West Hertfordshire Hospitals NHS Trust

St Albans City Hospital

Quality Report

Waverley Road,
St. Albans,
Hertfordshire,
AL3 5PN
Tel: 01727 866122
Website: www.westhertshospitals.nhs.uk

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

Ratings

Overall rating for this hospital	Inadequate
Minor injuries unit	Good
Surgery	Inadequate
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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

West Hertfordshire NHS Trust provides services from three sites Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection of Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital between 14 and 17 April 2015.

Overall, we rated St Albans Hospital as inadequate with two of the five key questions which we always rate being inadequate (safe and well led).

The main concerns were particularly where one of the three core services (surgery) we inspected and rated was rated as inadequate. Only one service was rated as good; the Minor Injuries Unit.

Overall we have judged the services at the hospital as good for caring. Patients were treated with dignity and respect and were provided with appropriate emotional support.

Improvements were needed to ensure that services were safe, responsive to people's needs and well-led.

We saw several areas of outstanding practice including:

- The trust had introduced a pilot pre-operative reminder telephone call service. The patient was called three days prior to their surgery for reminders and checks. Staff said if the service proved successful then it would become permanent.
- The service had systems in place to minimise patient visits to the hospital. For example, all negative results were reported by phone for eye tests, ear nose and throat and oral surgery.

Importantly, the trust must:

- Review the governance structure for the MIU, surgery and outpatients to have systems in place to report, monitor and investigate incidents and to share learning from incidents as well as complaints.
- Ensure that governance and risk management system in MIU, surgery and outpatients reflect all current risks in the service and all staff are aware of the systems.
- Ensure that there is an effective audit program and the required audits are undertaken by the services.
- Ensure that they review outstanding incidents in a timely manner.
- Ensure that learning from incidents is shared across all staff groups.
- Ensure all surgical areas are fit for purpose and present no patient or staff safety risks.
- Take action to clinically review all of the patients who may have had surgery in Theatre 4 at St Albans.
- Ensure that the ladies changing room at St Albans is fit for purpose.
- Ensure that medicines are always administered in accordance with trust policy.
- Ensure that all staff have received their required mandatory training.
- Ensure that all staff are supported effectively via appropriate clinical and operational staff supervisions systems.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.

The trust should also:

Summary of findings

- Involve the service in wider organisational planning regarding major incidents and include in trust wide plans or training simulations.
- Enable all staff to access appropriate developmental training opportunities as required.
- Ensure that they take the required actions to meet the 18 week refer to treatment national target.
- Review issues identified and associated with transport problems when accessing outpatient appointments.
- Put in place a clear strategy for leadership development at all levels.

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	Good	We visited the Minor Injury Unit at this location. Patients received treatment in a suitable environment by caring staff that understood their roles and had undertaken training to perform in this capacity. Whilst staff were very experienced we found that they were not given regular supervision, although all had had an appraisal. We saw that the environment was visibly clean and well maintained and staff took action when there were concerns about cleanliness. The unit's performance exceeded the Department of Health's national target to discharge 95% of people within four hours. Key risk and performance data was monitored at a local level and we found that there were robust systems for ensuring that x-rays were correctly interpreted. We saw there were good systems in place to identify vulnerable people at risk of abuse and staff were very clear about their safeguarding responsibilities. Those who had a disability were able to access the service effectively and that signposting both within the hospital and on surrounding roads was clear and effective. People using the service were very complimentary of the staff and understood exactly what services the minor injury unit could offer. We found that there were effective systems in place to treat and transfer people who arrived in a life threatening condition. Staff said the unit had not been involved in wider organisational planning regarding major incidents and was not included in trust wide plans or training simulations. The trust's Major Incident Plan dated 2013 did include the role of the unit in supporting the trust's main Emergency Department in case of a serious incident. At local level we saw that there was strong leadership and that staff were happy in their team, however they also told us that they lacked support from senior managers within the organisation who were managing a number of units across multiple sites within the organisation.

Summary of findings

Surgery

Inadequate

Surgical services were inadequate to support safe care. The environment in the ladies changing room was not suitably maintained which included tiles missing off the walls. There were six theatres at St. Albans. However, during our visit Theatre 4 was closed due to issues relating to the ventilation system which had been identified for a period of time but had not been addressed.

Although there was a culture of incident reporting staff on the ward and in the day surgery unit said they had not received feedback following the reporting of incidents. We saw incident reports on De La Mare ward which were outstanding and had not been addressed by management. We observed that staff were not following infection prevention and control guidelines on De La Mare ward. This was brought to the attention of the ward manager. We observed that this had been addressed when we revisited the ward.

The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls which were identified in the records seen. The environments were visibly clean. The hospital's surgical safety checklists were fully completed for all patients. Patients were appropriately escalated if their condition deteriorated. Medical handovers were well structured within the wards visited. There was good storage of medicines on the ward, the recovery area and day surgery unit.

Treatment and care was provided in accordance with evidence-based national guidelines. There was good practice, for example, in pain management, and the monitoring of nutrition and hydration of patients in the perioperative period.

Multidisciplinary working was evident. Staff had access to training and most staff had received annual appraisals. Staff confirmed they had not received regular supervision. Consultant-led, seven-day services had been developed and were embedded into the service.

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff who worked well as part of an MDT. Staff sought consent from patients prior to delivering care and treatment. Staff understood the legal requirements of the

Summary of findings

Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS). The average length of stay for elective patients across was longer than the England average in two of the specialist services.
Patients told us that staff treated them in a caring way and were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect. The friend and family test showed that 98% of patients were extremely likely to recommend the trust to family and friends.
The national time of 18 weeks between referral and surgery was not being met in some specialists. The trust utilized the enhanced recovery programme to support patients in their recovery after having major surgery.
There was support for people with a learning disability and reasonable adjustments were made for them. For example, patients were given a longer surgical time to take account of any anxiety. Staff were able to refer any issues or concerns to the learning disability lead. Information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how any complaints made were dealt with.
We found well-led was inadequate because although there were clinical governance systems in place that allowed risks to be escalated we found that, when issues were identified, timely action had not been taken by the trust to: for example, the closure of Theatre 4. Senior staff on De La Mare were not aware of the risks associated with the ward and did not know how these identified risks could be included on the risk register and the subsequent action to be taken.
The trust had completed national and local audits. On De La Mare ward the audits showed the ward was compliant regarding infection control and hand hygiene practices. During our visit we observed nursing, medical and therapist staff not adhering to safe hygiene procedures. This meant there were no procedures in place to monitor the results of audits to ensure good practice.
Patient safety was monitored and incidents were investigated. Some staff said they had not received feedback on incidents. This meant that some staff were not involved in learning from incidents assisted

Summary of findings

learning to improve care delivery. Patients received care and treatment by trained, competent staff who worked well as part of a multidisciplinary team (MDT).

Outpatients and diagnostic imaging

Requires improvement

Overall, we found that this service required improvement.
We found that most incidents were reported and that the service had learned from incidents. We saw evidence during the inspection that the service had carried out reviews of minor incidents and that sharing of these and learning had taken place. However, some staff said that incidents were not always reported in line with trust policy. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in the outpatients and diagnostic imaging services.
Equipment had been maintained in line with manufacturers' recommendations.
Clinics were often cancelled and patients experienced delays when waiting for appointments. We received some negative feedback from patients and staff about waiting times, the patient transport service and patient parking.
Risk management and quality measurement systems were reactive and not proactive. Outpatients and diagnostic imaging services had not identified all the risks to service users, and some of those identified were not being managed effectively.
We saw written information about the complaints procedure and the Patient Advice and Liaison Service within the outpatients' reception area.
We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Some of the information given to us by senior managers was not found to be what was happening at local level.
Senior staff said they were aware of key performance indicator targets that required appointments to be made within the 18 week referral to treat target.
The processes for decontamination and sterilisation of instruments complied with Department of Health

Summary of findings

(DH) guidance. There was evidence that the service focussed on he needs of patients. There were systems in place to audit both clinical practice and the overall service.
Emergency equipment was available in each centre, and included medication, oxygen and a defibrillator. We saw that equipment checks had been carried out regularly.
There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.
We found that staff were approachable and witnessed them being polite, welcoming helpful and friendly.
Outpatient services were caring and most patients spoke positively about the care and treatment they received.

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

St Albans City Hospital is the Trust's elective care centre. It provides a wide range of elective care (both inpatient low risk surgery and day-case) and a wide range of outpatient and diagnostic services with in excess of 70,000 outpatient appointments. It has forty beds and six theatres (including one procedure room for ophthalmology) and a Minor Injuries Unit (MIU), open every day of the week from 9am to 8pm.

The Breast Care Unit was formed in 2005 from the centralisation of breast services across west Hertfordshire. The unit sees and investigates around 3000 new patients per year.

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals NHS Trust

Head of Hospital Inspections: Helen Richardson

The team included 12 CQC inspectors and a variety of specialists including junior doctors, medical consultants, senior managers, child and adult safeguarding leads, trauma and orthopaedic nurses, paediatric nurses, an obstetrician, midwives, surgeons, an end of life care specialist and experts by experience who had experience of using services.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about West Hertfordshire NHS Trust asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, the trust development authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

Detailed findings

We held a listening event in the week leading up to the inspection where people shared their views and experiences of services provided by West Hertfordshire NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at West Hertfordshire NHS Trust.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Good	Not rated	Good	Good	Requires improvement	Good
Surgery	Inadequate	Good	Good	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Good	Good	Requires improvement	Inadequate	Inadequate

Notes

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

Minor injuries unit

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

Information about the service

The Minor Injuries Unit (MIU) is located within St Albans City Hospital. Last financial year the unit treated 14,862 people and was open from 9 am to 8pm every day except Christmas day. Those using the service came mainly from St Albans and surrounding towns. The MIU was designed to see people who required prompt treatment but whose conditions were not life threatening or requiring admission to hospital. Common conditions treated by this unit included minor head injuries and broken bones. The service treated both adults and children.

The MIU was staffed by experienced nurse practitioners who had undergone specialist training and were able to examine, diagnose and treat patients independently. Many of the nurses had also undertaken training that allowed them to prescribe certain medication and interpret x-rays independently.

Summary of findings

We rated this service as good overall.

Patients received treatment in a suitable environment by caring staff that understood their roles and had undertaken training to perform in this capacity. Whilst staff were very experienced we found that they were not given regular supervision, although all had had an appraisal. We saw that the environment was clean and well maintained and staff took action when there were concerns about cleanliness.

The unit's performance exceeded the Department of Health's national target to discharge 95% of people within four hours. Key risk and performance data was monitored at a local level and we found that there were robust systems for ensuring that x-rays were correctly interpreted. We saw there were good systems in place to identify vulnerable people at risk of abuse and staff were very clear about their safeguarding responsibilities

The minor injuries unit was accessible for people with a disability. Signposting both within the hospital and on surrounding roads was clear and effective. People using the service were very complimentary of the staff and understood exactly what services the minor injury unit could offer. We found that there were effective systems in place to treat and transfer people who arrived in a life threatening condition; however the unit had not been considered in the organisation's major incident plan.

At a local level we saw that there was strong leadership and that staff were happy in their team, however they

Minor injuries unit

also told us that they lacked support from senior managers. Senior managers lead on emergency and urgent care at two other locations within the organisation.

During our inspection we spoke to five members of staff and five patients.

Are minor injuries unit services safe?

Good

Overall, we rated this service as good for safety.

We found there were efficient systems in place for reporting incidents and monitoring performance. All the staff we spoke with were clear about how to report incidents and what sorts of events constituted incidents.

Staffing levels were suitable to meet patients' needs and we saw evidence that they were geared to match peak demand.

We saw that there was equipment in place and that all staff had been suitably trained in the event that a critically ill patient, either adult or child arrived at the unit. Staff were also supported by a comprehensive policy that guided them in this area.

We found a robust system in place to identify adults and children who were vulnerable to abuse and to notify relevant authorities, and all nursing staff had undergone training in this area.

Staff said the unit had not been involved in wider organisational planning regarding major incidents and was not included in trust wide plans or training simulations. The trust's Major Incident Plan dated 2013 did include the role of the unit in supporting the trust's main Emergency Department in case of a serious incident.

Incidents

- There was a policy in place that guided staff through the reporting and investigation of incidents.
- Nursing and administration staff we spoke with were confident about reporting incidents and understood the types of events that should be reported via the trust's electronic incident reporting system.
- Staff were able to identify recent incidents and were able to clearly outline the learning from them. The unit benefitted from a stable workforce who had been in post for a number of years which ensured incidents were learned from and not repeated. There was evidence in staff meeting minutes of learning from incidents that had taken place in other similar units across the trust.

Minor injuries unit

- We saw that incidents were investigated thoroughly, through a root cause analysis and learning was disseminated to staff via both e-mail and a team folder in the staff room.
- We saw the incident log for the past year. It contained a brief description of the incident and a section which identified learning points and actions taken to ensure that incidents were not repeated. This ensured the unit made changes to practice to prevent reoccurrences of incidents.
- We saw from minutes taken at regular staff meetings that incidents were considered and when we spoke to staff they confirmed this was happening.

Cleanliness, infection control and hygiene

- The environment was visibly clean, well maintained and in a good state of repair.
- We found that waste was appropriately segregated and that sharp bins were available to staff at the point of care.
- We saw audits that showed that cleanliness was being effectively monitored and staff were able to escalate concerns about cleaning and documented that they had done so. This was documented on a daily check list, which we were shown.
- All the staff we spoke to had undergone regular infection control training and understood the principles of good infection control practice.
- We observed that staff practiced the principles of good infection control such as regular hand washing and being 'bare below the elbow'.
- The waiting room was clean and staff had access to cleaning equipment should this be required.
- All cleaning equipment was stored out of reach of children and members of the public.
- Data showed no cases of methicillin resistant staphylococcus aureus (MRSA) or clostridium difficile (C.Difficile) were attributed to the MIU in the last year.
- The MIU had suitable procedures, equipment and isolation facilities for people who were suffering from a potentially infectious condition.

Environment and equipment

- The MIU was well maintained, safe and secure.
- The Unit had a trolley of resuscitation equipment for both adults and children. Records demonstrated they it was checked daily and was all within expiry date. This included an Automated External Defibrillator (AED) which was functioning and had been tested.
- Equipment was checked and decontaminated quickly and we saw checklists in place that assigned individual members of staff to this task.
- Staff were made aware of alerts issued by the trust and external organisations regarding potential problems with medical devices and product recalls. We saw that these were acted on and the items removed from use.
- Adequate equipment was available in all areas, however the machine that recorded vital signs was old and staff told us they sometimes found it difficult to gain reliable readings in the case of young children. Staff had escalated this problem to the senior management team who were reviewing this.

Medicines

- Medicine policies and guidance were available to staff next to the medicine storage area which made access to them in a timely way easy.
- All medicines were stored in locked cupboards in a room only accessible by keypad. The MIU had no controlled drugs on site.
- Medication that required refrigeration was kept in a locked fridge. The temperature of the fridge was checked daily by staff and kept within the range advised by the drug manufacturers. The fridge was used solely for medicines in accordance with advice from the pharmacy.
- Emergency Nurse Practitioners were able to prescribe from a formulary if they had undergone specialist training or use Patient Group Directions (PGDs) and this ensured that those using the service received appropriate medicine in a timely way.
- We looked at five medicines packets selected at random and found them to all be stored correctly and within expiry date.
- Medication that had expired was disposed of safely.
- The supply and stock of medicines was undertaken with support from the hospitals pharmacy, staff told us they were able to order medicines if they ran short and that this system was effective.

Records

Minor injuries unit

- The MIU used a combination of paper and computer based system. Patient records were written on paper. The paper record was a copy of a booklet used by the trust's Emergency Department (ED). This meant many of the questions were not relevant to the setting and were therefore not filled in.
- Patient records were filed and kept in a very well organised system.
- On occasion the MIU received a patient from the ambulance service who was suffering from a condition that could be appropriately treated there. Staff told us that, in contrast to the ED, they had no way of accessing or printing the electronic documentation used by the ambulance service. This led to a delay in treating the patient whilst the ambulance crew copied the information to paper.

Safeguarding

- The MIU had an effective system in place for identifying vulnerable people who were known to other agencies such as social services.
- Staff were able to follow very straightforward advice when concerned about an adult or child. They told us they were also able to access advice from specialist safeguarding teams the trust if they required it.
- All patient documentation regarding children was reviewed by a specialist team of health visitors a short time after the attendance to ensure that there were no issues that required further attention.
- The MIU had a system in place to alert carers for people with learning difficulties who had attended the unit.
- Staff were able to give us examples of when they had made referrals regarding safeguarding and told us they found the system easy to access and those they referred to very supportive.
- All staff working with vulnerable children and adults had received appropriate additional training that outlined their responsibilities and actions.

Mandatory training

- We saw documentation that showed that 100% of the units' staff had received mandatory training in accordance with the targets set by the organisation. This included topics such as infection control and moving and handling.
- All staff had also undertaken appropriate child safeguarding training (level 3) and training in safeguarding vulnerable adults.

Assessing and responding to patient risk

- All patients who self-presented were initially booked in by a receptionist. There was no formal triage process. The Emergency Nurse Practitioners (ENP's) performed screening and treatment of patients based on their ailment. All the patients that we spoke with understood that the MIU was for non-life threatening conditions and that during its hours of opening there were no doctors working in the service.
- At times of high demand we saw staff reviewing the documentation of the patients waiting to be seen to see if they required more urgent treatment.
- If patients' became too unwell to be safely treated in the MIU, staff told us that there was a system in place to convey the person to a more appropriate setting via an ambulance. We were shown the policy that supported staff in this.
- We saw evidence that all clinical staff had undergone intermediate life support (ILS) and paediatric intermediate life support (PILS) which included the initial stabilisation of a critically ill patient.
- There were early warning scores in place to identify any deterioration in a patient's condition.
- The waiting room was visible from the nurses' office and reception so people where within a line of sight of the staff. There were a number of examination cubicles available for people who could not wait to be seen in the waiting room.

Nursing staffing

- The MIU benefitted from a stable workforce who had worked in the department for a long time.
- Shift patterns consisted mainly of 12 hour shifts however there was flexibility in this for some staff.
- Staffing was matched to days of peak activity with an extra member of staff on duty during the unit's busiest day; Monday.
- Staff said a staffing needs assessment had not been undertaken. The trust provided further information to show a dependency assessment had been completed and that staffing levels were sufficient to meet patient needs.
- The manager and staff told us that when other units became busy or were short staffed, staff from the MIU were transferred ensure these units were suitably staffed. When this happened, this could leave one member of clinical staff and one member of

administration staff. There was no policy for how clinical care should differ in this instance or who should be contacted within the hospital in the event of a very unwell patient arriving. This risk was not highlighted on the divisions risk register.
- The unit used agency staff very infrequently and relied on overtime from permanent members of staff.
- Staffing levels had not been benchmarked against any recognised tool; however staff told us that they felt there were enough staff to provide safe care except at times when a member of staff was taken to support another unit.
- We looked at staff rotas and saw that there were currently no vacancies within the team and that staffing levels had been stable for at least the preceding three months.

Major incident awareness and training

- Staff at the MIU did not form part of the major incident planning and had not been involved in any major incident preparedness training. The trust's Major Incident Plan dated 2013 did include the role of the unit in supporting the trust's main Emergency Department in case of a serious incident.
- Senior managers within the Trust had not discussed the procedure for major incident with the manager of the unit.
- Staff had been given very limited guidance about actions to take in the event of a surge of patients arriving in a short space of time.

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

Not sufficient evidence to rate

We inspected but did not rate this service.

There was no effective audit program and no audits were being undertaken by those working on the unit. In addition to this there was no regular system of clinical supervision for staff which meant staff were not able to review clinical cases in detail or develop their skills and knowledge fully. We saw that all staff working in the unit had had an appraisal within the last year.

Staff told us that they did not feel that they were able to access training opportunities very easily; they told us that recently they had been asked to implement a change to treatment for patients with fractures but had not been able to access the training that was provided by the trust as part of the change.

Care and treatment was provided using evidence based guidance that complied with national guidance and advice given by external bodies such as the National Institute for Health and Care Excellence (NICE).

Patients were assessed promptly for pain and appropriate relief and this was administered quickly, staff were able to provide medication via a number of routes including soluble medication for those who had difficulty swallowing.

The unit was complying with department of health guidance that all patients should be seen and either treated or admitted within four hours.

Evidence-based care and treatment and outcomes

- Policies and guidance available to staff followed guidance from a number of external advisory bodies such as the Royal College of Emergency Medicine (RCEM) and the National Institute for Health and Care Excellence (NICE).
- We reviewed 25 patient treatment records and found that decisions relating to treatment followed guidance outlined in the units policies and procedures.
- Guidance documents were available for staff to read in the staff room.
- Changes in practice were discussed at staff meetings or emailed to staff.
- The unit was not undertaking any clinical audits and had not been included in any wider trust clinical audits.
- Other units in the division were taking part in audits that would have had implications for the clinical practice of staff working in the MIU, however the results of these audits were not shared meaning that learning was not maximised across the organisation.

Pain relief

- We examined records and found that pain relief was given promptly to those who required it.
- In all 25 records we reviewed we found that pain level had been discussed.
- The unit had a variety of different pain medicines which could be used depending on the situation.
- Staff were also able to provide pain relief in soluble form for those who had swallowing difficulties or for children.

Minor injuries unit

Competent staff

- We saw documentation that showed that all staff had undergone an appraisal in the last year.
- Staff did not undertake regular supervision from a senior clinician or manager. Whilst there was an expectation that staff would attend training and group supervision this was not mandated and staff told us they found it difficult to attend this as it was in another location. The ENPs in this location worked in an autonomous way and the lack of effective supervision meant staff were not as effectively supported in their roles as they should have been.
- Staff told us they did not feel included in training and development and noted that none of the training is hosted at their location and is often cancelled on the day due to organisational pressure. A recent change in practice involving a new system to review and support those with fractures and to reduce the number of patients attending fracture clinic was due to be implemented shortly after our inspection. This involved staff applying new types of limb support and accessing a new referral pathway. However staff told us they had not been able to access training for this despite being asked to implement a different treatment regime. This meant that patients may have been treated by staff who had not received full training.

Multidisciplinary working

- Staff at the unit were able to link with community services and GPs if required. We saw good interaction between the nursing and administrative staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff told us that they sought verbal or implied consent due to the nature of the conditions people attending the unit presented with. We observed staff requesting consent from patients during their consultation.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and could access advice from the safeguarding lead if required.
- In the case of children and young people and those unable to give informed consent staff were clear about their responsibilities with regard to those with parental responsibility and family members.
- Staff we spoke to were also clear about involving young people and children in their care and explaining their treatment options in a way they could easily understand.
- There was written information displayed that informed those using the service that their details may be shared with other agencies.

Are minor injuries unit services caring?

Good

We rated this service as good for caring.

Staff treated people with dignity and respect. Patients spoke very positively about the staff they had seen on the day of our inspection as well as previous attendances. We witnessed very positive interactions between staff and those using the service. We saw staff use a combination of verbal and non-verbal reassurance and welcome patients to the unit in a friendly manner.

We reviewed some patient satisfaction surveys and a recent survey found all of the 13 patients who had responded would be likely or extremely likely to recommend the service. This placed the service second out of the 51 services audited in the trust.

Compassionate care

- We saw a number of interactions between patients and staff. Without exception these were positive in nature with staff protecting people's dignity and actively listening.
- We saw a number of patient satisfaction comment cards. These were positive with people describing care as 'excellent' and staff as 'helpful'.
- People using the service told us they were very pleased with the standard of care.
- Patients were assessed and treated in clinical rooms with doors which ensured both privacy and dignity were maintained. However when patients booked into reception, the reception area did not have screen which meant other people within the vicinity were able to hear personal information being discussed.
- During our inspection we noted that staff would only discuss patients' medical conditions in areas that were well away from public areas so that these conversations where not overheard.

Minor injuries unit

- We witnessed staff discussing patient's injuries and the impact the injury would have on not only their physical health but also their activities of daily living. In this way staff ensured that care was delivered in a way that treated the key aspects of person's daily activities.
- Even though some of the conditions that people came to seek treatment for where sometimes very minor staff were seen to take care to ensure that people using the service felt welcome
- We witnessed a staff member reassure a person using the service that they were not wasting people's time and in this way helped to reduce their anxiety.

Emotional Support

- Staff were clear about the importance of providing patients with emotional support. We saw staff provide emotional support to people who were in discomfort.
- When we spoke to staff it was clear that they understood that even very minor injuries can have an emotional impact requiring support and reassurance.

Understanding and involvement of patients and those close to them

- Every person we spoke with was clear about what on-going treatment and appointments would be required. Patients that we spoke with at the end of their treatment said they felt that staff had listened to them and explained their diagnosis in a way they could understand.
- When we looked over the few negative comments that had been made about the service in recent months in the friends and family survey none of them criticised the care given by staff.
- Staff were very clear about how they could access additional support from outside agencies for people who were vulnerable following an injury. For example there was a referral pathway for staff to alert other services involved if they had treated someone with learning difficulties.
- When people were discharged from the unit they were given appropriate leaflets and information on where they could seek further information as well as the plan for ongoing care.
- On a number of occasions we heard staff check with people they were treating that they understood their treatment plan and had the opportunity to ask questions.

Are minor injuries unit services responsive to people's needs?

(for example, to feedback?)

Good

We found that this service was good for responsiveness.

Patient flow through the department was very effective and people were seen in order of priority with those in the most need seen first. Patients told us they did not feel rushed when being treated. There was good access provided to those with mobility difficulties and suitable equipment for bariatric patients was also available.

The unit could only request x-rays within weekday office hours which led to patients having to be transferred to other units where x-ray was available. Staff accepted this led to a less responsive service at these times and a poorer patient experience. Whilst the patients who we spoke to who used the service where aware of the different hours of operation they found it frustrating.

There were patient information leaflets in the MIU, however, these were only available in English, and we also found that not all staff were clear how to access translation services.

Service planning and delivery to meet the needs of local people

- There was very limited flexibility in the staffing numbers if there was a sudden increase in demand. The manager told us they felt they could ask for more support should the need arise, however it was not always possible to provide extra staff in this eventuality.
- Staff worked hard to ensure patients were seen as quickly as possible, even at busy times and this was evident because the MIU was meeting the four hour target.
- There was a small children's play area in the main waiting room but there was no separate children's waiting area. These meant children were not effectively screened from the adult waiting room.
- At the MIU x-ray services were only available on weekdays between 9am and 5pm. Outside of this time patients had to either attend another unit or return when x-ray services were open, this meant there was a

difference in the standard of care delivered depending on when the patient arrived. Staff told us that after 4pm they tried to see potential fractures as a priority in order to request an x-ray in time; however this meant that other patients waited longer as a result.
- Patients we spoke with were all aware of the of x-ray opening hours, but described rushing to the unit in order to arrive in time. One person told us they believed that the MIU should be supported by the x-ray department during the MIU opening hours. Staff supported this view and told us that it impacted on their ability to offer a consistent service.

Meeting people's individual needs

- The unit had a combination of leaflets and notice boards which gave patients and relatives information about the process for assessment and treatment. We also saw a range of leaflets that gave advice on common conditions and effective self-care steps.
- Patients were assessed and treated in self-contained consultation rooms with curtains so that privacy and dignity was maintained during consultation,
- There was no audio or visual screening at reception which was situated close to the waiting area which meant people's details could be overheard.
- There was very little information available for people who did not speak English. Staff told us they had a book of common phrases for a number of common languages, however when we looked at this book we found that it did not provide staff with common answers to the questions posed, which meant staff were unable to reply.
- There was good access for people with mobility difficulties and provision had been made to ensure step free access to clinical rooms.
- We saw that there were a number of toys and other items for distracting young children during frightening or painful procedures.
- There was provision in place for bariatric patients and equipment in place to treat them safely.

Access and Flow

- The unit met the Department of Health target to treat, transfer or discharge 95% of its patients within four hours. Staff said when people did wait for longer than four hours, which was very unusual, it was due to either ambulance delays in them being transferred to a more appropriate setting or because staff were waiting for a specialist opinion.
- We asked the trust to provide us with data showing how long it took for people arriving at the unit to be reviewed by an ENP; however they were unable to provide data for this unit.
- The route for patients was streamlined and well laid out; there was clear signposting to areas of the department and clinical rooms were located along a central corridor. This meant that it was clear for people to direct themselves around the unit to various areas including x-ray

Learning from complaints and concerns

- The manager of the unit displayed a number of recent 'thank you' cards in the staff rooms and staff told us they felt that compliments were communicated with them very effectively.
- We looked at all the correspondence from a recent complaint and saw that at the conclusion of the investigation the person who had made the complaint was happy with the outcome. The complaint had been resolved within a short timescale and the findings were thorough and detailed.
- Staff told us they knew how to escalate complaints to the appropriate manager.
- The unit manager told us they felt supported in answering complaints and could access support if required.
- Complaints formed part of the agenda for staff meetings which helped to avoid repetition and improve future learning we saw this was documented in the meetings minutes.
- In the previous year data from the trust showed that the unit had received one complaint. We saw that this had been responded to within the agreed time frame.

Are minor injuries unit services well-led?

Requires improvement

This service required improvement for being well led.

Governance arrangements were not effective The unit did not have its own clinical governance meeting and we were

told any governance issues would be discussed at the divisional clinical governance meeting although this was not recorded. This meant that specific governance issues relating to the minor injury unit was not fully explored

At local level staff told us they felt supported by their manager and their team. Staff told us they felt that more senior managers were not visible enough, though they understood this was because they had a number of areas to manage.

Staff also told us they felt marginalised by the wider organisation and not included in discussions about new changes to patient pathways that directly affected them. One example of this was the changes that had recently been made to the process for onward management of fractures. Staff told us they did not feel part of this change and had not been consulted about how best to implement it in their area.

Staff told us that no member of the trust board had visited the unit for a considerable period of time and whilst they were aware of the trusts objectives they felt some members of the senior team were not entirely clear about how the minor injury unit functioned.

There was information available to people using the service asking for their views and we saw that there was engagement with the public. Staff were less clear about how senior management engaged with them and were not sure about what the results of the last staff survey were.

Vision and strategy for this service

- All staff understood the vision for the service and told us that they aimed to provide the best care possible for the patients that they treated.
- There were a number of new posters outlining the trust's vision for providing safe care in a friendly, listening and informative way. The interactions that we witnessed between staff and patients was very much in line with this approach
- Staff were clear about the broad vision of the trust but did not feel the MIU was valued sufficiently by the executive team. Staff, some of whom had worked at the unit for a number of years told us they had never seen a member of the trust board in the unit. The trust subsequently informed us that both the Medical Director and Director of Operations (unscheduled care) had visited the MIU recently.
- Most of the staff had worked for the organisation for a long time and had not attended any training or information sessions on the organisations future direction.
- One member of staff told us that the only strategy they had been involved in was how to prepare for the Care Quality Commission inspection.

Governance, risk management and quality measurement

- Staff were aware of the measurement performance activity and Department of Health targets for Emergency Care.
- The unit did not have its own clinical governance meeting and we were told any governance issues would be discussed at the divisional clinical governance meeting. We looked at minutes for the last two clinical governance meetings and saw that there was no documented discussion regarding how to implement the decisions made in the minor injury unit. One example of this was the divisions' strategy for treating a patient with suspected Ebola, which did not mention any variation in practice at the minor injury unit compared to the ED. This meant that specific governance issues relating to the minor injury units were not fully explored.
- We saw documentation that showed that risks that had been identified such as cold weather or a medical device recall were discussed at unit meetings or at handovers at the beginning of the day

Leadership of service

- Within the unit there was a clearly defined leadership structure and a visible unit manager. The unit manager was given some time to perform management tasks. However they told us that sometimes it was not possible to undertake all the managerial work within the allotted time. The manager told us that this was due to their clinical commitments
- The unit manager told us they felt that, apart from job title there was no recognition of the extra responsibilities that they had.
- Staff felt that they were well supported by their direct manager although they felt that the manager with overall responsibility for the service was managing the MIU, an urgent care centre and an emergency

department was not very visible. More than one member of staff told us that this manager had a very large remit and they understood the pressures they were under.
- Senior managers responsible for the service was available by phone and e-mail but also managed other areas of the trust. This meant that senior management support was very rarely on site.
- The unit manager told us that they worked clinically most of the week and supported other staff.

Culture within the service

- Staff told us they felt able to raise concerns with their manager and that these concerns would be acted upon and the staff we spoke with gave us examples of these, one example of this was a medical device that was dated and was possibly giving unreliable results in some groups of patients, this had been escalated and was currently under consideration by senior management.
- Staff told us that morale within the team was good and the team members supported each other. Staff consistently told us that their support came from the team they worked with and their unit manager rather than anyone in a more senior role in the organisation

Public and staff engagement

- Information on how the public could provide feedback was displayed in the waiting room and also on the trust website. We reviewed the latest report containing feedback from those who used the service and their relatives. Feedback was overwhelmingly positive, with many positive comments about staff attitude. Common areas for improvement identified by patients included adequate car parking and more comfortable chairs in the waiting room.
- Staff told us that they felt they had limited engagement with the trust as a whole and did not feel that the members of the trust board valued the views they had on the service.

Innovation, improvement and sustainability

- Given the service's low profile within the trust, we saw limited evidence of continuous learning, improvement and innovation throughout the MIU.

Surgery

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

Information about the service

St Albans hospital is a local general hospital offering a range of services, including a minor injuries unit. In September 2007 a new elective care centre opened at the hospital and St Albans has been the site for the majority of planned surgery in West Hertfordshire which includes both inpatient low risk surgery and day-cases.

St Albans has six theatres and 40 elective surgery beds. It sees up to 70,000 out-patients a year. St Albans hospital also provides a wide range of diagnostic, outpatients and ophthalmology facilitates.

We carried out a visit of St Albans Hospital as part of our announced inspection on 15, 16 and 17 April 2015. St Albans is part of West Hertfordshire NHS Trust and provides specialist services and has close links with other specialist hospitals.

St. Albans offers a wide range of treatment and services which included for example; endocrine and gallbladder surgery, the repair of femora hernias and varicose vein stripping. The breast care unit was formed in 2005. This unit sees and investigates around 3,000 new patients per year.

The trust's information system identified that within the surgical services 74% were day cases and 26% were elective cases.

We spoke with 16 patients. We observed care and treatment and looked at nine care records. We spoke with 39 staff which included nurses, doctors, consultants, ward managers and therapists. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the hospital.

Surgery

Summary of findings

Overall, we found that the service was inadequate.

We found the environment in the theatre changing rooms was not suitably maintained.

Although there was a culture of incident reporting, staff on the ward and in the day surgery unit said they had not received feedback on those they had reported. We saw incident reports on De La Mare ward which had not been addressed.

There were six theatres at St. Albans. However, during our visit Theatre 4 was closed due to issues relating to the ventilation system This issue had been identified on the trust's risk register for over 12 months and there was no evidence that this issue had been acted upon in a timely manner. The trust acknowledged this and recognised that their governance systems in managing such risks had not been optimal.

We observed that staff were not following infection prevention and control guidelines on De La Mare ward. This was brought to the attention of the ward manager. We observed this had been addressed upon our return to the ward.

The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls which were identified in the records seen. The environments were visibly clean. The hospital's surgical safety checklist was fully completed for all patients. Patients were appropriately escalated if their condition deteriorated. Medical handovers were well structured within the wards visited. There was secure storage of medicines on the ward, the recovery and day surgery unit.

Medical staffing was appropriate and there was good emergency cover. Although there was a recognised shortage of nursing staff across the service, we found that the service was appropriately staffed with the use of bank/agency staff.

The surgical services provided effective care and treatment that followed national clinical guidelines. Staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with services in similar-sized hospitals and performed in line with the England average for most safety and clinical performance measures. There was good practice, for example, in pain management, and the monitoring of nutrition and hydration of patients in the perioperative period. Multidisciplinary working was evident. Staff had access to training and most staff had received annual appraisal. Staff said they had not received regular supervision. Consultant-led, seven-day services had been developed and were embedded into the service.

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff who worked well as part of a multi-disciplinary team. Staff sought consent from patients prior to delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The average length of stay for elective patients across the hospital was longer than the England average in two of the specialities. The surgical services had taken action to reduce the length of stay for patients by using enhanced recovery care pathways

Patients told us that staff treated them in a caring way and were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect. The friend and family test showed that 98% of patients were extremely likely to recommend the trust to family and friends.

Surgical services were not responsive overall. The national time of 18 weeks between referral and surgery was not being met in some specialisms. The trust utilised the enhanced recovery programme to promote patient recovery after having surgery.

There was support for people with a learning disability and reasonable adjustments were made. For example, patients were given longer surgical time to take account of any anxiety. Staff were able to refer any issues or concerns to the learning disability lead. We saw some information leaflets were available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were dealt with.

We found well-led was inadequate. Although there were clinical governance systems in place that allowed risks to be escalated we found that, when issues were

Surgery

identified, timely action was not always taken by the trust to address those risks: for example, the closure of Theatre 4. Senior staff on De La Mare were unaware of the registered risks associated with the ward and did not know how identified risk should be included on the risk register and the subsequent action to be taken.

The trust had completed local as well as national audits, for example a record keeping audit which ensured the records were accurate and compliant with national standards. During our visit to De La Mare the audits showed the ward was compliant regarding infection control and hand hygiene practices. During our visit we observed nursing, medical and therapy staff not adhering to safe hygiene procedures. This meant that the ward matrons did not monitor the audits produced to ensure good practice.

Patient safety was monitored and incidents were investigated. Some staff said they had not received feedback on incidents. This meant that some staff were not involved in learning from incidents to improve care delivery to patients. The surgical services provided care and treatment that followed national clinical guidelines and local clinical audits. Staff used care pathways effectively. Patients received care and treatment by trained, competent staff who worked well as part of a multidisciplinary team (MDT). Patients spoke positively about their care and treatment from staff. Patients were treated with dignity and received compassionate care

There was effective teamwork and clearly visible local leadership within the surgical services. The majority of staff were positive about the culture and support available across the surgical services.

There was routine public and staff engagement and actions were taken to improve the services. The staff we spoke with told us that they received good support and regular communication from their line managers.

Are surgery services safe?

Inadequate

We found surgical services was inadequate for safety.

The environment in the ladies' changing room within theatre was not maintained suitably. During our inspection we saw tiles were missing off the wall and there was a potential risk of cross infection due to the possibility of the exposed wall not being appropriately cleaned or decontaminated. We also observed dirty clothes left against the wall in the ladies' changing room.

Theatre 4 was closed due to issues relating to the ventilation system. This issue had been identified on the trusts risk register for over 12 months and there was no evidence that this issue had been acted upon in a timely manner. The trust has acknowledged this and recognised that their governance systems in managing such risks had not been optimal.

We observed that staff were not following infection prevention and control guidelines on De La Mare ward. This was brought to the attention of the ward manager at the time of the inspection. We observed this had been addressed upon our return to the ward.

Staff told us they were encouraged to report any incidents which were discussed at weekly meetings. However, there was inconsistent feedback and learning from incidents reported.

We saw there were 30 incidents outstanding and waiting to be addressed during our visit to De La Mare ward.

We found that only 78% of staff at the day surgery unit and 77% on De La Mare had completed their mandatory training.

The records seen on De La Mare ward showed that only 10% of staff had received safeguarding vulnerable adults training. However, the mandatory training records provided by the trust showed that 71% of staff were compliant with their training as of April 2015.

Although there was a recognised shortage of nursing staff across the service we found that the staffing levels and skill mix were sufficient to meet patients' needs and staff assessed and responded to patient risks.

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Medicines were stored safely and given to patients in a timely manner.

The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls which were identified in the records seen.

The hospital's surgical safety checklist was fully completed for all patients. Patients were appropriately escalated if their condition deteriorated. Medical handovers were well structured.

There was access to appropriate equipment to provide safe care and treatment

Incidents

- There had been no "never events" within surgery. A Never Event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented.
- Between February 2014 and January 2015, the Strategic Executive Information System (STEIS) data showed that there had been 46 serious incidents reported in relation to surgical services across the trust. During the inspection, we saw evidence that these incidents had been investigated and remedial actions implemented to improve patient care. The most frequently reported incident type was pressure ulcer grade 3. Other reported incidents included drug incidents and C. Difficile and health care acquired infections.
- Some staff said they had not received any feedback on incidents reported.
- On our visit to De La Mare ward, we saw there were 30 outstanding incidents waiting to be addressed. This meant that incidents that staff had reported had not been assessed and therefore actions to prevent these reoccurring were not evaluated or where necessary taken to prevent potential harm to patients.
- Theatre staff said they were encouraged to report incidents. Incidents were discussed at weekly meetings. Information provided showed that all incidents in the surgical services had been addressed in a timely manner. Examples included sharps injuries and incomplete documentation regarding patients' allergies. We saw a change in practice as a result of incidents whereby the femoral head on a prosthesis was added onto the "swab board." We saw a form in place to note the size required and only one was requested and brought to theatre. Staff said this emphasized the importance of documentation and the need for the correct size to be written down.
- Staff had responded to an increase in falls by improving the monitoring of patients, and when required, this was supported by the trust with extra staff.
- The records showed that there had been no falls within the surgical services from July 2014 to December 2014. We saw completed risk assessments which had identified the risk.
- In operating theatres, the staff had implemented robust measure to reduce the likelihood of pressure ulcers developing during operations. Risk assessments were completed for patients having operations, and appropriate devices were used, such as heel pads and arm supports to reduce pressure damage.
- Senior staff were able to tell us of the new duty of candour regulations. They said the trust was committed to being open and transparent in their approach to safe care. They said they were incorporating the new duty of candour regulations during team meeting discussions to ensure that this was cascaded to staff.
- NHS safety thermometer information was displayed at the entrance to the ward and the day surgery unit so that all staff were aware of the performance in their ward or department. This included information about infections, new pressure ulcers, new urinary tract infections (UTIs) and venous thromboembolism (VTE).
- For surgical services, frequency rates of catheter urinary tract infections (C.UTIs) have remained low throughout December 2013 and December 2014. We saw there were five recorded C.UTIs during this period. The records showed that there had been no falls recorded from July 2014 and December 2014.
- The number of pressure ulcers had increased slightly over the services. There were 18 recorded incidents from February 2014 to January 2015 across the trust. Care and treatment records showed that appropriate risk assessments were carried out upon admission to the wards at St. Albans Hospital and patients identified as being at risk had the appropriate care plans and supporting equipment (e.g. pressure-relieving mattresses) in place to minimise the risk of acquiring a pressure ulcer.

Cleanliness, infection control and hygiene

Surgery

- The surgical ward and day surgery unit visited were visibly clean with the appropriate green "I am clean" sticker on the equipment being used.
- Instructions and advice on infection control were displayed in the services' entrances for patients and visitors, including performance on preventing and reducing infection. Personal and protective equipment, such as gloves and aprons, were available in sufficient quantities.
- There was a high awareness among staff about infection control. Staff said they followed the trust policy on infection control. However, during our visit to De La Mare ward we observed medical and nursing staff not washing their hands and using hand gel between patients. This was brought to the attention of the ward manager during our visit. We observed during our revisit staff adhering to the use of hand gel. Staff told us the manager had called a meeting to discuss infection control and hygiene procedures following our visit. We observed adherence to 'bare below the elbow' policy in clinical areas.
- In the ward areas, staff had audited performance on adherence to infection prevention and control measures, reports were shared with staff at meetings and on noticeboards.
- We found soiled theatre scrubs piled up against the walls in the ladies theatre changing room. This meant there was a risk of contamination to people who may enter the changing room.
- We attended a staff meeting which discussed the cleaning audits for theatre. We saw the results which showed that clinical areas were 95% compliant and outside areas at 85%.
- Patients' belongings were placed in a blue box beneath the bedside chairs. We saw these were cleaned in-between patients.
- Managers and staff completed audits to check that bacteriological screening of patients had been completed prior to admission. All patients prior to elective surgery had been fully screened for hospital acquired infections.
- Effective decontamination of surgical instruments is critical in the management of healthcare associated infection and patient safety. We were informed that the theatre sterile surgical unit (TSSU) was conducted off site. Staff said they had no issues or concerns regarding the sterility of equipment.
- We observed the "spill" station was wall mounted with no issues or concerns identified.
- The theatres were cleaned overnight by allocated cleaners. There was two hours assigned at lunch time for offices, changing rooms and kitchens. The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines.

Environment and equipment

- There were six theatres at St. Albans. During our visit, Theatre 4 was closed due to issues relating to the ventilation system. This issue had been identified on the trust's risk register for over 12 months and there was no evidence that a previous external report relating to this issue had been acted upon in a timely manner. The trust acknowledged this and recognised that their governance systems in managing such risks had not been optimal.
- We saw the remaining theatres were clean and well maintained. All the theatre areas were free from clutter and we saw that equipment and consumable items were stored appropriately. We observed that stored equipment had "I am clean" green stickers on them which were signed and dated.
- Medical equipment had up to date checks. These had been bar coded as "asset checked."
- The ladies changing room was in a poor state of repair for example, we saw tiles off the walls in the shower area. The wear and tear of the general environment within the ladies changing room meant that there was a potential infection control risk because the sections with exposed wall may not be appropriately cleaned or decontaminated.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.
- Staff completed equipment checks of all bedside areas each morning. This included the oxygen cylinders, lights and call bells.
- We observed that the beds on De La Mare ward had two electrical sockets allocated. The ward manager told us this was insufficient to carry out day to day checks on patients and they currently ran extra cables from electrical wall sockets. We saw these sockets in use during our visit. The manager said the lack of electrical sockets had caused problems with the deflation of electrical beds. The ward manager said that patients

were unintentionally unplugging the electrical beds for their own personal for example; mobile phones and "I" pads. They said this problem had now been resolved and patients were made aware of unplugging essential equipment.
- Reusable surgical instruments were sterilised off site. Theatre staff told us they had access to the equipment they needed to meet patients' needs.

Medicines

- We saw two units of "O" negative blood was routinely kept in the blood fridge. We saw the checks for the reading and changing of bloods were up to date.
- The surgical services had two transfer bags. We observed the drugs had the expiry dates highlighted on laminated sheets. Staff said there were plans for the operating department practitioner (ODP) to hold the crash bleep. This was currently held by the nursing staff and an anaesthetist.
- Medicines within the wards were stored correctly, including in locked cupboards or fridges when necessary. We found that medicines were ordered and disposed of in a safe and appropriate manner.
- However, we found there was no audit of the stock medicines retained in the clinical room of the day surgery unit.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed that a pharmacist carried out reviews on De La Mare ward.
- We examined the controlled drug (CD) registers and found these to be appropriately completed, with CDs checked at the beginning and end of each operating sessions.
- We looked at the temperature of the medicine fridge on the day surgery unit and saw there were gaps in the recordings. This was brought to the attention of the ward manager. During our re-visit to the service we observed that procedures were in place regarding the monitoring of stock and the recording of fridge temperatures.
- We looked at the medication charts for six patients on the day surgery unit and De La Mare ward and found these to be complete, up to date and reviewed on a regular basis. We saw that antimicrobial prescribing stop and review dates were completed and reasons for any medicines not given were documented clearly. Medicines given to patients 'as required' had minimum and maximum doses recorded.
- We observed the temperature for the medicine clinical room within the recovery area was at 25 degrees Celsius which is the maximum temperature most medicines should be stored. There was no temperature check in place to monitor this. We brought this to the attention of the ward staff. During our re-visit to the recovery ward we observed that staff had implemented the temperature check of the clinical room which we saw was being completed.
- We saw the medicine audit for De La Mare which showed they were a 100% compliant. Areas covered included; medicine storage, fridge temperatures and drugs were securely locked.

Records

- Staff used paper-based patient records and these were securely stored in each area we inspected.
- In the surgical ward and day surgery unit we looked at nine patients' case records. The medical and nursing notes were structured, legible, complete and up to date. This included assessments for patients treated in operating theatres. There were detailed and comprehensive pre-operative assessments made on patients prior to admission. Important information was raised as an alert message to anaesthetists and the theatre team for example, a patient's allergy to medicines. The five steps to safer surgery checklist records were completed for all patients.
- Patient records included risk assessments, for example for patient falls, venous thromboembolism (VTE), pressure care or nutritional risks.
- The wards had care plans to identify what care should be given to patients. This meant that agency nurses who were new on the wards had access to information on how to care for a patient.
- Comfort rounds, 'turnarounds', were undertaken every two hours, this included change of position and pressure area care as required. We saw these were clearly documented in the records.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. However, the records seen showed that only 10% of staff had received

safeguarding vulnerable adults training on De La Mare ward. However, the mandatory training records provided by the trust showed that 71% of staff were compliant with their training. The ward manager said they were aware of the shortfall and they were arranging refresher training for all staff.
- Information on how to report adult and children's safeguarding concerns was displayed in each area we inspected.
- Staff in all clinical areas were able to identify abuse and report safeguarding concerns.
- The wards and theatres also had safeguarding link nurses in place. Staff told us that they could contact the hospital-wide safeguarding lead if they required additional guidance or support.

Mandatory training

- All new employees received a corporate and local induction that welcomed them to the trust and introduced them to their respective departments. All staff received mandatory training as part of their induction programme. The surgical team had designed their own induction programme.
- The mandatory training covered key topics such as infection control, information governance, manual handling and resuscitation training. The records showed that most staff had received their mandatory training. We found that 78% of staff at the day surgery unit and 77% on De La Mare had completed their mandatory training. In the Board Performance Report for March 2015, no target for compliance with mandatory training had been set for the trust overall.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and bed co-ordinators to address these risks.
- Upon admission to the surgical ward and prior to undergoing surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for VTE, pressure ulcers, nutritional needs, risk of falls and infection control risks. Patients identified as being at high risk were placed on care pathways. Care plans were in place to ensure that risks were mitigated and patients received the right level of care.
- The surgical wards used the national early warning score (NEWS) to identify if a patient was deteriorating. There were clear directions for actions to take when patients' scores increased, and staff were aware of these.
- Staff carried out 'intentional rounding' observations every two hours and this increased to hourly checks if there was a deterioration in the patient's medical condition.
- We saw the trust analysed the reasons for the transfer to Watford general hospital of patients whose condition had deteriorated. The records showed that six patients had been transferred from 07 January to 11 April 2015. Examples included post-operative bleeding and lumber haematoma.
- We spoke with staff in anaesthetic and recovery areas, and found that they were competent in recognising deteriorating patients. In addition to the early warning score, observation chart and procedures, pathways and protocols for different conditions or operations were used.
- The trust assessed the appropriateness of patients for surgery using the ASA physical status classification. For example; ASA1 meant the patient was healthy and ASA2 for mild systemic disease. Only patients with a status of 1-2 were initially considered at St Albans. However, due to pressures ASA3 (severe systemic disease) were being accepted. We saw that patients with a classification of ASA3 were reviewed on the morning of surgery. This meant that patients were appropriately assessed to ensure their safety prior to surgery.
- We observed the theatre teams undertaking the 'five steps to safer surgery' procedures, including use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- Staff carried out an audit to monitor adherence to the WHO checklist by reviewing the completed checklist record. We saw that St Albans had achieved 95% compliance in the completion of the checklist.
- We saw that new wall/door apertures were being built to protect clinical areas within the day surgery unit. Staff said this would prevent inappropriate persons entering the building and utilising their facilities. We observed the new wall/doors did not protect the reception staff or the waiting/TV room adjoining the reception area. We spoke with two receptionists who said they had no

concerns as a new intercom/CCTV system was to be installed at the main door to restrict entry from outside. Staff were unable to say when this system would be installed and we found no risk assessment in place to support staffs' safety.

Nursing staffing

- Nursing numbers were assessed using the national safer nursing tool and there were identified minimum staffing levels. The required and actual staffing numbers were displayed in the areas visited.
- Staffing 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 could be seconded when shortages occurred.
- The ward managers reported they were understaffed and vacancies were filled with bank and agency staff. We saw the NHS choices records for February 2015 which showed that the percentage of registered nurses day hours filled as planned was 94% with 100% for the night staff. With regard to unregistered care staff this showed 90% for the day staff and 86% for the night staff. They said some staff picked up additional shifts to support the wards and they used bank staff. They said they requested the same bank staff to ensure continuity within the wards.
- The trust board meeting report for April 2015 showed that as of 31 February 2015 the vacancy for registered nurses and midwives was 16% (229 whole time equivalent (WTE)) and 15% (83 WTE) across the trust. We saw that De La Mare ward was above the safer nursing care tool (SNCT) of 32.80 by 2.21 WTE. The records for January 2015 showed that the ward had achieved 100% for planned registered nurses and care staff. We observed this figure was slightly lower for night staff which averaged 97% for registered nurses and 87% for care staff. We saw the report identified the reasons for the lower percentage which included sickness and staff working clinically on another ward. This had resulted in the ward having an amber rating which equates to "staffing numbers not as expected with minor adjustments required to bring staffing to reasonable levels."
- We saw the records showed that six staff were allocated to the recovery area. However, on the day of our visit, they were one nurse down for the morning shift. This meant the recovery area could only accommodate five patients at any one time as all patients were supported on a one to one basis.
- Staff in both surgical wards and theatre said they recognised recruitment as a major safety risk to the service. It was captured on the directorate risk register. The management team told of various measures they had undertaken, such as open recruitment days and overseas recruitment initiatives to decrease the vacancy factor. Staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.
- Nursing handovers occurred at the change of shift. Staffing for the shift was discussed as well as any high-risk patients or potential issues

Surgical staffing

- The wards and theatres we inspected had a sufficient number of medical staff with an appropriate skill mix to ensure that patients were safe and received the right level of care.
- The health and social care information centre's (HSCIC) statistic data from September 2013 showed that the proportion of middle-career doctors (e.g. SHOs) within the surgical services was 21% compared with the England average of 11%. The ratio of junior doctors was also greater than the England average (19% compared with an average of 13%). The ratio of consultants was 33% compared with the England average of 40%. The ratio of registrars was also below the England average (26% compared with an average of 37%).
- One of the surgical consultants said that the medical staff were "excellent and dedicated." They said they had good knowledge and were very experienced.
- Locum doctors were used to cover for existing vacancies and to provide cover for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure that they understood the hospital's policies and procedures. We saw there was a high usage of locums on De La Mare ward. The trust told us that four regular agency Resident Local Medical Officers (RMOs), as part of a permanent contract, were used to cover De La Ware ward. These regular RMO's underwent recruitment checks and induction training to ensure that they understood the hospital policies and procedures.

Surgery

- We found that surgical consultants from all specialties were on call over a 24-hour period and there was sufficient medical cover out of hours and at weekends.
- Ward rounds took place twice a day. During the day all new patients were seen by an RMO within one hour following their admission.
- Staff told us there were no issues with the staffing levels within theatre.
- Handovers were consistently formalised and structured. During our announced visit we attended a ward handover. The handover covered care of patients based on the severity of their condition and any anticipated problems.

Major incident awareness and training

- Staff received mandatory training in resuscitation and had clear instructions for dealing with medical emergencies such as a patient going into cardiac arrest.
- There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff took part in quarterly simulations relating to deteriorating patients and the transfer of patients to Watford General Hospital when this was dictated by clinical needs. This was confirmed by staff.

Are surgery services effective?

Good

We found effectiveness within the surgical services to be good because:

The surgical service provided effective care and treatment that followed national clinical guidelines. Staff used care pathways effectively. The service participated in national and local clinical audits. The surgical service performed in line with services in similar-sized hospitals and performed in line with the England average for most safety and clinical performance measures.

The service demonstrated that care was provided in accordance with evidence-based national guidelines. National guidelines and pathways were used extensively, so that best practice was used to manage patient's care. 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.

Patient's pain was appropriately managed as was the nutrition and hydration of patients particularly in the perioperative period. Multidisciplinary working was evident to coordinate patient care. Staff had access to training. Most staff had received annual appraisal with the exception of the surgical team which showed a compliance percentage of 38%. The surgical manager confirmed they were aware of the shortfall and we saw dates had been allocated for staff to receive their annual appraisal. Staff said they had not received regular supervision. The surgical service had a consultant-led, seven-day service.

Patients received care and treatment by trained, competent staff who worked well as part of an MDT. Staff sought consent from patients prior to delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS).

The majority of patients had a positive outcome following their care and treatment. However, the average length of stay for elective patients across was longer than the England average in two of the specialities. The surgical services had taken action to reduce the length of stay for patients by using rapid recovery care pathways.

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.
- Staff in the surgical wards used enhanced care and rapid recovery pathways, in line with national guidance. We saw a copy of the orthopaedics and spinal pathway which identified the procedures to take. For example; referral to the spinal assessment service and the use of the STarT back screening tool for lower back pain. The aim of the STarT back screening tool is to classify back pain patients according to their risk of persistent pain and then to refer them to the appropriate treatments.
- Local policies such as the pressure ulcer prevention and management policies were written in line with national guidelines and staff we spoke with were aware of these policies. Staff had been allocated training dates for "BEST SHOT" pressure care awareness days.
- St Albans participated in the patient reported outcome measures (PROMS). All NHS patients having hip or knee replacements, varicose vein surgery or groin hernia surgery were invited to fill in PROMs questionnaires. The

questionnaire asks patients about their health and quality of life before and after they have had an operation. The results enables the NHS to measure and improve the quality of its care. We saw St Albans had achieved -1.08 which was below the national average of -0.21.

- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, orthopaedics and ear nose and throat (ENT). This focused on thorough pre-assessment, less invasive surgical techniques, pain relief and the management of fluids and diet, which helped patients to recover quickly post-operatively. We reviewed the enhanced recovery pathway documentation for colorectal surgery and both major and minor open liver surgery. There was clear guidance for staff regarding the recording of pre-operative care pathways.
- We saw NICE surgical site infection guidelines on display within De La Mare ward for staff.
- Findings from clinical audits conducted in the surgical services were reviewed at monthly clinical audit meetings and any changes to guidance along with the impact these would have on staff practice were discussed.
- We saw local completed audits for the day surgery unit and De La Mare ward. These included weekly pressure sores, legionella and hand hygiene audit and monthly weight audits.
- Nursing and medical staff told us that policies and procedures reflected current guidelines and were easily accessible via the hospital's intranet.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff monitored patient symptoms using a pain assessment score and carried out 'intentional rounding' observations at two-hourly intervals to identify patients who required pain relief.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- The nursing staff told us that they could access a pain management team if they needed additional support or guidance.
- Patients spoke positively about the way in which staff managed their pain relief symptoms and said that staff gave them analgesia as prescribed in a timely manner.

Nutrition and hydration

- The patient records we looked at included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool (MUST).
- Where patients were identified as being at risk, there were fluid and food charts in place. These were reviewed and updated by staff. Patient records also showed that there was regular dietician involvement where patients were identified as being at risk of malnutrition.
- Patients with difficulties eating and drinking were placed on special diets. Surgical wards used the red tray system so that patients living with dementia could be identified and supported by staff during mealtimes.
- The majority of 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.
- Patients on the day surgery unit said they were offered a cup of tea and a biscuit or piece of toast prior to leaving the ward.

Patient outcomes

- The surgical service had a performance dashboard that it used to monitor the quality of care provided.
- We saw the patient led assessment of the hospital care environment (PLACE) results. PLACE is utilised to measure the quality of the hospital environment in which care is delivered. We saw the results for St Albans showed they had achieved 95% for cleaning, 89% for food and hydration, 72% for privacy, dignity and well-being and 88% for condition, appearance and maintenance of the hospital.
- Theatre staff attended monthly mortality and morbidity meetings across the surgical specialities. The information was reported through the governance structure to ensure early intervention. The data was monitored by the central team and reported to the trust board. Between April and June 2013, the hospital standardised mortality ratio (HSMR) for West Hertfordshire hospital was 108. By the end of September 2014, it had dropped to 85. We saw the mortality rate at the trust had dropped by more than 21%. This was compared to a national decrease of 3.3%.
- Patients considered their outcomes as being good. One patient said they would be "happy to come back" to the hospital and another said the hospital was "brilliant."

- The trust's hospital episode statistic (HES) for July 2013 to June 2014 data showed that 28,774 patients were admitted for surgery at the hospital. HES 2013/14 data showed that 74% of patients underwent day case procedures and 26% underwent elective surgery at St Albans.

Competent staff

- All new staff undertook competency tests to ensure they had the necessary skills to carry out their role. Examples of areas covered included anaesthetics and care of deteriorating patients. We reviewed the record for a new staff member which had been completed and signed by senior staff.
- Agency and locum staff underwent recruitment checks and induction training prior to commencing employment.
- The records showed that 38% of staff in the surgical specialties had completed their annual appraisal whilst 100% of staff on the day surgery unit and De La Mare ward had received their appraisals. The surgical manager confirmed they were aware of the shortfall and we saw dates had been allocated for staff to receive their annual appraisal.
- Staff within the surgical specialities and De La Mare ward confirmed they had not received clinical supervision.
- The General Medical Council (GMC) National training Scheme Survey for 2014 had a response rate of 98%. The average indicator score for five key indicators namely; adequate training, induction, handover, educational supervision and clinical supervision. Handover showed the least score at 62% with clinical supervision being the highest at 92%.
- Consultants underwent peer appraisals and were overseen by the associate medical director. The medical staff we spoke with did not highlight any concerns relating to appraisal and revalidation.
- Staff said they had been given the opportunity to progress through additional learning. One staff member said they had undertaken the postgraduate certificate in education in research and healthcare. Another said they had been encouraged by their consultant to complete the "perioperative specialist practitioner" course.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us that they were supported well by their line management.

Multidisciplinary working

- There was daily communication between the multi-disciplinary teams within the surgical ward and theatres.
- Staff handover meetings took place during shift changes which ensured that staff had up-to-date information about risks and concerns.
- We observed a daily ward round. Medical and nursing staff were involved in these together with physiotherapists or occupational therapists as required.
- We observed a good working relationship between theatre and ward staff during our visit.
- Nursing staff said that they could access medical staff when needed to support patients' medical needs.
- Doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical ward and the day surgery unit.
- Patients' records showed they were referred, assessed and reviewed by dieticians and the pain management team when required.
- There was good interaction with the learning disability lead, which was able to provide advice and support to surgical teams.
- There was dedicated pharmacy support on the ward we visited which helped to speed up patient discharges with take home medicines.
- The records viewed identified family involvement at admission to encourage effective discharge.
- Staff described the multidisciplinary team as being very supportive of each other. Health professionals told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.

Seven-day service

- Staff rotas showed that nursing staff levels were sufficiently maintained out of hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by doctors as well as by on-site and on-call consultant cover. Newly admitted patients were seen by a consultant at the weekends. Existing patients on the surgical wards were seen by the doctor on duty during the weekends.

- Imaging services, for example x-rays were not available at weekend. Staff said this caused a problem as patients were referred to Watford General Hospital for these procedures at weekends.
- Surgeons undertook Saturday working to clear the outstanding patient lists. Staff said there were occasions when they supported the surgical team on Sunday's. We were told and saw the lists were covered by bank staff and/or long term agency staff.

Access to information

- The hospital used paper-based patient records. The patient records we looked at were complete, up to date and easy to follow. The records we looked at contained detailed patient information from admission and surgery through to discharge within the patient record. This meant that staff could access all the information needed about the patient at any time during the patient journey.
- Discharge letters given to patients and sent to GPs were written by the responsible medical staff and included all the relevant clinical information relating to the patient's stay at the hospital.
- Staff told us that information about patients was easily accessible.
- We saw that information such as staffing levels, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the hospital's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were seen by the consultant or their registrar and the anaesthetist prior to their surgery. They obtained consent to the procedure on the day. The ward manager told us they were planning to organise consent prior to the patients' arrival on the day.
- The nursing and medical staff we spoke with had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear about how they sought verbal informed consent and written consent before providing care or treatment.
- Patient records showed that verbal or written consent had been obtained from patients or their representatives and that planned care was delivered with their agreement. We observed consent being obtained prior to surgery.
- Patients confirmed they had received clear explanations and guidance about the surgery and said they understood what they were consenting to.
- Staff we spoke with had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) and were clear about their roles and responsibilities.
- Where patients did not have capacity to consent, formal best interest decisions were taken in deciding the treatment and care patients required.
- Where patients lacked the capacity to make their own decisions, staff told us that they sought consent from their carers or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals, in accordance with the hospital's 'best interests decision-making policy'.

Are surgery services caring?

Good

We rated caring within the surgical services to be good.

Patients spoke positively about their care and treatment. They said staff were brilliant and provided exceptional care.

We observed staff were caring and compassionate to patients' needs and treated patients with dignity and respect.

Patients said they were kept informed and felt involved in the treatment received.

The Friends and Family Test showed that 98% of patients were extremely likely to recommend the trust to family and friends.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. One patient told us that nurses always answer the call bell "promptly."
- During our inspection, we spoke with 16 patients. All the patients we spoke with said that they thought that

nursing staff were kind and caring. One patient said that they would be "happy to come back" to St Albans if they needed further treatment. Another said that both the service and staff were "brilliant" and "very professional."
- We observed staff in theatre being kind and caring and providing a full explanation to the patient of their procedure. We saw staff providing attention to their privacy and dignity.
- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that curtains were drawn in the ward bays to ensure that patients' privacy and dignity were maintained.
- The NHS Friends and Family Test (FTT) results were displayed within the wards. We saw posters encouraging patients to feedback so they could improve the care provided. We saw the results from 151 responses which showed that 98% of patients were "extremely likely" to recommend the trust to family and friends.
- We attended a ward round and saw that doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- The matron for surgical specialties told us that response rates were monitored and discussed at monthly meetings to raise staff awareness. In order to improve response rates, the Friends and Family Test had been added to the nurses' discharge checklist to prompt staff during patient discharges.

Understanding and involvement of patients and those close to them

- Staff respected patients' right to make choices about their care. We observed staff speaking with patients clearly and in a way they could understand.
- The patient records we looked at included pre-admission and pre-operative assessments that took into account individual patient preferences and records of discussions with patients' relatives.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- The patients we spoke with told us that they were kept informed about their treatment. Patients spoke positively about the information they received verbally and also in the form of written materials for example; advice for patients having skin surgery. This included what to do if the area showed signs of infection and how to keep the wound clean.
- We observed a medical ward round which included input from the nursing staff and other health professionals, such as physiotherapists and social workers if needed.

Emotional support

- Staff understood the importance of providing patients with emotional support. The patients we spoke with told us that they were supported with their emotional needs. One patient told us they experienced anxiety following surgery and the ward staff were helpful and supportive.
- Staff said that visitors/relatives were not invited onto the day surgery unit unless the patient presented as being very anxious or diagnosed as being vulnerable.

Are surgery services responsive?

Requires improvement

We rated the responsiveness of surgical services required improvement.

NHS England data for April 2013 to November 2014 showed that national targets for 18- week referral to treatment (RTT) standards for general surgery, oral surgery, ENT, urology, ophthalmology, and trauma and orthopaedics ranged between 69% and 87% during this period, which meant that the hospital was not meeting the waiting time target of 90% for these specialties. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standards.

The trust's surgical services did not meet the England average of 5% for patients whose operation was cancelled and were not treated within 28 days.

The trust utilised the enhanced recovery programme to support patients in their recovery after having major surgery.

Patients experienced delayed transfers of care to other providers, such as community intermediate care or nursing homes. We saw the service worked closely with the local authority and social workers attended ward meetings when required.

There was support for people with a learning disability and reasonable adjustments were made. For example, patients

were given longer surgical time to take account of any anxiety. Staff were able to refer any issues or concerns to the learning disability lead. We saw some information leaflets were available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were dealt with.

Service planning and delivery to meet the needs of local people

- The hospital provided a range of elective surgical services for the local community. This included orthopaedics, ophthalmology and general surgery (such as gallbladder surgery).The hospital provided breast surgery services for patients but did not offer paediatric or emergency services.
- NHS England data for April 2013 to November 2014 showed that national targets for 18- week referral to treatment (RTT) standards for general surgery, oral surgery, ENT, urology, ophthalmology, and trauma and orthopaedics ranged between 69% and 87% during this period, which meant that the trust was not meeting the waiting time target of 90% for these specialties. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standards.
- The hospital had a total of six operating theatres. On the days of our visit one of the theatres was temporarily closed.
- 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 with elective (planned) surgery were admitted to the surgical admissions ward. They were seen by the nurse and prepared for surgery and the post-operative ward.
- The surgical management team were working Saturdays to improve referral to treatment times and said that on occasions they had a Sunday theatre list.
- The surgical team attended weekly planning meetings and mapped the surgeries. For example; surgeries six weeks in advance were discussed, surgeries allocated in four weeks' time were re-offered to others if the theatres were not used. All planned theatre lists are locked down three weeks in advance thus enabling the surgery and admission team to appropriately book patients and order the relevant equipment as necessary.
- The hospital ran a scheduled list Monday to Thursday between 8am and 9pm and 8am and 6pm on Fridays.
- St Albans utilised the enhanced recovery programme. An enhanced recovery programme helps people recover more quickly after having major surgery. Areas covered included hips, knees, gynaecological, spinal and ear nose and throat. There was however no on-call process in place for the enhanced recovery team. We were told that the trust was looking to develop a high dependency unit (HDU) so an on-call service may be required in the future due to more complex/demanding surgery being performed.
- De La Mare ward had access to physiotherapist seven days a week. This was confirmed by the therapist spoken with and patients who said they saw them regularly. We observed good interaction between the physiotherapists and a patient when completing their exercises.
- We saw that 81% of patients had their symptoms discussed at the multi-disciplinary meetings against the England and Wales average of 96% in the lung cancer audit.

Access and flow

- During the inspection, the patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- The ward manager said they had introduced staggered appointment times to reduce the waiting times for patients. Patients were given morning or afternoon appointment times. The patients and staff we spoke with told us that patients were treated in a timely manner and patients did not experience extended waiting times.
- We observed a meeting with the admissions teams and bed managers to discuss suitability/numbers of admissions.
- Surgeons said they could accommodate changes to theatre lists to ensure the theatres' capacity were utilised. For example; the percentage of theatres utilised for the two weeks from 30 March and 10 April 2015 showed a range of between 78% and 84%.

Surgery

- Patients requiring overnight stays were accommodated by the surgical wards. Staff said they liaised with the wards and there were no issues or concerns in the obtaining of a bed. This was confirmed by the bed co-ordinator on the wards.
- We saw the theatre cancellation figures for 01 January to 16 April 2015 over the speciality services. General surgery showed that a total of 215 patients had been identified and 206 in ophthalmology. The report showed that 21 patients in general surgery had received their operation earlier, and 36 patients in ophthalmology were deemed not fit for the operation. Examples included a patient not fit for surgery at St Albans due to high body mass index (BMI), high blood pressure and urinary tract infections (UTIs).
- We saw the "did not attend" figures for October 2014 to March 2015. This showed that an average of 23 patients had not attended their appointments over this period.
- We saw the surgical services' patient snapshot for the pain team which identified an increase of referrals per calendar year. For example the records showed that in 2010; 920 referrals were made whereas the number of referrals for 2014 had increased to 1351. The record showed that for January 2015 they had received 85 referrals with a total of 199 patients not yet seen. These records showed that 140 patients had not been seen within four weeks.
- The average length of stay was below the national average for elective surgery at St Albans hospital. This included trauma and orthopaedics, breast surgery and general surgery.
- The hospital had a surgical pre-operative assessment unit. All patients attend up to 12 weeks prior to their surgery. As a routine all patients were asked to complete their personal details. We observed that some patients completed their medicine details. During our visit we found an error with a medicine details in a patient's record. The patient had written their dosage in milligrams instead of micrograms. This was brought to the attention of the manager. The manager confirmed they had a system whereby all medicine details were reviewed to ensure errors did not occur. They confirmed that they had not as yet reviewed the record we had identified and we saw the checklist had not been completed.
- Patients were checked for Methicillin-resistant Staphylococcus Aureus (MRSA) during their visit to the pre-operative assessment unit. Patients also underwent a general health check which included the taking of their pulse, blood pressure and urine sample.
- The trust's surgical services did not meet the England average of 5% for patients whose operation was cancelled and were not treated within 28 days. The records for April to September 2014 showed the average at just fewer than 10%. This resulted in three patients not been seen during July to September 2014. This showed a decrease from January to March 2014 when 11 patients had not been seen. In the trust's April 2015 Board performance report, there were 37 cases were patients had had their operation cancelled and not treated within 28 days in the year to February 2015, which was significantly above the trust target of zero cases.
- Patient records showed that discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists). Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure that patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patient's stay at the hospital.
- The discharge planning process started as soon as a patient was admitted onto a ward. This was overseen by the discharge coordinator. This detailed the reason for admission and any investigation results, treatment and discharge medicines. Staff told us discharge was often delayed due to waiting for signed discharge letters and "to take out" (TTO) medicines.
- Upon discharge, patients were either transferred to a discharge lounge or discharged directly from the wards, so staff could continue to monitor them during their wait.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us that they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- Staff told us that people with learning disability or anxiety were encouraged to visit the hospital so they

could become comfortable with the process. People with a learning disability were given longer surgical times which took into account their anxiety. Information leaflets and consent forms were not available in easy-to-read formats.

- Where staff were unable to communicate with patients, they could access communication cards that included easy-to-follow visual prompts. Ward staff also discussed patient needs with relatives or carers and these discussions were documented in the patient records we looked at.
- Ward staff told us that they applied 'reasonable adjustment' principles for patients with learning disabilities and we saw that specific care plans and risk assessments were in place to provide guidance for staff on how to care for patients with learning disabilities such as autism.
- A discharge summary was sent to a patient's GP upon discharge. This detailed the reason for admission and any investigation results, treatment and discharge medication.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access the leads to discuss any concerns and receive advice.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. We saw this was in an easy to read format. These included information on how to contact the customer care team, which included the Patient Advice and Liaison Service (PALS). We saw this was in an easy to read format
- The patients we spoke with were aware of the process for raising their concerns with the hospital.
- We saw that noticeboards included information such as the number of complaints and compliments received during the current month. The staff we spoke with understood the process for receiving and handling complaints.
- Formal complaints were recorded on the hospital's incident-reporting system and managed by the customer care team. The ward and theatre managers were responsible for investigating complaints within their areas.
- Staff told us that information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes reviewed.

Are surgery services well-led?

Inadequate

We rated well-led as inadequate due to concerns about governance and risk management.

We saw minutes which identified there was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. However, we found that there was not an effective system to manage risk.

Incidents were not always reviewed in a timely manner meaning that risks were not always identified and actions to prevent incidents reoccurring not taken.

When issues were identified, timely action was not always taken to address those risks: such as the Theatre 4's ventilation issue and on De La Mare ward there were 30 outstanding incidents waiting to be addressed.

Senior staff on De La Mare were unaware of the registered risks associated with the ward and did not know how identified risk should be included on the risk register and the subsequent action to be taken.

The trust had completed local as well as national audits, for example regular audit to ensure staff record keeping and accuracy were compliant with national standards. During our visit to De La Mare ward the audits showed the ward was compliant regarding infection control and hand hygiene practices. However, during our visit we observed nursing, medical and therapists not adhering to safe hygiene procedures. This was brought to the attention of the sister in charge of the ward.

There was effective teamwork and visible leadership within the surgical services. The majority of staff were positive about the culture and support available across the surgical services.

The surgical specialties had a clear vision and strategy with clear aims and objectives.

Surgery

The trust's quality strategy for 2014–19 included performance targets relating to patient experience, effectiveness of services and patient safety.

Some staff were unsure about the wider trust and the roles and responsibilities of senior trust leaders.

There was routine public and staff engagement and actions were taken to improve the services. Staff told us they received good support and regular communication from their line managers. Staff participated in team meetings across the wards and theatres we inspected.

Innovation was encouraged from all staff members across all disciplines. Staff said they were encouraged to develop new ideas and to make continuous improvement in the service provided.

Vision and strategy for this service

- The surgical specialties had a clear vision and strategy with clear aims and objectives.
- The trust's quality strategy for 2014 to 2019 included performance targets relating to patient experience, effectiveness of services and patient safety.
- The trust vision and values were visibly displayed across the wards and theatre areas we inspected and most staff had a good understanding of the vision and values.
- The trust's values included providing consistently good, safe care in a friendly, listening and informative way and always with dignity and respect.
- Staff were passionate about improving the service for patients to ensure they provided a quality service.

Governance, risk management and quality measurement

- During the inspection, we looked at the risk register for surgery and saw that key risks had been identified. However, staff on De La Mare ward told us they were unaware as to how entries should be included on the trust's risk register and the subsequent action to be taken.
- There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks. However we found there was not an effective system to manage risk.
- Incidents were not always reviewed in a timely manner meaning that risks were not always identified and actions to prevent incidents reoccurring not taken as on De La Mare ward there were 30 outstanding incidents waiting to be addressed.
- We found that, when issues were identified, timely action was not always taken to address those risks: for example, the risk to patients receiving treatment in Theatre 4.
- The theatre's users group met fortnightly at Watford General Hospital. This included speciality leads, divisional nurses lead and managers from St Albans Hospital. The group meeting was also attended by external advisors.
- The service had good practice sharing which included; prosthesis proforma and practice educators information.
- We saw the theatres' team brief which was printed and circulated to staff. This included a resume of the recorded/documented theatre list. These were kept for one working week for reference before being filed. We observed signage in the anaesthetic room confirming this.
- The staff minutes were printed and circulated to staff. We saw a copy on display on the staffs' notice board.
- In each area we inspected, there were staff meetings to discuss day-to-day issues and to share information on complaints and audit results.
- The service had quality dashboards on display on the ward and the day surgery unit. This showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings.
- The trust had completed local as well as national audits, for example regular audits to ensure staff record keeping and accuracy were compliant with national standards. During our visit to De La Mare the audits showed the ward to be compliant regarding infection control and hand hygiene practices. During our visit we observed nursing, medical and therapists not adhering to safe hygiene procedures. This meant that the trust did not monitor the audits produced to ensure good practice.

Leadership of service

Surgery

- The surgical services were divided into specific surgical specialties and each specialty had a clinical lead in place. The surgical specialties were consultant-led and medical staff spoke positively about the support they received.
- Staff were aware of the head of nursing within the hospital whom they said was visible and approachable. Staff said they were visited monthly by the chief nurse and the non-executive director.
- Some staff said the leadership from the trust could be improved and felt that St Albans "got ignored."
- Some staff were unsure about the wider trust and the roles and responsibilities of senior trust leaders.
- The ward manager on De La Mare and the day surgery unit provided day to day leadership to members of staff. Staff told us the managers were visible and approachable.
- The theatre staff told us that they received good support from the theatre leads and they were visible and approachable in the theatre department.
- Some staff said the leadership from the trust could be improved and felt their ideas did not always filter down to staff.
- Ward managers said they had access to leadership development courses which were good and they had protected training.

Culture within the service

- The staff we spoke with were passionate about the care they delivered, highly motivated and positive about their work.
- Surgical staff said there was a culture of quality improvement within the trust with regular meetings between the medical, nursing staff and doctors.
- Staff were passionate and driven to provide good care to patients but felt that this could not always be given due to the pressure of work. For example, we saw staff spending time talking to a patient describing how they could provide support and reassurance. We observed staff being supportive to a relative of a patient who was distressed.
- Staff we spoke with worked well together as a team and said they were proud to work for the trust.
- Staff sickness levels were reviewed daily and staffing levels were maintained through the use of bank and agency staff

Public and staff engagement

- The trust held monthly care group engagement session for all staff. These sessions had a different focus every month for example training updates.
- The surgical divisional leads held monthly clinics whereby staff could raise any concern or share an experience.
- The theatre and ward-based staff we spoke with told us that they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of compliments and complaints was displayed on noticeboards in each of the wards we inspected.
- Patients were engaged through feedback from the NHS Friends and Family test. The survey showed that of 151 responses 98% said they would be extremely likely to recommend the hospital as a place to be treated.
- The staff survey showed that from 800 responses 63% would recommend the trust to family and friends if they needed care and treatment and 54% said they would recommend the trust as a good place to work.
- Staff said they received good support and regular communication from their line managers.

Innovation, improvement and sustainability

- The trust had introduced a pilot pre-operative reminder telephone call service. The patient was called three days prior to their surgery for reminders and checks.
- Staff said they had recognised patient's frustration regarding their length of wait for surgery on the day of admission and had created and had produced a letter informing patients that their appointment time was not their theatre time. They said this has reduced the number of complaints within their department.
- The service had systems in place to reduce patient visits to the hospital. For example, all negative results were reported by phone for eye tests, ear nose and throat and oral surgery.
- Clinical audit meeting minutes showed that medical staff carried out local audits in areas such as VTE assessment and medication prescribing to look for ways to improve staff practice and patient care.
- The use of the enhanced recovery care pathway had reduced the average length of stay for patients undergoing elective hip and knee surgery.

Outpatients and diagnostic imaging

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

Information about the service

West Hertfordshire Hospitals NHS Trust had outpatients departments at three hospital sites, Watford General Hospital, Hemel Hempstead Hospital and St Albans Hospital. They provide outpatient services across a wide range of specialisms; for example, cardiology, ophthalmology, respiratory, urology, radiology. The trust had approximately 435,959 appointments across the three hospitals between July 2013 and June 2014, with 97,880 patients attending St Albans Hospital for their appointments.

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

We visited the outpatient area in St Albans Hospital which included for example; cardiology, ophthalmology, respiratory and urology clinics. People also attended the hospital at St Albans for investigations such as radiological procedures or phlebotomy.

We spoke with nine patients and relatives and six staff. We observed care and treatment, looked at records and spoke with two senior managers responsible for services at St Albans Hospital. During our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Overall, we found that this service required improvement.

We found that most incidents were reported and that the service had learned from incidents. We saw evidence during the inspection that the service had carried out reviews of minor incidents and that sharing of these and learning had taken place. However, some staff said that incidents were not always reported in line with trust policy. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in the outpatients and diagnostic imaging services.

Equipment had been maintained in line with manufacturers' recommendations.

Clinics were often cancelled and patients experienced delays when waiting for appointments. We received some negative feedback from patients and staff about waiting times, the patient transport service and patient parking.

Risk management and quality measurement systems were reactive and not proactive.

Outpatients and diagnostic imaging services had not identified all the risks to service users, and some of those identified were not being managed effectively.

We saw written information about the complaints procedure and the Patient Advice and Liaison Service within the outpatients' reception area.

Outpatients and diagnostic imaging

We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Some of the information given to us by senior managers was not found to be what was happening at local level.

Senior staff said they were aware of key performance indicator targets that required appointments to be made within the 18 week referral to treat target.

The processes for decontamination and sterilisation of instruments complied with Department of Health (DH) guidance. There was evidence that the service focussed on he needs of patients. There were systems in place to audit both clinical practice and the overall service.

Emergency equipment was available in each centre, and included medication, oxygen and a defibrillator. We saw that equipment checks had been carried out regularly.

There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.

We found that staff were approachable and witnessed them being polite, welcoming helpful and friendly.

Outpatient services were caring and most patients spoke positively about the care and treatment they received.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Overall, we rated that this service was requiring improvement for safety.

Incidents were not always reported. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in outpatients.

Patient records were not always available for appointments.

Medicines were not always administered in accordance with trust policy.

Staff told us that their mandatory training was up to date. The trust provided information after the inspection that showed outpatient service staff were compliant with mandatory training.

The storage room for records held in the outpatients department was found to be small with limited space. We observed staff locked the storage room after each use. This meant that records were securely stored and could not be read or removed by unauthorised people.

There was a high awareness among staff about infection control. Staff followed the trust policy on infection control.

Equipment was maintained in line with manufacturers' recommendations.

Safeguarding vulnerable adults and children was given priority. Staff took a proactive approach to prevent abuse and responded appropriately to allegations of abuse.

Incidents

- Staff knew how to report any incidents on the trust's electronic reporting system and described a range of what they would report. Examples included cancelled clinics and unsafe staffing levels.
- Incidents were not always reported. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in outpatients.
- Senior staff were aware of incidents and said these had been discussed during regular team meetings.

- Some staff told us that they did not received feedback about the outcome of serious incidents that had happened but there was no mechanism in place for analysing local incidents so that trends could be investigated with outcomes learnt.
- However, we were informed by the trust management team that learning from incidents and complaints was a standing agenda item on the Outpatient Leadership Team meeting agenda which occurred monthly.
- Senior staff were aware of the duty of candour regulations and told us they were in the process of cascading this information to staff. Most staff said they were aware of the trust's openness and transparency when things went wrong.

Cleanliness, infection control and hygiene

- On visiting the hospital at St Albans outpatients' departments we saw the environments were clean and well maintained.
- There was a high awareness among staff about infection control. Staff followed the trust policy on infection control. During our visits we observed staff washing their hands and using hand gel between patients. There was adherence to 'bare below the elbow' policy in clinical areas.
- Hand gel was available in all clinical areas. Notices were displayed regarding hand washing and infection control.
- Regular hand hygiene audits demonstrated high compliance rates throughout the department and infection control guidelines were clearly displayed in the outpatients department.
- There were systems in place for the segregation and correct disposal of waste materials such as x-ray solutions and sharp items. Sharps containers for the safe disposal of used needles were available in each clinical area. Notices were displayed in clinical areas explaining the actions staff should take in the event of an injury from a needle.
- Staff told us they received mandatory training in infection prevention and control training. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- The trust commissioned an external provider to manage its cleaning schedules within the hospital.

Environment and equipment

- 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 saw treatment being carried out in single rooms which were well equipped with couches and hand washing facilities
- The trust's electrical maintenance engineering department were responsible for annual portable appliance testing (PAT) and equipment we looked at complied with regulations.

Medicines

- There was a pharmacy on site. They checked and replenished stock medicines in all departments and provided an outpatient dispensing service. This service was available Monday to Friday.
- In outpatients, medicines were stored in locked cupboards. Lockable medicines fridges were in place, with daily temperature checks. This meant that the services were following the appropriate guidance on the safe handling and storage of medication.

Radiology outpatients

- There were procedures and processes for eliminating exposure to radiation across the outpatient services. Staff had personal protective equipment for their use.
- Radiographers across Watford, Hemel Hempstead and St Albans hospitals used patient group direction (PGD) policies to allow staff, who were not trained, to prescribe specific medicines for certain procedures.

Records

- We saw concerns were raised by staff about patients who had to wait to be seen due to their records not being available. Staff confirmed patients were seen without their full records being available frequently. This had been recognised by the trust and was on the local risk register. The trust had plans to audit the number of missing notes. We saw that some audits had started and we were informed this was a work in progress.
- Information radiology received about patients was dependant on the referrer including all personal information and relevant information, such as any allergies, health issues that might impact on their treatment. They had their own IT system which did not allow them access to all patient information available to the trust. This meant that when the electronic referral

information was not accessible staff would follow the Business Continuity Plan to ensure that patients were not inconvenienced. We saw incidents that had been reported in the trust where the wrong personal information had been included on the referral but no evidence of action being taken to address these incidents.

- Staff told us the IT system was unreliable and they would have periods without being able to access it. This meant that when the electronic referral information was not accessible patients would arrive for appointments and staff would not have all the information they needed to be able to assess people appropriately. The trust told us that when the electronic referral information was not accessible staff would follow the Business Continuity Plan to ensure that patients were not inconvenienced.

Safeguarding

- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately in relation to abuse or neglect for vulnerable adults and children.
- We saw there were safeguarding policies in place with clear procedures to follow if staff had concerns. Staff confirmed they had received a copy of the safeguarding policy.
- We saw safeguarding was included in the on-going mandatory training.
- Senior staff informed us dates were being arranged to capture all outstanding training.
- Staff told us they were aware of the trust's whistleblowing policy and that they felt able to report and raise concerns through these processes.
- Staff said they knew about the trusts' lone working policy and adhered to them.

Mandatory training

- All staff received mandatory training as part of their induction programme.
- The mandatory training covered key topics such as infection control, information governance, manual handling and resuscitation training. Staff told us that their mandatory training was up to date.
- The trust could not provide data that showed outpatient service staff's compliance with mandatory training as this was included in the clinical specialities information as a whole. This meant we were unable to confirm that outpatient mandatory training was up to date. In the Board's Performance report for March 2015, no target had been set for staff compliance with mandatory training.

Assessing and responding to patient risk

- Outpatients and diagnostic imaging services had not identified all risks to service users, and those identified were not being managed effectively.
- Staff were aware of how to escalate key risks that could impact on patient safety, such as inadequate staffing and cancelled clinics.
- Staff demonstrated knowledge and understanding of patient risk, particularly for elderly or frail patients with more than one medical condition.
- Processes were in place within outpatients to manage patients who deteriorated or became unwell in the department. There was an emergency response team in place who could be summoned rapidly.

Nursing staffing

- Nursing numbers were assessed using the national safer nursing tool and there were identified minimum staffing levels. The required and actual staffing numbers were displayed in the areas visited.
- Senior staff reported they were understaffed and vacancies were filled with bank and agency staff. They said they requested the same bank staff to ensure continuity within the clinics.
- Staff in the outpatient's service at St Albans Hospital said they recognised recruitment as a major safety risk to the service. It was captured on the directorate risk register.
- The management team told of various measures they had undertaken, such as open recruitment days and overseas recruitment initiatives to decrease the vacancy factor. Staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.
- Most nursing staff told us that although they were busy, they felt they provided good and safe patient care in outpatients.
- Some outpatient nurses felt that staffing was generally sufficient but when clinics were overbooked then they did not have enough staff to manage this.
- Locum percentages across all outpatients were "around 12% for agency and 1.5 % for non-medical bank.

Outpatients and diagnostic imaging

Medical staffing

- Consultants were supported by junior colleagues in some clinics where this was appropriate.

Outpatients services

- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.

Major incident awareness and training

- The trust had a major incident policy which staff were aware of.
- There were business continuity plans in place to ensure the delivery of the service was maintained.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We have not rated this service for effectiveness.

Some staff received appraisals and opportunities for further training; however in other areas staff had not received appraisals or regular one to one sessions with line managers.

Staff worked well together in a multidisciplinary environment to meet people's needs. Information relating to patient's health and treatment was obtained from relevant sources prior to clinic appointments. Information was shared with the patient's GP and other relevant agencies.

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.
- Nursing and medical staff told us that policies and procedures reflected current guidelines and were easily accessible via the hospital's intranet.
- Radiographers followed the ionising radiation (medical exposure) regulations (IRMER) that required radiographers to routinely check previous images before continuing with a scan or x-ray. Incidents discussed at the "radiation summit meeting" suggested some radiologists were not routinely doing this. The outcome from the summit did not suggest any changes to protocols or practice to minimise risks for patients.
- We saw protocols were in place to ensure fast tracking where there were significant imaging findings for known or unknown cancer diagnoses, as well as severe abnormalities relating to benign or malignant growths. These findings were reported to the referrer and passed immediately to the multidisciplinary team for review and action. We saw audit evidence that radiography staff across the trust were following the guidance.

Pain relief

- Pain relief could be prescribed within the outpatient's department and subsequently dispensed by the pharmacy department.
- Patients could be referred to the pain management clinic if assessed as needing this by their consultant.

Patient outcomes

- In radiology, the number of patients waiting for an examination was less than six weeks. This was better than the England average.
- For the period July 2013 to June 2014 the trust ratio between new and follow up patient appointments was similar to England average.

Competent staff

- Trust data that showed completed appraisal rates across different departments was not available.
- Most staff told us that they had received an annual appraisal and that it was a useful process for identifying any training and development needs.
- All new employees received a corporate and local induction that welcomed them to the trust and introduced them to their respective departments.
- There was evidence that staff competency was checked on recruitment and that some staff received appraisals and opportunities for further training.

Multidisciplinary working

- There was evidence of multidisciplinary 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 the clinics. If one clinic was very busy then staff would support patients if they needed it and share information to ensure the right information was available for doctors.
- The My Cancer Treatment report 2014 for St Albans Hospital identified that only 41% of the Breast multidisciplinary team (MDT) meeting in the reported time period were quorate. This meant that patients were not benefiting from the knowledge and expertise of a full MDT when decisions were made about their diagnosis and care. We saw the trust response which included the development of a business case that included an increase in medical and clinical oncology capacity to attend MDT meetings.

Seven day working

- The outpatients department was open from 8.30am to 5pm, Monday to Friday. However, extra clinics were also scheduled in the evening and at weekends to meet the needs of the local population. These were staffed by current trust staff working additional hours and bank staff.

Access to information

- We spoke with staff about the process of sending notes to the outpatients department to ensure that doctors had the correct information available. We were told that, due to a shortage in administration staff, sometimes records were not available.
- Referrals for x-rays and scans were received as either paper or as an electronic referral. Referrals that came in by paper were put onto the system by administration staff.
- Administration staff told us about the challenges in their department. We were told that referrals to clinics for example breast clinics had grown rapidly. Managing the workload and storage issues were a huge pressure for staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at the radiography department's policy on consent. Radiographers told us that they followed the policy to ensure that patient consent was gained for each scan or procedure. We observed staff following this policy as they gained consent from patients.
- Staff received training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and were confident about seeking consent from patients.
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would be obtained in the outpatient clinic.

Are outpatient and diagnostic imaging services caring?

Good

We rated this service as good for caring.

Feedback from patients said they were treated with privacy and dignity.

Information was not always communicated to patients in a timely way. For example: not all clinics kept patients informed of waiting times whilst in clinic.

Staff responded compassionately to patients who needed support. For example; we observed staff took extra time to communicate with patients if they needed it and saw that staff were aware that patients with complex needs may need additional support.

We found that staff were approachable, kind, polite and friendly.

People we spoke to told us that the staff were "very good" and the outpatient's survey results contained positive comments about the caring ability of the staff in outpatients and diagnostic imaging services.

Compassionate care

- Patients were admitted into individual rooms so that they could discuss their procedure in privacy.
- We observed staff greeting patients in a friendly, but appropriate manner. Patients praised the staff and told us they were, "really helpful" and "communicated well."
- We saw that clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics.

Understanding and involvement of patients and those close to them

- Patients were aware of why they were attending the outpatients department.

Outpatients and diagnostic imaging

- Patients were asked whether they wanted their family or friends to be present during consultation and treatment.

Emotional support

- We observed staff speaking with people and giving appropriate information.
- Staff had good awareness of people with complex needs and those people who may require additional support should they display anxious or challenging behaviour during their visit to outpatients.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We found the responsiveness of this service required improvement.

The organisation of some clinics was not responsive to patients' needs.

Some patients were not able to access services in a timely way for an initial assessment, diagnosis or treatment.

Some clinics frequently over-ran and some patients told us they had experienced long delays in their appointment time.

Some clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled often several times.

Patients concerns and complaints did not always lead to improvements in the quality of care.

Staff told us that the trust did not collect full details for waiting times for RTT and follow up appointment timeframes for outpatient's appointments at St Albans. The trust told us that all patients on an 18 week pathway, including review patients were tracked and were reviewed weekly at the trust's Access meeting where actions were agreed to ensure all patients have a plan.

Referral To Treatment performance had recently improved at the time of inspection.

Clinic non-attendance was in line with the national average.

Service planning and delivery to meet the needs of local people

- There was no evidence that service was evaluated to ensure it met the needs of local people.
- There were no regular audits of service delivery or of feedback from patients to ensure the service met the needs of the local population.

Access and flow

- 2526 patients attended their first appointment at St Albans in April 2015. On average they had waited 43 days (6 weeks and 1 day) excluding two week wait patients. At the end of April, this had fallen to 39 days (five weeks and 4 days) as a result of the focus the trust had taken to improve the RTT performance.
- The trust did not have data available for all outpatient clinics showing how many patients' appointments were cancelled. When we asked staff they told us managers were not aware how many patients were cancelled and the trust told us they did not record this information for all clinics.
- The trust monitored the demand for outpatient appointments and the utilisation of the clinics available in order that waiting targets were not breached. However we saw that there was an on-going issue with cancelled and overbooked clinics. We were told by staff and patients of frequent cancelled clinics in some specialists. For example respiratory clinics.
- Between July 2013 and June 2014 the trust 'did not attend' (DNA) rates for St Albans Hospital showed a percentage of 7%. This was based on 97,880 patients. This was similar to the England average.
- Challenges in radiology included an increase in demand for imaging in CT, MRI and ultrasound referrals. There was no out of hours on-call service however, routine Ultrasound lists were performed at weekends to accommodate patient choice.
- The trust did not meet its 18 week referral to treatment (RTT) standard of 95% from September 2013 onwards. The trust was consistently worse than the England average for that entire period. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standard.

Outpatients and diagnostic imaging

- The 18 week referral to treatment (RTT) target for cardiology outpatient's patients was achieved but routine follow appointments were being booked for March 2016 in order to accommodate the annual review requirements of patients.
- The national target for urgent GP referral is two weeks. The trust met this target between April 2013 and March 2014 but fell below the target between April 2014 and September 2014. Between October 2014 and January 2015 the trust had performed better than the target.
- The target for people waiting less than 31 days from diagnosis to first definitive treatment is 96%. The trust achieved the performance standard with the exception of May 2014 from April2013 to June 2014.
- The target for people waiting less than 62 days from urgent GP referral to first definitive treatment was 85%. The trust performance has not been below the England average since April 2014 but there was a poor performance of 76% in January 2015, but since then trust performance has been better than the England average.

Meeting people's individual needs

- On the day of our visit the orthopaedic clinic should have taken place, however, we were informed the clinic did not take place as the consultant did not arrive. Staff told us they re-assigned the patients to the three registrars attending clinics. Staff said this happened quite regularly.
- One patient feedback from a clinic stated "the doctor did not turn up and as I had arranged childcare I had to leave." They said the delay had cost them "valuable time and money."
- Another comment from a patient on the same clinic date stated they were not happy about the doctor not turning up and had been told they were in Watford General hospital. The patient was added to the list of one of the registrars. One patient commented that the delay was one and a half hours, and another said they had waited two hours.
- On the same day an additional clinic was put on without staff knowledge. Patients and a registrar turned up in the outpatients. The clinic rooms were already planned to be used by someone else.
- Senior staff told us they had been running extra clinics on a Saturday but said these caused issues. For example, respiratory clinics had no access to x-ray or imaging on a Saturday. This meant that patients had to go to Hemel Hempstead or Watford General Hospital for CT scanning and then return for another appointment. This caused delays as waiting lists for follow up appointments were very long.
- We were informed that the urology service had run additional weekend clinics since August 2014. The My Cancer Treatment report for August 2014 identified an increase of 28% in the number of patients referred with suspected breast cancer. This impacted on the MDT capacity to meet the two week wait cancer target and may result in delays in treatment for patients. The trust had responded by arranging weekend clinics to address the problem. The increase of referrals had been raised with the Clinical Commissioning Group.
- Senior staff said the extra clinics were not resourced and they had to ask staff to volunteer for these extra clinics. This meant staff worked extra bank shifts as well as their normal working hours.
- The trust risk register stated in September 2014 that "due to increase in demand for dermatology services" there was a lack of availability of dermatology clinics and resourcing issues in the outpatient booking team. They said there was a backlog of over 500 new referrals across the three outpatient sites waiting to be seen for an appointment. They were concerned this could lead to breaches in 18 week RTT target, patient safety and possible financial and reputation consequences to the Trust. We saw that the action plan was to increase the booking team staffing. However, this was dated March 2015. It was not clear what if anything had been done since September 2014 to manage the waiting list.
- Data was not available for all outpatient clinics showing how many patients' appointments were cancelled. Managers were not aware how many patients were cancelled and the trust told us they did not record this information for all clinics. This meant that patients were at risk of their conditioning worsening.
- Staff told us that most outpatient clinics were regularly overbooked, with ophthalmology, dermatology, cardiology and respiratory clinics most under pressure due to demand. Staff told us there were not enough doctors to manage the waiting list. There was not enough nursing staff and they were encouraged to work extra shifts.
- Overbooking of appointments was evident across all the trust outpatient clinics and staff told us this was so the

trust did not breach the 18 week RTT target. Staff told us respiratory clinic appointments were regularly double and triple booked due to the volume of people needing to be seen and there were long waiting lists.

- Staff said they were unable to access full patient's case notes and care and risk assessments as they did not have permission to do this. They can only see what a referrer had written on the referral in their local IT system. The trust told us Radiology staff have access to PAS and Clinicom to access the full patient record. Staff were also able to access the referral system (ICE) to source the information required.
- Patients told us that it was not easy to access translation services and they were expected to bring a family member with them who could translate. We saw that information displayed on trust noticeboards said that services were available on request. Feedback from patients groups highlighted lack of access to translation services.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any recommendations for treatment. These could be provided in different formats if required for example large print.

Learning from complaints and concerns

- The trust wide central booking administration department was responsible for cancelling clinics. The process did not work as all patients did not get told their appointment was cancelled. Staff told us some patients regularly turned up for their appointments. Complaints from people who turned up were that they had not received a letter telling them the clinic was cancelled.
- Most complaints were about delays in clinics. Staff and patients told us most were verbal and dealt with at the time. However staff said they highlighted concerns with line managers but said the same situations continued to happen and nothing improved.
- The trust "I want great care" (iWGC) survey asked people for feedback on their visit. On the day of our visit we saw six feedback forms from patients. All of them complained about waiting times, and that the consultant had not arrived. This meant they had to be added to other registrar's clinics.
- Initial complaints were dealt with by reception staff and if more serious by the outpatient senior staff. If they were unable to deal with the person's concerns satisfactorily, they would be directed to the Patient Advice and Liaison Service (PALS). If the person still had concerns, they would be advised how to make a formal complaint. Feedback from an external "listening event" held to gather patient's views about the trust highlighted concerns from patients commenting that "they often don't answer the phone and when messages are left they don't always phone back". We saw an example of this on the trusts respiratory complaints list that stated the complaint was about postponements of outpatient appointments. The patient contacted the consultant's secretary and PALs with no outcome. Then waited 14 months for appointment.
- Complaints were not handled in line with the trust's policy. This stated that the (PALS) will "provide advice and support" and that when a "concern needs to be escalated to the clinical team or department to assist resolution. Where possible escalation will occur via personal contact …… to ensure a rapid response. These concerns usually need a rapid investigation; a response can often be given verbal". However feedback from patients was that verbal complaints were not recorded or passed onto PALS so data provided by the trust would not give a true record of the number of issues or concerns raised by patients.
- In all the areas we visited poster information on how to make a complaint was displayed.
- Staff confirmed that they were aware of some complaints and had received feedback via the staff meetings.
- In radiology complaints were discussed in staff meetings. We saw minutes of these and evidence of learning, for example, wrong information on referral that had not been checked with the patient correctly. There was a discussion regarding the correct procedure and signposting to the relevant policy. Changes had been made in the way checks were done using a "6 point test" to ensure the correct personal details were known.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We found that the service required improvement to be well-led.

Outpatients and diagnostic imaging

Staff told us that the managers were approachable and the culture within the service was seen as open and transparent, however not all leaders had the necessary experience, knowledge or capacity to lead effectively. Leaders were not always clear about their roles and their accountability for quality.

There was poor monitoring, audit and data collection regarding waiting times and delayed clinics, with staff struggling at times to manage the volume of patients during clinics.

We did not find there were robust arrangements for identifying, recording, managing and reviewing risk issues and mitigating actions.

There was a limited approach to obtaining the views of people who use services. Patients' experiences were not monitored consistently and actions were not taken.

The reporting structure in outpatients and diagnostic services was clear. Staff knew who they reported to.

There were structures in place to maintain clinical governance and risk management however these did not always operate effectively.

Some staff at St Albans were aware of the trust's vision to become an organisation that is a national and international leader in healthcare and could direct us to the posters on display.

Staff could say how they aimed to achieve and deliver the best care for patients through staff education and training.

There was a commitment from the managers to learn from feedback, complaints and incidents.

Staff were aware of the practice ethos to provide a caring and responsive service.

Vision and strategy for this service

- Most staff at St Albans were aware of the trust's vision and could direct us to the posters on display. However, some felt that the trust was unaware of what was going on within the outpatient clinics.
- Staff said they felt well supported at a local team level and highlighted individual senior managers who were contributing to making change happen as the trust restructured.

Governance, risk management and quality measurement

- On the trust's risk register we saw that all risks were rated according to the likelihood of them happening and their risk to the patients, business continuity, or staff. There was a completion date for all risks; however, very few of them appeared to have regular updates of progress. This meant that the trust board may not have had current oversight of risk or assurances the risks were being managed or minimised. For example; at St Albans' risks had been raised about the lack of space for storing patient records and some patients being seen without all their medical records being available. This had been reported in September 2012 and July and November 2014. It was unclear whether the action plan to ensure there was adequate storage has been completed as it had not been updated since August 2014.
- We found that the trust had carried out audits on the secure storage of medicines and controlled drugs in early 2014. This audit had identified many deficiencies in the safe storage of medicines, but many of the recommendations of the audit remained to be implemented. For example; the pharmacy risk register raised concerns that staff were not completing patient's medicine allergy status on documentation. This meant that patients could be given medication that would cause them harm.

Leadership of service

- Outpatients as a service was managed by the divisional director. Day to day management was the responsibility of each individual division and these management groups meet monthly. Staff told us there were no meetings where issues and concerns could be shared and a joint strategy identified to address the issues around overbooking, cancellation of clinics and long waiting times for patients. However the trust told us that issues relating to clinics and waiting times were discussed at weekly Access Meetings which were minuted.
- The trust had polices in place to ensure people were not discriminated against. Staff we spoke with were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.
- Communication between senior, middle managers and staff was good. Staff told us they were able to discuss any concerns and highlight issues which may impact on patients and staff.

Outpatients and diagnostic imaging

- Staff in outpatients said they worked together to resolve any conflict and everyone shared the responsibility to deliver good quality care.

Culture within the service

- Outpatient's staff and teams were encouraged to work collaboratively but some individual specialisms needs took priority over other areas. Outpatients were managed by the medicine divisional directorate.
- Some staff told us they were not consulted and were not clear how decisions were made. For example: the addition of extra clinics meant staff were stressed and clinics ran late. This often meant staff unable to go home on time. Staff told us this happened on a regular basis.
- Staff told us they worked well together and there was obvious respect between different roles and responsibilities within the multidisciplinary teams working in the different outpatient departments.
- Throughout the inspection, all staff were welcoming and willing to speak with us.

Public and staff engagement

- Staff moral within the outpatients' department at St Albans was very positive. Staff said they felt listened to by senior staff.
- We did not find within outpatients regular audits of service delivery or feedback of patients experience to ensure the service met the needs of the local population.
- The trust gained people's views about services in a number of ways. They requested feedback from "I want great care" IWGC questionnaires that were available in locations throughout outpatients. Posters advertising this were on notice boards. However trust data showed response rates were low and it was unclear what had been done to try and find the reasons for this.
- Data from iWGC for the year 2014 to 2015 has shown that the trust overall had 54,079 reviews from patients. 89% of these patients would recommend the trust to family and friends, and 1% were unlikely to recommend the trust. Responses were broken down into individual specialities.
- Targeted patient surveys had not been undertaken to measure quality and identify areas for improvement.

Innovation, improvement and sustainability

- We were unable to gather enough relevant information to make a view on how the impact on quality and sustainability is assessed and monitored when considering developments to services or efficiency changes.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had introduced a pilot pre-operative reminder telephone call service. The patient was called three days prior to their surgery for reminders and checks. Staff said if the service proved successful then it would become permanent.
- Staff had recognised patient's frustration regarding their length of wait for surgery. This resulted in staff creating and had produced a letter informing patients that their appointment time is not their theatre time.
- The service had systems in place to minimise patient visits to the hospital. For example, all negative results were reported by phone for eye tests, ear nose and throat and oral surgery.

Areas for improvement

Action the hospital MUST take to improve

- Review the governance structure for the MIU, surgery and outpatients to have systems in place to report, monitor and investigate incidents and to share learning from incidents as well as complaints.
- Ensure that governance and risk management system in MIU, surgery and outpatients reflect all current risks in the service and all staff are aware of the systems.
- Ensure that there is an effective audit program and the required audits are undertaken by the services.
- Ensure they review outstanding incidents in a timely manner.
- Ensure that learning from incidents is shared across all staff groups.
- Ensure all surgical areas are fit for purpose and present no patient or staff safety risks.
- The trust must take action to clinically review all of the patients who may have had surgery in Theatre 4 at St Albans.
- Ensure that the ladies' changing room at St Albans is fit for purpose.
- Ensure that medicines are always administered in accordance with trust policy.
- Ensure that all staff have received their required mandatory training.
- Ensure all staff are supported effectively via appropriate clinical and operational staff supervisions systems.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.

Action the hospital SHOULD take to improve

- Involve the service in wider organisational planning regarding major incidents and include in trust wide plans or training simulations.
- Enable all staff to access appropriate developmental training opportunities as required.
- The trust should ensure they take the required actions to meet the 18 week refer to treatment national target.
- Review issues identified and associated with transport problems when accessing outpatient appointments.
- Put in place a clear strategy for leadership development at all levels.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1)(b),(c),(e) HSCA 2008 (Regulated Activities) Regulations 2014 **Premises and equipment** All premises and equipment used by the service provider must be suitable for the purpose for which they are being used. Concerns were found regarding the suitability of the premises in surgery and outpatients.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a),(b),(c) HSCA 2008 (Regulated Activities) Regulations 2014 **Good Governance** Systems or processes must be established and operated effectively to ensure compliance with assessing, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity, maintaining and keeping secure appropriate records and evaluating and improve their practice in respect of the processing of the information. The regulation was not being met because governance arrangements for auditing and monitoring clinical services were ineffective and unclear. Although there was some evidence of nursing audit and learning, information and analysis were not used proactively to

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Requirement notices

identify opportunities to drive improvements in care. Risks identified were not always responded to in a timely manner. Records were not stored in accordance with trust procedures.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1), (2),(a),(b) HSCA 2008 (Regulated Activities) Regulations 2014 **Staffing** Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed and receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. There was not a robust system in place for staff supervision and appraisal across all services. Not all staff had had mandatory training as required by the trust's policies. Opportunities for developmental training were limited.