 24hours. We were told during the inspection that VTE repeated assessments were recorded on the front of the patient's medication chart and not in the risk assessment booklet. However, on review of medication charts this was not always the case. In July 2016, the trust VTE audit showed a 91% compliance with VTE assessments against a target of 95%.Senior managers informed us that the proforma for VTE risk assessments was being updated to emphasise the requirement for an additional VTE assessment to be completed within 24 hours of admission. Monitoring of VTE assessments was due to be undertaken by the surgical divisional director at the next surgical governance meeting in October 2016.

- In the operating theatres, staff had implemented robust measures to reduce the likelihood of patients developing pressure ulcers during operations. We saw completed risk assessments and subsequent actions taken, with appropriate devices used, such as heel pads and arm supports, to reduce the risk of pressure damage.
- Trust data showed pre-operative temperatures of patients was recorded in 40% to 71% of cases between July 2015 and April 2016. NICE guidance: Hypothermia: prevention and management in adults having surgery (2008), recommend all patients should have a temperature recorded within an hour of admission to theatre to help prevent hypothermia during their operation. Patients who suffer from hypothermia feel greater discomfort and have poorer outcomes. The trust were unable to provide evidence of actions to improve compliance pre-operative temperature recording however a separate action plan for WHO compliance in surgery theatres at St Albans showed increased temperature monitoring in September 2016 to 88%.
- A sepsis-screening tool was incorporated into the risk assessment documentation within the patients' notes. This gave clear, best practice guidance on the assessment and treatment for sepsis. There was a trust policy for management of sepsis (blood infection) and a sepsis bundle, which could have been implemented if sepsis was suspected.
- Theatre staff had safety huddles before the morning and afternoon procedures commenced. During these huddles, staff discussed all risks, including patient acuity, bed capacity, staffing issues and any necessary escalations. There was a standard operating procedure to support this process.
- Nursing staff on De La Mare ward told us they had regular huddles throughout the day to update each other on patient care and activity. The matron attended huddles with theatre and day surgery staff to discuss any service risks.
- Staff told us they had taken part in simulations relating to deteriorating patients and their transfer to Watford General Hospital.
- It was trust policy for all staff to receive mandatory training in resuscitation and there were clear processes in place for dealing with medical emergencies, for example, a patient going into cardiac arrest.
- In ward areas, nursing and physiotherapy staff used shared assessment records to ensure risk assessments were completed and accessible to all staff including doctors. For example, falls' risks assessments were completed for all patients in hospital and updated following their operation.

Nursing staffing

- Senior staff used the 'national safer nursing tool' to assess, identify and plan staffing levels. The areas that we visited displayed the required and actual staffing numbers. Records showed no concerns with planned and actual staffing numbers. Where lower numbers of nurses had been on duty, staff told us this was because there were fewer patients on the ward. Staff rotas showed levels were maintained out of hours and at weekends. On our unannounced visit, there had been two nurses on duty during the night instead of the recommended three. Staff told us the ward was not fully occupied and on this occasion, two nurses had provided an appropriate level of cover.
- Across surgical services at St Albans, the planned staffing levels in May 2016 were a ratio of 69 registered nurses to 31 health care assistants and the actual staffing levels were 66 registered nurses to 34 healthcare assistants. This meant the service had less nurses and health care assistants than required to fill the number of available shifts. Overall, the service reported a vacancy rate of 0.5%. Bank and agency nurses filled most vacancies. We saw some staff worked additional shifts to support the wards and departments. Staff said they often had the same agency nurses return to ensure continuity within the wards. In April 2016, 14% of shifts requiring to be filled were done so with agency staff.

- Skill mix was appropriate in the clinical areas with sufficient registered and unregistered staff to enable delivery of patient care and treatment. We saw that staffing establishments had been reviewed in line with activity.
- Staff confirmed their professional registration had been revalidated or they were working through this process. Staff were aware managers were monitoring revalidation dates and they were aware of the consequences of allowing their registration to lapse.
- Staff in both surgical wards and theatre said they recognised recruitment as a major safety risk to the service. This was captured on the directorate risk register. The management team told of various measures they had undertaken, for example, open recruitment days, virtual interviews, and overseas recruitment initiatives to decrease the vacancies. Staff were aware of these initiatives and were supportive of them. There was agreement that recruitment and retention of nursing staff was seen as a priority by the trust.
- We saw completed induction checklists for bank and agency staff and evidence that completion of these inductions was being audited within De La Mere ward.
- Nursing handovers occurred at the change of shift and took place in the ward at the nursing board. Information shared included staffing for the shift and concise patient information. We observed patients who had returned from theatre being handed over to the recovery staff. We heard a comprehensive handover between nurses, which included the patient's ASA score, anaesthetic details, procedural details, wound checks and analgesia (pain relief) given and prescribed.
- We saw further a handover on De La Mere ward took place at the patient's bedside. Other patients and relatives could overhear the patient information being discussed which meant that a patient's privacy, dignity and confidentiality could not be maintained.
- During the night, there was no senior nurse on site and a band 7 nurse based at Watford General managed nursing issues. Up until 8pm, a band 8 nurse provided cross-site assistance from Watford. This was a new initiative to help coordinate care, manage problems such as major incidents, bed management, and provide nursing advice when required. Some staff said they had not received any additional training to carry out this role and raised concerns that they may not have all of the necessary skills required. Staff said they had highlighted these concerns to senior managers.
- We spoke to a student nurse who reported they felt well supported during their clinical placement and hoped to obtain a permanent position on the ward upon completion of their training.

Surgical staffing

- Doctors saw patients throughout the day on Beckett ward prior to their operation. Staff told us consultants visited their patients at various times during the day depending on their operating schedule. Consultants worked throughout the week and some weekends they were on call. Specialist registrars supported the consultants during the weekends.
- Following their operation, patients were nursed on De La Mare ward. A junior doctor, at F1/2 level, (known in the hospital as a resident medical officer) (RMO) was available on De La Mare ward 24 hours a day, seven days per week. The RMO had access to more senior doctors via switchboard if they required any advice.
- The RMO on duty during our inspection had not received a trust induction. Trust inductions are an important method of ensuring all staff have the minimum amount of information to enable them to carry out their role safely and effectively. For example, infection control formed part of trust induction. The trust advised us it did not have a policy regarding RMO inductions. However, the RMO's agency contract informed that it was the trust's own responsibility to induct new the RMO prior to commencement of work.
- The RMO was trained in advanced life support and their responsibilities included providing emergency assistance for medical emergencies out of hours.
- The RMO who had worked during the day handed over to the RMO who was working the night duty. RMOs told us during these handovers they discussed the patients' condition, any concerns and changes to planned care.
- Doctors ward rounds included the RMO, a doctor from the consultant's team/speciality, nurses and therapy staff. We were not able to observe a doctors round on our visit.
- Staffing levels for the surgical team were in accordance with the Association of Perioperative Practice (AfPP)

guidelines. Staff within the surgical team cross-covered both the Watford and St Alban sites. This meant that staff were able to support each other when staff shortages occurred.
- The service's business plan identified that there had been an increased demand in inpatient activity, requiring further medical recruitment within some specialities. We were told the trust had recruitment and retention challenges within FY2 and middle grade doctors and registrars. An action plan to increase doctor numbers included offering rotational rotas with other local orthopaedic hospitals to attract doctors to the trust.
- Across all surgical services, the trust employed six physicians' assistants which allowed junior FY1 doctors to be able to concentrate on more complex care needs.

Major incident awareness and training

- Senior staff were aware of the procedures for managing major incidents, winter pressures and fire safety incidents. We were told about a recent practice scenario, which had involved all of the emergency services working through a hypothetical incident.
- There were clear instructions for staff to follow in the event of a fire or other major incident. Staff could access these via the trust's intranet.
- There was a bed management system in place which was aimed at ensuring patients' needs were met when there were increased demands on beds.

Are surgery services effective?

Good

We rated the service as good for effective because:

- The surgical service provided effective care and treatment that followed national clinical guidelines.
- Staff used enhanced and rapid recovery care pathways effectively.
- The service participated in national and local clinical audits. Performance was in line with both similar-sized hospitals and the England average for most safety and clinical performance measures.
- Policies and procedures were accessible for staff and staff were able to guide us to the relevant information.
- Care was monitored to demonstrate compliance with standards and there were good outcomes for patients.
- There were competency frameworks for staff in all surgical areas.
- We found effective multidisciplinary team working that delivered coordinated care to patients.
- Patients were following care pathways which had been developed following National Institute for Health and Clinical Excellence (NICE) guidance.
- Staff demonstrated an understanding in the application of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Patient pain scores were recorded regularly.
- All patients had a nutritional risk assessment on admission to the hospital.

However, we also found that:

- Pre-assessment documentation did not include identification of patients who were living with dementia or a learning disability.
- Not all staff had received an appraisal in the previous 12 months.
- Patients did not have access to a full seven-day service on the St Albans site.
- In the medical and dental group of staff, less than 75% had completed training in MCA and DoLS.

Evidence-based care and treatment

- Patients received care according to national guidelines. Clinical audits included the monitoring of guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons.
- Trust polices were current and we saw that the hospital had systems in place to provide care in line with best practice guidelines. For example, the service used an early warning score to alert staff should a patient's condition deteriorate (in line with NICE CG50 Acutely ill patients: Recognition of and response to acute illness in adults in hospital 2007).
- The trust recorded medical device implants on the National Joint Register to ensure outcomes for patients undergoing joint replacement surgery were monitored.
- Local policies such as the falls prevention and management policies were written in line with national guidelines. Staff we spoke with identified these policies and knew how to access them.
- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, orthopaedics and ear nose and throat (ENT). These pathways focused on thorough pre-assessment, less

invasive surgical techniques, pain relief, and the management of fluids and diet. These all helped patients to recover quickly post-operatively. We reviewed the enhanced recovery pathways for total hip replacements and spinal surgery and saw they followed current guidance.

- We saw NICE surgical site infection guidelines on display within De La Mare ward.
- Findings from clinical audits conducted in the surgical services were reviewed at monthly clinical audit meetings so all information was shared. There were local completed audits for the day surgery unit, recovery and De La Mare ward. These included, cleaning, weekly pressure ulcer reporting, legionella, hand hygiene audits and monthly weight audits. We saw minutes of the meetings, which showed audit results had been shared.
- Nursing and medical staff told us that policies and procedures reflected current guidelines. The policies we saw were current and the hospital had systems in place to provide care in line with best practice guidelines. For example, there was an early warning score in place, to alert when a patient's condition deteriorated (in line with NICE CG50 Acutely ill patients: Recognition of and response to acute illness in adults in hospital).
- Venous thromboembolism (VTE) assessments were evidence based, however there were not always repeated in line with the trust policy.
- The pre-operative assessment clinic assessed and tested patients in accordance with NICE guidance: Preoperative tests for elective surgery, Clinical Guidance (CG3), (2003). Examples included MRSA testing.
- When patients attended pre assessment clinic they received advice on smoking cessation and reducing alcohol consumption to ensure that they were supported in being as fit as possible for their surgery.
- On De La Mare ward, we saw an ice machine had been installed to aid recovery post operatively. Guidance and procedures for the use of this therapy were being written at the time of our inspection.

Pain relief

- Patients, pain was assessed and managed appropriately. Patients received information on pain relief during their pre-operative assessment.
- Patient care records showed that pain relief had been risk assessed using consistent and validated tools, such as the pain scale found within the NEWS document. Results were recorded alongside other vital signs. Handovers discussed patient's pain when appropriate.
- Patients spoke positively about the way in which staff managed their pain relief symptoms and said that staff gave them pain relief quickly when required. A patient required pain relief following their operation and we saw this was provided in a timely manner.
- Staff carried out 'intentional rounding' observations at two-hourly intervals to check on all patients and to identify those who required pain relief.
- The nursing staff told us that they could access the pain management team if they needed additional support. During working hours, a clinical nurse specialist provided ongoing advice on pain management for patients. This was supported by the anaesthetist on site. Out of hours, advice was available via senior medical cover at Watford General Hospital.
- We were shown a list entitled; 'pain audits.' However, it just itemised a short list of audits, it was unclear whether the two audits for 2015/16 in anaesthesia and gynaecology had taken place. We were not shown any results or accompanying action plans.

Nutrition and hydration

- The Malnutrition Universal Screening Tool was used to assess patients' risk of malnutrition. Patients identified as at risk of malnutrition were referred to the hospital dietetic service for assessment, with regular monitoring of nutritional condition in place.
- Patient's nutrition and hydration intake was recorded when applicable. We saw evidence of food diaries recording daily intake.
- We observed staff completing fluid charts to monitor patients' fluid intake. We saw that patients had jugs of water on their bedside tables, which were within reach to promote hydration.
- Healthcare assistants checked and monitored patients were taking regular drinks and we saw them providing extra drinks on request.
- There were processes in place to ensure patients who needed assistance with eating and drinking were identified and supported. Staff used a red tray system to alert staff that particular patients required support with diet.

- Patients who presented with nausea and vomiting post-surgery were given antiemetic medicines (a medicine to prevent vomiting and nausea) where appropriate. We saw these medicines had been both prescribed and administered appropriately.
- The patients we spoke with told us that they were offered a choice of food and drink and spoke positively about the quality and portion size of the food offered. Meals were available for special diets including halal meals and Indian food.
- Day surgery patients said they were offered drinks and snacks post operatively.

Patient outcomes

- The service continuously reviewed and improved patient outcomes through participation in national audits including the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry and surgical site infection audits.
- PROM audits measure health gain in NHS patients in England. Patients having hip or knee replacements, varicose vein surgery or groin hernia surgery are invited to complete PROMs questionnaires regarding their health and quality of life before and after they had surgery. The results enabled the NHS to measure and improve the quality of care. We saw St Albans had achieved mixed results for varicose veins, hips, and knees with overall scores similar to the national average. Results for groin surgery were slightly better than the England average.
- Two patients needed to go back to theatre postoperatively due to complications between January and September 2016. These were recorded as untoward incidents.
- There service reported they had undertaken a number of local audits to measure patient outcomes. These included an audit of spinal surgery and another of patient satisfaction with the information they had received prior to undergoing facial surgery. However, although we were provided with a list of audits, the results of them and any associated action plans were not provided.
- The average length of stay was better than the national average for most elective specialities including general surgery and trauma and orthopaedics. It was longer for breast surgery and urology.
- Patients described their outcomes as good. One patient said they had been to De La Mare ward twice previously and would definitely choose the ward again because of the results they had. Another patient said they were very happy with previous surgery at the hospital and so chose to come back when an additional operation was required.
- The surgical service monitored and reported their audits through the governance structure to ensure early interventions were implemented if required. Hospital mortality was reviewed bi-monthly to identify root causes and share learning across clinical teams.

Competent staff

- All staff were required to have an annual appraisal to identify leaning needs and opportunities for development. Information provided by the hospital indicated that from April 2015 to March 2016, 59% of nursing staff in theatres and 60% of nursing staff in on De La Mare ward had undergone an appraisal against a trust target of 90%. However, the manager on De La Mare ward told us there were problems with the accuracy of the appraisal database due to different reporting periods. The trust provided us with updated information for April 2016 to September 2016 which showed that the service was on track to exceed the target for 2016/17. All staff with whom we spoke confirmed they had been appraised within the previous three months.
- There was an induction programme for all new staff. This included mandatory training and competency based ward skills for nurses. All staff employed by the trust that we spoke with, confirmed they had attended an induction. However, the RMO was employed by an agency and they told us although they had been in post for eight months, they had not received a trust induction.
- Staff told us they were given competency assessments and workbooks when they were new to the trust, for example in medicine administration but we did not look at these during our inspection.
- Some theatre staff told us they had not undergone clinical supervision since their initial training at induction Practice educators were available, however, three staff said they had concerns about the lack of practical assessment and clinical updates including observation of practice in theatres. Some staff expressed concerns that competence was not continually assessed. We asked the trust to provide us

with evidence of clinical supervision in theatres. There was no formal process in place but we were told that clinical supervision was due to commence in theatres at St Albans. A timescale was not given.
- The trust had introduced a sepsis bundle to enable staff to screen patients for sepsis. Doctors we spoke with confirmed they had received sepsis training but some nurses said they had not. This meant we were not assured that all staff had the right training to recognise patients who may have developed sepsis.
- Leadership courses were available to band 6 and above nursing staff. We talked to nurses who were on leadership courses or who had completed them recently. Staff told us after completing the course they felt more able to carry out their senior duties including supervision of junior staff and handling complaints effectively.
- Agency nurses received a local induction in the ward area. This included a tour of the ward, introduction to staff and details of the equipment used. We saw completed templates used for this process.
- Nursing staff reported supernumerary working when commencing a new role. This was to ensure they were competent to carry out all of the skills required. The senior sister on De La Mare ward told us all new staff were allocated both a "buddy" and a mentor to work alongside them and provide support.
- Newly qualified nursing staff were supported through a preceptorship programme which offered role specific surgical pathway training and support.
- Ward based nursing staff who we spoke with said they were able to access study days relevant to their area of work and were satisfied with the level of additional training offered to them. Several staff said they had undergone ice therapy training.
- Nursing staff told us consultants delivered training sessions in the wards to provide updates on national guidance and therapy initiatives.
- Junior doctors had specific training and development plans and had scheduled training sessions. They had both educational and clinical supervisors. Junior doctors told us they felt supported in their role.

Multidisciplinary working

- There was daily communication between the multi-disciplinary teams within the elective surgical pathway. We saw communication between ward and theatre staff, between pre admission clinic staff and ward admission staff. There was access to a discharge team if patients required assistance, for example aids or extra support to enable them to go.
- We observed daily huddles between staff groups where information was shared about patients and the service.
- Nursing handover meetings took place at shift changes, which ensured that staff had up-to-date information about risks and concerns.
- A daily ward round took place in the morning between medical and nursing staff together with physiotherapists and occupational therapists as required.
- Doctors, nursing staff and allied healthcare staff told us they worked well together within the surgical specialities and that they felt supported by each other. We saw evidence of this on the surgical ward and the day surgery unit. Surgical doctors told us they could refer patients to their medical colleagues for review if required.
- We observed a good working relationship between theatre and ward staff during our visit. Senior staff told us they were in regular contact with each other throughout the day to ensure information was shared in a timely way.
- Nursing staff said that they could contact medical staff when required to support patients' medical needs.
- Patients' records showed they had been referred and reviewed by dieticians when required.
- Therapy staff documented their contribution to care in the patient's medical notes. This meant the information was easily accessible for all staff.
- There was dedicated pharmacy support on De La Mare ward. This helped to expedite patient discharges, during normal working hours in relation to take home medicines. In addition, advice and support to medical and nursing staff was provided when required.

Seven-day services

- A full seven-day service was not available from the St Albans site. The onsite pharmacy was not available at weekends or after 5pm in the week. This meant that any medication required out of hours was obtained from Watford.
- Dietetics and speech and language therapy provided a Monday to Friday 9am to 5pm service as did diagnostics. There were no plans in place to move to a seven-day service for diagnostics. However, physiotherapy and occupational therapy provided a seven-day service.

- Out-of-hours medical cover was provided by the RMO. Senior medical advice out of hours was available from Watford General hospital.
- Elective procedures only were carried out at St Albans and were generally undertaken Monday to Friday. Patients were not admitted at the weekend as a routine, unless an extra operating list had been agreed for Saturdays. Staff told us surgeons undertook weekend working to help clear the outstanding patient lists.
- New patients undergoing surgery were seen by a consultant at the weekend with existing patients seen by the consultant's registrar.
- Imaging services, for example, x-rays and scans were not available at weekends or after 5.30 in the evening. Staff said this did cause a problem because patients had to travel to Watford General Hospital for these procedures out of hours. Some staff said there had been delays in transferring patients to Watford either due to a delay in receiving authority to transfer or due to non-urgent ambulance transport.

Access to information

- Staff, including agency and locum staff, had good access to patient-related information and records when required. This included care and risk assessments, case notes and test results to enable them to care for patients appropriately.
- Staff were able to demonstrate how they accessed information on the trust's intranet. Staff could access information such as policies and procedures from the hospital intranet.
- Nursing staff told us that when patients transferred between theatres and the wards a comprehensive handover was provided. This ensured that staff were aware of the patient's condition, relevant medical and social history and on-going care needs and plan of treatment.
- Medical staff completed electronic discharge letters, which included details of the patient's admission, medication to take home, and details of any follow up appointments.
- GPs received copies of discharge letters to ensure continuity of care within the community. The summary had the consultant surgeons contact details. This meant that the GP had a point of reference if further information was needed.
- The hospital used paper-based patient records. The patient records we looked at were complete, up to date, and easy to follow. The records contained detailed patient information from admission and surgery through to discharge. This meant staff could access all the information about a patient any point during their pathway.
- We saw information such as staffing levels, performance information, and internal correspondence displayed in all the areas we inspected.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Staff understood consent, decision-making requirements, and guidance. There was an up to date policy on consent for surgical treatment.
- We saw consent forms were available for patients who were able to consent for themselves and those for patients who were not able to give consent for their operation, for example if they were under eighteen years of age, or did not have mental capacity. All consent forms used complied with department of health guidelines.
- Training records showed 100% of nursing and midwifery registered staff had undertaken MCA and DoLS training.
- Medical staff training in MCA and DoLS was below 75% for most specialities including orthopaedics, oral surgery, ENT, and general surgery. In anaesthetics, 60% of medical staff had received training in MCA and 69% in DoLS training. The trust target for all training was 90%. There was no action plan in place to improve compliance.
- Staff we spoke to were clear about their roles and responsibilities regarding the MCA and understood the requirements of DoLS. There were no patients subject to restrictions during our inspection.
- The records we observed showed clear evidence of informed consent and identified the possible risks and benefits of surgery. Patients confirmed they had received clear explanations and guidance about the surgery, and said they understood what they were consenting to.
- Pre-operative assessment clinic staff advised us they communicated to surgeons and anaesthetists any concerns about a patient's mental capacity. However, there were no questions in the pre-assessment documentation to prompt or alert staff around learning disabilities and dementia.

- Where patients lacked the capacity to make their own decisions, staff told us that they made decisions about care and treatment in the best interests of the patient and involved the patient's representatives, family, friends, and other appropriate healthcare professionals.
- The ward sister on De La Mare informed us that increased MCA and DoLS training had been provided on the ward following learning from an incident. Nursing staff reported being supported by the safeguarding team and knew how to access them.
- Staff in the pre-assessment unit told us that if they were concerned about a patient's mental capacity they communicated this to the surgeons and anaesthetists; however within the assessment documentation there were no prompts to determine whether a patient lacked capacity to make certain decisions, for example, if the patient lived with a learning disability or with dementia.

Are surgery services caring?

Good

We rated surgery services as good for caring because:

- Patients spoke positively about their care and treatment. They said staff were 'brilliant' and they provided exceptional care. Several patients told us they had needed to use the service more than once and chose to come back.
- Staff were caring and compassionate to patients' needs and treated patients with dignity and respect.

Compassionate care

- We saw staff respected patient's' privacy and dignity during personal care, for example, staff pulled curtains around the bed space and spoke quietly to patients to reduce being overheard.
- Staff were welcoming to patients and visitors. We saw patients admitted on the morning of their surgery and observed the interaction and kindness from the nursing team. Staff smiled at patients.
- Staff understood the importance of respecting individuals including their, cultural, social and religious needs. Staff gave us examples of how they had shown this respect, including offering alternative meals to patients and providing access to spiritual services.
- The NHS Friends and Family Test (FFT) showed that between January 2016 and May 2016 between 96% and 98% of patients who completed the survey were extremely likely to recommend the trust to family and friends. The FFT response rate at St Albans was 52% against the national average of 30%.
- In August 2016, we saw that 190 patients had completed internal feedback while on De La Mare and Beckett ward. The response rate was 84%. The overall score awarded was 4.97points out of 5 points.
- We saw a poem attached to the notice board on De La Mare ward written by a patient's relative, describing how wonderful all the staff were on the ward.
- One patient told us he was dreading being in a hospital bed overnight because he was a young, fit man but staff on De La Mare ward had gone out of their way to make him feel relaxed and comfortable. Other comments received from patients included 'outstanding' and 'better than excellent', and 'the best care I have ever had'. Patients told us they would not want to go anywhere else for treatment.
- A patient who visited the CQC engagement stand told us their care was 'wonderful' and it had been delivered by 'caring and efficient staff'.
- Staff told us that when patients were particularly anxious pre operatively, there was a side room on Beckett ward, which allowed a relative to wait with them to help reduce anxiety.
- Staff told us that if patients did not have any visitors they ensured patients had things that they liked. For example, staff provided patients with snacks, such as fruit and squash and found magazines or newspapers.
- Patients told us that they had managed to rest and sleep.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt informed about their care and treatment and were aware of their estimated discharge date.
- Consultants usually visited their patient's daily and were available to answer any questions they might have. Staff told us that consultants often came in to the hospital late in the evening to review their patients.
- We observed nursing staff on Beckett ward introducing themselves by name to new patients as they arrived.
- Patients were involved in making choices around their care within their care pathway. For example, a patient told us that staff talked to them about the treatment options available and supported them in their decision.

Another patient told us they had felt very anxious about the possibility of having pain after their operation. Staff took time to explain some of the pain relief options and advised them about the specialist pain nurse who was called when required.
- Patients told us they sometimes saw different doctors but that they always introduced themselves.
- Patients told us that they felt comfortable asking questions and that staff took time to explain and answer their queries.
- Staff were able to recognise when a patient required help with understanding their treatment had they had access to interpreters, including sign language if required.

Emotional support

- Clinical nurse specialists (CNS), for example, orthopaedic nurse practitioners and breast care nurses were available to patients. Details of CNS's were provided in pre assessment clinic, which enabled patients to contact them prior to their operation if they had any questions. This meant that patients received specialist emotional and practical support when coming to terms with any adaptions in their everyday lives.
- Patients we spoke with told us they knew who to contact if they had any worries about their health and said staff had supported them emotionally as well as physically post operatively.

Are surgery services responsive?

Requires improvement

We rated surgery services as requires improvement for responsive because:

- Between June 2015 and May 2016, the overall referral to treatment (RTT) indicators within 18 weeks was worse than the England average in all specialities.
- The service performed worse than the England average for number of patients not offered another appointment within 28 days of a cancelled operation.
- Pre-assessment documentation did not identify if patients were living with dementia or a learning disability.
- The service was not meeting its target of responding to complaints within set timescales.

However, we also found :

- The hospital had a nurse led pre-assessment clinic, which provided pre-booked, short notice and drop in appointments offering flexibility to patients.
- The service utilised enhanced recovery programmes to support patients after having major surgery.
- Orthopaedics had a dedicated nurse practitioner who supported patients from pre-assessment to discharge and provided further advice once the patient had been discharged.
- Translation services were available to support patients, which ensured they could access the relevant information about their care.
- Care booklets and documentation were available to support patients living with dementia and/or a learning disability.
- Complaints were handled in line with the trust's policy.
- There was a trust stakeholder group.
- The hospital held regular bed capacity meetings attended by representatives from the service.

Service planning and delivery to meet the needs of local people

- The service was committed to the vison set out in 'your care, your future,' which was a strategy for developing health and care services for the local population of West Hertfordshire. This strategy was taken into account when services were being planned.
- The facilities and premises were appropriate for the services provided to patients.
- The senior management team told us their surgical strategy for the next three to five years included maximising the separation of planned surgery from emergency surgery to ensure planned care, for example patients undergoing joint replacements, were protected from emergency care pressures.
- There were initiatives in place to improve planned surgery pathways and promote team working in an effort to improve planned surgery pathways, decrease the patient's length of hospital stay, and improve efficiency.
- An enhanced recovery programme was used for most elective procedures including hips, knees, spinal and ear nose and throat surgery. An enhanced recovery programme identifies individual patient's needs prior to surgery, targets what they need, so that they recover more quickly after having major surgery.

Surgery

- The service had a day surgery unit, which enabled people to have minor procedures without having overnight stays in hospital.
- On the day of their surgery, patients undergoing elective (planned) surgery were admitted to the surgical admissions ward, where they were seen by the nurse and prepared for their surgery.
- Patients told us their appointment times had been arranged to accommodate their own needs and that they appreciated the flexibility of the booking system.
- When appointments ran late, patients said that staff had informed them about the delay. However, some patients told us at our CQC focus group that appointments always ran late in ophthalmology.
- Patients staying overnight had access to physiotherapist seven days a week.
- The laboratory where samples, such as blood, were sent for testing was at Watford General Hospital. Staff said sometimes there was a delay on the day of a patient's discharge, as they had to wait for blood samples to be collected by a taxi and taken to Watford for processing.

Access and flow

- Patients did not always have timely access to initial assessment, diagnosis, and treatment. Between June 2015 and May 2016, the trust's referral to treatment (RTT) indicators were below the England average across all six surgical specialities.
- NHS England data for August 2015 to July 2016 showed that national targets for 18 week referral to treatment times (RTT) for ENT, urology, ophthalmology, and trauma and orthopaedics surgery ranged between 58% and 71%. In ENT for example, the RTT was 58% of patients were treated within 18 weeks of referral compared with the England average of 74% of patients treated within 18 weeks. In orthopaedics, the RTT was 67% of patients were treated within 18 weeks, compared with the England average of 70%.
- RTT times had been improving in the service over time. Data supplied by the hospital for the month of August 2016 only, indicated that the trust had made improvements in RTT times with urology 86%, trauma, and orthopaedics 84%, ENT 73% and ophthalmology 88% of patients treated within 18 weeks. The trust told us they reviewed the records of patients who had waited over 18 weeks for treatment but it did not contact patients' GPs and inform them of extensive waiting times. This meant patients who required their surgery quickly, may not have been assessed appropriately and in a timely manner.
- The percentage of patients who had operations cancelled and were not offered another appointment within 28 days was worse than the England average of approximately 8%. NHS England Data showed that between April 2016 and June 2016, 122 patients had their surgery cancelled and 26 (21%) were not offered another appointment within 28 days.
- Data supplied by the trust shows from June 2016 to 11 September 2016, 20 patients had their operations cancelled on the day of surgery. Eight (40%) of these were due to operating lists overrunning. 11 patients (55%) whose surgery was cancelled on the day were not offered another appointment within the recommended standard of 28 days. This data is for all sites and we were unable to obtain data specifically for the service at St Albans City Hospital.
- Patients were discharged seven days a week. Staff told us delays in discharge sometimes occurred at weekends due to waiting times for medication to take home (TTO's). This was due to the pharmacy at St Albans being closed at the weekend. Prescriptions for TTO's were sent to Watford pharmacy and delivered back to St Albans by taxi. We were told patients could not collect the tablets themselves from Watford. This meant patients wishing to go home had wait for their tablets, had to go back to St Albans to collect them, even if they lived nearer Watford. Staff tried to minimise this delay by requesting TTOs the day before discharge, wherever possible.
- The hospital had six operating theatres. During our last inspection in April 2015, we saw one theatre was out of use however, during this visit all six theatres were fully operational.
- The hospital scheduled theatre lists Monday to Thursday between 8am to 9pm, and 8am to 6pm on Fridays. The surgical management team were working Saturdays to improve referral to treatment times and reduce waiting lists.
- Minutes of meetings showed that there had been discussions in an effort to improve patient waiting times. Staff told us an external company had been used to review their processes with regards to theatre management time. They told us they were considering surgeons theatre sessions with a view to improve make

them more efficient. The hospital had scheduled theatre initiative lists in order to reduce their wait times. This included Saturday operating. These lists were staffed by regular agency workers and trust staff.

- Staff told us they accepted for surgery, ASA3 level theatre patients in order to ease bed pressures at Watford. They told us each patient was thoroughly risk assessed on the morning prior to any surgery.
- The hospital episode statistics for the year ending February 2016 showed that the length of stay was better than the national average for elective general surgery, trauma, and orthopaedics but worse for breast surgery.
- There was an electronic system for managing blood test results. Staff told us they were able to access the system and it worked well.
- We saw that patients' discharges were planned at pre assessment and at admission. Screening was undertaken to identify patients who may have required assistance on discharge. Patients had also been assessed for their suitability for rapid recovery programmes.
- Staff we spoke with told us that there were no medical outliers patients treated on Beckett and De La Mare wards. Medical outliers are patients who are in hospital because they require medical care rather than a surgical procedure.

Meeting people's individual needs

- We saw that the surgical services planned and coordinated patients' individual needs. This started in the surgical assessment unit and continued through the anaesthetic room and recovery when needed. Information from pre-assessment was clearly recorded and relevant information was documented on the electronic theatre scheduling system. However, we saw that the pre assessment documentation did not include screening to identify patients that were living with dementia or a learning disability. This meant staff may not have been aware of patient's individual needs and level of support required prior to their admission.
- Information leaflets were available in English and staff could obtain different languages and braille if required. Lifts and ramps where available throughout the service for wheelchair users.
- At a CQC engagement group where we met patients and members of the public, seven out of eight patients told us they had received written information about their care and treatment.
- Staff understood the importance of respecting individuals including their, cultural, social and religious needs. Staff gave us examples of how they had shown this respect, including offering alternative meals to patients and providing access to spiritual services.
- The trust had a named learning disabilities team and lead nurse and staff told us they could seek advice from them when required.
- Patients who were particularly anxious about their operation were permitted to visit the post-operative ward area in advance of their admission.
- Staff demonstrated an awareness of meeting the needs of patients with learning disabilities and those living with dementia. Staff were able to show and describe the use of the dementia care: "This is me'' document, which included patient preferences and other useful information to enable staff to support them. A member of the day surgery team told us they had attended a dementia awareness course and they were a link nurse for learning disabilities and safeguarding.
- The trust told us staff in this service did not have specific dementia training because patients with complex needs were treated at the Watford site only. However, it was clear this was not the case. We looked at one serious incident involving a patient with complex needs who had been treated at the hospital.
- Dementia screening was not routinely carried out at pre assessment. This meant that we were not assured that staff had the appropriate competence to deal with patients with dementia. We were advised there was a small element of dementia awareness covered in the safeguarding training.
- There was a dementia care lead nurse based at the Watford site who was available to offer advice and support in the care of people suffering with dementia.
- Staff in pre-assessment gave an example of meeting patients' needs by arranging for a patient with a learning disability and their carer to arrive at the clinic via a different door, which exited directly to the car park. This adjustment minimised the long walk through the main entrance to the department and reduced the patient's anxiety.
- Staff in pre-assessment clinic referred patients directly to a dietitian where appropriate and leaflets were available advising patients on healthy weight loss where required. The leaflet contained information on supportive organisations.

- Patients who attended the pre-operative assessment clinic had access to information leaflets such as; you and your anaesthetic, preventing thrombosis, a day case pack and ward specific information. Lifestyle information leaflets were also available for example on reducing alcohol consumption and increasing daily activity for health.
- Translation services were available for patients who required them.
- There were processes in place to ensure patients who needed assistance with eating and drinking were identified and supported. Staff used a red tray system to alert staff that particular patients required support with diet.
- The patients we spoke with told us that they were offered a choice of food and drink and spoke positively about the quality and portion size of the food offered. Meals were available for special diets including halal meals.
- The ward had protected visiting times during mealtimes. We saw that during mealtimes patients sat out of bed in order to eat and staff were available to assist if needed.
- Discharge planning commenced at pre-assessment where a patient's expected discharge date was discussed so that plans could be made for discharge.
- Information was available on how to contact members of the chaplaincy team to meet individual spiritual needs and patients had access to a prayer room on site.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Staff were aware of the policy and could explain, broadly, what it contained. Initially staff attempted to resolve a patients concerns locally, however if they were unable to find a resolution, patients were directed to the patient advice and liaison service (PALS). Information was also provided on how to make a written complaint.
- We saw notice boards that displayed posters and information leaflets advising patients and their relatives how to raise a concern or complaint both formally or informally. Information leaflets were also available about how to contact the Care Quality Commission.
- Unit managers told us they received all complaints relevant to their service and provided feedback to any staff directly involved in the complaint. Any lessons learnt from the complaints were shared with the department during team meetings. Staff confirmed they were aware of recent complaints and lessons learnt.
- Surgery services in the trust received more complaints than other departments in the hospital. Between July 2015 and July 2016, 11 complaints were received in day surgery, nine on De La Mare ward and five on Beckett ward. Most complaints involved issues with clinical treatment.
- We reviewed details of 23 surgery complaints supplied to us by the trust. All the complaints we looked at were upheld, or partially upheld. Most complaints (18) had actions to complete, for example, send a letter of apology, or reschedule appointments. We found there was very limited evidence, for example in meeting minutes, that there had been any lessons learnt from the complaint.
- All complainants were given details of how to contact the parliamentary health service ombudsman (PMSO) if they were not satisfied with the hospital's response of the outcome. We saw from the trust complaints and PALS annual report presented to the trust board on 1st September 2016, eight surgical complainants sought further advice from the PMSO in the year ending March 2016.
- The service was not meeting the trust target of resolving 85% of complaints within 25-35 working days (depending on type of compliant). We saw complaints in surgery were closed on average within 31 working days. However, we also found 26% of complaints took over 50 working days to resolve with the longest being 93 working days.

Are surgery services well-led?

Inadequate

We rated surgery services as inadequate for being well-led because:

- Not all staff were aware of the trust's mission, vision, and strategic objectives.
- Some staff did not receive any feedback from concerns they had raised.

- Not all incidents were reported. This meant although there was a policy and procedure for reporting and recording incidents, it was not embedded in practice.
- There were inconsistencies in the monitoring of assurance systems which were in place to keep patients safe.
- Sufficient improvements to the governance and risk management systems, to demonstrate full compliance with the requirement notice that was issued after the last inspection, had not been made.
- There was a policy for infection control, which included guidelines for best practice. Staff were not always following these guidelines. This means there was insufficient monitoring and challenging of staff about clinical issues.
- There was a lack of appropriate reporting and senior management oversight of patients requiring admission to Watford General Hospital.
- The policy about the maintenance of equipment was not followed and there was a lack of oversight from the senior management team about this.
- There was little evidence of learning lessons from complaints.

However, we also found :

- Surgical services were within the surgery, anaesthetics, and cancer division and had a divisional director, manager, and head of nursing. Each clinical ward area had a ward manager and matron who provided day-to-day leadership to staff.
- The trust had systems in place to identify and monitor risks.
- The service had directorate meetings and there was a divisional quality and safety meeting to discuss issues, such as complaints and audits.
- Staff we spoke with were clear about their roles and responsibilities.
- Leadership courses were available to staff.
- There was a sense of pride amongst staff.
- Staff described a supportive working environment.
- The hospital recognised the views of patients and the public.

Leadership of service

- Surgical services were led by a divisional director, a manager, and a head of nursing. Each clinical area had a manager and matron. Staff we spoke with were aware of who their managers were.
- Most staff said they had awareness of the chief executive officer (CEO) and the director of nursing and saw them around the hospital. Some staff told us they were aware the CEO had an open door policy. One member of staff told us they had recently accessed the CEO via their open door policy.
- The majority of staff within the surgical services said they felt supported by their managers who were interested in their welfare. They felt able to raise concerns, which they were confident would be acknowledged. However, some staff of all grades told us they had raised concerns but had not received any feedback or resolution. Two members of staff in one area told us they did not feel supported by their manager.
- Ward sisters said they had access to leadership development programmes. However, staff in some departments told us they did not feel that they were supported with ongoing training and further professional development.
- The ward manager on De La Mare held drop in sessions every afternoon where all staff could discuss ideas, worries, or issues. Staff on the ward told us they had accessed these sessions and found them supportive.
- During our visit, we saw clinical leaders, visible in the departments and services for which they were responsible.

Vision and strategy for this service

- The trust had a clear mission, vision, and clear values. This had recently been updated. Staff we spoke with were not aware of the vision which was to deliver 'the very best care for every patient, every day'. However most staff were aware of the trust values of 'commitment, care, and quality'.
- Staff told us they were not involved in the development of the trust's values or vision.
- A strategy for the service was incorporated into the trust's overarching clinical strategy, which outlined priorities for the trust in the next three to five years. This included continuing to develop as a planned care centre with extended complex diagnostics and one-stop models.

Governance, risk management and quality measurement

- The trust had systems in place to identify and monitor risks, including a governance framework in place to

support the delivery of the strategy and good quality care. However, sufficient improvements to the governance and risk management systems, to demonstrate full compliance with the requirement notice that was issued after the last inspection, had not been made.

- We saw there were inconsistencies in the monitoring of assurance systems that had been put in place to keep patients safe. For example, the policy to ensure equipment had been adequately maintained was not consistently followed. In addition, although the trust reported reviewing all cases of patients transferred to Watford Hospital, it did not do this consistently. No reviews were carried out on patients transferred in April or May 2016 and only partial data was available for March 2016. We also found fire risks that were not being controlled by managers accountable for that department.
- The trust's surgical division held its own risk register and clinical leads we spoke with were able to identify some of the risks it contained. Overall, trust risks were reviewed at monthly quality and safety meetings and then fed back to staff through team meetings. The service also had a risk review group that met monthly to review existing risks and discuss any new ones.
- St Albans used a risk register so that key risks were clear. We reviewed the surgical and anaesthetic division services risk register, which contained 34 risks. The list included the date and a description of the risk and the actions that had been taken to mitigate the risk. Each risk had an identified owner.
- A monthly divisional governance meeting was held where quality and performance indicators were discussed, for example, RTT times, complaints, and service risks.
- We saw inconsistencies across the service in the use of two different forms and methods of recording the five steps to safer surgery checklists. We raised this with divisional leads who told us they were trialling a different process and planned to adopt a single checklist following evaluation of trial data.
- Staff we spoke with were clear about their roles and understood what they were accountable for.

Culture within the service

- There was a sense of pride amongst staff towards working in the hospital and they felt respected and valued.
- Clinical leaders appeared focussed on promoting staff wellbeing and gave examples of how they had encouraged healthy lifestyles.
- Some staff said the culture within the service had improved recently and they now felt more confident in the trust making improvements all around. However, some staff approached us, both during our visit and via the CQC national service centre to report concerns, which they believed were not being properly addressed. We discussed one of these concerns with the senior management team during our unannounced visit and were told there was an ongoing investigation. In addition, some staff reported they were dissatisfied with the leadership in their department and reported an unprofessional communication style.
- Most staff described a supportive and encouraging working environment and one in which openness and honesty was encouraged. A staff member said that their manager in the breast clinic was particularly supportive and it was a great environment to work in.
- There was evidence of collaborative working throughout the service and a shared responsibility to deliver good patient centred care.

Public engagement

- All wards distributed patient feedback forms regularly to ensure they captured patient comments and any concerns.
- The staff within the surgical service recognised the importance of gathering the views of patients and actively sought comments and offered comment cards within clinical settings.
- Each clinical area displayed thank you cards from patients and relatives.
- Data from the friends and family test was used to monitor and influence the standards of the services provided.
- Information on patient experience was reported alongside other performance data. This information was used to informed decisions about the service.

Staff engagement

- All staff we spoke with were committed to providing a high standard of safe care and were proud of the services they provided.
- Senior managers we spoke with said they felt well supported and there was effective communication with the executive team.

- Managers held an annual thank you lunch for volunteers at the hospital.
- The staff satisfaction survey response rate for July 2016 was 17% against a target of 50%. This meant that fewer staff responded to a survey asking about their experience of working in the trust than anticipated. The National Staff Survey for 2015 had a response rate of 33% against the average for acute trust, which was 42%. The trust had an action plan to improve engagement with staff, about completion of the survey, which included divisional ownership of response rates.

Innovation, improvement and sustainability

- Staff in the day surgery unit had developed a handwashing booklet and video guide specifically for patients with a learning disability.
- Junior sisters on De La Mare ward were given short secondments to assist the senior sister in her role. This allowed the ward to improve the skill of its leadership team and allowed succession planning. Staff also reported an increased level of job satisfaction following the secondment.
- Staff on De La Mare ward had received training in ice therapy and the ward had purchased an ice machine. At the time of our inspection, the guidelines for use were being prepared.
- Staff in De La Mare ward told us about how they had improved care pathways for patients and received awards by external healthcare organisations, for example, the hip enhanced recovery pathway.

Outpatients and diagnostic imaging

Safe	Good
Effective	
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, ophthalmology, respiratory, urology, dermatology and rheumatology.

The trust had approximately 475,634 appointments across the three hospitals from March 2015 to February 2016, with 112,330 appointments at St Albans City Hospital (SACH).

Outpatients includes all areas where patients 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.

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

St Albans outpatients department sees children aged from 0-16years in dermatology, audiology and ear nose and throat clinics.

We visited the outpatient area in St Albans Hospital and diagnostic imaging. The imaging departments include x-ray, breast imaging service and ultrasound scanning.

The outpatients department has 20 consulting rooms, two newly refurbished treatment rooms and a separate breast care unit. There is a large reception desk and two electronic booking in stands.

We carried out an inspection at St Albans City Hospital on the 8 September 2016. As part of our inspection, we observed patients' care and their treatment and spoke with five patients, two relatives, and 10 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 16 sets of patient records and reviewed performance information provided by the hospital. Some of the data used in this report is trust wide, as the trust did not separate data for the three different hospitals.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated outpatients and diagnostic imaging as good because:

- Staff reported patient safety incidents and there was evidence of learning from incidents and patient complaints. Staff were confident in how they would recognise and report incidents.
- Senior staff had oversight of risks in their areas.
- Patient records were stored securely in locked records trolleys.
- Outpatients appeared visibly clean and staff used personal protective equipment, such as gloves and aprons.
- Patients' care and treatment was delivered in line with current national standards and legislation. Staff demonstrated a commitment to patient-centred care.
- There were some areas that provided a proactive service to patients which included several one-stop clinics which provided efficient co-ordinated care.
- Services were caring and patients spoke positively about the care and treatment they received.
- Staff were approachable and we 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.
- The outpatient's service was meeting the two-week urgent referral target.
- The service had made an improvement to the telephony service in the central booking office. This mean that they had a reduction in the amount of abandoned calls and the average wait for a call to be answered had reduced.
- The service had introduced an SMS text messaging service to remind patients of their upcoming appointment. This had reduced the amount of patients not attending appointments by 10%
- 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.
- Staff felt supported by immediate line managers and clinicians. They said they were listened to and able to raise concerns.
- Following their last inspection, many improvements had been made 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, we also found that:

- 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. The trust had a plan in place to address this once we raised it as a concern.
- Patient records were not always available for their appointments.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safety as good because:

- Staff knew how to report incidents and could describe the requirements of the duty of candour. There was good evidence of learning from incidents.
- Patients were cared for in a clean, hygienic environment. There were effective systems in place to reduce the risk and spread of infection.
- There was sufficient well-maintained equipment to ensure people received safe treatment.
- Appropriate arrangements were in place for obtaining, recording and handling medicines.
- Accurate and appropriate patient records were maintained and stored securely.
- Equipment was maintained in line with the manufacturers' recommendations.
- Medicines were stored and checked in line with the trusts medicines management policy.
- Safeguarding of adults was completed to level two by radiographers and nursing staff.
- Patients undergoing x-rays and scans were safeguarded, by the staff appropriately using the 'pause and check' procedure, to ensure they are the right patient, for the right scan, at the right time.
- Mandatory figures for staff showed they were compliant with the trust target.
- Risk assessments were carried out to maintain patient and staff safety in both services.
- The outpatients department used an induction checklist for all agency and new staff.

However, we also found that:

- Not all medical staff were not trained to level three in safeguarding of children when children were seen in main adult outpatient clinics. The trust had a plan in place to address this once we raised it as a concern.
- Patient records were not always available for patient appointments.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and how to report them.
- The service reported one serious incident from July 2015 to June 2016. 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 harm. There was evidence of learning from incidents shown in the clinical governance and quality meetings. One of these learning points resulted in putting up signs on the 'separation barriers' in the waiting room of outpatients, to warn people not to lean on them, due to one patient falling. They were also looking at different forms of queue barrier systems. When we spoke with staff, they could tell us of incidents that they had been communicated to them during meetings.
- 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.
- Staff we spoke with during the inspection were aware of how to report incidents. 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, in radiology an increased radiation dosage was administered to a patient. The incident was escalated and staff reported it electronically, the outcome and learning was discussed with all staff at their daily meeting, and support and training was given to the member of staff involved.

Outpatients and diagnostic imaging

- Staff told us managers were trained to manage and investigate incidents within their own areas. We saw evidence of training sessions in staff competency folders. The managers told us they encouraged staff to openly report incidents.
- Learning from incidents was communicated through team meetings and emails circulated to all staff. 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 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, were reported to the Care Quality Commission (CQC) in line with the regulations. From December 2015 to May 2016 the trust had reported two incidents to the CQC under regulation (45) of IR(ME)R, where the patient received a dose much greater than intended. There was a good local incident management approach, and these had both 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.
- We saw from the monthly clinical governance meetings that mortality and morbidity was reviewed and discussed.
- 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.
- Managers and section heads 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. We looked at an example of an incident where Duty of Candour had been put into practice: this was cross-referenced with the medical records and was documented.

Cleanliness, infection control and hygiene

- Reliable systems were 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. Sharps boxes for the disposal of items such as needles were used in accordance with trust guidelines. Handwashing facilities were available in the consulting and treatment rooms and we observed staff washing their hands appropriately.
- Infrequently used water outlets were flushed weekly to help reduce the risk of Legionella bacteria, which can cause a potentially fatal type of pneumonia.
- There was a high awareness among staff regarding infection control in both outpatients and diagnostic imaging. Staff followed the trust infection control policy regarding hand washing and the use of personal protective equipment.
- 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. We saw staff wearing personal protective clothing such as disposable gloves and aprons. All staff adhered to the 'bare below the elbow' policy.
- 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.

- Monthly 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 97% 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 (IPC) 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. 100% of outpatient clerical staff were compliant, however only 83% of nursing staff had completed the infection prevention module against a trust target of 90%. There were to be learning modules for staff to complete online to increase compliance.

Environment and equipment

- The maintenance and use of facilities and equipment kept patients safe. Clinic and diagnostic imaging rooms were well organised and well-led. All electrical equipment we examined was tested appropriately.
- There was sufficient equipment to maintain safe and effective care. We saw that equipment used in the clinical rooms were visibly clean and stored appropriately. We saw sterilised instruments were checked and monitored in accordance with local and national guidance.
- We observed treatment carried out in consulting rooms which were well equipped with couches and hand washing facilities.
- There was emergency resuscitation equipment in all departments. 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). There were no gaps seen on the checklist register. There was also resuscitation equipment for children and the defibrillator mode could be changed to be compatible for children.
- During the course of our inspection, we observed specialised personal protective equipment was available for use within radiation areas. Staff wore personal radiation dosimeters (dose meters), and these were monitored in accordance with legislation. A radiation dosimeter is a device that measures exposure to ionizing radiation.
- Radiation local rules were displayed and described the duties undertaken by staff. Local rules were written to enable work with ionising radiation to be carried out in accordance with the 'Ionising Radiations Regulations (IRR99)'. It was the primary responsibility of the radiation protection supervisor (RPS) to supervise work and observe practices to ensure compliance with these regulations.
- There was a children's play area away from the main waiting area, with clear signage explaining children must not be in the area unattended. This was child friendly with toys and books that could easily be cleaned.

Medicines

- The management, storage, and administration of medicines kept patients safe. 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 department.
- Lockable medicine fridges were in place in both departments, with daily temperature checks monitored and recorded appropriately. This meant that the service was following the appropriate guidance on the safe handling and storage of medicine.
- The senior nurses were responsible for checking medicines, and we saw a check book to record this. They were also responsible for the safe management and control of medicine keys.
- There was a pharmacy on site, which provided an outpatient dispensing service. This service was available Monday to Friday at 9am to 5pm and closed from 1pm to 1.30pm for lunch.
- The doctor's prescription pads were kept in a locked cupboard. This was managed by the senior sister of the outpatients department. Each prescription was signed out and documented in a record book.
- The consultants who worked in outpatients followed a local antibiotic formula and the trust prescribing list, these were available on the hospitals internal website. The consultants could access this from the clinic rooms, each having a computer terminal.

Outpatients and diagnostic imaging

Records

- Patients' individual care records were written and managed in a way that kept them safe. 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's medical records were in paper format.
- Medical records were kept securely in all areas we visited, in lockable notes trolleys with keypad access. We checked four of these trolleys during the inspection and all were locked.
- We reviewed eleven sets of patient notes. All were in good condition; pages were secure and could easily be found as they were sectioned off. The writing was legible, dated, and signed in compliance with trust guidance.
- In radiology, we found staff managed and handed over inpatient case notes safely. We reviewed five electronic patient records to check whether radiology staff had completed the safety checks for pregnancy. All patients of reproductive age 12-55 years old were risk assessed for pregnancy.

Safeguarding

- 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 some of the adult outpatient clinics. 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. The sister in charge realised this and told us she was looking into getting the trained staff onto level three training. However, we saw no formal evidence of this in place.
- 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 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. We were told an example of a young child who was caring for their parent, having to push her in a wheelchair, with no adult help. This was shared with the safeguarding team, it was reported back to clinic staff that the child was assessed and identified as a child in need.
- Safeguarding issues were highlighted on the patients' medical records, and staff documented this on the patient's care pathway.
- The 'pause and check' 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.
- There was no interventional radiology at SACH. This is a sub-speciality of radiology providing minimally invasive image-guided diagnosis and treatment of diseases in organ systems. These procedures were carried out at Watford General Hospital site.

Mandatory training

- Staff mostly received effective and timely mandatory training in the safety systems process and practices. Trust staff attended annual mandatory training which included equality and diversity, fire, health and safety, information governance, infection control, manual handling, conflict, resuscitation and safeguarding.

- Trust data showed that 93% of the administrative and clerical staff and 80% of nursing staff were up to date with mandatory training in the outpatients department. The trust target for staff to be trained was 90%. The sister in charge explained the shortfall of staff receiving their training was due to staff sickness, and were now all booked onto relevant courses.
- Staff we spoke with in radiology confirmed they were up to date with their mandatory training. A number of new staff we spoke with showed us their personal induction records, which included appraisals, trust mandatory training and supervision completed within the departments. 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.

Assessing and responding to patient risk

- Most risks to patients were assessed, and their safety monitored and maintained.
- The outpatient and diagnostic imaging services completed risk assessments and responded appropriately in order to maintain patient safety. This had improved since the last inspection in 2015. These risk assessments included, slips, trips and falls, needle stick injuries, lone workers and ligature points.
- 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.
- From April 2015 to March 2016, 96% of patients were seen with their full medical records. This was the same as Hemel Hempstead Hospital. A manual audit was undertaken in December 2015, 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. The results showed that out of 392 notes, 50 were unavailable for clinic. A further audit undertaken in March 2016 showed that 79 medical records were required and nine were unavailable. The two main reasons for the unavailability for both audits were, the records were not at the last tracked location, and due to late additions to the clinic, they had not arrived in time.
- The service was looking at having medical record storage at both St Albans City Hospital and Hemel Hempstead, to try and reduce the amount of unavailable medical records for clinic appointments.
- 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 diagnostic imaging department had a radiation protection supervisor. There was a good liaison with the radiation protection team and staff were knowledgeable about safety procedures.
- 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. Clear national and local diagnostic reference levels were available in mammography and x-ray.
- 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 five 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.
- 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. We saw

evidence in the radiation protection panel meetings that this took place. After a risk assessment of the bone density scan, it was shown to need replacing, and this was carried out at the beginning of 2016.

- We observed the 'pause and check' system used in mammography, ultrasound and x-ray. This was 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 saw that staff were available to observe patients in waiting areas, which meant that if a patient's condition deteriorated, it would be escalated appropriately.
- All radiation premises had secure access. Radiation warning signs were displayed with the use of illuminated 'do not enter' signs within all areas using radiation.

Nursing staffing

- Staffing establishments for the outpatient department were based on clinic volumes and clinic capacity. There was no formal acuity staffing tool for outpatients departments to use. Skill mix was determined by clinic speciality and complexity**.** We looked at the staffing rota, which showed that for Monday and Thursdays the planned staffing was for nine registered nurses and seven registered nurses for the Tuesday, Wednesday and Friday. The planned number of nurses required per shift changed on a weekly basis depending on what clinics were running, for example, on one Friday the planned was for five registered nurses.
- On the day of our inspection, the planned staffing was for seven registered nurses and the actual staffing was four, the sister in charge was helping with certain clinics. We did not observe any disruption during this time. The planned staffing level for health care assistants was eight and there were six on duty with three agency health care assistants, making the actual staffing nine**.**
- The overall vacancy rate was 9% in May 2016, which meant a 1.6 whole time equivalent vacancy. At the time of our inspection, there were two full time vacancies at band 5. A business plan had been submitted for an increase to their trained nursing establishment.
- The outpatient department used agency staff and we spoke to two agency health care assistants during our inspection. They had both received a formal induction and support from the team, and we saw evidence of the agency staff induction checklist. The outpatient department had an average of 3.6% use of agency from May 2015 to April 2016, this worked out at approximately one agency nurse per shift.
- There were two whole time equivalent (WTE) radiation protection supervisors (RPS's) employed within the diagnostic imaging department.
- Agency and bank radiographers completed local induction and equipment training which was signed off before they were allowed to work unsupervised. We were not given the actual figures of agency usage in diagnostic imaging, but we were told that it was low.
- 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.

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. They were given their own specific induction training.
- The individual specialities arranged cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and the numbers.
- 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.
- The breast care unit was headed by three consultant surgeons and two consultant oncologists. The unit's staffing was at full establishment. We saw evidence of two more breast radiologists commencing in September and October 2016.
- The diagnostic imaging department was aspiring to become a nationally recognised centre for trainee radiologists.

Major incident awareness and training

- Potential risks to the service were anticipated and planned for in advance. Departments had clear signs indicating emergency exit points and information about first aiders. Staff we spoke with had not taken part in any emergency evacuation or major incident rehearsals.

Staff in both departments had received basic fire training and separate fire evacuation training as part of their mandatory training, however, no specific major incident training was given.
- Staff we spoke with were aware of the major incident policy and told us where they could find it.
- 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.

Are outpatient and diagnostic imaging services effective?

We have not rated this service for effective.

- Care and treatment was provided in line with appropriate professional guidance.
- Care was provided by a range of skilled staff who had access to further training if required.
- Multidisciplinary team working was evident throughout both services.
- Staff took part in a number of local and national audits.
- We saw evidence of staff competency checks and individual learning logs.
- 100% of staff had completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

However, we also found that:

- 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. 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 staff showed us. We also saw evidence of protocols in folders which were in date and available in the sisters office.
- 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 audit was in January 2016.
- We observed radiographers following the IR(ME)R regulations that require radiographers to routinely check previous images before continuing to scan or x-ray.
- We saw evidence of local audits carried out and a plan for the audit programme for 2017. These included GP audit of referrals and bowel cancer screening patient satisfaction audit planned.

Nutrition and hydration

- Nutrition and hydration needs were not formally assessed as part of the outpatient process.
- There were arrangements in place if patients required food, for example if they were diabetic and did not bring any provisions with them. The staff could order food from the restaurant, and make drinks from there staff kitchen. There was a water dispenser available in the waiting room for both patients and relatives.
- Patients who were waiting for hospital transport would be given food and drink whilst waiting.

Pain relief

- 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. There was a pain management clinic on site at St Albans City Hospital (SACH).
- A pain assessment tool was used if patients were showing signs of pain; they used the numeric pain rating scale from 0-10. Zero being no pain, and 10 being the worst possible pain.

Patient outcomes

- The outpatients department had a local audit programme for March 2016 to April 2017, these included, audit of GP referrals, two-week wait pathway for gynaecology and service provision for fertility services. As well as environment and infection control audits. 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.

- The follow up to new rate for St Albans was consistent, ranging between 1.5 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. This was an improvement since the last inspection, where there follow up to new rate was from 2.3 to 2.9
- In June 2016, the trust cancelled 4% of clinics, compared to the national standard of 8%. This was across all three sites. There had been a significant reduction in cancellation rates since the last inspection, where 11% of clinics appointments were cancelled. 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. The service lead for the department told us they were currently working on an audit looking at reasons for cancellations, this was ongoing, therefore no data to show us.
- The breast unit carried out a mammography patient dose audit at St Albans in January 2016. The result had been compared to the previous audit, to results from a regional audit comprising similar equipment to that in use at St Albans, and compared to the national diagnostic reference levels for mammography. The results showed that local doses to standard breasts remained consistent since the last audit and were below both the regional and national reference doses, which was a positive result.
- 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 SACH, were aware of the schemes and thought it may be due to financial pressures as to why they had not yet applied.

Competent Staff

- NHS organisations should provide staff with clear roles and responsibilities, personal development and line management support. 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 nursing or administration staff. Trust figures showed that 38% of nursing staff and 79% of administration staff had received an appraisal from April 2015 to March 2016. Management staff told us that this had been looked at and staff who had not had a recent appraisal were now booked in with their line manager. We saw evidence of this. At the time of inspection, the service was on track to meet the trust target of 90% for 2016/17.
- Staff we spoke to during the inspection had either received an appraisal or were booked in with the line manager to have one. The staff who had received an up to date appraisal told us they were useful and constructive, and had plans for further training. Senior staff nurses were offered the band 6 (junior sister) development programme and two had completed it.
- 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 to say they had read and understood the local rules and guidelines. 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.
- All staff who administered radiation were appropriately trained to do so, and we saw evidence of this in staff competency folders. Staff who were not trained to administer radiation, but worked within the diagnostic imaging department were appropriately trained to understand and follow IR(ME)R guidelines in how to practice safely.
- 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.
- Staff we spoke to were knowledgeable about their area of work and felt supported by their line managers to develop further skills. Examples included radiographers going on further training programmes to become mammographers and health care assistants given the opportunity to do their nurse training.

Outpatients and diagnostic imaging

- The breast care unit also included an associate specialist, staff grade and a specialist nurse practitioner, who all specialised in breast disease. They had four Macmillan breast care nurses who further supported in breast care, an oncology research nurse and the clinic sister.

Multidisciplinary working

- There was evidence of multidisciplinary (MDT) working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together. For example, staff told us they helped each other in clinics. If one clinic was busy then staff would support patients if they needed and share the right information to ensure this was available to the doctors.
- There was some involvement with other departments, such as physiotherapy, surgical and anaesthetic support for patients needing operations.
- Since the last inspection, the breast multidisciplinary meetings now involved more medical and oncology staff and radiographers would attend these weekly meetings. This meant patients benefitted from the knowledge and expertise of a full MDT when decisions were made about their diagnosis and care.
- 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 Hemel Hempstead if needed, to discuss patient's previous images. This ensured that patients did not receive unnecessary scanning and radiation.
- The urology service ran one-stop services for patients with prostate cancer, as did the breast care unit, which provided specialist nurse led clinics. Audiology had one-stop clinics for patients with tinnitus. Patients were diagnosed and treated at the same time if they were suitable, improving patient experiences and reducing visits to the clinic.

Seven day services

- The outpatients and diagnostic imaging departments both were 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 management team told us, that they hope to make the outpatient department a permanent six-day service. This was still just being discussed at the time of the inspection.
- The breast care unit held rapid diagnostic clinics nine times a week, on Mondays, Tuesdays, Thursdays and Fridays. Oncology clinics ran all day on a Tuesday and Wednesday.

Access to information

- Records were available 96% of the time for clinics. 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.
- Following an outpatient appointment, the clinic sent a letter to the patient's GP, in an electronic format, which would be sent within two weeks if not urgent. Senior staff told us that this always happened and had had no incidents of GPs not receiving these letters.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at five 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.
- We observed a patient giving consent to a procedure; they were very concerned about the procedure and staff explained everything clearly and ensured the patient had all the relevant information they needed to give informed consent.
- 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.
- Figures provided by the trust showed us that 100% of outpatient and diagnostic staff had attended MCA and DoLS training.
- 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.
- Two out of five nurses asked 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.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because,

- Patients were treated 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.
- Patients were given the opportunity to bring in their relative or friend for the consultation.
- Both services offered patients a chaperone for examinations and tests.
- Staff explained the consultation and information fully in a manner patients could understand.
- There were private rooms available in the breast unit to discuss sensitive issues.
- The staff had access to Macmillan nurses for help, advice and support for patients and their relatives.

Compassionate care

- Patients were treated with dignity and respect. Many patients told us staff were friendly, polite and kind. Staff established a rapport with patients and relatives to help put them at ease. One patient attending for blood tests told us they had a fear of needles but the staff always reassured them in a kind manner.
- In the outpatient department, the nursing and health care assistants accompanied patients from the waiting area to the treatment room. They provided assistance as needed and spoke with patients clearly and discreetly, making good eye contact. Patients told us that staff treated them as individuals, and got to know them if they were regular attenders.
- The breast care unit and outpatient department provided areas of privacy for discussing sensitive news.
- Details of 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.
- Patients may find some consultations, examinations or treatment distressing and may like to have a chaperone present. When a patient needs to undress they may feel vulnerable, and a chaperone can act as a safeguard for both patient and clinician. It is good practice to make patients aware they can request a chaperone. We observed posters in outpatients, breast care unit 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.
- The outpatient department took part in the 'I want great care' patient survey. The department was in line with the England average in regards to questions about their care and treatment. The average percentage of patients who would recommend the service to family and friends from April 2016 to September 2016 was 71%.

Understanding and involvement of patients and those close to them

- Patients and relatives who we spoke with in the outpatients department told us they were involved in their care and understood their treatment and care plans. Patients described how during conversations

with the doctors and consultants, they had been able to ask questions and discuss how they felt about their treatment and care. Opportunities were also given to relatives to discuss any concerns.
- Patients were always encouraged to bring a friend or relative with them to sit in consultations with them.
- 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.
- Patients were given information leaflets and phone numbers to call if they required any further information, and we observed this during our inspection.
- For patients and relatives who required translation services the staff could arrange this through the hospital patients advice and liaison service (PALS).

Emotional support

- The breast clinic used the Macmillan nurses to help support the medical staff when needed to further support patients with dealing with a new diagnosis.
- 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.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

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.

However, we also found that:

- Staff provided visible information for patients on how long they might have to wait.
- Patients were given clear instructions prior to their appointment with regards to directions and tests that they may have.
- 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.
- The diagnostic waiting time was consistently better than the England average.
- Clinic non-attendance was in line with the national average.
- There was a trust policy for the care of patients with learning disabilities who attend the outpatients and diagnostic imaging departments.
- The introduction of a SMS test messaging service, to inform patients of their appointment, had helped reduce the non-attendance rate.
- Patients living with dementia would be given earlier appointment times, and generally would be seen first to reduce anxiety.
- Staff were aware of complaints procedures, and knew where how to advise patients and relatives if they wanted to make a complaint.

Service planning and delivery to meet the needs of local people

- St Albans City Hospital provided a range of outpatient and diagnostic imaging services to meet people's needs. Routine and more specialist scans, such as magnetic resonance imaging (MRI) and computed tomography (CT) were available at Watford General Hospital and Hemel Hempstead Hospital.
- 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.

Outpatients and diagnostic imaging

- Seating in the waiting areas was comfortable and sufficient. There was a water dispenser and a separate area for children to play.
- There was sufficient signposting for all departments, with a staff welcome board, with all staff members' picture, name and role.
- Car parking availability was not an issue for patients and relatives. However, there had been feedback regarding the parking charges not being made clear, so this was being looked at by the hospital's managers, and patients were informed of this via an information whiteboard in the waiting area. Patients were able to get car-parking refunds if clinics were to run late.
- Ambulance patients were offered a drink and a snack if they were waiting for transport.
- Walk in services for x-ray plain film examinations were provided between the hours of 9am to 4.45pm Monday to Friday.
- Extra clinics during evenings and weekends 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.
- There were pathways in place for patients with specific needs to attend alternative sites within the trust, for example, patients with sickle cell anaemia could be seen at Watford General hospital. St Albans held certain specialist clinics such as a diabetic clinic, breast care and audiology.

Access and flow

- Patients were referred to outpatient services by their GPs, hospital consultants and other practitioners, for example opticians. Some clinics had a walk-in system, which patients could attend without an appointment.
- All routine and urgent referrals were sent to the outpatient booking office. They were received either in a paper format or electronically via the 'choose and book' service. Choose and book is a national service that combines electronic booking and a choice of place, date and time for first outpatient appointments. As a general principle, referrals were sent to the consultant with the shortest waiting time for the specified speciality. However, the patients did have a right to choose a certain consultant if they wished.
- All patients who were not referred via the 'choose and book' service would receive an invite letter confirming their first outpatient appointment. Patients who went through the choose and book service would receive a letter of confirmation from the trust once it had been reviewed an accepted by the clinical team.
- 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.
- Some patients were seen within 18 weeks of their referral reaching the hospital. The national standard for NHS trusts 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 from June 2015 to May 2016, for example, for dermatology 97%, and geriatric medicine 98%. However, they were slightly below the England average for gynaecology at 95%, urology at 91% and ENT at 87%.
- 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 December 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.
- 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 trust told us that ongoing referral demand had been highlighted to the clinical commissioning group (CCG) on a number of occasions, particularly in relation to cardiology and pain. 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.
- 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, was 34 minutes, according to the audit carried out from December 2015 to June 2016.
- 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.
- From March 2015 to February 2016, the percentage of appointments which patients failed to attend at SACH was around 6 to 8%. This was similar to the England average of approximately 7%. If patients failed to attend urgent referrals for cancer, staff 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.
- An improvement in clinic attendance has been seen since the trust introduced a text messaging service to patients, reminding them of their appointment time and date.
- On the outpatient improvement plan was a plan to implement a clinic room availability schedule, which would identify rooms to hold ad-hoc clinics. Plans were also in place to analyse hospital-initiated cancellations under six 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 included on the trust quality improvement plan as a (QIP) 'must do'. These actions were ongoing.

Meeting people's individual needs

- St Albans City Hospital serves a population of approximately 144,834, of which 91% are white, and 9% from minority ethnic groups. Information, such as leaflets were not readily available in other languages other than English, however staff were able to access leaflets in other languages when needed. The trust planned to order all leaflets in five other languages and signage, and we saw this on the outpatient improvement plan. These improvements were due to be made by July 2016, but it was still ongoing, and planned to be in place by the end of 2016.
- The outpatients and diagnostic imaging departments had patient information on display, including large whiteboards with waiting times and clinics running for that day.
- 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. None of the staff we spoke with had experience of using this service.
- There was support given to patients 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 patients with additional needs. There was also a learning disability nurse for the trust, who the staff could contact for advice and support.
- 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 patients 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.
- The breast care unit had dedicated rooms which were used to speak to patients regarding their test results. The outpatient department utilised quieter consulting rooms when needed for private discussions.
- There was a spiritual and pastoral care service, which the staff could contact for patients or relatives through the hospital switchboard. There was no chapel at St Albans City Hospital (SACH), however, there was a designated 'quiet room' available for prayer. If patients and relatives requested to speak with a chaplain, this service was available.

Learning from complaints and concerns

- All 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).
- 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 about waiting times, due to it being a new service set up.
- The trust 'I want great care (iWGC) survey asked people for feedback on their visit. On the day of our visit, we saw 10 feedback forms, all of them positive with no complaints.
- Systems and processes were in place to acknowledge, investigate and respond to complaints within a defined period, and show openness and transparency. Complaints were discussed to share findings and identify learning outcomes at departmental and governance meetings. We saw evidence of this in meeting minutes and reviewing examples of complaint responses, for outpatients and diagnostic imaging.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Clinical leadership was good at local and corporate level, with the introduction of the lead nurse and divisional director.
- The new leadership team had taken action to address the concerns found at the last inspection to drive improvements in the service.
- Both services held regular governance meetings and shared information.
- There was commitment from the managers to learn from feedback, complaints, and incidents.
- Support and leadership was given with clinicians, lead nurses, and senior staff working alongside junior staff.
- 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.

Outpatients and diagnostic imaging

- 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.

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. The new leadership team had taken action to address the concerns found at the last inspection to drive improvements in the service.
- Staff we spoke with told us that their management leads provided clear clinical and nursing leadership. Staff felt supported by the management leads.
- 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. Feedback was open and honest and was shared with them.
- 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.

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. Which 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.
- The trust's vision was on display in outpatient and diagnostic imaging departments. The chief radiographer in radiology told us their own individual aim was "to become the best radiology department in the country".
- There was not a joint strategy or vision to take the service forward specifically for outpatients or diagnostic imaging; however they had made many improvements since the last inspection.

Governance, risk management and quality measurement

- The accountability for the management and performance of outpatients and diagnostic imaging was delegated to the four clinically led divisions. 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 reviewed three sets of minutes for the medical division governance meetings. Issues were discussed, and actions allocated to staff to complete. For example, it was minuted that there was a backlog in cardiology clinic letters being typed, due to the reduction in agency staff. Additional staff had now been employed and the backlog reduced. The CCG were aware and the management team had daily updates regarding this.
- 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 SACH 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 led to poor patient experience and staff working conditions. We saw during our inspection that on the SACH site, work had been carried out in two of the treatment rooms to improve ventilation and provide more space. 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.
- All clinical audits were in place to measure quality and identify where improvements could be made. For example, the services performance data, environmental audits, and infection control.

Culture within the service

- During our inspection, staff were friendly and relaxed. They demonstrated commitment to providing a good service for patients.
- 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.
- Staff informed us that they felt there was an open, supportive and transparent culture within the trust. Staff felt confident that they could raise concerns without fear of reprisal and were aware of the whistle blowing policy.

Public Engagement and staff engagement

- The outpatients department used the 'I want great care' (iwgc) patient survey. These were available in locations throughout the department, and there were posters advertising this. The results and patients comments were displayed on the information board in the waiting room.
- We saw from minutes of the outpatient's department meeting, that staff from the 'patient information' department, were holding training sessions in improving the patient experience, and how to deal with conflict.
- Staff felt more involved in the trust's processes and decisions since our last inspection.
- Throughout the inspection, the staff gave us examples of small changes that had been made following staff suggestions and contributed to developing new ways in working, such as an increased time in between clinic times, to help with delays.
- The trust had a 'patient panel'. They were a small group of people who live in West Hertfordshire, and had been, or were currently a patient at the trust. They visited all three sites and look at the food quality, cleanliness and the environment. The outpatient's service had started sending one of the sisters whilst they carried out their visit. This meant that the staff could see what their department was like 'through the eyes of a patient'.

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, 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 and improved lighting, ventilation and upgraded patient trolleys and treatment rooms at SACH.

- 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 maybe 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 diagnostic imaging department were implementing mentor and assessor badges, for staff to wear. This meant that students would be able to identify staff easily. They were using red badges to show staff who were assessors and green badges for staff that were to be mentors; this was implemented following a nursing initiative.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the hospital MUST take to improve

- To ensure that there are effective streaming systems in place in the unit 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 in the MIU.
- To ensure that there are effective processes in place in the MIU to provide clinical oversight for patients waiting to be seen.
- To ensure non-clinical staff in the MIU receive sufficient support or training to provide oversight to recognise a deteriorating patient.
- To ensure the MIU has 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.
- 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 MIU.
- To ensure that staff in the MIU are given training and support to understand the duty of candour statutory requirements.
- To ensure all staff in the MIU, surgery and outpatients have had the mandatory training relevant to their roles and that all staff receive an annual appraisal.
- To ensure medicines are stored at correct temperatures in all areas and ensure appropriate action is taken if temperatures are outside the recommended range in surgery.
- To ensure the surgery service is compliant with recommendations for the safe management of controlled drugs.
- 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.
- To ensure all resident medical officers (RMOs) staff receive a trust induction.
- To ensure all staff received feedback after reporting incidents.
- To ensure all staff in surgery report any issues, concerns and incidents using the trust's electronic incident reporting mechanism.
- Actions on fire risk assessments in surgery are should be completed urgently and areas are regularly monitored for future compliance.
- The five steps to safer surgery checklists should be incorporated into all services and the three step checklist should be removed from use.
- 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 MIU environment more child-friendly in line with national recommendations.
- To consider ways of developing an audit process in MIU 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 review the environment and facilities to enhance privacy and dignity in the MIU reception area.
- To consider ways to ensure that staff are aware of the strategy for the MIU and continue to develop ways for their views to be heard.
- To establish clear escalation processes to manage the MIU during periods of high demand or excessive waiting times.
- To monitor how pain assessments and management systems being used in the service.

Outstanding practice and areas for improvement

- To review processes for monitoring those patients transferred from the MIU to other services in an emergency.
- All patients should have a venous thrombus embolism (VTE) assessment within 24 hours of admission and follow the National Institute of Health and Clinical Excellence (NICE) guidelines on VTE assessment and treatment.
- Action should be taken reduce the number of cancelled surgery operations and benchmarking should be undertaken against other similar hospitals.
- Pre-assessment documentation should include an assessment for patients living with dementia or a learning disability.
- All patients transferred, because of complications, from St Albans hospital should be fully reviewed. This should include an audit of any delay in this transfer.
- To review delays for patients receiving take home medicines and a plan put into place to minimise these delays.
- All complaints should be responded to within the agreed timescales.
- To review ways in which all staff are made aware of the trust's mission, vision, and strategic objectives.
- To improve the availability of medical records for clinic appointments more than 96% of the time.
- To provide advice leaflets in a variety of other languages.
- 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service was not meeting this regulation because:** • There were not effective streaming systems in place in the MIU 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 in the MIU. • There was not a process so that all children were seen by a clinician within 15 minutes of arrival. • The MIU did not have sufficient systems in place to ensure that patients who were waiting to see a clinician were safe to do so. • Non-clinical staff in the MIU had not received sufficient support or training to provide oversight to recognise a deteriorating patient. • Theatre teams were not consistently using the five steps to safer surgery checklist. • In the surgery service, medicines were stored in treatment rooms where temperatures exceeded recommended levels. During inspection, there was limited evidence that this had been reviewed or escalated appropriately. • Controlled drugs were not disposed of in line with current guidance in surgery. • In surgery, processes already in place to protect patients from harm were not always followed. This included infection control guidelines, reusable medical devices guidelines, water safety policy and fire safety. • 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%.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service was not meeting this regulation because:** • The MIU did not have effective governance systems, policies and processes in place to monitor, review and improve safety and quality performance. • Risks to patient safety in the service had not been identified in the MIU and surgery. • There was no a robust audit programme in place within the MIU. • There were not clear systems for assessing, monitoring and improving the quality and safety of the services provided in surgery. • Referral to treatment (RTT) times in surgery were below the England average. • Not all staff received feedback after reporting incidents. • Not all staff in surgery reported any issues, concerns and incidents using the trust's electronic incident reporting mechanism. • Actions on fire risk assessments in surgery were not be completed and monitored in a timely manner.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The service was not meeting this regulation because:** • The MIU did not have direct access to a registered children's nurse at all items and that paediatric competencies for emergency nurse practitioners were not recorded as a part of their continuous professional development (CPD) in line with national recommendations. • Not all staff in the MIU and surgery 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. • Not all resident medical officers (RMOs) staff in surgery received a trust induction.

This section is primarily information for the provider

Requirement notices

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: Staff in MIU had minimal understanding of the duty of candour regulation and its requirements.

This section is primarily information for the provider

Enforcement actions

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...