Care Quality Commission

Bradford Teaching Hospitals NHS Foundation Trust

St Luke'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	Requires improvement	🟠
Medical care (including older people's care)	Good	🟢
Outpatients and diagnostic imaging	Requires improvement	🟠

Summary of findings

Letter from the Chief Inspector of Hospitals

Bradford Teaching Hospitals NHS Trust is an integrated trust, which provides acute and community health services. The trust serves a population of around 500,000 people in the Bradford and surrounding area. The trust operates acute services in Bradford Royal Infirmary and St Luke's Hospital. The trust has four community hospitals; Eccleshill, Shipley, Westbourne Green and Westwood Park. Eccleshill Hospital was closed at the time of the inspection.

St Luke's Hospital provides general medicine for adults as well as rehabilitation and therapy services. The hospital also provides outpatient services for adults and children.

We carried out a follow up inspection of the trust from 11-13 January 2016. This was in response to a previous inspection conducted as part of our comprehensive inspection programme in October 2014. In addition, an unannounced inspection was carried out on 26 January 2016.

Follow up inspections do not always look at every service the trust provides. They focus on the areas identified as requiring improvement in the previous inspection and any areas of concern identified in the time since the last inspection. In addition, not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

At this inspection of St Luke's Hospital we re-inspected the safe domain for medicine as we previously rated this service as requires improvement. We did not inspect the other domains for medicine as they were previously rated as good. We also re-inspected the safe, responsive and well-led domains in outpatient services as they were previously rated as inadequate for safety and requires improvement for the responsive and well-led domains.

At this inspection we rated St Luke's Hospital as requires improvement. This was because outpatients was rated as requires improvement overall. Medicine remained rated as good overall, however safety was still rated as requires improvement.

Our key findings were as follows:

- In relation to outpatient services, the trust had taken the necessary steps to ensure that the backlog of over 250,000 on non-referral to treatment patient pathways identified in May 2014 and April 2015 had been clinically reviewed and actions taken to reduce risks to patients, including prioritising appointments and the assessment of potential harm. An improvement plan had been developed and systems and processes had been changed. The trust had revised executive, clinical and managerial leadership arrangements for outpatients and invested in additional administrative staff and a rolling programme of staff training.

- However, the new systems and processes had not yet been embedded within the outpatient service and further work was required to establish the new centralised patient booking system. Staff did not feel engaged with the changes and expressed frustration at the new systems and processes. There were still a large number of patients waiting for outpatient appointments, which could delay access to treatment.

- Policies and procedures in outpatients and diagnostics were not always up to date.

- At the previous inspection in October 2014, concerns were raised about the out of hours medical cover at St Luke's Hospital and the management of the deteriorating patient. At this inspection we found that all staff had a good understanding of the arrangements for medical cover out of hours. The trust had also commissioned an external review of medical staffing at St Luke's and had concluded the medical cover was adequate for the service.

- We had concerns about nurse staffing levels in medicine and found a number of occasions when the number of staff on duty was significantly below the planned level. We saw occasions when there was only one registered nurse and two health care assistants to look after 27 patients.

Summary of findings

- Nursing records were not stored securely on Ward F3. This meant there was a risk of confidential patient information being accessed.

- In medicine, improvements had been made with safeguarding training and mandatory training rates were now above the trust target of 95%.

- Ward and outpatient areas were visibly clean and staff generally followed infection prevention and control practices. There had been no cases of MRSA or Clostridium difficile on the medical wards at St Luke's from January 2015 to the time of our inspection.

We saw several areas of good practice including:

- Systems were in place to report and learn from incidents, wards monitored safety and harm-free care and safety thermometer information was now visible.

- We saw evidence of shared learning between Bradford Royal Infirmary and St Luke's Hospital. Staff at St Luke's were able to tell us about a recent serious incident that had occurred at Bradford Royal Infirmary.

- There were robust arrangements in place to ensure that only suitable patients were admitted to St Luke's Hospital. We observed a nurse on F6 take a handover of a new patient and they challenged the staff member to ensure the patient was medically stable and appropriate for the ward

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

Importantly, the trust must:

- Ensure that there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified, assessed and managed.

- Ensure there are improvements in referral to treatment times and action is taken to reduce the number of patients in the referral to treatment waiting list to ensure that patients are protected from the risks of delayed treatment and care.

- The trust must ensure that robust arrangements are in place to ensure that policies and procedures (including local rules in diagnostics) are reviewed and updated.

- Ensure patients notes are securely stored to ensure patients' confidentiality is maintained.

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients' dependency levels.

In addition the trust should:

- Consider identifying a nominated individual at the hospital who is responsible for coordinating any concerns out of hours and at the weekend.

- Review the use of interpreters in outpatients and diagnostics to ensure that patients' privacy is maintained.

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?

Medical care (including older people's care)

Good 🟢

Overall, we rated this service as good. However the safe domain remained as requires improvement. We did see some improvements from out last inspection. However, we found problems with medicine fridges and no action had been taken when temperatures were recorded out of range. Documentation was to a good standard with risk assessments completed, however, patient's notes were not always stored securely.

The trust had taken action to address concerns about nurse staffing levels by closing beds on ward F3 and moving Eccleshill Community Hospital to ward F5. However, we did not have assurances about staffing levels and found a number of occasions when the number of staff on duty was below the planned level.

However, we found systems were in place to report and learn from incidents, wards monitored safety and harm-free care, and safety thermometer information was now visible.

Improvements had been made with safeguarding training and mandatory training rates were now above the trust target of 95%.

At the previous inspection in October 2014, concerns were raised about the out of hours medical cover, and the management of the deteriorating patient. All staff had a good understanding of the arrangements for medical cover out of hours. The trust had also commissioned an external review of medical staffing at St Luke's and had concluded the medical cover was adequate for the service.

Outpatients and diagnostic imaging

Requires improvement 🟠

We inspected the outpatients department at St Luke's Hospital in October 2014 as part of a comprehensive inspection. We rated the service overall at that inspection as inadequate. We rated safety, being responsive and well led as inadequate. Caring was rated as good. The effectiveness domain was inspected but not rated.

We had serious concerns over the large backlog of patients waiting for a review of their outpatient care pathway. There had been around 205,000 patient

Summary of findings

pathways to be reviewed. This figure was revised in April 2015 when a further 47,000 non-refer to treatment (RTT) backlog was identified adding to the previous backlog accumulating to around 250,000. At this inspection, we rated the service overall as requires improvement. We rated safety as good, responsive and well led as requires improvement. We found that a great deal of work had been undertaken to improve the arrangements for booking appointments, addressing concerns over the identified backlog with outpatient appointments and develop assurance mechanisms. The new systems and processes had not yet been embedded within the outpatient service and further work was required to establish the new centralised patient booking system. Staff did not feel engaged with the changes and expressed frustration at the new systems and processes. A programme of training and development had been introduced as part of the improvement plan to establish the centralised patient booking service. This was work in progress at the time of this inspection.

We found that there were systems and processes in place for incident reporting and learning from incidents.

St Luke's Hospital

Detailed findings

Services we looked at

Medical care (including older people's care);Outpatients and diagnostic imaging

Detailed findings

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Detailed findings from this inspection

Background to St Luke's Hospital

St Luke's Hospital is part of the Bradford Teaching Hospitals NHS Foundation Trust. It is situated in Bradford and serves a population of around 500,000 people in the local area. The trust employs around 5,500 members of staff.

The hospital provided general medicine and rehabilitation and therapy services for adults as well as outpatient services for adults and children. The hospital also had a virtual ward. This team delivered care in the community and aimed to keep people at home, where possible.

At the time of the inspection the wards at St Luke's had recently undergone a restructure with services from Eccleshill Community Hospital being moved to St Luke's. Eccleshill Community Hospital had moved to ward F5, and stroke and neurology rehabilitation had moved from ward F5 to F3. The hospital had approximately 63 beds.

The health of people in Bradford is generally worse than the England average. Deprivation is higher than average and around 23.9% (29,225) of children live in poverty. Life expectancy for both women and men is lower than the England average. The Bradford area has a higher than average proportion of the population who are under 16 years old. The black, asian and minority ethnic (BAME) population is higher than the England average, with 32.7% BAME residents compared to an England average of 14.6%.

We carried out a follow-up inspection of the trust on 11-13 January 2016 in response to a previous inspection conducted as part of our comprehensive inspection programme of the Bradford Teaching Hospitals NHS Foundation Trust in October 2014.

Our inspection team

Our inspection team was led by:

Chair: Christopher Tibbs, Medical Director, Royal Surrey County Hospital

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The team included CQC inspectors, a pharmacist inspector and a variety of specialists including a consultant surgeon, a medical consultant, senior nurses, including a children's nurse, executive directors and a safeguarding lead. We were supported by an expert by experience who had personal experience of using or caring for someone who used the type of service we were inspecting.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

However, as this was a focussed inspection we did not look at the whole service provision. We focussed on areas that were rated as requires improvement following the comprehensive inspection of the trust in October 2014. Therefore, not all of the five domains: safe, effective, caring, responsive and well-led were reviewed for each of the services we inspected.

Prior to the inspection we reviewed a range of information that we held and asked other organisations

to share what they knew about the trust. These included the clinical commissioning group, Monitor, Health Education England, the General Medical Council, Local Authorities and local Healthwatch organisations. We also held four focus groups in which we spoke to 37 people from local community groups who had experienced care and treatment provided by Bradford Teaching Hospitals NHS Trust.

We carried out the announced inspection visit between 11 and 13 January 2016. During the inspection we held focus groups and drop-in sessions with a range of staff including nurses and midwives, consultants, allied health professionals (including physiotherapists and occupational therapists), healthcare assistants and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' records of personal care and treatment.

Facts and data about St Luke's Hospital

The trust became a Foundation Trust on 1 April 2004.

The trust had a total revenue of £369 million in April 2014 to April 2015. Its full costs were £376 million.

The trust had around 5,500 staff, of which 753 were medical staff, 2,721 were nursing staff and 3,494 other staff groups.

Between January 2014 to June 2015 there were 475,000 outpatient attendances at the trust.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	N/A	N/A	N/A	N/A	Good
Outpatients and diagnostic imaging	Good	Not rated	N/A	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Detailed findings

Notes

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

2. Follow up inspections focus on the areas identified as requiring improvement in the previous inspection and any areas of concern identified in the time since the last inspection. Therefore, at this inspection, not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

Medical care (including older people's care)

Safe	Requires improvement 🟠
Overall	**Good** 🟢

Information about the service

St Luke's Hospital (St Luke's) is part of the Bradford Teaching Hospitals NHS Foundation Trust. Medical services at St Luke's comprised of three medical wards: F6 care of the elderly rehabilitation, F5 community rehabilitation and F3 stroke and neurology rehabilitation. The wards at St Luke's had recently undergone a restructure with services from Eccleshill Community Hospital being moved to St Luke's. Eccleshill Community Hospital had moved to ward F5, and stroke and neurology rehabilitation had moved from ward F5 to F3.

At the time of our inspection, ward F6 was a 24 bed rehabilitation ward, nine beds were intermediate care beds and 15 were care of the elderly beds for sub-acute elderly patients requiring a longer period of rehabilitation. Ward F3 was a 12 bed stroke and neurology rehabilitation ward. Ward F5 was a 27 bed intermediate care ward providing rehabilitation. There was a virtual ward based at St Luke's. This team delivered care in the community setting and aimed to keep patients at home.

The above services were inspected during an announced comprehensive CQC inspection in October 2014 in which the service was rated as good overall. At that time, we rated effective, caring, responsive and well-led as good and we rated safe as requiring improvement.

During our follow up inspection, we reviewed the safe domain. We visited the following ward areas: F3, F5 and F6. We spoke with 11 staff, including doctors, nurses, healthcare assistants, ward managers, matrons and consultants. We also looked at the records of 10 patients. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Overall, we rated this service as good. However the safe domain remained as requires improvement. We did see some improvements from out last inspection. However, we found problems with medicine fridges and no action had been taken when temperatures were recorded out of range.

Documentation was to a good standard with risk assessments completed, however, patient's notes were not always stored securely.

The trust had taken action to address concerns about nurse staffing levels by closing beds on ward F3 and moving Eccleshill Community Hospital to ward F5. However, we did not have assurances about staffing levels and found a number of occasions when the number of staff on duty was below the planned level.

However, we found systems were in place to report and learn from incidents, wards monitored safety and harm-free care, and safety thermometer information was now visible.

Improvements had been made with safeguarding training and mandatory training rates were now above the trust target of 95%.

At the previous inspection in October 2014, concerns were raised about the out of hours medical cover, and the management of the deteriorating patient. All staff had a good understanding of the arrangements for medical cover out of hours. The trust had also commissioned an external review of medical staffing at St Luke's and had concluded the medical cover was adequate for the service.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement 🟠

We found that there had been improvements since out last inspection but there were still some areas that required improvement because:

- The hospital was still experiencing nursing staff shortages. The trust had taken steps to minimise the risk to patients by closing beds on ward F3 and moving Eccleshill Community Hospital services to ward F5. However, on a number of occasions the number of staff on duty was below the planned level. We saw one occasion when there was one registered nurse and two health care assistants to look after 27 patients.
- No action had been taken to address the issues raised about systems in place to report and ensure repair of refrigerators (fridges) used for storing temperature dependent medicines when these were showing faults.
- Documentation was to a good standard with risk assessments completed. However, patients' notes were not always stored securely.

However, we found that:

- Systems were in place to report and learn from incidents, wards monitored safety and harm-free care, and safety thermometer information was now visible.
- Mandatory training rates had improved and were now above the trust target of 95%. We also saw an improvement in safeguarding training rates, 93% of staff had completed safeguarding training.
- At the previous inspection in October 2014, concerns were raised about the out of hours medical cover, and the management of the deteriorating patient. All staff had a good understanding of the arrangements for medical cover out of hours. The trust had also commissioned an external review of medical staffing at St Luke's and had concluded the medical cover was adequate for the service.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are in place. There were no never events reported in medicine between October 2014 and September 2015.

- Serious incidents are incidents that require reporting and further investigation. For the medicine directorate, across all sites, 33 serious incidents were reported between October 2014 and September 2015. Of these incidents 25 were pressure ulcers that met serious incident criteria. The remaining included, falls, unexpected patient death and care of the deteriorating patient.
- Between February 2015 and January 2016 there were 340 incidents reported on the medical wards at St Luke's. Five incidents were classified as 'moderate harm', 69 low harm and 266 as no harm. The most commonly reported incidents were falls, slips and trips accounting for 232 of all incidents reported. Other themes of incidents included: pressure ulcers, communication issues when patients were transferred and service provision issues such as staffing.
- Staff were aware of how to report incidents and told us they did this via an electronic reporting system. Staff told us they were able to access the system and report incidents themselves.
- Staff provided us with examples of incidents they would report. Examples included falls, pressure ulcers and a recent incident where a patient was transferred without their medical notes or prescription chart.
- Staff explained that they received feedback on incident outcomes via e-mail and incidents were discussed at monthly sisters meetings.
- We observed inconsistencies in the way information and lessons from incidents were shared. At Bradford Royal Infirmary (BRI) we observed safety huddles where staff shared lessons from incidents. This practice was not observed on the medical wards at St Luke's. Staff on F3 told us they did not have 'safety huddle's' as they had at BRI.
- Staff told us that they would complete an incident form for all pressure ulcers and a root cause analysis would be completed for a grade three or above. A root cause analysis is a structured method used to analysis serious incidents. We reviewed a root cause analysis relating to a fall, which identified lessons learnt, recommendations and included an action plan.
- We saw evidence of shared learning. Staff were able to tell us about a recent serious incident that had occurred on a medical ward at Bradford Royal Infirmary (BRI). Staff on F5 said they had developed more robust links with the mental health liaison nurse following an incident.

Medical care (including older people's care)

- The Duty of Candour regulation sets out specific requirements that providers must follow if something goes wrong with a patient's treatment or care. The regulation ensures that providers are open and transparent with people who use their services. Most of the staff we spoke with were aware of the duty of candour and spoke about being open and honest but they were unable to provide us with any specific examples of when it had been implemented.
- Mortality and morbidity was reviewed as part of clinical governance meetings. We reviewed clinical governance minutes across medicine and found inconsistences in the recording and reviewing of mortality and morbidity. This was unchanged from our previous inspection in 2014.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections. In contrast to our previous inspection, safety thermometer information was now displayed on all the wards we visited.
- Between April 2015 and August 2015 we saw that F3 recorded one pressure ulcer and forty-nine falls. Between April 2015 and November 2015 we saw that F5 recorded no pressure ulcers and thirty-eight falls. Staff said to reduce the risk of falls they would cohort patients together in a bay close to the nurses' station and they would use falls sensors to alert staff to when a patient has stood up.

Cleanliness, infection control and hygiene

- There had been no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) on the medical wards at St Luke's from January 2015 to the time of our inspection.
- Monthly infection control audits were undertaken. Data from April 2015 to October 2015 for the medical division showed good compliance with hand washing, central and peripheral venous catheter hygiene, urinary catheter care and dress code.
- The wards we visited were visibly clean.

- All staff we observed during the inspection followed the uniform policy, with the exception of a doctor who was not bare below the elbow. We found that not all staff were comfortable to challenge medical staff when they did not comply with policy.
- Hand sanitising gel was available on the entrance to all the wards we visited. We observed that personal protective equipment (such as disposable gloves and gowns) was available to staff but not always outside of side rooms where patients were isolated.
- We observed staff using appropriate protection such as gloves when entering the isolation room and disposing of these appropriately when they left.
- Cleaning assurance labels were used on equipment to indicate they were clean. However, there were inconsistencies. On F3 we saw two commodes and two bed pans that were visibly clean but did not have cleaning assurance labels. Therefore, it was unclear if they had been cleaned.
- We saw that waste and linen was appropriately segregated and disposed of correctly in accordance with trust policy.
- Staff on ward F5 told us they had an infection control link worker who was responsible for developing and sharing best practice in relation to infection prevention control.

Environment and equipment

- Resuscitation equipment was available on every ward we visited and daily checks had been completed.
- We looked at the results of the 2015 patient-led assessments of the care environment (PLACE). All the wards at St Luke's achieved 100% for cleanliness with the exception of F5 which scored 94.2%.
- Inpatient services at Eccleshill Community Hospital had recently moved to ward F5 which had 27 intermediate care beds. Staff said the environment was not suitable for rehabilitation as there was a lack of therapy space, no dining room and no day room for patients. When we visited the ward, dining tables had been placed in the middle of the six bedded bays. This made the environment appear cluttered. Staff said they felt it was having an impact on patients' rehabilitation, as they previously encouraged patients to walk to the dining room for meals as part of their rehabilitation. This meant that patients may be at risk of not receiving the treatment they require. Staff were unaware of how long they would be staying on F5.

Medical care (including older people's care)

- We saw that patients who were identified as needing pressure relieving equipment had the correct pressure relieving cushions and mattresses in place.
- Staff said equipment for bariatric patients was available and arrived promptly.
- Staff told us that they would report any faulty equipment to medical physics and they responded in a timely manner.
- F6 had a new computer with a camera to allow staff to video link with doctors at BRI. Staff told us this had yet to be used.
- We saw that F3 had five side rooms closed. Staff told us this was due to staffing levels and it also gave them more flexibility to move patients on the ward, allowing them to change the gender of the bays depending on patient need.

Medicines

- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked rooms and fridges.
- Controlled drugs were appropriately stored with access restricted to authorised staff. We checked the recording of controlled drugs and found accurate, up to date stock checks had been kept.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. However, on F3 we saw the fridge temperature had been above the maximum temperature since 31st December 2015. Staff told us this had been reported but no immediate action had been taken. If stored at an incorrect temperature, the safety and efficacy of medication can be affected.
- When we visited F5 we saw that the drug fridge was condemned. Staff told us they were awaiting a replacement. The fridge was not in use and staff were using a fridge on another ward.
- We reviewed 11 medication charts. We found medication had been administered as prescribed and at appropriate times and allergies had been documented.
- Staff told us that medicines usually came with patients when they were transferred from BRI.
- Pharmacy cover was available during the week from 9:30am till 5:30pm on F3 and F6.
- Staff on F5 told us they had pharmacy cover in the morning during the week.

- If the ward required medications at the weekend staff told us they had to photocopy the patient's drug chart and send it to BRI in a taxi with a requisition chart.
- On F5 the nurse in charge completed a daily list of essential checks including checking fridge temperatures and the controlled drug book. The checklist had been completed daily and was up to date.

Records

- We looked at 10 sets of paper records which were completed to a good standard with clear and concise information logged. Risk assessments were completed and any actions taken were record in all the patients' notes we reviewed.
- Nursing records on F3 were kept in an unlocked cabinet opposite the nursing station. The ward manager told us they were trying to obtain a lockable cabinet and were in discussion with the matron. This meant that there was a risk of confidential patient information being accessed.

Safeguarding

- Mandatory training at the trust included adults safeguarding levels one and two, and children's safeguarding training, levels one, two and three. The trust had set a target of 95% for completion of adult and children's safeguarding training.
- On the previous inspection in October 2014, the number of staff across medicine who had completed safeguarding training was below the trust target. 90% of staff who required training were trained to safeguarding Level 1, 31% trained to Level 2 and 41% trained to Level 3. This was against a trust target of 95% for each level.
- Training figures provided by the trust at this inspection for wards F5 and F6 at St Luke's, showed 93% compliance rates with all levels of safeguarding training for both adults and children. This was an improvement on the previous inspection but still below the trust target of 95% for each level. No information was provided for F3 and no dates were attached to the training figures.
- Staff could explain the safeguarding process and knew who they could contact for further information or advice if needed.
- On F5 we saw an information poster on how to identify and make a safeguarding referral.

Mandatory training

Medical care (including older people's care)

- On the previous inspection in October 2014, the compliance with mandatory training within medicine was 60%, below the overall trust target of 75%.
- Training figures provided by the trust for wards F5 and F6 at St Luke's, showed mandatory training rates had improved to 82%.
- Staff said they were up to date with mandatory training, however, they reported it was difficult to attend face to face training and complete learning via the electronic learning system due to staffing levels on the ward.
- One ward manager told us they were waiting for access to the electronic staff record in order to see mandatory training compliance levels for their staff.
- Staff on F5 told us that the electronic learning system could be accessed from home. The ward manager tried to give staff one shift a week to complete any mandatory training.
- We saw the overall compliance for mandatory training on F5 was 89%. Staff told us they did not complete all the mandatory training due to the nature of the patients. For example they do not do blood transfusion training as this was not relevant to the care they gave to patients.

Assessing and responding to patient risk

- Staff knew how to identify and respond if a patient was deteriorating. They told us they used the National Early Warning Score (NEWS) to record patients' observations and to assess if a patient's condition was improving, deteriorating or stable. The score from the NEWS acted as a trigger to escalate concerns to medical staff on the ward.
- From the previous inspection in 2014, concerns were raised about medical cover out of hours, how staff responded to deteriorating patients and the number of patients transferred back to BRI, due to deterioration in their condition.
- On this inspection, staff told us patients transferred to St Luke's were screened by the discharge team to ensure they were suitable for rehabilitation, and the consultant had to agree to take over the patient's care.
- Staff told us they ensured patients transferred to St Luke's had a clear escalation plan and patients were medically stable. We observed a nurse on F6 take a handover of a new patient and they challenged the staff member to ensure the patient was medically stable and appropriate for the ward.

- Staff told us if they were concerned about a patient out of hours they would contact the on call medical registrar on ward 3 at the BRI. There was no medical cover on site at St Luke's Hospital out of hours. Staff told us they would have to describe the patient's presentation over the phone.
- Staff said if they had serious concerns about a patient out of hours they would call '999' and transfer the patient back to the BRI. Staff said they would try and transfer patients to ward 3 (elderly assessment unit) or ward 9 (stroke ward), however, if there were no beds patients would have to go to the accident and emergency department. Staff on F5 told us they would hold the patient's bed open for 24 hours so the patient can come back to the ward once medically stable.
- Staff gave us an example of when a patient deteriorated and required transfer back to BRI. They told us the process worked well and the ambulance arrived in less than seven minutes.
- In the event of a cardiac arrest, staff told us they would dial '999' and commence basic life support until the ambulance arrived.
- Staff told us they had intermediate life support training but not advanced life support training.
- The practice we observed was in line with the trust's operational policy for inpatient wards at St Luke's Hospital.
- Ward F6 had just introduced telemedicine to assist doctors in reviewing patients. However, staff told us the technology did not get used.
- Staff told us that patients assessed as a high falls risk were identified at morning handover and by using magnetic symbols on the patient's name board. To prevent falls staff told us they would cohort patients together in a bay close to the nurses' station and they would use falls sensors to alert staff to when a patient has stood up.

Nursing staffing

- The numbers of staff planned and actually on duty were displayed on each ward.
- The integrated patient acuity monitoring system (iPAMS) was used on the wards to enable nursing staff to ensure safe staffing levels based on the acuity of patients cared for. Staff told us they completed this daily.

Medical care (including older people's care)

- Data provided by the trust showed the number of nurse and healthcare contracted hours within medicine had reduced from 796.96 contracted whole time equivalent (WTE) in April 2015 to 759.38 contracted whole time equivalent hours in October 2015.
- Staff told us there were widespread issues with staff shortages. Most wards tried to cover gaps with their own staff or used bank or agency staff.
- F3 had closed five beds in response to staffing levels and had gone from 17 beds to 12. On the day of the inspection the planned level of staffing was two nurses and three healthcare assistants in the day and two nurses and two healthcare assistants at night. The ward actually had two nurses and two healthcare assistants during the day and two nurses and two healthcare assistants at night. This meant they were short of one healthcare assistant during the day.
- Staff on F3 told us they had 6.5 WTE vacancies for nursing staff and the band 7 nurse was on a 12 week secondment and had only been in post one week. The ward manager was not supernumerary. The ward used bank staff to fill shifts and had a bank nurse on each night shift due to staff shortages.
- F6 is a 24 bedded ward. Staff on F6 told us they had recruited a nurse and they were now at the correct establishment. The planned staffing levels for this ward were 3 registered nurses and 3 health care assistants in the day and 2 registered nurses and 2 healthcare assistants on a night. On the day of the inspection the ward had the same number of planned and actual staff during the day and at night.
- We reviewed the staffing rota for F6 for a one month period from February 2016 to March 2016. We found that on 24 days staffing levels were lower than planned. We saw one late shift and a night shift with only one registered nurse on duty. On 11 occasions the ward was short staffed by one registered nurse resulting in a nurse to patient ratio of 1:12. We only saw 5 occasions when shifts were back filled by either a registered nurse or a health care assistant.
- Staff on F5 said they had moved from Eccleshill Community Hospital as they did not have enough staff to maintain patient safety. When we visited the ward they had the same number of planned and actual healthcare assistants and nursing staff during the day and at night. Staff told us they had 1.9 WTE vacancies for nursing staff and had a full establishment of healthcare assistants.
- The ward manager on F5 told us they only get one day a week supernumerary.
- We reviewed the staffing rota for F5 for a one month period from December 2015 to January 2016 and found 12 days when staffing levels were lower than planned. We saw no evidence of these shifts being filled by bank or agency staff. On one shift there was only one registered nurse and 2 health care assistants on duty to care for 27 patients.
- When we visited F5 we observed a patient whose fall sensor was alarming. A nurse arrived in approximately thirty seconds to come and assist the patient.
- During the previous inspection in October 2014, concerns were raised about the lack of senior nurse cover at night and on a weekend. The most senior member of nursing staff was frequently a band 5 staff nurse. During our inspection, staff told us there was no on-site senior nurse cover at night, or on a weekend. Staff told us they contacted the manager on-call team or the medical team at Bradford Royal Infirmary if they had concerns.
- From our previous inspection in October 2014 the trust produced an action plan to address concerns raised. We reviewed the action plan, and found that nurse staffing at St Luke's Hospital was rated as red, indicating that this concern had not been addressed.
- Staff told us agency and bank staff get a ward induction and have an induction checklist.

Medical staffing

- From the previous inspection in October 2014 concerns were raised about medical staffing out of hours.
- There was on-site medical staffing cover from Monday to Friday until 4pm, at St Luke's Hospital.
- Staff on F3 told us that a foundation year 1 (FY1) worked on the ward Monday – Friday from 8am until 4pm. A stroke consultant and neurology consultant completed a ward round twice a week. During this time the consultant would meet with patient's relatives.
- F6 had a foundation year 2 (FY2) doctor onsite from Monday to Friday, 8am – 3pm.
- F5 had 27 intermediate care beds. The senior management team told us these patients were sub-acute and patients had a clear escalation plan and were carefully selected. Staff told us they had two part-time GP's who did two sessions a week on a Monday afternoon and a Wednesday morning. On a

Medical care (including older people's care)

weekend and out of hours the ward had no medical cover. Staff said they could phone local care direct which was an out of hours GP service if they had concerns about a patient.

- There was no medical cover overnight at St Luke's or on a Sunday. Medical cover on a Saturday was one foundation year 2 (FY2) doctor, who was based on F6.
- Staff told us if they needed to contact a doctor out of hours for advice they could call the medical registrar on ward 3 or ward 4 at Bradford Royal Infirmary. If the patient required urgent medical input, staff called '999' for an emergency ambulance.
- In the event of a cardiac arrest the senior management team and nursing staff told us cardio-pulmonary resuscitation (CPR) was commenced they would call '999' for urgent medical input.

- The senior management team told us there were no national guidelines for recommended medical staffing levels in community hospitals, and they had no concerns about the medical cover at St Luke's or the arrangement for out of hours cover.
- The senior management team told us they had commissioned an external review in December 2015 of the arrangements for medical cover at St Luke's Hospital. The trust shared the review with us, and it concluded that the medical cover both in and out of hours was similar to other intermediate care facilities
- The medical cover we observed was in line with the trust's operational policy for inpatient wards at St Luke's Hospital.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with were aware of this.

Outpatients and diagnostic imaging

Safe	**Good**	🟢
Effective	**Not sufficient evidence to rate**	⚫
Responsive	**Requires improvement**	🟠
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

Bradford Teaching Hospitals NHS Trust provided a wide range of outpatient clinics at Bradford Royal Infirmary (BRI) and St Luke's Hospital, predominantly at BRI. Between January 2014 and June 2015, 709,602 patients attended outpatient clinics across the two sites.

The outpatient services were managed through the diagnostic and therapies directorate and had recently transitioned to a centralised booking service, which was located at St Luke's Hospital. Diagnostic and imaging services provided on an outpatient basis included radiology (plain film), general ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI) scans. The clinic area comprised of a main reception and waiting area and consulting rooms.

We have inspected this service as a follow up to the last inspection and inspected the safety, responsive and well led domains. We visited the diagnostic and imaging services and a number of outpatient clinics, including pain management, rheumatology and respiratory. We spoke with 9 members of staff and 8 patients, checked equipment and looked at 6 sets of medical records.

Summary of findings

We inspected the outpatients department at St Luke's Hospital in October 2014 as part of a comprehensive inspection. We rated the service overall at that inspection as inadequate. We rated safety, being responsive and well led as inadequate. Caring was rated as good. The effectiveness domain was inspected but not rated.

We had serious concerns over the large backlog of patients waiting for a review of their outpatient care pathway. There had been around 205,000 patient pathways to be reviewed. This figure was revised in April 2015 when a further 47,000 non-refer to treatment (RTT) backlog was identified adding to the previous backlog accumulating to around 250,000.

At this inspection, we rated the service overall as requires improvement. We rated safety as good, responsive and well led as requires improvement.

We found that a great deal of work had been undertaken to improve the arrangements for booking appointments, addressing concerns over the identified backlog with outpatient appointments and develop assurance mechanisms. The new systems and processes had not yet been embedded within the outpatient service and further work was required to establish the new centralised patient booking system. Staff did not feel engaged with the changes and expressed frustration at the new systems and processes. A programme of training and development had been introduced as part of the improvement plan to establish the centralised patient booking service. This was work in progress at the time of this inspection.

Outpatients and diagnostic imaging

We found that there were systems and processes in place for incident reporting and learning from incidents.

There were staff shortages across outpatients and diagnostic and imaging services. However, there were arrangements in place to assess whether staffing levels were safe, access support through agency or locums and from colleagues in other clinics.

There had been a reduction in the number of patients waiting on the total RTT waiting lists and in particular the backlogs identified in August 2014 and April 2015. However, there were still a large number of patients waiting for appointments, which could delay access to treatment.

There were times when there were delays in accessing interpreting services and on occasion patients' relatives were translating questions, which may not have been appropriate or protecting patient privacy.

Are outpatient and diagnostic imaging services safe?

Good ●

We rated safety as good because:

- The trust had taken the necessary steps to ensure that the backlog of patients on the non-RTT pathway identified in May 2014 and April 2015 had been clinically validated and actions taken to reduce risks to patients, including prioritising appointments and the assessment of potential harm.
- There were systems in place to report incidents and lessons from incidents were shared with staff.
- There were robust safety and assurance systems in place within the imaging and diagnostic services.
- There were generally sufficient numbers of staff across outpatients and the diagnostic and imaging services. Where there were shortfalls in staffing, there were arrangements in place to access cover.
- The environment within outpatients and diagnostic and imaging services was clean. There were systems and practices in place for the prevention and control of infection, including an audit programme and isolation facilities.
- Mandatory training rates across outpatients and diagnostic and imaging services were above the trust target of 95%.

However, we found that-

- Not all staff were aware of the guidance available on reporting incidents or what was a reportable incident and feedback to individuals was sometimes inconsistent.

Incidents

- There had been one serious incidents reported at the trust on the Strategic Executive Information System (STEIS) between August 2014 and July 2015. A review had been undertaken of 13 patients from the first cohort backlog of cases on the non-RTT pathway without an appointment, of these six had been assessed as resulting in no harm, 6 resulting in low harm and 1 with moderate harm. An investigation was in progress regarding this patient.

Outpatients and diagnostic imaging

- There were no never events reported during this period. Never events are serious, preventable patient safety incidents that should not occur if the available preventative measures are in place.
- Staff were aware of how to report incidents and had been trained in using the trust's electronic reporting system. Staff who had not yet received training on the system reported incidents through their line manager.
- Not all staff were aware of the guidance about what incidents should be reported, although they were clear about some events, for example a fall in clinic.
- Some staff in diagnostic and imaging services stated that not all changes relating to referral requests and 'did not attend' (DNA) were reported on the electronic reporting system.
- Learning from incidents was discussed at team meetings, although three staff members told us that there was some inconsistency in receiving individual feedback.
- Incidents were discussed at monthly governance and team meetings.
- We were told that a 'huddle' took place in some outpatient departments. This was an informal meeting, which took place at the start of the week to discuss service provision and any issues that had arisen. There were no minutes of these meetings.
- Within the diagnostic and imaging service, incident reporting in compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) linked to moderate harm and above were fed back at team meetings. In addition, learning took place through emails to staff and at other meetings.

Cleanliness, infection control and hygiene

- All outpatient areas visited were visibly clean and equipment, such as weighing scales had been marked with green stickers to indicate that it was clean and ready to use. A cleaning audit had been undertaken in December 2015. The service achieved 98.50% compliance with standards in this audit.
- The environment within the diagnostic imaging departments appeared clean and well maintained. There was a deep clean service and segregated areas available to isolate patients who may have an infection.
- The outpatient and diagnostic imaging departments completed infection control audits every month, which monitored compliance with practices such as hand hygiene, dress code and environment. Audits also

included spot checks on hand hygiene practices and cleaning standards. Audit results ranged from 94% to 100% from January 2015 to December 2015. Action plans were developed to address any identified issues and we saw within the documentation where concerns were escalated for example to the maintenance department.
- We saw staff follow the trust bare below the elbows policy and wore disposable gloves and aprons when required. Hand sanitising gel was available and regularly used by staff.
- In outpatient clinics there were systems in place to manage patients with a suspected infection, with isolation facilities available.
- Appropriate arrangements were in place for disposing of clinical waste in outpatient clinics and the diagnostic imaging department.

Environment and equipment

- Outpatient clinics comprised of reception, waiting areas and consultation rooms.
- Emergency resuscitation trolleys were accessible in all outpatient areas we visited. We saw that the majority of the equipment had been regularly checked and appropriate supplies were available on the trolleys. However, resuscitation guidelines were out of date with no superseding guidance in place.
- Daily checks were taking place on adult and paediatric resuscitation and monitoring equipment within the diagnostic and imaging services.
- Oxygen equipment was available and in date.
- The trust had maintained compliance with their annual programme of assurance for the testing of x-ray equipment across all modalities. There were systems in place for responding to national medical equipment alerts.
- The IR(ME)R safety checklists were displayed.
- There were appropriate risk assessments in place for the introduction of new equipment and protocol changes.
- Radiation risks were clearly sign posted and displayed.

Medicines

- We found few medicines used in the outpatient clinics.
- Medicines observed were stored appropriately according to national guidelines.
- Medicines seen were all in date.

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- Medicine fridges were checked daily to ensure that medicine requiring a controlled temperature range were stored correctly and safe to use.
- There was a robust training programme in place within the diagnostic and imaging service for the use of patient group directions.

Records

- We reviewed 6 sets of medical records during our inspection. These were completed appropriately and contained all relevant patient information. The trust was in the process of moving to an electronic patient record system, which it anticipated would address many of the issues encountered with handling and storing paper records.
- We saw that outpatient records were paper based. These were requested in advance of outpatient appointments from the records team.
- Records were appropriately stored in secure areas of the outpatient clinics we visited. No records were left accessible to patients or visitors.
- A report provided by the trust for the period October 2014 to October 2015 showed between 92 and 93% of records were delivered to clinics by 3.30pm on the day prior to clinic. The report showed that between 97 and 98% of records were delivered to clinics on time, with less than 3% of patients being seen with loose paper notes.
- The Audit of Clinic Utilisation and Efficiency Report September 2015 showed that of 33 completed audit forms, 13 of these related to surgical clinics, 7 medical clinics and 13 clinics for women's and children's services. Out of a total of 490 patients seen 17 records were on loose sheets of paper. Of the 33 clinics audited, 64% had medical notes available, and 85% had the clinic outcome form available. Overall, 64% of forms had incomplete data.

Safeguarding

- Completion rates for safeguarding training were 97% for adult safeguarding Levels 1, 2 and 3. For children's safeguarding training Levels 1, 2 and 3 there was 92% completion.
- Staff could explain the safeguarding process and who they would contact for support and to report any concerns.

- Staff were aware of the safeguarding lead within the trust and how to access information on safeguarding policies and procedures via the trust intranet.
- We saw that posters and information leaflets were on display in outpatient areas setting out the safeguarding process and encouraging patients and visitors to raise any concerns.
- Senior staff considered that they could recognise domestic abuse and knew where to go for support and advice.
- Senior staff were in the main aware of the national reporting expectation for female genital mutilation (FGM) and related guidelines.

Mandatory training

- Staff were above the trust target for completion of mandatory training, with 92% of staff having completed mandatory training.
- Staff confirmed that they were up to date with their mandatory training or were booked on to the necessary courses.
- Access to training was via an electronic system and face to face sessions. Staff also received updates from the electronic system to confirm when training was due to be completed.
- Staff told us that they did not always receive dedicated time for mandatory training and this often had to be completed around the working day.

Assessing and responding to patient risk

- In May 2014, the trust identified a significant backlog of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. This number increased in April 2015 when a further group (cohort) of 47,000 pathways were identified resulting in a total of over 250,000 that did not have an active referral to treatment pathway or were on a review waiting list. Of the 47,000 the trust identified that 9,400 patients had no 'see by date'. This extended across all specialities. This meant that there was a significant risk that decisions about treatment or diagnostics were delayed for some patients
- The trust commissioned an external organisation to assist it with the validation of the cohort of patients and these were reviewed by the medical directors' office in order to identify any patient safety issues.

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- An administration review of the patient pathways and a clinical review was undertaken for both cohorts identified. Actions were taken to address any risks identified and assess any harm caused.
- Staff could describe how they would contact the resuscitation team if they saw a patient's condition deteriorating or they required life-saving treatment.
- There was guidance within the diagnostic and imaging service on risk assessing patients undergoing procedures and these were clearly documented. For example, appropriate identification and pregnancy checks were in place across all modalities, with vetting of booking forms.

Nursing staffing

- Staffing levels within outpatients were dependent on the numbers of patients attending clinics across the two hospital sites.
- We looked at staffing data from January 2015 to December 2015. Health care assistant staff levels were consistently below planned levels, on two occasions only 79% of planned hours were filled. However, registered nurse staffing levels generally exceeded planned levels.
- There were systems in place to request additional staff or to cover gaps in rotas.
- Staff told us that there was frequent use of agency staff within the outpatient areas. These were routinely drawn from a single agency and we were told that many agency staff were 'regulars' within the trust.
- All health care assistants had completed the trust's competency based training framework.

Medical staffing

- Medical staffing was agreed and arranged through the specialities' division for example surgery or medicine.
- The individual divisions were responsible for mandatory training, appraisal and the revalidation of staff.

Other staffing

- Staff within the diagnostic and imaging services covered the on call for clinical areas; however due to low staff numbers staff reported this meant that they were frequently on the rota. There was a high use of locum staff within these services, although recruitment was taking place.

- Staff within the record management teams told us that they had to employ agency staff in order to meet demand.

Major incident awareness and training

- The trust had a major incident policy and business continuity plans, which staff could refer to if needed.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate ⬤

Are outpatient and diagnostic imaging services responsive?

Requires improvement 🟠

We rated responsive as requires improvement because:

- It was clear that there had been a great deal of development undertaken to streamline and improve services. However, the processes within the central patient booking service were not embedded leading to delays, inconsistent practices and confusion to patients and staff.
- There had been a reduction in the number of patients waiting on the total RTT waiting lists and in particular the backlogs identified in August 2014 and April 2015. However, there were still a large number of patients waiting for appointments, which could delay treatment.
- There were times when there were delays in accessing interpreting services and on occasion patients' relatives were translating questions, which may not have been appropriate or protecting patient privacy.

Service planning and delivery to meet the needs of local people

- The trust had changed the way it booked patients' clinic appointments and had moved from the majority of specialities managing arrangements to a centralised patient booking service (CPBS). The ultimate aim was to have all appointments booked through the centralised system processes.
- The trust commissioned external reviews of the outpatient services including the CPBS following the

identification of a large backlog of 200,559 patient pathways in August 2014 and a further group (cohort) of 47,360 in April 2015 of patients on the non-RTT pathway waiting for appointments.

- It was identified that of the original 200,559 cases around 150,000 had no record of appointment on the system meaning that the trust was unable to identify which patients required follow up. To address this situation the trust obtained external support to individually validate each case, ensuring that each one was recorded on the trust's electronic system and that follow up appointments were made for patients who required these. A clinical review was also undertaken through the medical director's office to identify if any harm had been caused due to delay and also to prioritise patients' appointments according to need. The validation of the 9,355 highest risk priority pathways was completed by the end of April 2015.

- Many staff we spoke with were critical of the newly created CPBS. Staff told us that this had caused issues in appointment booking, including appointments being booked into the wrong clinic, patients not being informed of cancellations, and difficulty in contacting the centralised booking team to discuss concerns.

- We found a mixed picture about the CPBS performance over responding to calls. Trust data showed that that the number of calls answered in the CPBS within 60 seconds had improved from 93.2% in May 2015 to 99% in October 2015. The number of abandoned calls had decreased from 15.7% to 6.6% over the same period.

- However, staff told us that phone lines at the CPBS were routinely closed between 1.30pm - 3.00pm. During this time the service could only be reached by e-mail. Staff told us that it could take some time before e-mails were responded to, which meant that urgent issues in regard to active clinics were often not resolved in a timely way. Calls to the booking system were routinely put on hold for considerable amounts of time or the call would be dropped.

- Patients interviewed on both sites highlighted problems with booking with five out of nine patients telling us of these problems.

- All the outpatient clinics we visited had the ability to book some appointments within specific timescales without the involvement of the CPBS team. This varied from a six month follow up in haematology to around three month periods in other specialties. In addition,

medical secretaries told us that they could also book patient appointments at short notice or where they felt that it was not appropriate to refer the patient back to the centralised booking service due to delays.

- We were told that the fast track cancer service also had the ability to book two week cancer appointments without the involvement of the centralised booking service. This meant that there were a variety of different ways in which appointments could be booked within the trust. Patients told us that they found this confusing and staff confirmed that patients often expressed confusion about who to contact in order to discuss appointments.

Access and flow

- Since the identification of the backlog in April 2015 of around 45,000 non-RTT patients, there had been a steady decrease to around 11,790 patients by December 2015. The trust was working to a base level of around 6,000, which they were aiming to reach by February 2016.

- In November 2015, there were 1,654 patients within the non-RTT process failure position for which an RTT or non-RTT pathway had been completed but the referral remained open with no clinically defined see by date.

- Planned patients waiting more than six weeks past their see by date had reduced from 263 in August 2015 to 66 in December 2015.

- The trust had not achieved the 90% target for admitted RTT performance from April to October 2015. The performance had been trending down and in October 2015 it stood at 76.67%.

- Referral to treatment within 18 weeks for non-admitted patients had been trending downwards since May 2015. The performance committee report dated 25 November 2015 stated that between April to October the trust had only achieved the 95% target in May. The performance in October 2015 was reported to be 90.67%.

- The target of 92% for the 18 week incomplete pathway had been achieved and stood at 92.02% for October 2015.

- The number of patients on the RTT total waiting list as of October 2015 stood at 22,087 patients.

- The number of patients waiting less than 18 weeks on the RTT total waiting list as of October 2015 stood at 1762 patients.

- The trust performed above the England average in all cancer waiting measures except in Q2 2014/15.

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- The trust performed below the England average in diagnostic waiting times up to and including July 2015, apart from August and September.
- Referrals into the service could be made through a variety of means, including GP and NHS Choose and Book. Staff told us that the majority of referrals were sent directly to the centralised booking system. However, some referrals were received directly into the departments and then had to be forwarded to the centralised booking team.
- It was evident from interviews with senior staff that there had been a great deal of development work undertaken within the CPBS, much of it aimed at streamlining and strengthening assurance processes. However, when speaking with staff in clinics and administration offices the process for accepting a referral was criticised. Staff explained that if a referral was received directly in a department then this was first sent to the centralised booking office. The centralised booking office noted the referral and sent it back to the department. The referral was then shared with clinical staff and sent back to centralised booking office to confirm appointment details. Finally, the referral was then sent back to the department in advance of a patient attending for their appointment. Staff raised concerns that this process did cause delay and the possibility for confusion.
- Staff were unaware of any policy in place for patients that did not attend their appointments and could not show us a copy of this policy on the trust intranet. Staff told us that any decision to discharge a patient for non-attendance would lie with their treating clinician. Staff said it was difficult to link patients not attending appointments to their vulnerability.
- Nursing staff completed patient outcome forms at the end of outpatient appointments. This pro-forma identified whether patients were for follow up (and the timescale), discharge, or if they had not attended clinic. Administrative staff in the clinic then entered details onto the electronic appointment system. If the patient was for a further appointment and it was within the timescale in which the clinic could book appointments then one would be booked at the time. If this was not, then staff told us that the patient was added to the waiting list to be managed by the central booking office.
- The Audit of Clinic Utilisation and Efficiency Report September 2015 showed that of 33 completed audit forms, 13 of these related to surgical clinics, 7 medical

clinics and 13 clinics for women's and children's services. Of the 33 clinics audited, 85% started on time, 64% had medical notes available, and 85% had the clinic outcome form available. Overall, 64% of forms had incomplete data.

Meeting people's individual needs

- Outpatient waiting areas had sufficient seating available for patients and visitors.
- We saw that magazines and newspapers were available in some waiting areas. Water was available in most outpatient areas.
- Staff told us that patient information leaflets were not routinely available in different languages. We did not see any patient information on clinical issues on display in different languages within the departments. We did see a complaints leaflet displayed in another language, but this had become out of date in 2012. This had been replaced by another 'Tell us what you think' leaflet (also on display) that was not available in another language in the department. This was also past its review date.
- Staff told us that they had access to translation services. Routinely, face to face interpretation was booked for patients who required support. Staff told us that any need was identified on the patient referral or when staff reviewed notes the day prior to clinics taking place. Any delays in receiving referrals or records could lead to insufficient time to book interpreter support. Staff were unsure if there was a translation policy.
- There was a mixed response about relying on family members or carers to provide interpretation for patients. Some would not use family members but other staff told us that they would feel comfortable using family members to interpret. This included reference by staff in diagnostic imaging to using family members to ask about patient pregnancy. There was a risk that this could lead to a patient being placed in a difficult position in disclosing sensitive information.
- Staff in the departments told us of times when people with learning difficulties were cared for based on their individual needs. All staff told us that they would actively engage with patients and carers to tailor care to the individual's preferences.
- Staff told us that chaperones would be available for patients attending outpatient clinics where this was

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necessary. Health care assistants routinely acted as chaperones in the areas we visited. However, there was no visible signage informing patients that they could request a chaperone at their clinic visit.

- A band 6 nurse informed us that she was a lead for dementia and attended regular link meetings trust wide. In addition, she had initiated a reminiscence resource for patients living with dementia.

Are outpatient and diagnostic imaging services well-led?

Requires improvement ●

We rated well-led as requires improvement because:

- There had been a difficult transition to a centralised patient booking service, which had revealed a range of problems such as poor quality data, incomplete data entries on the system, multiple routes of referral and inconsistent booking across the service. This had resulted in delays in access for patients to appointments, confusion and frustration amongst staff and patients across the service.
- However, the trust had invested a great deal of time and funds into developing an improvement plan that incorporated recommendations from external organisations and information generated internally. External reviews had been commissioned and work was in progress to address identified issues and move the service to a much more structured, streamlined and responsive system. A programme of activities had been introduced including a staff training and development programme and more robust reporting and monitoring systems. Assurance mechanisms had been strengthened.
- It was clear from speaking with staff in the outpatients' service that there was still frustration over the changes and that further engagement would be needed.
- The service was experiencing challenges over staffing levels, although arrangements were in place to ensure that clinics ran safely. Some specialities had recovery plans in place to address backlogs in waiting lists and a range of contingencies had been put in place such as working with external providers in order to reduce the numbers of patients waiting.

- The diagnostic and imaging services had well established governance and assurance arrangements in place. There was a high level of confidence in the leadership and management of the service and staff felt well supported and actively encouraged to develop as professionals.

Vision and strategy for this service

- Across the outpatients' service the majority of staff were unclear on the wider vision or strategy for the trust. However, staff were able to tell us that they aimed to provide safe and high quality care, but were unable to articulate the trust's mission or values.
- Outpatient services were allied to their core medical or surgical services. This meant that the vision and strategy for the outpatient services was allied to the strategy for the core service. An example of this was in the haematology/oncology clinics where staff were aware of the move to a new day unit and the benefits that would bring to the wider service.
- Within the diagnostic and imaging services, there was a local department vision and staff reported there was strong leadership and investment in staff development.

Governance, risk management and quality measurement

- There had been significant development work across outpatient services including the governance arrangements within the CPBS and individual clinics over the last 18 months. The trust had worked with external agencies and organisations in order to identify issues and develop improvement plans.
- The trust invited in the NHS England Intensive Support team to undertake a follow up review of the booking system and delivery of the 18 week refer to treatment (RRT) standard in February 2015. This review highlighted issues with the new system. Problems associated with the transition to the new booking system included the quality of data and recording, poor clinical involvement and lack of training for staff.
- In addition, the trust commissioned two external organisations; one to review the incomplete pathway and the other to assist with the backlog and implementation of changes to the CPBS.
- The independent review of the incomplete pathway found that there were multiple issues that were required to address the situation but also to sustain improvements in the future. A varied approach to the

cashing up clinics (this is when the clinical outcomes to a consultation with a patient are recorded), issues over data entered onto the system including timing delays, concerns over the capacity of the teams transitioning into the new CPBS and training issues were some of the findings of the review. Recommendations included strengthening assurance processes such as the committee structures and formalising processes for escalation.

- An action plan had been developed that captured areas for improvement from a number of sources including external reports and information generated internally.
- The trust had introduced weekly monitoring at speciality level which was reviewed at the corporate divisional general management performance meeting. In addition, there was continued divisional monitoring at clinical governance meetings. These included a clinical review process for the non-RTT waiting list to remove the risk of harm due to delays. Any suspected harm found due to delay following a review appointment was to be logged on the electronic incident reporting system, investigated and escalated to the medical directors' office. The progress with access and the CPBS was added as an agenda item at the monthly performance meeting.
- The trust introduced weekly validation by the corporate access team to close referrals and add patients to review waiting lists with see by dates.
- An education and training programme had been introduced as part of the improvement work within the CPBS. The development programme was aimed at staff across the service in admissions, ward clerk roles and medical secretary teams.
- Recovery plans had been developed for each speciality with a backlog, for example with gastroenterology. The endoscopy service was working with external providers to reduce the backlog with the diagnostic gastroenterology surveillance patients. The trust had aimed to reduce the backlog by October 2015, but this had been extended to January 2016.
- A corporate tracking tool had been created to monitor and report clinical reviews.
- Management staff told us that there were monthly governance meetings within the directorates which they attended. Minutes were available on the intranet. These were service specific and no overall outpatient themes were evident on those seen.

- Risk registers were maintained in outpatients and the diagnostic and imaging services, these were fed up to the corporate risk register and the executive team. Senior staff were able to tell us what was on their risk registers and what action was being taken, such as staff recruitment. One example was in orthopaedics where there was a 'trips and falls' risk highlighted because of the porch floor becoming slippery when wet. This had been mitigated by work to extend the carpeting into the porch area.
- A significant challenge experienced by the service was the shortage of staff to operate outpatient clinics. Some areas such as dermatology were particularly impacted by the lack of registered nurses. There were arrangements in place to assess the requirements of each clinic and whether they were safe to operate. Contingency arrangements were in place to access agency/locum workers and to seek support from colleagues in other clinics.
- There continued to be delayed access to some clinics and targets for RTT and non-RTT were not always being met. There were a range of specialities who were not achieving their access targets. Recovery plans had been put in place to support these services and reduce patient waits.
- Staff on both sites reported good multidisciplinary (MDT) working especially those areas which had associated in-patient beds.
- It was also reported that there was good external MDT working, for example when transfers between sites was required and that there were service level agreements in place to cover these.
- Within the imaging and diagnostic services there were local governance frameworks in place with active national and local clinical auditing. However, we found that policies under IR(ME)R were out of date, including the Local Rules. We were told that these were currently under review and a risk assessment had been undertaken to assess continued use of the documents whilst updated documents were ratified. There were no standardised protocols or version control evident on the documents examined.

Culture within the service

- Clinical staff felt supported to deliver care and were comfortable in approaching their managers for advice and support.

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- Staff within the diagnostic and imaging service felt well supported. New staff had clear orientation, competencies were well established and there was a buddy scheme in place. Staff returning to work were put on the buddy scheme and staff were encouraged to develop additional skills for promotion purposes. Post graduate studies were particularly supported. Staff reported that there was excellent clinical supervision and mentorship within the service.
- Staff told us that they felt supported by their immediate managers and that they had confidence in their leadership. For example, HCA's were involved in handwashing and dress code audits.
- Senior staff felt supported in furthering their own personal development. One example of this was the senior nurse in vascular dressing service who was undertaking a Master's Degree. He considered that the study time and other resources for this were good

Public engagement

- The wound management unit had conducted an annual patient satisfaction survey in 2015. This had involved asking 30 patients to complete questionnaires about the service they received. The survey showed positive feedback from patients, with over 96% rating staff as 'excellent'.
- The orthopaedic outpatient areas displayed patient feedback and examples of actions taken to address patient concerns. An example of this included feedback that seating in the area was poor. The service had responded by seeking charitable funding and replacing the chairs.

- We observed that staff encouraged patients and their relatives to complete the family and friends (FFT) feedback survey.
- Results from the FFT survey showed that between 97 – 100% of patients attending women and children's clinics would recommend the service, between 83 – 100% of patients would recommend the surgery and anaesthetic clinics, between 92 – 100% of patients would recommend the medical clinics and between 93 – 100% would recommend the diagnostic and imaging services.

Staff engagement

- Staff expressed frustration about the transition to the CPBS and the impact this had on the service, staff and patients. Some staff felt that there had been little engagement and support with the transition. Some staff felt that they had not been listened to when they had raised concerns about the transition.
- Continued problems associated with the transition and the establishment of the new system persisted and there was a lack of confidence in the new ways of working in many areas. However, the trust had put in actions to improve the communication with the service and work was progressing on improving engagement with clinicians and staff as part of the improvement plan.

Innovation, improvement and sustainability

- There were two nurse led clinics in the orthopaedic area and a nationally recognised course in plaster casting being held regularly to 'grow' in house expertise in this field.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified, assessed and managed.

- Ensure there are improvements in referral to treatment times and action is taken to reduce the number of patients in the referral to treatment waiting list to ensure that patients are protected from the risks of delayed treatment and care.

- The trust must ensure that robust arrangements are in place to ensure that policies and procedures (including local rules in diagnostics) are reviewed and updated.

- Ensure patients notes are securely stored to ensure patients' confidentiality is maintained.

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients' dependency levels.

Action the hospital SHOULD take to improve

- Consider identifying a nominated individual at the hospital who is responsible for coordinating any concerns out of hours and at the weekend.

- Review the use of interpreters in outpatients and diagnostics to ensure that patients' privacy is maintained.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** The trust must ensure there are improvements in referral to treatment times and action is taken to reduce the number of patients in the referral to treatment waiting list to ensure that patients are protected from the risks of delayed treatment and care.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 HSCA (RA) Regulations 2014 Good governance** The trust must ensure that there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified, assessed and managed. The trust must ensure patients notes are securely stored to ensure patients' confidentiality is maintained. The trust must ensure that robust arrangements are in place to ensure that policies and procedures (including local rules in diagnostics) are reviewed and updated.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Requirement notices

The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients' dependency levels.