

Barts Health NHS Trust

# St Bartholomew's Hospital

## Quality Report

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

## Ratings

### Overall rating for this hospital

Good



Medical care

Good



Surgery

Good



Critical care

Good



Outpatients and diagnostic imaging

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

St Bartholomew's Hospital is a teaching hospital in the City of London and part of Barts Health NHS Trust.

St Bartholomew's Hospital is the oldest hospital in Britain, occupying the site it was originally built on. The hospital provides a range of local and specialist services: including treatment of heart conditions, cancer, fertility problems, endocrinology and sexual health conditions. The hospital has a minor injuries unit and a specialist Heart Attack Centre, but does not offer A&E services.

The hospital has recently seen much building redevelopment, including the demolishing of parts of the site to make way for a new PFI funded building that houses the trusts specialist cancer and cardiac services. This includes the Barts Heart Centre (BHC), formed by the merger in 2015 with staff and services at the London Chest hospital and the Heart Hospital (University College Hospital).

The hospital has 365 inpatient beds and 108 day case beds, and employs 870 nursing and medical staff.

The BHC is Europe's largest specialised cardiovascular centre, covering a population of three million people across north and east London, west Essex and beyond. The facilities include: 10 theatres, 10 catheterisation labs, 250 general cardiac beds and 58 critical care beds, delivering specialist cardiac and respiratory services. The BHC aspires to perform more heart surgery, MRI and CT scans than any other centre in the world.

We inspected four core services: medical care, incorporating oncology and cardiology services; surgery, including theatre and recovery; critical care, including the specialist intensive care facilities the hospital provides; outpatients & diagnostic imaging, including radiotherapy. We did not inspect end of life care services.

We rated the well led domain in surgery and critical care as outstanding. Overall, we rated St Bartholomew's hospital as good.

Our key findings were as follows:

### Safe

- There was a good incident reporting culture and learning from incident investigations was disseminated to staff. Staff were able to tell us about improvements in practice that had occurred as a result.
- Staff had an understanding of safeguarding systems and there was a safeguarding team within the trust. We found deprivation of liberty and mental capacity was assessed in line with trust policy and legislation.
- The surgery service had significantly reduced the number of surgical site infections in the last 12 months.
- Most clinical areas were clean, well maintained and free from clutter.
- We predominantly observed good adherence to infection control protocol.
- We observed good medicines management, including safe storage of medications and controlled drugs.
- Clinical practice was evaluated and benchmarked through an on-going programme of local and national audits, peer reviews and service development.
- There had been a sustained investment in recruitment of nursing staff.

However, we also found:

- Understanding and implementation of sepsis six (a procedural guideline designed to reduce the mortality of patients with sepsis) was variable among staff, and an action plan had been introduced to improve this.
- Understanding and learning from never events was not consistent across services.
- Nursing care bundles and documentation were not always completed consistently, and we found gaps in the recording of risk assessments and safety observations across medical inpatient areas.
- Nursing vacancies across some services remained above the trust target: bank and agency staff usage was high in some clinical areas, although this had had minimal impact on patient care.

# Summary of findings

- Mandatory training rates across services were variable.
- Medicines fridge temperatures were not always consistently monitored in some clinical areas.
- There was limited signage in the x-ray department informing patients of the dangers of radiation, and the signage did not carry the radiation protection supervisors' details.
- Risks associated with the storage of chemicals, sharps and hazardous waste were not consistently managed in line with national and international guidance.

## Effective

- Patient care was delivered in line with national clinical guidance and best practice.
- Pain was well managed across the services we inspected.
- There was effective multi-disciplinary team working in place within and across services.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was better than the national average of 90 minutes.
- The average length of stay for elective and non-elective medical inpatients, with the exception of clinical haematology patients, was shorter than national averages.
- Results from the national lung cancer audit indicated the hospital performed better than the national average in every indicator.
- Clinicians demonstrated an on-going commitment to developing pathways that improved patient outcomes.
- Consultants were participating in a multi-partner heart improvement programme to reduce late admissions and improve patient outcomes.
- A nurse education team and specialist educators were in post in each clinical area to lead on staff development and training.
- There were effective training opportunities available for clinical staff.
- A rehabilitation support team and multidisciplinary therapy team supported cardiac patients with rehabilitation goals and strategies to improve their recovery. This was part of a broad multidisciplinary approach to care and treatment that ensured patients received a holistic and individualised recovery plan.
- Surgery patients that we spoke with felt they had been well informed regarding their treatment and that consent had been well explained in pre-admission and pre-operatively

However, we also found:

- The critical care service did not fully participate in providing data to Intensive Care National Audit and Research Centre (ICNARC), which was an expectation for critical care services.
- There was not daily on-site cover from a tissue viability nurse and ward nurses told us they did not feel confident in identifying or treating pressure sores. This was reflected in the number of hospital-acquired pressure sores in the previous 12 months.
- There were gaps and inconsistencies in staff knowledge with regards to the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. We found insufficient and inappropriate documentation and records of monitoring with regards to this in two medical wards.
- We found 15 policies in radiotherapy that were not up to date.

## Caring

- We saw examples of staff providing compassionate care with dignity to patients across the services we inspected. Staff took time to discuss care and treatment with patients and relatives and kept them well informed.
- Patient survey results were consistently good and there was evidence staff used narrative feedback to improve and develop services.
- We observed staff in each clinical area providing emotional support based on the needs of their patients.

However, we also found:

# Summary of findings

- NHS Friends and Family Test response rate was lower than the national average in medical services. However, ward managers demonstrated how they were working to improve this.
- Results from the 2016 cancer patient experience survey indicated there was room for improvement in how patients accessed private discussions with staff and in the sensitivity of staff when communicating.

## Responsive

- Flow through surgery services was well managed.
- The specialised cardiovascular surgery service provided inter-hospital support for a number of district general hospitals in the north and east London area. Emergency on-call surgeons were available 24/7 to treat complex aortovascular patients.
- Recruitment of Clinical Nurse Specialists provided additional support for patients with specific clinical needs.
- The sexual health service had adapted to the needs of the local population including through the provision of a team of consultants, nurse practitioners and sexual health technicians who provided targeted support for patients with specific sexual risks.
- A new neuro-oncology rehabilitation service had been implemented to support patients with complex rehabilitation needs relating to cancer.
- A specialist team of nurses had developed an apheresis clinic in the chemotherapy day unit, which had expanded the range of specialist services available.
- Patients referred to cancer services were seen within two weeks of referral in 99% of cases and 98% of patients began their first treatment within 31 days. In addition 92% of patients were seen within 18 weeks of referral across all specialties, which met the national target.
- Clinical services had adapted access times and pathways to provide a safer and more responsive service. This included a two-week wait for angiograms and angioplasty after a cardiac inpatient stay in the heart centre.
- Specialist nurses led a 24-hour chemotherapy advice line, which patients could use during their treatment to ask questions or to access emergency admission pathways.
- The outpatients department had developed some nurse-led clinics; there were also rapid access clinics for patients experiencing conditions such as asthma and chest pain.
- The access issues resolution service (AIRS) was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues.
- Diagnostics and imaging services were meeting waiting time performance criteria.
- Medical wards had private space for patients and relatives to relax, socialise or talk privately. This included libraries, TV rooms and kitchens to make drinks and snacks. Hospital volunteers also provided daily snack and toiletry services on inpatient wards.
- A new catering contractor had improved the food service to patients and we saw an individualised service was now provided.

However, we also found:

- There were capacity issues in some outpatient clinics that meant there was insufficient number of clinics to deal with demand. Clinic rooms were booked up quickly and there was limited spare room capacity.
- Signage in some medical areas was difficult to identify and did not support easy navigation.

## Well-led

- There was strong medical and nursing leadership and achievable strategies were in place to develop services.
- The senior leadership operating model allowed for good lines of governance and communication.
- Staff stated that the transition of services during the merger and formation of the Barts Heart Centre had run relatively smoothly, with minimal impact to the quality of patient care.
- Staff we spoke to across services emphasised the positive and collaborative culture following the merger.
- There was a high priority on research and senior clinical teams provided dedicated time for this.

# Summary of findings

- Clinical teams used dashboards and risk registers effectively to review incident investigations and track the level of risk presented to patients, staff and services.
- Staff across services demonstrated that contingency planning worked well to minimise disruption during a prolonged IT failure.
- We saw innovation in clinical areas aimed at future service sustainability and the development of research
- Cardiothoracic surgery services were leading a number of innovations both within the UK and internationally.

However, we also found:

- Staff in sexual health services said human resources or occupational health had not supported them during a period of unpredictable change.
- The risk register in outpatients and diagnostic imaging did not contain action plans to explain what actions had been taken to mitigate identified risks or identify timescales for completion of actions to mitigate risks

We saw several areas of outstanding practice including:

Medical Care:

- Senior teams encouraged staff to participate in research and develop innovative projects to improve care in their clinical area. For example, staff in ward 6 had been recognised as finalists for a Health Service Journal award in November 2016 for their work in redesigning a specialist service. In addition, staff teams from wards 4C, 5D and 6D had conducted falls prevention research that led to the introduction of falls champion badges for staff who had demonstrated skills development in falls prevention and who could train or coach colleagues. A research ambassador group supported staff to engage in research in line with national ethics guidance.
- Staff in the sexual health clinic were encouraged to apply to present their work at the annual British Association of Sexual Health and HIV conference as a strategy to share best practice and new learning. For example staff had attended a 2016 conference to present a reflection on their clinical practice in the management of syphilis and to present the work of a satellite screening partnership clinic with a nearby private pharmacy.
- The trust was participating in the East London Cancer Board initiative. This was collaboration between 20 organisations and 50 professionals who sought to agree priorities for improvements and drive positive change in local cancer services. In January 2017 the board announced its key areas of focus and planned work together including incorporating patient experience narratives and identifying opportunities for new care pathways such as for prostate cancer follow-up care.
- An experimental medicine cancer centre had recruited 934 patients to trials developing practice-changing medicine for four cancer types.
- An international cancer specialist organisation had selected the hospital as one of 20 global sites of excellence in immune-oncology to advance the development of cancer immune therapy.
- Staff in the chemotherapy assessment unit provided a 24-hour telephone triage and advice service for patients who were feeling unwell during their treatment and patients who had completed a course of treatment within the previous six months.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was significantly better than the national average of 90 minutes.

Surgery:

- Staff we spoke with stated they felt it had been a significant achievement by the leadership of surgery to bring three services together into one organisation, standardise processes efficiently, and continue to maintain the quality of care while doing so. Staff stated that the move into surgery services at St Bart's Hospital had been well managed and the transition was relatively smooth.

# Summary of findings

- Surgery services were in the process of introducing a robotic surgical team with a fully adapted robotic surgery theatre. This would allow the surgery services to offer less invasive cardiothoracic surgery procedures, which led to faster recovery times, minimised trauma, and reduced pain. The robotic surgical programme would be the only dedicated cardiothoracic robot in the UK. The Robotic Epicentre for teaching and training in the UK will move to St Bart's Hospital in 2017.
- Surgery services had clinical research collaboration with a leading electronics company to develop visual applications for thoracic surgery. To support this, surgery services had developed a hybrid theatre, which could allow on-table visualisation of very small cancerous lesions, allowing more precise excision and reducing loss of health lung tissue.
- St Bart's Hospital was the first site in Europe to perform Electromagnetic Navigation Bronchoscopy, and was the only centre offering this in the UK as a routine service. Surgery services are also a training centre for this procedure in Europe.
- The hospital's Grown Up Congenital Heart disease (GUCH) programme had recently received national accreditation and is one of the largest in the world. The service provides supported transition from childhood to adulthood for those born with heart disease via a well-established transition programme with a leading London paediatric hospital.

## Critical Care:

- The service had set up a well-governed and safe Extracorporeal Membrane Oxygenation (ECMO) service to provide both cardiac and respiratory support for patients and had put in a bid to become a national funded service.
- Since the merger of the three hospitals the service had developed a well governed critical care service with excellent medical and nursing leadership.

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

## Medical Care:

### The trust should:

- Ensure that nursing care bundles, including patient risk assessments, are completed consistently and without omissions.
- Ensure that adequate contingency plans are in place to reduce the risks of medicines management errors in the absence of pharmacy support.
- Ensure all teams meet the 90% target for completion of safeguarding training.
- Ensure all teams meet the 90% target for completion of mandatory training.
- Ensure there is adequate expertise on-site to ensure patients at risk of conditions associated with tissue breakdown or pressure sores receive appropriate care and treatment.
- Ensure further emphasis on making sure that all staff accurately and appropriately use the national early warning scores (NEWS) when assessing patients.
- Ensure staff working in laboratories have appropriate training in using personal protective equipment and protecting themselves from the risks associated with coming into contact with infectious material.
- Ensure FP10 prescription pads in the sexual health clinic are stored and managed in line with NHS Protect security of prescription forms guidance 2015.

## Surgery:

### The trust should:

- Ensure there are processes in place to monitor consistent recording of temperatures for medication refrigerators on surgery wards.
- Ensure NEWS scores are correctly scored and there are sufficient structures in place to frequently monitor performance in this regard.

# Summary of findings

- Ensure patients who have appointments cancelled are offered an alternative.
- Ensure there is screening for patients who may have dementia, and that additional support is available for patients with dementia or other complex needs.
- Improve communication with patients regarding their discharge planning from surgery wards.
- Improve signage in the outpatients building for pre-admission appointments.
- Ensure they are meeting the trust target for appraisals of non-medical staff within surgery services.

Critical care:

The trust should:

- Ensure sepsis six pathway is fully integrated into practice and staff are educated appropriately.
- Ensure the first floor critical care units submit data to the Intensive Care National Audit and Research Centre (ICNARC) dataset to ensure patient outcomes are benchmarked against similar services nationally.
- Consider increasing the number of dieticians to meet national guidelines.

Outpatients and Diagnostic Imaging:

The trust should:

- Ensure clinics running late are reported as incidents in line with trust policy.
- Ensure clinic 5 has access to a sluice facility.
- Improve signage in the x-ray department informing patients of the dangers of radiation.
- Record ambient room temperatures are recorded in all rooms where medicines are stored.
- Ensure risk registers are fit for purpose and record actions and timescales to mitigate risks

**Professor Edward Baker**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Medical care

### Rating

Good



### Why have we given this rating?

An incident reporting system was embedded into the operation of the hospital and staff at all grades told us they felt confident in escalating concerns and mistakes. We saw evidence senior staff consistently investigated incidents and learning was broadly disseminated and shared, and we saw changes in practice and policy occurred as a result.

Infection prevention and control processes were effective and we saw staff consistently adhered to these. Staff adhered to good medicines management protocols that ensured patients were safe from the risks associated with improper storage and documentation. Pharmacy teams were proactive in identifying areas for improvement in medicines management and worked with clinical teams and senior leadership teams to implement safer practices.

Staff at all levels demonstrated a consistently proactive approach to reporting safeguarding concerns and working within multidisciplinary teams to keep people safe.

Senior clinical staff had adapted services provided to patients in response to identified risks, including the introduction of a consultant of the week model and emergency transfer care pathways.

An improved recruitment strategy and the implementation of nurse development pathways had led to lower vacancy rates and consistent nurse to patient ratios. An action plan was in progress to reduce vacancy rates further through international recruitment and internal development of existing nurses.

Each clinical area demonstrated improvements to patient outcomes through service developments and staff initiatives. This included a reduction in falls in the cancer wards through the introduction of a falls prevention competency framework.

Multidisciplinary working with internal and external colleagues resulted in better patient care.

A structured multidisciplinary education programme and the development of a junior doctor education hub had improved training and development opportunities.



# Summary of findings

Clinicians had established multidisciplinary pathways and structures that meant patients treated at more than one of the trust's hospitals received coordinated, continual care.

Patients and relatives we spoke with provided consistently positive accounts of their care experiences. Good survey results and the demonstrably caring and compassionate approach of all staff we observed supported this.

Clinical processes were structured to ensure patients were included in their assessment, care and treatment. We saw evidence of this through observing ward rounds, speaking with patients, looking at patient records and looking at survey results.

Staff in each area demonstrated how they engaged patients in the service, both for improvement and to gather informal opinions and feedback.

There was evidence of innovation and a drive towards service development and sustainability in each clinical area. This included through research and the implementation of new and experimental services and treatments based on new guidance and evidence.

We also found:

Although there was consistent pharmacy support and cover in most clinical areas, there was a lack of contingency planning and elevated risks when this was not available.

Nursing care bundles and documentation were not always completed consistently and we found gaps in the recording of risk assessments and safety observations across inpatient areas.

We saw good infection control and hand hygiene practice during our inspection but this was not always supported by good long-term audit data. For example, the infection control team reported avoidable instances of hospital-acquired methicillin resistant *Staphylococcus aureus* (MRSA) and inconsistent hand hygiene compliance.

Risks associated with the storage of chemicals, sharps and hazardous waste were not consistently managed in line with national and international guidance.

Completion of mandatory training was variable and no single group of staff had full compliance with the trust's minimum 90% completion rate.

# Summary of findings

We found overall inconsistency in how staff assessed and recorded patient mental capacity in some inpatient areas. This included for one patient with a Deprivation of Liberty Safeguards authorisation in place. Staff in the sexual health service described a lack of engagement or support from the trust, human resources and occupational health during a time of uncertainty.

## Surgery

Good



Staff we spoke with felt there was a good attitude from managers towards reporting and learning from incidents within surgery, and they felt encouraged to report concerns or issues. Root-cause analysis of the never events resulted in review of standard operating procedures, and the introduction of Local Safety Standard for Invasive Procedures (LocSIPP) to minimise the risk of a repeat incident.

The service had significantly reduced the number of surgical site infections (SSI) in the last 12 months.

Most of the surgery wards and theatres we visited were clean and well-maintained.

There were a number of audits in place to monitor performance of medicines administration and management.

Surgical pathways were delivered in line with national clinical guidance and best practice

There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the surgery service.

Staff we spoke with stated they found the appraisal process useful, and felt there were good opportunities for professional development with the trust. Surgery staff were meeting most of the mandatory training targets for the trust.

There was effective multidisciplinary team (MDT) working in place. We attended a number of ward meetings attended by medical, nursing, and MDT staff, and found communication to be effective and well managed.

Patients we spoke with gave us positive feedback on the quality of care they received. Positive interactions between staff, patients and their families was observed. Patients and family we spoke with felt they had been well involved in their care.

Feedback from the Family and Friends Test (FFT) was consistently good across surgical wards, with an average of 98% for the period between April 2016 and February 2017.

# Summary of findings

Flow through surgery services was well managed and efficient.

The specialised cardiovascular surgery service provided inter-hospital support for a number of district general hospitals (DGHs) in the north and east London area. Emergency on-call surgeons were available 24/7 to treat complex aortovascular patients.

Surgery services had access to a number of Clinical Nurse Specialists who could provide additional support for patients with any additional clinical needs.

There were a number of post-discharge wound clinics available to support patients with their recovery.

There was a positive culture within surgery services at the hospital. The leadership team was well established and there were good connections throughout the service. The team were managing a very complex critical care environment in a very integrated and seamless way.

The senior leadership team within surgery had effectively overseen the joining of three separate specialist surgery services into one organisation since 2015. This included standardising process, developing a unified culture and identity for surgery services, and maintaining quality of care for patients.

Surgery services had divisional level business plans and strategies for developing the service within each area of clinical speciality for the next one to five years, which aligned with the hospital-wide priorities for the future.

There were effective governance arrangements in place and senior staff had a good understanding of risks facing the service.

There were a number of leadership development courses available to staff who wished to have more responsibility.

Cardiothoracic surgery services were leading a number of innovations both within the UK and internationally.

We also found:

We found examples of National Early Warning Scores (NEWS) being incorrectly scored for patients on surgical wards.

There were significant vacancies in the nursing and medical teams, however this was mitigated by the use of regular bank staff. Surgery services also had a robust recruitment programme with a number of new staff due to start.

Refrigerators for medication on surgery wards did not have their temperatures checked consistently.

# Summary of findings

The trust had recently had a major IT shortage prior to the inspection, which had resulted in severe disruption to accessing electronic images and blood results. Some of the policies we reviewed on the trust intranet for surgery services had passed the date from review. Surgery services were not meeting the trust target for appraisals for non-medical staff. There was variable performance in surgery services relating to care for dementia patients. Patients stated that communication from staff regarding discharge planning could be inconsistent. There was limited signage in the outpatients building for pre-admission appointments.

## Critical care

Good



There was a good incident reporting culture and learning from incident investigations was disseminated to staff in a timely fashion. Staff were able to tell us about improvements in practice that had occurred as a result.

The environment was suitable to provide effective care and treatment and equipment was available and safe for use. Required checks were completed in most cases and we observed good infection prevention and control practice.

Staff had an understanding of safeguarding systems and there was a safeguarding team within the trust. We found deprivation of liberty and mental capacity was assessed in line with trust policy and legislation. Care and treatment was delivered using up to date evidence based practice.

We saw examples of staff providing compassionate care to patients. Staff took time to discuss care and treatment with patients and relatives and kept them well informed.

Patient and relative feedback was very positive about the care provided across the critical care services. Staff were described as caring and compassionate.

There was good access and flow within the critical care service. Delayed discharges on the general critical care unit were below the national average and minimal elective surgeries were cancelled due to a lack of critical care bed.

There was strong medical and nursing leadership and the service had a strategy in place to develop the service, which was achievable.

# Summary of findings

The leadership team were well established and there were good connections with all staff throughout the service. The team were managing a complex critical care environment in an integrated and seamless way. The leadership team had a good oversight of local risks and risks were fully documented, discussed and we saw appropriate mitigation to reduce risks. There was an open and positive culture within the unit. Leaders were visible, supportive and approachable. We also found:

We were not assured sepsis six and the new sepsis pro forma was fully integrated into practice as staff knowledge was varied.

The first floor did not participate in the Intensive Care National Audit and Research Centre (ICNARC) dataset. We were told there were plans to include the first floor in the future.

The service was not meeting national guidance for dietician and occupational therapy input. Visiting times were not always responsive to the needs of relatives and patients. Whilst we saw some examples of flexibility, this was not consistent.

## Outpatients and diagnostic imaging

Good



Outpatients and diagnostic imaging staff had completed mandatory training and rates were 100% in most teams. Staff were clearly able to explain their role in raising safeguarding concerns and how they would escalate concerns in this regard.

There was evidence of the WHO checklist being completed and audited. Patient protocols were in place in radiology.

There was effective use of the national early warning score (NEWS) to identify a patient who might be deteriorating. Patients received care and treatment that was evidence-based and in accordance with national guidance. However, we found 15 policies in radiotherapy that were not up to date.

There was compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). Staff worked together in a multidisciplinary environment to meet patient's needs.

There was a range of audits in place across outpatients, diagnostics and imaging to monitor patient outcomes.

# Summary of findings

Consent was sought from patients prior to their receiving care or treatment. Staff received training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DoLS).

The outpatients department had developed some nurse-led clinics; there were also rapid access clinics for patients experiencing conditions such as asthma and chest pain.

The access issues resolution service (AIRS) was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues.

Interpreters were available to enable staff to communicate with patients where English was not their first language.

Between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician was mostly lower than the England average.

St Barts had introduced a call reminder service to remind patients of their appointments.

Outpatients' managers told us they had not had to cancel any clinics as a result of the IT failure on 20 April 2017.

The trust had consistently performed better or similar to than the operational standard and England average for cancer waiting times.

Diagnostics and imaging services were meeting waiting time performance criteria.

Staff offered care that was kind and promoted people's dignity. We saw relationships between people who use the service and those close to them and staff were strong, caring and supportive.

Most patients and relatives we spoke with told us they were involved in decision making about their care.

Patients and those close to them also understood their treatment and choices available to them.

There was a range of emotional support options for people to talk about their condition, including access to chaplains, social workers and community support staff.

Interpreters were available to enable staff to communicate with patients where English was not their first language.

Staff told us there had been improvements in leadership at both an executive and local level in outpatients, diagnostics and imaging. Local leaders were visible and staff felt that concerns they raised would be addressed.

# Summary of findings

Quality reports and dashboards were sent to the managers and matrons of outpatients and diagnostic imaging on a monthly basis; this included reviews of key performance indicators (KPI).

Governance systems internally within outpatient and diagnostic imaging services demonstrated information was shared and lessons were learnt about events. However, shared learning across the divisions was more limited.

Most staff knew about the trust's values and could explain what these meant to their role.

Staff told us relationships between outpatients and diagnostic imaging had improved. Staff felt that there was an open culture within services.

We also found:

Incidents in regards to clinics running late were not always reported in accordance with trust policy.

Clinic 5 did not have a sluice and staff were emptying urine into a toilet. This created an infection risk of bodily fluids splashing in the toilet area.

There was limited signage in the x-ray department informing patients of the dangers of radiation, and the signage did not carry the radiation protection supervisor's details.

Staff could not be assured that medicines were stored within the required temperature for the safe storage of medicines in clinic 1 as ambient room temperatures were not recorded.

There was an identified risk as a result of the age of the ultrasound machines and the potential to produce suboptimal images. Although there had been no incidents of this.

IT failures on 20 April 2017 and 30 May 2017 had led to clinicians having to leave their clinical areas to view images in the imaging department. Work was in progress on an investigation and a clinical harm review. There was a risk to ongoing service development in regards to the rolling out of a paperless records system due to the reliability of the trust's IT systems.

The risk register did not contain action plans to explain what actions had been taken to mitigate identified risks or identify timescales for completion of actions to mitigate risks.

Between December 2015 and November 2016 the 'did not attend' (DNA) rate was mostly higher than the England.

## Summary of findings

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There were capacity issues in some clinics. Clinic rooms were booked up quickly and there was limited spare room capacity.

There was a risk to ongoing service development as clinic space was at a premium and as demand increased, the outpatients' model may make meeting the demand unsustainable.

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