

University Hospitals Coventry and Warwickshire NHS
Trust

University 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

Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals Coventry and Warwickshire NHS Trust is one of the UK's largest trusts and serves a population of about 1,000,000 across Coventry, Warwickshire and beyond. Inpatient and outpatient services are provided from two hospital sites, University Hospital at Coventry and Hospital of St Cross, at Rugby. In total, the trust has 1,250 beds and provides both elective and emergency care. A major trauma centre, University Hospital specialises in cardiology, neurosurgery, stroke, joint replacements, in vitro fertilisation and maternal health, diabetes, cancer care and kidney transplants.

During this inspection we only inspected outpatient and diagnostic imaging services provided by University Hospital. This was an unannounced follow up inspection on 28 September 2016, due to the outpatient and diagnostic imaging service being rated 'inadequate' for safe in our March 2015 comprehensive inspection.

We did not inspect any other services provided by the trust. Therefore, the overall rating for University Hospitals Coventry and Warwickshire NHS Trust remains as requires improvement, as per the March 2015 inspection.

Overall, we rated outpatient and diagnostic imaging services at University Hospital as requires improvement with three of the five questions we ask, safe, responsive and well led being judged as requiring improvement.

We rated caring as good. Patients were treated with kindness, dignity and respect.

Our key findings were as follows:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. However, we did find that in some areas incidents were not always reported in line with trust policy.
- Learning and feedback from incidents was inconsistent. The action taken as a result of some incidents did not always address the cause of the incident.
- Governance systems were in place to monitor and assess risk, but these were not always accurately recorded.
- In ophthalmology there were medicines that were not securely stored.
- Systems in place to prevent and protect people from a healthcare associated infection were not always followed.
- There was inconsistent handover of inpatients when they arrived and waited for their radiology investigation or procedure.
- Patients were not always kept informed about how long they were expected to wait to be seen in clinic. Some patients arriving for their appointments waited a considerable time to be seen. In ophthalmology patients left the clinic without being seen due to the long waits.
- We identified areas in radiology where there was insufficient action taken to maintain patient privacy and dignity.

However, we also found that:

- Patients were treated with compassion, kindness, dignity and respect.
- Patients we spoke with felt well informed about their care and treatment.
- The trust was generally meeting referral to treatment times.
- There were facilities to meet the needs of patients with complex conditions.
- Staff described when the duty of candour applied and demonstrated an understanding of when it should be implemented.
- Arrangements were in place to safeguard adults and children from abuse.
- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. Where there had been staff shortages, we saw no evidence of patients coming directly to harm.
- There was a systematic programme of clinical and internal audit.
- Staff were encouraged to suggest improvements.
- Most staff felt that managers were visible, supportive and approachable.

Summary of findings

- Staff were proud to work at the hospital and passionate about the care they provided.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure all medicines are stored in accordance with trust policies and national guidance.
- The trust must ensure all incidents are reported in line with trust policy.
- The trust must ensure that infection control practices follow trust policy and recommended guidance, including correct hand hygiene and use of personal protective equipment.
- Ensure there is a robust policy for transporting patients with an infection or who may be at risk of acquiring an infection in the hospital, so that staff are aware that special precautions need to be put in place to protect the patient and the public.
- The trust must ensure that there sufficient patient information handed over between clinicians to ensure that the health, safety and welfare of the patients is maintained.

In addition the trust should:

- The trust should ensure all staff have received their required mandatory training to ensure they are competent to fulfil their role.
- The trust should ensure staff receive appraisals which meet the trust target.
- The trust should ensure that patients are able to access outpatient services in a timely way for initial assessments, diagnoses and/or treatment, with the aim of meeting trust and national targets.
- The trust should ensure that all risks are identified on the risk register and appropriate mitigating actions taken.
- The trust should ensure that meeting minutes clearly record recommendations and lessons learnt from incidents.
- The trust should ensure equipment is always stored appropriately and fit for use.
- The trust should ensure that staff in phlebotomy ask if they have any allergies prior to the application of the cleaning spray.
- The trust should ensure that hazardous chemicals are stored in line with Control of Substances Hazardous to Health Regulations 2002.
- The trust should ensure that patients privacy and dignity is protected at all times, in particular within radiology.
- The trust should minimise the percentage of outpatient clinics cancelled.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Outpatients and diagnostic imaging

Requires improvement

Rating



Why have we given this rating?

Overall, we rated the outpatient and diagnostic imaging service as requires improvement because:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. However, we did find that in some areas incidents were not always reported in line with trust policy.
- Learning and feedback from incidents was inconsistent. The action taken as a result of some incidents did not always address the cause of the incident.
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- In ophthalmology there were medicines that were not securely stored.
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- There was inconsistent handover of inpatients when they arrived and waited for their radiology investigation or procedure.
- Patients were not always kept informed about how long they were expected to wait to be seen in clinic. Some patients arriving for their appointments waited a considerable time to be seen. In ophthalmology patients left the clinic without being seen due to the long waits.
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- There were facilities to meet the needs of patients with complex conditions.

Summary of findings

- Staff described when the duty of candour applied and demonstrated an understanding of when it should be implemented.
 - Arrangements were in place to safeguard adults and children from abuse.
 - Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. Where there had been staff shortages, we saw no evidence of patients coming directly to harm.
 - There was a systematic programme of clinical and internal audit.
 - Staff were encouraged to suggest improvements.
 - Most staff felt that managers were visible, supportive and approachable.
 - Staff were proud to work at the hospital and passionate about the care they provided.
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University Hospital

Detailed findings

Services we looked at

Outpatients and diagnostic imaging;

Detailed findings

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Detailed findings from this inspection

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Background to University Hospital

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Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Charlotte Rudge, Care Quality Commission (CQC)

The team included three CQC inspectors and a specialist advisor radiologist.

How we carried out this inspection

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

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

We carried out this inspection as part of our follow-up programme of re-visiting trusts which had inadequate domain ratings following our comprehensive inspection. We undertook an unannounced inspection on 28 September 2016.

Before visiting, we reviewed a range of information we held about University Hospital, as well as information available regarding the outpatient and diagnostic imaging services performance.

Detailed findings

We talked with patients and staff from outpatient and diagnostic imaging services.

We spoke with staff individually as requested.

We would like to thank all staff, patients and carers for sharing their balanced views and experiences of the quality of care and treatment at University Hospital.

Facts and data about University Hospital

University Hospitals Coventry and Warwickshire NHS Trust employs 6767.9 whole time equivalent (WTE) staff as of August 2016, with a head count of 7718 staff members. The trust's staff in post is 27.1 WTE behind the workforce plan of 6795 WTE. The trust's monthly staff in post has increased by 44.0 WTE from the July 2016 figures. The vacancy rate compared to funded establishment indicator has improved but remains above the target of 10% for August 2016. This is reflected in the agency costs against total costs which has decreased from 8.9% to 8.4%.

As of August 2016 the trust's is reporting a £1.8m deficit year-to-date against a planned year-to-date deficit of £1.1m. This is a further deterioration of £0.36m in actual position from previous month. The trust is forecasting delivery of £24.1m against £24.5m of potentially identified savings. This gives a potential forecast under-delivery of £1.4m against the trust revised cost improvement programme target of £25.5m for 2016/17.

Activity

Hospital Episode Statistics for March 2015 to February 2016 showed that there were 719,363 outpatient appointments for this trust. University Hospital accounted for 650,254 (90%) of these outpatient appointments.

The trust in 2015/16 admitted 158,193 patients with 184,966 attendances to the emergency department. The

first quarter of 2016/17 the bed occupancy at the hospital was 98.9%. This did not meet the trust target of 93% and was worse than the national average (88.2%). It is generally accepted that bed occupancy over 85% is the level at which it can start to affect the quality of care provided to patients and the orderly running of a hospital.

Population served

The trust provides hospital care to a population about 1,000,000 across Coventry, Warwickshire and beyond.

Deprivation

Coventry is ranked 46 out of 326 Local Authorities in the Indices of Multiple Deprivation, with deprivation levels in the most deprived 20% compared to other Local Authorities. This is in comparison to the districts of Warwickshire which are ranked: North Warwickshire 160, Nuneaton and Bedworth 110, Rugby 249, Warwick 187 and Stratford Upon Avon 274, where deprivation levels are in the least deprived 20% compared to other local authorities.

About 27% of children live in poverty. Life expectancy for both men and women is worse than the England average. The rate of statutory homelessness, teenage pregnancy, physical activity in adults and hospital stays for alcohol related harm and self-harm is worse than the England average.

Our ratings for this hospital

Our ratings for this hospital are:




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

Detailed findings

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at the University Hospital in Coventry are located throughout the hospital, with a hub situated on the ground floor, which is served by several reception desks. From March 2015 to February 2016 the trust facilitated 650,254 outpatient appointments at University Hospital.

The hospital provides outpatient services covering a range of specialities and conditions including, medicine such as cardiology, ophthalmology, neurology, rheumatology, diabetes, respiratory and elderly medicine. There were surgical clinics such as ear, nose and throat, colorectal, vascular, orthopaedics and trauma. Blood test services were provided within the outpatient department.

The fracture clinic and dermatology clinics were nearby the main outpatient department, with separate receptions and facilities.

We also visited the Wisdem Centre, which is located on the University Hospital site. The centre provides clinical support to patients with diabetes and related hormonal illness through education and research, and physiotherapy.

The radiology department located on the ground floor, supported outpatient clinics as well as inpatients, emergency and GP referrals and provided imaging for the diagnosis and interventional treatment of a number of conditions.

During our inspection we spoke with nine patients as well as some of their relatives. We also spoke with 17 members of staff including nurses, radiographers and radiography

assistants, reception and booking staff, secretaries, managers, cleaning staff, health care assistants, medical students, doctors, consultants, therapists and phlebotomists.

We observed care, including a patient and doctor consultation. We also reviewed performance information about the department and the trust.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatient and diagnostic imaging service as requires improvement because:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. However, we did find that in some areas incidents were not always reported in line with trust policy.
- Learning and feedback from incidents was inconsistent. The action taken as a result of some incidents did not always address the cause of the incident.
- Governance systems were in place to monitor and assess risk, but these were not always accurately recorded.
- In ophthalmology there were medicines that were not securely stored.
- Systems in place to prevent and protect people from a healthcare associated infection were not always followed. Although there were some improvements in outpatients since our March 2015 inspection, infection control practices in radiology required improvement.
- There was inconsistent handover of inpatients when they arrived and waited for their radiology investigation or procedure.
- Patients were not always kept informed about how long they were expected to wait to be seen in clinic. Some patients arriving for their appointments waited a considerable time to be seen. In ophthalmology patients left the clinic without being seen due to the long waits.

However, we also found that:

- Patients were treated with compassion, kindness, dignity and respect.
- Patients we spoke with felt well informed about their care and treatment.
- The trust was generally meeting referral to treatment times.
- There were facilities to meet the needs of patients with complex conditions.
- Staff described when the duty of candour applied and demonstrated an understanding of when it should be implemented.

- Arrangements were in place to safeguard adults and children from abuse.
- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. Where there had been staff shortages, we saw no evidence of patients coming directly to harm.
- There was a systematic programme of clinical and internal audit.
- Staff were encouraged to suggest improvements.
- Most staff felt that managers were visible, supportive and approachable.
- Staff were proud to work at the hospital and passionate about the care they provided.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



Overall, we rated the outpatient and diagnostic imaging service as requires improvement for being safe because:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. However, we did find that in some areas incidents were not always reported in line with trust policy.
- Learning and feedback from incidents was inconsistent. The action taken as a result of some incidents did not always address the cause of the incident.
- In ophthalmology there were medicines that were not securely stored.
- Systems in place to prevent and protect people from a healthcare associated infection were not always followed.
- There was inconsistent handover of inpatients when they arrived and waited for their radiology investigation or procedure.
- Not all staff were up to date with mandatory training.

However, we also found that:

- Staff described when the duty of candour applied and demonstrated an understanding of when it should be implemented.
- The trust had a major incident plan which was available to staff on the intranet and staff participated in “mock” major incident events
- Arrangements were in place to safeguard adults and children from abuse.
- The department had introduced effective systems to ensure appropriate and up-to-date information was made available for clinicians to review patients who attended outpatient appointments.
- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. Where there had been staff shortages, we saw no evidence of patients coming directly to harm.

Incidents

- There had been no never events reported for outpatient and diagnostic imaging services from August 2015 to

July 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- There had been no serious incidents reported for outpatient and diagnostic imaging services from August 2015 to July 2016.
- There were arrangements in place to implement good practice and an open culture to encourage focus on patient safety and risk management practices. Patients were generally protected from abuse and avoidable harm, as most staff had confidence in reporting incidents.
- Most staff confirmed they knew how to escalate and record incidents using the trusts incident reporting system. However, not all staff recorded incidents in line with the trust incident reporting policy. For example, nursing staff within the ophthalmology department told us that due to work pressure, they did not always report incidents on the electronic system which meant they did not comply with trust policy.
- The May 2016 board walk round review visit to ophthalmology (where executive team members visited the department) identified that the incident reporting culture was low. The review recognised the need to encourage incident reporting and to understand why reporting was low. However, we did not see an action plan to address this issue which meant there was a risk of staff not having all the information required to ensure lessons were learnt throughout the service.
- Four nursing staff in ophthalmology told us they did not receive feedback from incidents submitted. This meant we were not assured learning was always identified from incidents reported.
- One phlebotomist told us they did not complete an incident form following a needle stick injury. However, they did go to the occupational health department and reported the incident there. We were unsure if the incident had then been reported via the electronic system.
- We saw patient safety incidents from September 2015 to August 2016 for the outpatient service. All were categorised between no harm and moderate harm. The majority of incidents related to delays in outpatients and poor communication. We saw the immediate action taken to redress the situation.

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- However, the action taken as a result of some incidents were unclear or did not always address the cause of the incident. For example, one incident denoted a patient who required a wheelchair to attend clinic, it took 90 minutes for a wheelchair to be sourced, which meant the appointment was late. The action stated 'No actions required. A wheel chair was eventually found'. However, this did not solve the issue for the future if another patient required the use of a wheelchair. Another incident reported an outpatient appointment for a patient with complex needs was cancelled due to transport services not being able to collect the patient at the required time. There was no immediate action documented but the long term action stated 'reporting this incident highlights potential repeated issues with the quality and provision of transport services', which did not address the underlying issues.
 - Staff in radiology were able to describe how they completed an incident form using the electronic reporting system. They told us how the form was processed and who was responsible for investigating the incident. We were told feedback was always provided at team meetings so that everyone could learn from the incident. We saw the radiation protection committee meeting minutes from June 2016 where an incident from the radiology department had been discussed and actions were put in place to reduce the likelihood of similar incidents occurring in future.
 - The radiation protection committee oversaw the development and operation of the radiation risk management arrangements within the trust. Radiology staff were able to tell us how an incident had led to improved practice, including the introduction of a check list for patients required to take medication at home prior to their appointment. This had reduced the number of patients attending appointments that had not prepared correctly for their test, avoiding ineffective appointments and unnecessary exposure to radiation.
 - From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
 - Staff described when the duty of candour applied and demonstrated an understanding of when it should be implemented.
- ## Cleanliness, infection control and hygiene
- Systems were in place to prevent and protect people from a healthcare associated infection. However, these were not always consistently followed.
 - All areas we inspected, including clinical and waiting areas, were visibly clean and tidy.
 - Toilets were clean and well equipped with hand washing gels and paper towels. We were told that since our March 2015 inspection hand air driers had been installed to prevent the incorrect disposal of paper towels and help ensure the area remained clean and tidy.
 - There was a baby nappy change facility located outside x-ray room three, but this area had no access to hand washing facilities.
 - We saw clinical rooms had facilities for the disposal of clinical waste and sharps. Waste management was handled appropriately, with separate colour coded arrangements for general waste, clinical waste and recycling. Clinical bins had foot pedal operated lids and were not overfilled. Sharps bins observed were assembled correctly, signed, dated and not overfilled.
 - Hand sanitising gel dispensers were available in corridors, waiting areas and clinical rooms. We saw posters in waiting areas and other communal areas advising patients and visitors to gel their hands.
 - We observed staff were 'bare below the elbows' in line with national guidance for clinical areas. Where one consultant was not bare below the elbow, we saw the matron challenge this practice and the consultant rolled up their sleeves.
 - There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons.
 - We saw the hand hygiene training compliance audit from March 2016 to August 2016. The radiology nursing showed 100% compliance, whilst the fracture clinic showed a range of between 93% to 100% and the main outpatient department showed a variance of 86% to 94%. Senior staff confirmed they oversaw the training figures which enabled them to monitor staffs' training and address any outstanding training needs.
 - We observed inconsistent hand hygiene in the radiology and phlebotomy department. We observed staff

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cleaning their hands with alcohol gel after patient contact. However, we saw hand hygiene was not always performed immediately before patient contact. For example, we saw staff accessing computers and writing notes but did not then re clean their hands prior to their next patient contact. The hospital's own policy on hand hygiene followed guidance produced by the World Health Organisation's (WHO) 'five moments of hand hygiene' which stated hands must be decontaminated immediately prior to every patient contact.

- We saw a health care assistant assist a patient with a urine bottle wearing gloves but no apron. Best practice dictates uniforms are protected from splashes when handling bodily substances (such as urine or blood) by wearing a disposable plastic apron. The trust's own policy on wearing PPE stated gloves and aprons should be worn when handling bodily substances. In the fracture clinic we observed a member of staff apply a sterile dressing to an open wound without wearing an apron.
- We observed staff wearing gloves inappropriately. Radiographers wore gloves while pushing patients in beds and wheelchairs around the department. This meant staff were not following the WHO (2009) guidelines on hand hygiene in health care. Gloves worn in this way prevent normal hand hygiene and have been linked to increased transmission and transfer of dirt and germs between pieces of equipment, the environment and patients. Additionally, prolonged and inappropriate glove use has been linked to adverse reactions and skin sensitivity in staff hands (epic3: national evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England). The trust's infection control policy advised gloves should only be worn if contact with blood or bodily fluids was anticipated. We asked staff why they were wearing gloves in these instances, they told us it was for 'infection control'. Therefore, we could not be assured that staff were aware and practising in line with the trust infection control policy or latest guidance.
- There were no designated rooms for treating patients with communicable diseases, such as influenza or tuberculosis. Staff told us that if it was necessary to isolate a patient, an appropriate consultation or treatment room would be designated for their use. The patient would not be seated in the waiting area, in order

to reduce the spread of any known communicable diseases to other patients and visitors. The room would then be thoroughly cleaned prior to any other patient use. This was in line with infection control procedures.

- Staff in radiology told us patients with known infections would be taken straight into x-ray and would not be left in the waiting area whenever possible.
- Staff in radiology told us that whenever possible an inpatient with a known infection would be seen last in the day, at lunchtime if it was an urgent request, or when fewer patients were in the department. Staff told us they would be responsible for cleaning the room following a patient with an infection and were able to describe the products available in order to carry out this effectively. We were told there was a rapid response cleaning team who could attend the department and carry out a deep clean if required.
- We saw some staff were unaware of infection control risks in the radiology department. We saw an inpatient in a wheelchair waiting and holding a catheter bag and a vomit bowl. Staff were unable to tell us why the patient had a vomit bowl but one suggested it might be required for sputum. Two further patients arrived in the department and were placed either side of the patient, exposing them potentially to either a gastric or respiratory infection.
- There was a process in place for staff to share information about patients with infections, but it was not always followed. Staff told us they were not always aware when an inpatient had a known infection because ward staff did not always handover this information in advance. Porter staff told us wards usually completed a red form if the patient had an infection which was handed to staff in radiology, but sometimes ward staff were too busy to complete this. Radiography staff told us a patient's infection status could be found using the electronic records system but this relied on doctors completing the information on the booking request, which did not always happen. Historical infections like MRSA could be seen if the patient had a red flag attached to their electronic record. However, we were told there were two electronic systems which contained different information and things did sometimes get missed.
- We saw patient safety incidents from September 2015 to August 2016 for radiology. All were categorised between very low and low harm. Eight incidents reported were categorised as 'lack of communication relating to

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infections', which reflects our findings. Actions from these incidents included patients returning to radiology at the end of the day to prevent the spread of infection, and a need to see trends and implement a plan if poor practice continued, however, we saw no plan in place to resolve this issue.

- At the hospital, MRSA screening compliance was reported by admitting wards so the hospital did not audit screen compliance specific to radiology or outpatient services. Between June 2015 and July 2016 there were 48 reported patients who attended pre-operatively as non-compliant with MRSA screening. This was due to delays in elective admissions rather than pre-operative performance.
- Individual infection control standard audits carried out by the trust in 29 outpatient areas between March and September 2016 found compliance cleanliness scores ranged from 54% to 90%. Examples included; 58% for main x-ray and 68% for clinic 5 (cardiology). Audits carried out by the infection control nurse in the same period showed compliance between 64% and 86%. The target rate was 85%. Staff told us the audit results were fed back at team meetings where local actions to improve compliance were set out and monitored by senior staff.
- Patient Led Assessment of the Care Environment (PLACE) cleanliness audit score for University Hospital for 2016 up to the time of our inspection was 99%. This was better than the national average of 98%. It was not possible to obtain PLACE data specifically for the outpatients and radiology department.
- On the physiotherapy outpatient rehabilitation unit staff board the daily housekeeping record was displayed, showing when equipment such as chairs, had been cleaned and when fridge temperatures had been checked. From 1 September to 28 September 2016, there were six working days where the record had not been completed. This meant that we could not be assured the checks had been made as required. However, we saw the department was clean, tidy and well maintained.
- Cleaning record sheets were available on the radiography base notice board and these were audited by the infection and prevention control link radiographer. The cleaning audit showed that the areas had been cleaned as per schedule. We saw a cleaning schedule in the waiting area of the fracture clinic that had been audited regularly with compliance above 85%.
- We saw appropriate cleaning wipes and chemicals throughout the departments. We saw fresh cleaning fluid had been made up daily and this was signed was dated appropriately. We saw notices on how to dilute the cleaning fluids to the correct concentration.
- We saw some ready to use hazardous chemicals were not locked away as per Control of Substances Hazardous to Health Regulations 2002 (COSHH). In the x-ray room fresh cleaning fluid was visible on the worktop areas and although staff would normally be present when a patient was in x-ray, there was a risk patients could still access the chemicals.
- We saw blood spillage kits in the phlebotomy clinic stored on open shelving and not locked away. These kits contain chemicals which are hazardous to health and must be stored in a locked cupboard to comply with COSHH regulations.
- In the ultra sound area, cleaning chemicals were stored in the clean store. However, we found this room unlocked during our inspection, despite having a keypad as some staff were unaware of the access code.
- We saw children's toys in the radiography area were on a cleaning rota. However, some of the toys were made of material which was difficult to clean, including soft toys and books. This meant that there was a risk these would not be cleaned appropriately to minimise the spread of infection.
- The children's waiting area outside x-ray three contained a full linen skip which was lined with a plastic linen bag. This was emptied during our inspection. The bag contained used adult hospital gowns. This waiting area also contained a clinical waste bin. Both of these items were potentially hazardous to children.
- In the radiography clinics we saw clean patient gowns were stored on open shelving in the patient waiting areas. These shelves were not covered and therefore, liable to dust collection. Gowns outside x-ray room three were on the bottom shelf and also alongside the children's toys. These gowns were at risk of splashing during routine floor cleaning and the shelves were dusty at the time of our inspection.
- In fracture clinic we saw evidence of daily tap flushing however, in the radiography department staff told us they did not record tap flushing. We were told it was the radiographer's responsibility to flush the taps daily in the room they were assigned to work but there was no system for flushing communal taps or taps in clinical rooms not in use. Guidance in the Health Building Note

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(HBN) 04-01, safe water in healthcare premises (HBN 04-01) recommends taps are flushed to prevent contamination of the water supply with Legionella and Pseudomonas aeruginosa. Staff we spoke to in the phlebotomy clinic were unaware of tap flushing requirements but said their taps were run frequently during working days for hand washing. Areas had been risk assessed in accordance with usage and patient group. Each month 62 water samples were tested for Legionella throughout the hospital. No positive results for Legionella had been reported for 12 months prior to the inspection.

- In the phlebotomy clinic we saw staff cleaning patient's skin prior to inserting the needle to withdraw blood. However, staff were using an antiseptic spray solution containing 20% chlorhexidine and 70% alcohol from a multi-use bottle and gauze from open multi packs. Single use antiseptic products containing 2% chlorhexidine and 70% alcohol are recommended for aseptic procedures (or povidone iodine in alcohol if patients are sensitive to chlorhexidine), (epic 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England). We saw patients treated in the phlebotomy clinic were not asked if they had any allergies prior to the application of the cleaning spray. Chlorhexidine has been known to cause reactions in patients, including blistering and anaphylaxis and therefore an assessment of product suitability should always be undertaken prior to application (epic 3). The bottles of skin cleaning fluid were not stored securely and could be accessed by unauthorised people including patients.

Environment and equipment

- Generally, the design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept patients safe.
- Clear and bright coloured signage was in place in the ophthalmology department to guide patients visiting the department.
- Resuscitation trolleys were strategically placed (outside clinics two and ten) within the outpatients department which ensured easy accessibility to all clinics. There were grab bags for treating children. Location of the resuscitation trolleys were displayed within the clinics visited. Staff spoken with knew the location of these trolleys.
- We examined the resuscitation trolleys and found evidence that regular checks had been completed and documented to ensure the equipment was fit for use.
- The trust maintained equipment including medical devices. However, during our inspection to ophthalmology one piece of equipment had malfunctioned. Although reported on the morning of the clinic, the service had not received either a replacement nor had the equipment fixed. The clinician had to source another room with sufficient equipment which meant that their clinic began late and was overrunning.
- Conditions were cramped in the ophthalmology department. We observed one consultation room was also used as a telephone triage room. We noted the phone was frequently ringing which could be a distraction to patients receiving treatment within the room. Staff confirmed that confidentiality was a concern and they often left the phone unanswered whilst they were attending directly to patients. This meant that they were unable to provide an effective service to patients requiring support and/or guidance.
- Radiation warning signs and lights were located outside all clinical diagnostic imaging areas, such as x-ray.
- The radiography department had separate waiting areas for inpatients and outpatients. The inpatient area was open plan but had two areas separated by a half wall. One area had a notice for patients using "wheelchairs", and one area for 'bedded patients'. However, we saw both groups of patients waiting in the bedded area. Staff said they only used the wheelchair area during busy periods, despite the signage. We saw patients in wheelchairs were in a row facing the patients in beds, and all areas were mixed sex. There was a risk that due to the environment it was difficult to maintain a patient's privacy and dignity.
- We saw in the radiography inpatient waiting area a changing room with chairs that were made with fabric covers. Fabric is difficult to clean and not recommended for a healthcare environment. One of the chair covers was badly ripped and exposed the inner padding.
- Equipment was not always stored appropriately. For example, we saw the patient transfer board was stored on the floor in the inpatient changing room and there was an unclean drip stand lying on the floor.
- Changing rooms were clean and small. They had thin curtains which could compromise privacy for larger patients.

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- We saw x-ray room three's heating system was broken and the room temperature reading was 18 °C. Staff informed us it was normally 20°C. We saw the fault had been reported on the day of our inspection and that a repair was also due that day. A portable heater had been provided for interim use.
- In the fracture clinic waiting area we saw that all available seats were taken and that some patients and visitors were standing. Some patients were waiting in wheelchairs, which reduced the available space further in the fixed seating area. We observed two patients who were brought through the department by transport services on trolleys. This appeared to be a health and safety risk as there was very little space available in the department. The trust advised us at busy times the fracture clinic had systems in place to try and reduce the overcrowding, including a bleep system where patients were asked to wait in the main outpatient area until their bleep went off and it ensured the responsible matron would visit the area daily to manage any problems.
- In the phlebotomy clinic we saw a blood warming machine was available to keep blood samples at the correct temperature. Temperatures of the warming equipment were recorded daily. However, we saw temperatures regularly above and below the target range of 40 to 42°C. In August 2016 the temperature had ranged from 14 to 51°C and no action to rectify this had been recorded.

Medicines

- We saw the medicines management controlled drug (CD) audit summary report for July 2016. The audit supported the Getting the Basics Right 3 programme which incorporated regulation and legislation standards, as well as best practice standards that applied to CDs storage and practice. These included; CD audit tool from the West Midlands Dispensary Managers, Department of Health: Safer Management of Controlled Drugs; A guide to good Practice in Secondary Care (Oct 2007); NHS Business Services Authority; NHS Protect: Medicines Security Ward/Department Checklist (Jan 2014); **National Patient Safety Agency (NPSA)** Alerts: 0295 and 0396; and Care Quality Commission (CQC) Essential Standards Outcome 9: Management of Medicines (March 2010). Feedback was provided to the nursing staff involved at the time of the audit. The results were presented to the medicines management committee in July 2016. The report showed a compliance rate of between 82% and 95%. Areas of compliance included:
 - All CD cabinets were found locked.
 - A separate page was used within the CD register for each drug, formulation and strength.
 - Entries were supported by two signatories.
- However, the report found four standards which required immediate action to improve compliance. These included; :
 - Standard 1.2 - The CD cupboard in centre for reproductive medicine did not comply with legislative standards British Standard (BS): 2881. The managers for the area had been informed of this concern in May 2016. The report identified an immediate recommendation for this cupboard to be replaced.
 - Standard 1.18 - CD stock lists were unavailable on or in the CD cabinet. These were issued by pharmacy and the audit identified that whilst the CD stock list review occurred the paper lists, over time, came away or torn. They were then removed from the CD cabinets. Arrangements had been made to ensure stock lists are laminated and re-distributed throughout the trust.
 - Standard 1.19 - The results found that pharmacy quarterly CD stock checks had been undertaken for the clinics where no stocks were held but only documented on pharmacy records.
 - Standard 1.5 - 29% of clinics' CD cupboards were found to contain items other than CDs. CD cupboards must be solely used for the storage of CDs and immediate arrangements were made to remove and relocate all other items.
- The service completed a self-assessment of its medicines storage. We saw the results for the computerised tomography (CT) and magnetic resonance imaging (MRI) area for May 2016. The audit did not identify any issues or concerns. The department kept medicines, such as sodium chloride 0.9% and contrast, within locked scanning rooms. The medicines were kept in the scanning room during clinical sessions and then locked in a cupboard at the end of the session.
- In the radiology department, staff told us all medication was locked in the fluoroscopy room. We did not see medication in any of the other radiology treatment rooms.

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- In ophthalmology there were medicines that were not securely stored. For example, we found eye drops (oxybuprocaine hydrochloride and phenylephrine hydrochloride) that were on desk in unlocked rooms accessible via the public corridor.
- The cylinder of oxygen was stored in a room within the respiratory clinic and was in-date. There was signage on the door to indicate that a compressed gas was stored in the room. The Department of Health has produced guidance on the storage of medical gases and recommends that the designated room should be clearly labelled with the types of cylinder contained and “no smoking” warning signs (Medical gases. Health Technical Memorandum 02-01: Medical gas pipeline systems. Part B: Operational management, 2006). This meant that the service complied with the Department of Health guidance on the safe storage of compressed gases.
- To ensure the safety and usage of stored medicines the service conducted daily recordings of medicine storage rooms and fridge temperatures. All temperatures were within the required ranges. However, in outpatient room 408 the seven working days in September 2016 (from 1 September to 27 September 2016) and six working days in August 2016 had no documentation recorded to indicate that fridge temperature check had been made.

Records

- Staff informed us that records were being converted to a new electronic system. However, no date had been set for when this should occur. Until the electronic system was implemented staff used a mixture of hard and electronic copies of records, such as x-rays.
- We saw that the records of patients who attended outpatient clinics were stored securely to maintain patient confidentiality.
- Staff told us patient records were usually available in time for clinics. All records were delivered twice daily and urgent requests could be made when required.
- Staff within ophthalmology reported missing records as a concern. We saw this was highlighted in the May 2016 board walk round review visit. This was identified due to multiple appointments in short time frames. The missing patient notes was recognised as an area which required escalation as it caused unnecessary delay in patient care.
- However, incidents from September 2015 to August 2016 for the outpatient service only had one incident reported where patient’s notes were missing, inadequate or illegible. This reflected what nursing staff in ophthalmology told us, that due to work pressure, they did not always report incidents on the electronic system.
- University Hospitals Coventry and Warwickshire NHS Trust outsourced the health records service. The trust provided electronic requests for patient records to the supplier on a daily basis for planned outpatient activity. From January 2016 to the inspection in September 2016, on average 1.8% of patient records were unavailable for clinic. This data was for the University Hospital and St Cross site, the trust were unable to break the data down into each site. The reasons records were unavailable was collected and included: the records were not in the last tracking location; the supplier was notified the records would be moved/ delivered internally by trust staff, but the records were not delivered to the clinic location; and the patient having treatment at another health care provider, that did not return the records in time for activity at University Hospitals Coventry and Warwickshire NHS Trust.
- The trust reported that it was infrequently reported that patients were not seen by the outpatient clinician if records were unavailable. This was because there was a substantial amount of patient information held electronically, for example, on the trust clinical results reporting system (CRRS), which assisted the majority of specialties in providing electronic data.
- The trust reported a series of actions they were undertaking to reduce the number of unavailable patient records within outpatient and diagnostics services. These included: the launch of a new trust intranet site TrustNav that had a health records section with guidance for staff, including policies and procedures and frequently asked questions; training for staff; and regular reviews of administration processes to ensure any changes in service did not disregard the health record requirement.
- The physiotherapy outpatient rehabilitation unit completed documentation audits and results were displayed on the staff notice board. For April to September 2016 they were 95.7% compliant with standards. There was no action plan displayed on the board about how they were going to improve but physiotherapists told us that this had been discussed within their daily team meetings.

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Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.
- Staff members from mixed roles told us how to escalate a safeguarding concern. Two staff members informed us how they would access the information on the trust's intranet system. We saw a safeguarding flow chart poster displayed within the main outpatient waiting area.
- Both the radiology and outpatient services were compliant with safeguarding adults and children level 2 training. For example, radiology achieved 97% and 98% respectively, whilst outpatients achieved 100% and 96%.
- The radiology department were 67% compliant with their level 3 children's safeguarding training, this equated to two out of the three required staff being compliant. The third staff member was booked onto the next monthly level 3 child protection session to be delivered in October 2016, which meant that the department would be 100% compliant.
- The 2015 Child Protection Training Strategy stated that managers should make an objective decision regarding level of training required and justify why training is needed or not needed. There was guidance with the strategy that reflected national guidance to help managers make these decisions.
- There were posters advertising current training sessions on safeguarding vulnerable adults in the imaging department staff room.

Mandatory training

- Mandatory training covered a range of topics, which included health and safety, manual handling, infection prevention control, health and safety and adult basic life support (BLS). All staff within the service were aware of the need to attend mandatory training.
- Training was completed as e-learning modules with some face-to-face sessions, such as mental capacity awareness.
- The trust used the red, amber and green (RAG) ratings regarding their mandatory training; with green at 95% or over, amber between 85% and 95% and red at lower than 85%. The trust target was 95%. The records showed that:

- Most outpatients' training was at 100% with an overall rating of 95%. We saw the following were rated as red: adult BLS (79%), obtaining venous blood (83%), the collection and transportation of blood and blood products (80%), and automated external defibrillation (77%).
- Most radiology mandatory training were rated either green or amber with the exception of automated external defibrillation (79%) which was rated red. The service had achieved an overall total of 94%.
- We spoke to a new member of staff in the radiology department who told us they had worked in the hospital for two months. They confirmed they had undergone a corporate induction during which time they had received mandatory training in information governance, fire safety and infection control.
- We saw the notice board in fracture clinic showed 100% compliance to mandatory training for all nursing and allied healthcare practitioners in the department.
- Phlebotomy staff showed us their training records which they accessed via the hospital electronic data base.
- Staff within the ophthalmology department told us they were often short staffed and found it difficult to get their training completed.
- We were told some staff had outstanding paediatric life support training in the fracture clinic but staff were scheduled to attend this training. Phlebotomy staff told us they did not have paediatric life support training.

Assessing and responding to patient risk

- Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for elderly or frail patients with more than one medical condition.
- Processes were in place within the outpatients department to manage patients who present at risk within the department. For patients in attendance who showed signs of rapid deterioration a call would be placed to the emergency response team who attended the department and assessed the risk to the patient and the actions to be taken.
- The trust had introduced a rapid access chest and heart failure pathway for low risk patients in order to manage patients in an appropriate and timely way. Once a patient was referred, an appointment would be made within two weeks to attend the clinic. During our inspection, we saw a rapid access clinic taking place. Patients said that they were very happy with the quick and efficient service.

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- The trust had a clinical procedure for decision to admit patient from main outpatients and fracture clinic policy. This provided guidance to staff in the safe transfer of patients by assessing and responding to the patient risk.
- We saw that inpatients were transported to the inpatient waiting area on beds and in hospital wheelchairs. We saw their notes were given to the administrator's desk but there was no verbal handover of the patient. Our previous inspection in March 2016 highlighted a lack of handover as a safety concern. In response the trust developed a transfer form for ward staff to complete prior to sending a patient to the department including information about a patient's infection status and whether or not they were subject to a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order. Completed forms were handed to the radiography assistants on arrival in the department to ensure important information was shared. The department had been auditing form completion compliance. From April 2016 to October 2016 audit results showed compliance varied between 22% and 47%. On the day of our inspection we saw that six forms had been completed out of 11 patients (54%) who had attended that morning.
- Incident reports from September 2015 to August 2016 for the radiology service highlighted seven cases where there was an inadequate patient handover or incorrect or insufficient patient information communicated between staff.
- Radiography staff we spoke with told us nurses usually did not escort patients to the department, even if patients had a learning disability or dementia, because they were too busy in their clinical area. Patients with additional needs would be provided with extra care by the radiography assistants. However, radiography staff told us it was preferential for ward staff to escort patients with confusion to provide continuity of care.
- The trust used blue pillow cases to identify patients living with dementia and staff we spoke with were aware of the blue pillow system. However, several staff in the radiography department told us blue pillows were not always available and so there was a risk that patients living with dementia might not be identified by the radiographers in a timely manner. The transfer from ward information form did not contain a specific screening question for dementia or learning difficulties but it did have a 'communication issues' box which could be adapted if necessary.
- On arrival to the department a radiography assistant completed a 'radiology bed wait form'. This was a tick sheet containing questions about patient identification and notes, repositioning, continence and oxygen requirements.
- In the phlebotomy clinics we saw patients having their identity confirmed by their name, address and date of birth. We saw blood samples were labelled immediately after being taken beside the patient. This helped to ensure the correct blood results were recorded for each patient.

Nursing staffing

- There is no national baseline acuity tool for nurse staffing in outpatients. The trust had developed a staff ratio calculator to determine staffing requirements across outpatient services. This was used to calculate how many nursing and healthcare assistant staff were required to cover the speciality clinic sessions held per week.
- Outpatient nursing staff told us that they were very busy and believed they provided good patient care.
- Where additional staffing was required to cover extra clinics, sickness or annual leave, this was covered by bank staff or permanent staff who volunteered to work over and above their contracted hours. The trust employed bank staff on an ad hoc basis.
- Staffing within the ophthalmology clinic was generally sufficient through the use of bank staff. However, staff said that due to the expertise required within the service, they did not feel confident in delivering a service that was safe to patients due to the lack of experience of bank staff. We spoke with a bank staff member who confirmed they had received an orientation of the department but had no experience in working within ophthalmology. This meant that we could not be assured that patients were seen by staff that had the relevant competency to manage the care and welfare of patients. This had been identified on the risk register.
- Incident reports from September 2015 to August 2016 for outpatients showed that there had been six incidents relating to lack of suitably trained /skilled nursing staff. Four in ophthalmology and two in dermatology. There was no evidence within the reports that incidents had resulted directly in patient harm but they had resulted in delays in delivering treatment.

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- We saw the vacancy figures extracted from the electronic staff record system (ESR) as of August 2016 which showed that:
 - Within radiology they had recently recruited three registered nursing whole time equivalent (WTE) staff who were awaiting start dates.
 - The trust was funded for 244.7 WTE staff of which 233.3 WTE were contracted within the outpatients and diagnostic services. This left a vacancy gap of 11.4 WTE staff equating to 5%.
 - The hospital was funded for 161.8 WTE staff (registered and unregistered) across the main outpatient cohorts, of which 138.7 WTE had been contracted. This left a vacancy gap of 23.1 WTE staff equating to 14%.
- In the x ray department we saw sufficient radiography assistants to look after the number of patients waiting for a procedure.

Medical staffing

- We found that staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment.
- In the outpatient department medical staffing for clinics was arranged by the individual specialities, such as rheumatology, cardiology, trauma and orthopaedics and ophthalmology.
- Incident reports from September 2015 to August 2016 for outpatients showed that there had been three incidents relating to lack of suitably trained /skilled medical staff. One in ophthalmology, one in paediatrics and one in renal services. There was no evidence within the reports that incidents had resulted directly in patient harm but they had resulted in delays in delivering treatment.
- Doctors and nurses spoken with said they had a good working relationship whereby they could discuss any issues or concerns. This was also confirmed by administration staff who said they were well supported by these staff.
- The trust had recognised that recruitment was difficult and were actively promoting the hospital to recruit suitably qualified nurses and doctors. The trust had an active retention and recruitment programme with ongoing advertisements, local media and university pitches to promote the hospital's recruitment programme.

- Consultants were supported by junior colleagues in clinics where this was appropriate.
- The imaging and diagnostics team had a total of 28 WTE locum staff which included 17 radiographers, three sonographers and eight medical staff. Staff completed an induction checklist with the manager in the area. The temporary staffing team arranged for appropriate long on details for the information technology system and training was provided locally within the area as part of reviewing trust documentation and processes.

Major incident awareness and training

- The trust had a major incident plan which was available to staff on the intranet. Staff said they were informed of any updates as and when they happened.
- Staff confirmed they participated in “mock” major incident events. They confirmed a mock incident had taken place in the last three months. However, they were unable to confirm how often these took place.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but did not rate the service for effectiveness.

We found that:

- Care and treatment was delivered in line with national guidelines.
- Staff had the information they needed to deliver effective care and treatment to patients.
- Patient's pain was managed appropriately.
- Staff demonstrated a good knowledge and understanding of obtaining consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients.
- Staff told us there were training opportunities and staff were encouraged to take responsibility for organising their own training.
- Most teams reported effective multidisciplinary working.

However, we also found:

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- Although there was no consistent seven day working across outpatient, a business case was being explored to look at this.
- Compliance rates for staff who had received an appraisal varied across departments.

Evidence-based care and treatment

- We saw evidence that specialities within the outpatients services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate. For example, the familial hypercholesterolaemia (FH) (raised blood cholesterol due to a genetic abnormality) service followed protocol for all lipid clinics.
- Outpatient and diagnostic services followed the trusts audit calendar to capture compliance against policy, procedure, mandatory training and NICE guidance. Data captured was displayed and reviewed by service leads to identify trends and development needs.
- The results of the respiratory audit programme for May 2016 showed the trust was on target with the exception of selecting the audit criteria in line with the NICE Cg 117 Tuberculosis.
- The trust complied with the NICE guidelines on hyperphosphatemia in chronic kidney disease (CG157). This was a multi-disciplinary team approach to ensure patients were managed appropriately. Included was the appropriate prescription of phosphate binders and dietary advice by a renal dietitian. The audit for May 2016 identified that 94% (39 patients) had been reviewed by a dietitian.
- The trust audit programme ensured the service was compliant with NICE guidance such as; NICE CG 180 Atrial Fibrillation: management of atrial fibrillation and NICE/British Association of Dermatologist (BAD) Guidelines CG 153.
- The audit programme results for 2016/17 showed the audiology service was compliant with British Society of Audiology recommended procedures.
- Staff we spoke with demonstrated how to access policies and procedures on the trust intranet.

Pain relief

- We observed doctors and nursing staff asking patients about their pain whilst attending the clinics. Patients we spoke with felt their pain was managed appropriately.

- Staff confirmed that when patients presented at the “hot clinics” they assessed and recorded the patient’s pain levels. This was commenced in the assessment clinic where actions to deal with pain management were discussed.
- The effectiveness of pain relief was evaluated and recorded in the patient’s records by using the pain scale within the National Early Warning Score charts. Pain control issues were referred to the appropriate doctors who assessed the patient and prescribed the appropriate medicine as required.
- An assessment of patient pain was made on arrival to the radiology department. If analgesic pain relief (medication) was not available, then alternative pain relief strategies would be tried, for example by repositioning patients in beds.
- Analgesic cream was available in the phlebotomy clinic for patients who might experience pain while blood was taken. This was normally used for children but was available for adults if required.
- We saw doctors gave patients healthy living advice to improve their symptoms and reduce pain. This included advice on who to contact for help with weight loss and how to get more active during the day.

Patient outcomes

- The follow-up to new appointment rate at the hospital was in line with the England average during the period March 2015 to February 2016, at 1:95.
- Clinical audit results from audits were presented at specialties quality improvement and patient safety meetings and actions agreed as applicable. The clinical audit lead for each specialty had overall accountability for ensuring clinical audit action plans were fully implemented.
- Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered in both the NHS and independent/private healthcare sector in England. These assessments were introduced in April 2013. The percentage for food (8%), cleanliness (99%), dignity and wellbeing (89%) and condition, appearance and maintenance (95%) had decreased from the previous year. However, all of these figures were better than the England average. The trust had implemented an action

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group to review patient catering in order to meet patient's needs. This included the introduction of new patient menus and the replacement of catering and beverage trolleys.

- The physiotherapy outpatient rehabilitation unit measures individual patient outcomes, which were not audited, and did not measure outcomes as a patient group.

Competent staff

- Staff told us there were training opportunities and staff were encouraged to take responsibility for organising their own training.
- Specialist clinic areas provided clinical training for staff to ensure competence in the speciality. Bespoke competencies were in place, as well as specific clinical skills required for specific specialities. For example, staff confirmed they had attended cannulation and stoma courses.
- Some staff in ophthalmology were signed up to attend clinical course later in the year. However, some staff said they had requested additional training but this was unavailable due to financial constraints or the lack of staffing to cover training time. Senior staff acknowledge that financial resources for study leave and training was a challenge.
- We spoke with bank staff who confirmed they had received an orientation of the service they were covering but no induction. The orientation was not recorded, which meant that we could not be assured that bank staff had received the appropriate induction to manage and monitor the care and welfare of patients visiting the service.
- All new staff were allocated a mentor who supported them during their induction. They received an induction booklet which they completed alongside their mandatory training. On completion of the booklet staff were re-assessed to ensure they were competent in their role.
- We spoke to a new member of staff in the radiology department who told us they had a competency book which they were working through and told us they were booked onto the effective care practitioner course (a course for assistant healthcare staff to help them gain skills in looking after patients) in November 2016. They told us they had a mentor who they worked with regularly and who helped them with their competency skills book.
- There was a student notice board in radiology showing details of mentors available to support students.
- The trust had two doctors identified under Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) as Practitioners for Nuclear Medicine and Position Emission Tomography (PET) studies within the examinations listed on their Administration of Radioactive Substances Advisory Committee (ARSAC) licenses. Nuclear medicine is a branch of medical imaging that uses small amounts of radioactive material to diagnose and determine the severity of, or treat a variety of diseases, including many types of cancers, heart disease, gastrointestinal, endocrine, neurological disorders and other abnormalities within the body. PET is a nuclear medicine, functional imaging technique that is used to observe metabolic processes in the body. The ARSAC license holder had responsibility for all aspects of those particular studies including referrals, justification, performance and evaluation. The doctors, where appropriate, delegated some of these duties to competent staff to enable continuous service provision.
- Under IRMER all diagnostic tests must be completed by competent operators who hold an ARSAC licence which enables them to administer radioactive pharmaceuticals and other non-radioactive medicinal products specified in the routine clinical protocols. We saw the policy (dated June 2016) which listed the staff that had been authorised to carry out these tests.
- Revalidation was introduced by the Nursing and Midwifery Council (NMC) in April 2016 and this ensured that all nurses and midwives maintained their registration every three years. ESR information was provided every month to all managers and matrons. The data included the name of all NMC registrants together with the expiry and revalidation date. Line managers and matrons reviewed the information to identify and check on the registrants' progress with submission.
- There were 81 doctors still to be revalidated due to their scheduling on the General Medical Council national timetable. Of these 31 were to be revalidated within the cycle April 2013 to March 2018. The remaining 50 doctors obtained their licenses after March 2013 and would be revalidated for the first time in the revalidation period April 2018 to March 2023. No non-engagement recommendations had been submitted by the hospital.
- Medical staff appraisals were collated from the trust's revalidation management system. The records showed the trust was 93% compliant which was in line with their

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key performance figure of 90%. Of the 41 doctors who were non-compliant 10 had valid reasons for not completing an appraisal (for example, maternity leave, sick leave, agreed postponement). However, the report did not identify any actions in the capturing of the remaining 31 doctors who were non-compliant.

- The trust RAG rated (red, amber, green) staff's appraisal compliance. We saw 142 out of 169 staff were up to date and 27 were out of date, which equated to an overall rate of 84% (amber). Dermatology had the lowest compliance at 60% (six staff out of date) and rheumatology the highest compliance at 100%.
- In radiology we saw 175 out of 201 staff were up to date and 26 were out of date which equated to an overall appraisal rate of 87% (amber). CT/MRI radiology was 82% compliant (five out of date), whilst vascular ultrasound and radiology nursing had achieved 100% compliance.

Multidisciplinary working

- Five outpatient staff members said they believed multidisciplinary working between teams was good and they were proud of this.
- The ophthalmology service had various multi-disciplinary clinics. The service has led nationally in training optometrists in enhanced roles such as eye emergencies and in corneal, vitreo-retinal and medical retina clinics.
- The ophthalmology department ran a cataract service. The care pathway provided multidisciplinary input in the management of patients with cataracts, and relied on the expertise of numerous professional groups.
- The Wisdem Centre treated patients with diabetes and related metabolic conditions. We saw good inter departmental working within the Wisden centre with good interaction between the different specialities, such as diabetes and cardiology. Staff said they worked well with local GP's and mental health teams to improve the care of patients through clinical care, education and research.
- We observed a friendly working relationship between porters, radiographers and radiography assistants.
- We observed a health care assistant in the outpatient department working closely with a consultant both before and after a patient review.
- Volunteers were available in outpatients and worked closely with reception staff to guide patients to specific clinical areas.

Seven-day services

- Outpatient clinics were available from 8.30am to 6.30pm, Monday to Friday. When the demand for appointments was greater than clinic availability, we were told that further clinics would be created. For example, Saturday clinics were arranged to accommodate a backlog of ophthalmology patients. The matron told us that a seven day working business case was being explored to manage patient demand.
- There was a dedicated eye casualty service available in clinic 9, the eye department, between 8.30am and 4.30pm, Monday to Thursday, 8.30am to 4pm on Fridays and 9am to 12noon on Saturday. Outside these times patients attended the main emergency department.
- Radiology services were routinely available from 9am to 4pm, Monday to Friday for outpatients. Some radiology services ran up to 7pm weekdays.
- The pharmacy was available 8.30am to 6pm on weekdays, and 9am to 1pm on Saturdays.

Access to information

- Staff generally had the information they needed to deliver effective care and treatment to patients.
- Clinic rooms had computer terminals which enabled staff to access patient information such as x-rays and blood results via the electronic reporting system.
- All staff we spoke to were aware of the trust's intranet and had access passwords. In radiography we saw a staff base with two computers for staff use for training and looking up information on line.
- Inpatients notes were brought to the imaging department with the patient and handed to the imaging reception desk on arrival. This meant the radiography staff had access to a patient's full medical history if required.
- Imaging requests were received online and appeared on the radiographer's electronic system. Any previous tests including images and blood test results could be reviewed online.
- Radiography staff reported inpatients sometimes arrived for a procedure but were not booked on the electronic system. This meant radiology staff could not access that patient's medical details. This happened when doctors requested tests but the system had not been updated in time before the patient arrived in the department. This meant vital information about a patient could be missed.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good knowledge and understanding of obtaining consent, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff could access these policies from the trust intranet.
- Staff could describe how they supported patients with reduced mental capacity and/or dementia. Staff could name the lead learning disability link nurse within the trust.
- Staff we spoke to were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected.
- We heard radiographers check patient details and ask for consent from patients before administering treatment. We saw consent forms in the radiology department were used for female patients of child bearing age to declare that they were aware of the hazard associated with radiation.
- Doctors discussed treatment options during consultations and where written consent was required this would be obtained at the time of the outpatient appointment.
- Patients told us that staff explained planned procedures or examinations before they were asked to consent to them being carried out.
- Training data showed that 53 radiology staff and 89 outpatient staff had attended face to face DoLS full day training provided by the safeguarding team. The online training package for level 2 adults safeguarding incorporated MCA and DoLS training. All ward/ departments had a resource folder within their areas for MCA and DoLS (which could be accessed on the trust's intranet system).
- The trust completed consent audits. We saw the May 2016 consent audits for dermatology, oncology and radiology. The audits were red, amber, green (RAG) rated. For example; the dermatology audit was compliant with the exception of; abbreviations used (77%), job title of the consultant not present (77%), and no patient date or signature (73%). The oncology audit was compliant with the exception of "a significant amount of time (i.e. more than 24 hours) elapsed since the patient signed the consent form" (73%). The radiology audit identified areas of concern which

- included: is it documented whether any additional procedures including blood transfusion may be required (33%), is it documented whether a leaflet has been provided to the patient (10%) and has the carbon copy of the consent form been given to the patient (i.e. is the carbon copy absent from the notes) (37%). All audits identified the area for improvement and the actions to be taken.
- We spoke with 3 staff in the phlebotomy service who confirmed they had MCA training. However, they did not understand the principles of informed consent and were unaware of DoLS. Staff said they always asked a patient if they could take blood but said if a patient had dementia they would get permission from their family.

Are outpatient and diagnostic imaging services caring?

Good



We rated outpatient and diagnostic imaging services as good for being caring because:

- Patients were treated with compassion, kindness, dignity and respect.
- We observed reception staff greet patients in a courteous and friendly manner and directing them to the appropriate waiting area.
- Patients we spoke with told us staff had introduced themselves and we saw this happening throughout the service.
- There was good rapport between doctors and nurses with their patients.
- Patients we spoke with felt well informed about their care and treatment.
- A clinical nurse specialist in the Wisdom Centre explained how they encouraged patients to self-manage their condition including sign-posting patients to other agencies for assistance.

However, we also found:

- We identified areas in radiology where there was insufficient action taken to maintain patient privacy and dignity.

Compassionate care

Outpatients and diagnostic imaging

- We saw patients were treated with compassion, kindness, dignity and respect.
- During the inspection we observed staff and volunteers interacting positively and respectfully with patients and their colleagues.
- We observed reception staff greet patients in a courteous and friendly manner and directing them to the appropriate waiting area.
- Patients were provided with the option of being accompanied by a friend or relative during consultations. We saw in fracture clinic a patient with a learning disability was accompanied by a friend who held their hand throughout the consultation. We saw doctors and nurses interacting with the patient and their friend in a caring and compassionate way.
- Chaperones were also available if required. The trust had a policy on the use of chaperones which stated that, wherever possible, the chaperone should be of the same sex as the patient.
- One patient told us that “staff are brilliant, can’t fault them” and another said that “staff are very good and do everything they can to help.”
- Patients who arrived at the reception areas stood in a queue before they were called forward to the reception desk. This reduced the risk of confidential information being overheard when patients were asked to confirm their personal details by the reception staff. The ophthalmology department had an electronic log in machine, but this was not working during our inspection which meant that patients had to queue for the receptionists. However, we observed one receptionist shout across the fracture clinic waiting room and clarify booking information with the patient.
- Patients we spoke to in radiology and outpatients praised staff for the level of care they received in the department. One patient said the radiography team were extremely kind and another said their consultant never rushed them through their consultation and always listened to their concerns.
- We saw there was good rapport between doctors and nurses with their patients. We heard staff laughing with patients in the fracture clinic. We sat in an outpatient clinic consultation and we saw the consultant and patient sharing a joke together. The doctor displayed good communication skills including eye contact, body language and listening attentively. The patient told us they had 100% faith in their doctor.
- We saw two nurses escorting a patient who was unsteady on their feet back to their family who were waiting outside.
- We observed staff knocking on clinic doors prior to entering to respect a patient’s privacy and dignity. However, we identified some areas where it would be difficult to maintain patient dignity. For example, we saw individual changing rooms in radiology were situated opposite patient waiting areas and we found some of the cubicles were very small and had thin curtains. We also saw there was limited space in the radiology waiting area. Staff told us this lack of space compromised their ability to respect the privacy and dignity of bariatric patients in particular. Due to the extra bed space requirements, these patients would always be placed in an end space with the curtains closed for “extra privacy”.
- We saw a female patient in night clothes on a hospital bed opposite a row of male patients sitting up in wheelchairs, all awaiting their appointment in radiology. We observed there was no privacy behind the curtains in the radiology wait area. If a patient required personal care or a bed pan for example, conversations were easily overheard. There had been two incidents reported where patient dignity had been compromised in radiology between September 2015 and August 2016.
- Patient-Led Assessments of the Care Environment (PLACE) scores for privacy and dignity in 2016 were 89% for the whole trust which was better than the national average of 84%. Individual outpatients and radiology department scores were not available.
- We saw the NHS Friends and Family Test (FFT) questionnaires throughout outpatient departments with posters, which encouraged patient’s to leave comments about the service. The FFT was launched by the NHS in 2013 for all acute trusts. The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used. The feedback gathered is designed so that services can improve patient experience. We reviewed the FFT data reported by the main outpatient department from October 2015 to September 2016. The response rate was 3%, which was worse than the England average of 6%. 90% of patients would recommend the service to friends or family. The national average for this period was 92%.

Outpatients and diagnostic imaging

- We saw the main radiography outpatient reception area had a notice board which included a relative and carer feedback box although there was no FFT questionnaires, pens or paper available for writing responses.
- The physiotherapy outpatient rehabilitation unit completed a bi-annually patient satisfaction survey. The results were displayed on the staff board and showed that 100% of patients rated the service as good or excellent in February 2016.
- The results of the patient satisfaction survey for the respiratory function clinic were displayed outside the clinic area. They showed that 100% of patients (n19) rated the service as good or excellent as of 19 September 2016.
- The phlebotomy department had a three faces for patients to rate their experience in the clinic, 'unhappy, ok or happy'. On the day of our inspection, we saw all patients had ticked the happy face.

Understanding and involvement of patients and those close to them

- In February 2016, UHCW NHS Trust launched the #Hellomynameis campaign across both sites and within the wider health community as an Always Event. We heard staff answer phones and greet patients face to face with the phrase "Hello my name is...".
- Patients we spoke with told us staff had introduced themselves and we saw this happening throughout the service.
- Patients we spoke with felt well informed about their care and treatment. One patient told us they "could not fault their treatment" and they felt "well informed to make any decision" and the consultant had "answered all their questions."
- Three patients said they were happy with the information provided by consultants and how they also included their family once permission was given.
- We observed reception staff checked that patients knew which clinic they were attending and which clinician they were going to see.
- We saw staff in the phlebotomy clinic asking patients which arm they would prefer to have their blood taken from. We saw a phlebotomist advising a patient who used a walking aid which arm would be least inconvenient for them and we saw a doctor offering a choice of when a patient would like their stitches removed.

Emotional support

- A clinical nurse specialist in the Wisdem Centre explained how they encouraged patients to self-manage their condition including sign-posting patients to other agencies for assistance.
- We saw clinical nurse specialists were available in the outpatient department to talk to patients and provide emotional support.
- We saw details of how to contact the hospital faith centre. Patients, visitors and staff could access the trust's chaplaincy service if they needed support.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

We rated outpatient and diagnostic imaging services as requires improvement for being responsive because:

- Patients were not always kept informed about how long they were expected to wait to be seen in clinic. Some patients arriving for their appointments waited a considerable time to be seen. In ophthalmology patients left the clinic without being seen due to the long waits.
- There were waits of 18 weeks for some specialities including ophthalmology and plastic surgery.
- Information on how to raise a complaint was displayed on notice boards in outpatient and diagnostic test areas. However, we did not see evidence of improvements to service provision in response to complaints received.
- We received some comments regarding difficulty in parking.

However, we also found:

- The trust was meeting cancer targets for referral to treatment times.
- Seven specialities were meeting the 18 week referral to treatment target, including geriatric medicine, thoracic medicine and neurology.
- Patients who required diagnostic assessment and/or treatment were seen within six weeks of referral.
- There was some service planning and delivery to meet the needs of local people

Outpatients and diagnostic imaging

- There were facilities to meet the needs of patients with complex conditions.

Service planning and delivery to meet the needs of local people

- The trust had established a familial hypercholesterolaemia (FH) service that aimed to find and treat people in Warwickshire with this condition. FH is an inherited cause of very high cholesterol which, in most cases, if left untreated will result in heart disease and related conditions. We observed a FH consultation and spoke with a patient who said the service had saved their life and those of their family. They confirmed their family had also been reviewed and, where appropriate, been treated. They said they could not fault the service or the consultants and their teams who they thought were “brilliant.”
- The physiotherapy department was working with the local council on a healthy lifestyle programme 'One Body One Life' to promote a healthy lifestyle.
- The hospital offered patients with long term health conditions a 10 week lifestyle management programme to support patients. The course aimed to boost patient confidence and empower patients to gain coping and recovery strategies opt help manage their condition.
- There was an ambulance liaison service desk located within the main outpatient waiting area that was provided by the local ambulance service. Staff manning the desk reported that they worked closely with the hospital to ensure patient transport ran smoothly. They had no clinical concerns about how services were planned and delivered to patients.

Access and flow

- The trust had a patient access policy which provided guidance to staff on the management of patients waiting for treatment. We saw the policy had been reviewed and was up to date.
- The September 2016 board paper noted that referral to treatment times (RTT) within the trust remained challenging due to capacity and numbers of patients in the backlog. Failure to meet RTT targets was on the corporate risk register and there was a recovery plan and trajectory in place.
- The imaging service did not have patients that waited longer than 12 weeks for treatment. The records showed that 12 patients waited between six and 12 weeks from March 2016 to August 2016.

- Seven specialities were meeting the 18 week RTT target, including geriatric medicine, thoracic medicine and neurology. They were better than the England average.
- However, we saw the outpatient's appointment times for over 18 weeks. Ophthalmology and plastic surgery showed 88% and 74% of patients met the 18 week RTT respectively. The trust had recognised a capacity gap within ophthalmology and agreed funding had been provided to increase capacity to reduce waiting times. Extra staff members were being recruited to the service. Within dermatology the trust had identified that some patients had been booked out of order due to a mixture of paper referral and e-referrals process. The patient access team were providing further training and process to the dermatology team to rectify this.
- The percentage of patients seen by a specialist within two weeks and the percentage of patients waiting less than 31 days from diagnosis to treatment were consistently better than both the England average and the standard.
- The cancer 31 day subsequent radiology treatment standard performance did not achieve the 96% target for August 2016. This was due to a higher than usual number of complex cases and a loss of a small amount of capacity when new software was installed to the system. However, the trust achieved 100% for 31 day subsequent treatment chemotherapy, subsequent treatment other and for 31 day treatment for rare cancers.
- The 62 day cancer waiting times standard was achieved in July 2016 with 87.5% of patients treated against the 85% standard. The year to date performance had improved to 82.4%.
- We saw waiting times for individual clinics were written on boards in outpatients. For phlebotomy service there was a television screen that showed the queue summary of waiting times, ticket numbers and which cubicle to go to. When we inspected, the waiting time for phlebotomy was 15 minutes.
- However, in the ophthalmology department we did not see any notification of waiting times. We spoke with four patients who confirmed they had to wait a long time to be seen without any announcement of how long they had to wait. One patient said they had to leave a previous eye appointment due to other commitments and another two patients said their average length of wait was between three and five hours.

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- Ophthalmology patients that required urgent assessments could be referred by GPs, optometrists or doctors working in other hospitals to the eye casualty service. Patients were also able to self-refer. At 2:25pm on the 28 September 2016 we found that 12 patients were waiting to be triaged within the eye casualty unit. One patient had been waiting since 11:51am. At 3pm, two patients, who had arrived at the service at 11:51am and 12:19pm, left the service without being seen due to the long waits. Senior managers were aware of the long waiting times and had visited other NHS trusts with similar services to identify ways to improve. However, changes had not made a significant impact and we did not see evidence that the trust was monitoring this issue. The long waits were recognised on the department risk register.
- Patients told us they were not kept informed of waiting times for fracture clinics and radiology appointments. Three patients told us they had been waiting over two hours, including one who said nearly three. We saw one patient ask the receptionist in fracture clinic how long they would be waiting to see the clinician but after speaking to the clinician, the receptionist told the patient they were unable to give a time.
- Patients showed us a paging device they had been given which allowed them to leave the department if they needed food or drinks. Some said this was of no use to immobile patients or those waiting to have casts fitted. We spoke to one patient who was leaving without being seen because they had to go to work and could not wait any longer. Patients told us the waiting times increased the cost of car parking and they felt this was unfair.
- All patients within the FH clinic were seen within the allocated time. Nursing and medical staff confirmed that should there be a build-up of patients they would open another clinic which forestalled all backlogs.
- All FH discharged patients received a follow up call to ensure they maintained their wellbeing and whether they required additional support.
- The records showed that 18,645 patients cancelled their appointment from January to August 2016 which equated to 4%. The records showed that 12,301 patients' appointments were cancelled by the hospital from January to August 2016 which equated to 3%. This meant that the hospital was monitoring and managing the outpatients' department access and flow.
- The trust monitored the patients who "did not attend" (DNA) their appointments. We saw the figures from

January to August 2016 showed the trust had seen 349,327 patients of which 30,537 did not attend. This equated to an average of 8% over the year. However, the report did not identify a target rate or an action plan to review and reduce the number of DNA's.

- The trust monitored the radiology DNA rate. We saw the figures from January to August 2016 which showed the trust had seen 34,406 patients of which 1,125 DNA their appointment. This equated to an average of 3% over the year. The report did not identify a target rate or an action plan to review and reduce the number of DNA's
- Staff informed us that all patients who DNA were contacted to re-schedule their appointment. If patients DNA they were referred to the consultant who reviewed the patient and either notified their GP of non-attendance or requested additional contact with the patient.
- Patient could sign up to free text message alert to remind them of their appointment seven days in advance, to prevent patients not attending.
- We heard receptionists asking when patients would like their appointment to accommodate patient's commitments.
- Some patient we spoke with complaint about the car parking provisions and that they needed to leave home earlier than required to ensure they got a space to park.

Meeting people's individual needs

- The board walk round team had visited ophthalmology outpatients in quarter one of 2016/17. The non-executive directors and senior staff were asked to identify both positive and negative key points, any issues which have been raised and remain unresolved, any issues requiring escalation, and also provide any general comments. Some of the feedback received included the ophthalmology outpatients clinic was identified as very efficient, including the use of the electronic check-in system which had reduced check-in time from 2.5 minutes to 0.5 minutes. However, this electronic check-in system was not working during our visit which meant that patients had to queue for the receptionists.
- We saw a wide range of information leaflets for patients in all areas of outpatients. This included a map of the hospital, general outpatient information and information about personal data confidentiality and coming into hospital. In addition there was information on particle clinical conditions and advise, for example,

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infection prevention and control; 'Carers Trust' information (The Carers Trust is an organisation which provides help and support to people who care for someone else); and in the fracture clinic we saw patient information leaflets on how to prevent falls at home. We also saw written information for patients following a MRI. However, we did not find condition-specific information on display within the ophthalmic services.

- The leaflets we saw were all in English, some leaflets were available in other languages on request.
- The trust had access to an interpreting service. We saw an interpreter had been provided to talk to a patient in the fracture clinic and we heard receptionists asking if patients required interpreters for their appointments.
- Hearing loop was available within the outpatients department.
- The patient access team service lead told us that the team were implementing larger print appointment letters for patients with visual difficulties. They reported that trying to identify a method of sending letters out in Braille or an audio version of a letter to meet the needs of patients with hearing difficulties, was a challenge. However, the team were working on finding the most appropriate solution to this.
- The outpatient clinics we visited were generally accessible to patients living with physical disabilities and wheelchair users.
- Staff in outpatient's clinics told us they had no way of identifying if a patient was living with dementia or a learning disability because notes were not flagged in any way.
- We saw drinking water was available for patients but one water jug had a last change date documented as being the previous day.
- Visitors and patients had access to refreshments from shops and cafes located within or near the main outpatient department.
- For patient with complex needs and that were in the department for a long time, snack boxes were available. We saw a member of staff offer a snack box to an elderly patient waiting for transport.
- In the fracture clinic waiting room we saw a poster displaying all of the various uniforms staff may be seen in and describing what each colour's job title was.
- The outpatient department had volunteers who we saw giving directions to patients.

- The physiotherapy service offered group sessions, including Nordic walking, to patients with Parkinson's disease and multiple sclerosis. Physiotherapists told us that this meant patients received peer support with their condition.
- In the main hospital reception area visitors were able to use umbrella bags to prevent umbrellas dripping water and reducing the risk of visitors slipping.

Learning from complaints and concerns

- Information on how to raise a complaint was displayed on notice boards in outpatient and diagnostic test areas.
- The trust July 2016 board papers reported that Issues with outpatient appointments, communication and the information provided to patients continued to be the main area of enquiry in quarter one of 2016/17 (April to June 2016). The top three specialty groups that received enquiries about issues with outpatient appointments were trauma and orthopaedics, ophthalmology and general surgery. There had been 33 complaints within outpatients between January and September 2016. Five complaints about outpatients related to delays or cancellation of appointments within the department. The highest number of complaints was within the ophthalmologic department.
- Staff in the phlebotomy service told us there were made aware of complaints by the team leaders. Phlebotomy staff said most of their complaints were about waiting times.
- The radiology department received 10 complaints between January and September 2016. Complaints about diagnostic imaging were mixed with no clear themes identified, but included three complaints about poor staff attitude. There was no information stating whether any of the complaints were substantiated.
- We did not see within the service specific learning or changes in practice from a patient complaint.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We rated outpatient and diagnostic imaging services as requires improvement for being well-led because:

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- Governance systems were in place to monitor and assess risk, but these were not always accurately recorded.
- In some areas incidents were not always reported in line with trust policy.
- Some staff had low morale in ophthalmology.
- We found lack of evidence to support patients' involvement in shaping and improving the services.
- Whilst we saw some improvements in response to our March 2015 inspection, issues such as infection control and privacy and dignity remain within parts of the service.

However, we also found that:

- The trust had identified an issue regarding the quality of scan reporting and had addressed this appropriately by considering duty of candour and informing relevant stakeholders.
- There was a systematic programme of clinical and internal audit.
- Staff were aware of the risks within their departments.
- Staff were encouraged to suggest improvements.
- Most staff felt that managers were visible, supportive and approachable.
- Staff were proud to work at the hospital and passionate about the care they provided.

Leadership of service

- The outpatient department sat within a variety of different clinical groups, dependent on specialty. Each of which was led by a management team comprising of a clinical director, modern matron and group manager. The services was represented at board level by the chief operating officer. The diagnostic department was managed by the clinical support director and had a group manager, clinical head of service, a head of operations and a matron.
- Staff were clear who their managers were and in most cases felt they could approach managers with concerns.
- Senior staff reported having good support from clinical leads and having regular one to ones.
- Ophthalmologic staff told us they did not feel supported by their managers and could not approach them with their concerns. However, the management were unavailable on the day of the inspection and we were unable to ascertain the interaction between management and staff.

- Staff told us that they knew the executive team and that they were visible on the 'shop floor' at times.
- There was a leadership behaviours poster in the main x-ray outpatient waiting area.
- On the main outpatient staff board we saw management concerns were highlighted. For example, in September 2016 there was a reminder about staff clearing their hair off of their collar to fall in line with the infection control policy. We saw staff adhering to this.

Vision and strategy for this service

- The outpatient services' vision and principles was to provide treatment to the 'right person, at the right place, on time'. We saw this on display throughout the outpatient service. Most staff were aware of these.
- There was a vision and values poster in the main X-ray department outpatient waiting area.
- Outpatient and diagnostic imaging services both had a strategy for 2017/20 and 2016/19, respectively. The outpatient strategy looked at issues such as seven day working, hand hygiene and optimising utilisation of resources to improve service delivery. The diagnostic imaging strategy looked at equipment, achieving nationally recognised accreditation and staff caseloads.
- The familial hypercholesterolaemia (FH) service had a five year projection plan to review genetics cases with a view of seeing the 2000 people identified in Warwickshire with the condition.
- In the physiotherapy outpatient rehabilitation unit their strategic plan and objectives were displayed which were based upon the trust vision.

Governance, risk management and quality measurement

- Staff were aware of the risks within their departments. The risk register captured these, demonstrating control measures, gaps in controls and assurance.
- Senior staff we spoke to were aware that in some areas of the service incident reporting was low and not in line with trust policy, and had met with staff to discuss this. However, this had not been identified on the risk register. It also meant that governance leads could not be assured all incidents were being reported and therefore patient safety could be at risk due to lack of learning.
- Learning and feedback from incidents was inconsistent. The action taken as a result of some incidents did not always address the cause of the incident.

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- Systems in place to prevent and protect people from a healthcare associated infection were not always followed. Hand hygiene was part of the outpatient strategy plan to improve.
- Monthly quality improvement and patient safety meetings were in place. The meeting discussed recent incidents, learning and incidents that remained open. In the July 2016 meeting minutes it was noted that there were no incidents that remained open for investigation and none had breached the 45 day policy. The radiology quality improvement and patient safety meeting minutes were in detail and clearly noted discussions regarding new guidelines, incidents and quality.
- However, the outpatient July 2016 meeting minutes of the quality improvement and patient safety meeting, the previous meeting minutes (June 2016) were not discussed and there was no documentation regarding the presentation that closed the meeting. Therefore, we were not assured that meeting was accurately recorded.
- There were modality meetings for each speciality, which discussed topics such as governance, business cases, staffing and quality. However, we saw minutes from several specialities, none of which were in details. For example, the vascular ultrasound meeting minutes for June 2016 had a topic for workforce such as appraisals and training, the minutes in the comment box just stated 'ok'. This meant there was no description to elaborate on if staff training and appraisals were meeting the trust target.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action was required. The trust had a clinical audit and effectiveness programme for 2016/2017 incorporates both mandatory and local clinical audits from specialities throughout the trust including outpatients and diagnostic imaging. The programme was developed annually in liaison with individual specialties and clinical audit leads. The clinical audit and effectiveness programme reported the total number of clinical audits and showed progress made towards completion of audits. Performance within the audit programme was reviewed and updated on a quarterly basis by the team of clinical audit facilitators and was reported to the patient safety committee on a quarterly basis and to the audit committee twice a year. Findings from audits and progress with completion of actions were monitored via quality improvement and patient safety meetings.
- In the physiotherapy outpatient rehabilitation unit there was a staff communication book where information, such as recent complaints, incidents and changes in clinical practice were noted. This meant that all staff had access to the most recent information about the department.
- The trust had identified an issue regarding a locum consultant radiologist reporting on scans. The locum had worked at the trust for approximately six months in 2015/16. The discrepancies came to light in May 2016 when it appeared wrong results were reported by the locum. Patients were told of the findings. In response the trust had audited 25 cases of reported scans by the locum. A discrepancy rate of 40% was identified. The NHS guidelines are that a discrepancy rate of about 30% is cause for concern. The trust had informed all the relevant stakeholders and was advised to check all scans reported by the locum. The trust believed there were between 900 and 1000 scans involved. They had sourced another provider to review the scans. This was underway during the time we inspected. Nine cases had been identified to date where the discrepancy was clinical significant and one scan discrepancy identified as significant. Patients were followed up where necessary. An oversight committee was set up to inform patients in line with the duty of candour.

Culture within the service

- Most staff were proud to work at the hospital and passionate about the care they provided.
- Most staff we spoke with felt respected and valued.
- Multidisciplinary teams worked collaboratively and were focussed on improving patient care and service provision.
- In most areas staff we spoke to reported an open and honest culture within the outpatient and diagnostic imaging department. Staff felt confident to escalate concerns and report incidents.
- Some staff had low morale in ophthalmology. Nursing staff were concerned about their skill mix and the lack of competency training available. Senior staff reported that they had encouraged staff to complete stress assessments and have referred staff to occupational health where required.

Public engagement

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- We saw the NHS Friends and Family Test (FTT) questionnaires throughout outpatient departments with posters, which encouraged patients to leave comments about the service.
- Relatives and carers feedback boxes were available in the main x-ray outpatient waiting area. Although no forms or pens were available to enable ad hoc patient comments.
- Patients and relatives we spoke with were generally positive about the service and care they received in outpatients.
- The hospital made use of social media to advise the public self-care advice on seasonal illnesses and responded to comments put on social media by patients or their relatives.
- We found lack of evidence to support patients' involvement in shaping and improving the services.

Staff engagement

- The main outpatient department staff board showed that for April to June 2016 92% of staff would recommend the trust to friends and family if they needed care or treatment, no staff would not recommend the trust. 58% of staff would recommend the trust as a place to work to friends and family which had increased by 5% from the previous quarter. 33% of staff would not recommend the trust as a workplace to friends and family, which had also worsened by 9% since the last quarter. There were no action plans on the board to denote how scores could be improved.
- On the main outpatient staff board we saw staff were encouraged to suggest improvements. For example, in August 2016 a staff member had identified that awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards needed to improve. As a result a booklet had been created to help raise awareness to understand the differences between the two.

Innovation, improvement and sustainability

- Whilst we saw some improvements in response to our March 2015 inspection, issues such as infection control and privacy and dignity remain within parts of the service.
- On the physiotherapy outpatient rehabilitation unit staff board there was a space for staff to propose innovative ideas. There was nothing in this space when we

inspected however, staff told us that they were encouraged to suggest ideas about how the department could improve and that these were listened to by their manager.

- The main outpatient team in July 2016 were nominated as 'world class colleagues' in the pride category of the trust awards.
- In February 2016, UHCW NHS Trust launched the #Hellomynameis campaign across both sites and within the wider health community as an Always Event. We heard staff answer phones and greet patients face to face with the phrase "Hello my name is...". The campaign had reached over 100,000 people on social media. As well as success on social media, the Patient Experience Team, accompanied by staff from all over the hospital, visited wards to increase engagement, participated in a hospital radio broadcast to raise awareness among the patients, and presented at the grand round. Following the inclusion of a question in an online survey asking respondents whether staff introduced themselves all of the time, some of the time or not at all, results demonstrated that over 50% of respondents told us that staff members introduced themselves all of the time. Since the launch of the campaign in February, the #Hellomynameis Working Group had targeted the outpatient department to ensure the practice was embedded. Staff within the outpatient and diagnostic services told us how proud they felt that the campaign had been a success in the area.
- A clinical audit for quality improvement award was held on an annual basis. The competition attracted entries from clinical staff of all disciplines that had carried out clinical audits demonstrating effective application of the recognised clinical audit cycle in accordance with the trust policy and had contributed the most to clinical quality improvement. In July 2016 a dermatology consultant won the award for their entry entitled 'Audit of pre-treatment assessment, prescription and monitoring of Methotrexate use in the dermatology department'.
- The trust participated in national promotion of clinical audit in conjunction with the Healthcare Quality Improvement Partnership Clinical Audit Awareness Week. The next event was due to take place in during the week of 22 November 2016. Plans were in place for three events to take.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must ensure all medicines are stored in accordance with trust policies and national guidance.
- The trust must ensure all incidents are reported in line with trust policy.
- The trust must ensure that infection control practices follow trust policy and recommended guidance, including correct hand hygiene and use of personal protective equipment.
- Ensure there is a robust policy for transporting patients with an infection or who may be at risk of acquiring an infection in the hospital, so that staff are aware that special precautions need to be put in place to protect the patient and the public.
- The trust must ensure that there sufficient patient information handed over between clinicians to ensure that the health, safety and welfare of the patients is maintained.

Action the hospital **SHOULD** take to improve

- The trust should ensure all staff have received their required mandatory training to ensure they are competent to fulfil their role.
- The trust should ensure staff receive appraisals which meet the trust target.

- The trust should ensure that patients are able to access outpatient services in a timely way for initial assessments, diagnoses and/or treatment, with the aim of meeting trust and national targets.
- The trust should ensure that all risks are identified on the risk register and appropriate mitigating actions taken.
- The trust should ensure that meeting minutes clearly record recommendations and lessons learnt from incidents.
- The trust should ensure equipment is always stored appropriately and fit for use.
- The trust should ensure that staff in phlebotomy ask if they have any allergies prior to the application of the cleaning spray.
- The trust should ensure that hazardous chemicals are stored in line with Control of Substances Hazardous to Health Regulations 2002.
- The trust should ensure that patients privacy and dignity is protected at all times, in particular within radiology.
- The trust should minimise the percentage of outpatient clinics cancelled.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 (2)(a)(b)(c)(g) HSCA 2008 (Regulated Activities) Regulations 2014</p> <p>Safe care and treatment</p> <p>1. Care and treatment must be provided in a safe way for service users –</p> <ul style="list-style-type: none">a. Assessing the risks to the health and safety of service users of receiving the care or treatment.b. Doing all that is reasonably practical to mitigate any such risksg. The proper and safe management of medicines.h Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;i Where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. <p>The regulation was not being met because:</p> <p>The trust did not ensure all medicines were stored in accordance with trust policies and national guidance.</p> <p>The trust did not operate effective systems designed to prevent, detect and control the spread of infection and did not maintain appropriate standards of cleanliness and hygiene. The trust did not ensure that infection</p>

This section is primarily information for the provider

Requirement notices

control practices followed trust policy and recommended guidance, in particular with relation to correct hand hygiene and use of personal protective equipment.

The trust did not ensure that there was a robust process for identifying in patients, with an infection, which could contaminate other patients, during transfers around the hospital.

The trust did not ensure that there was sufficient patient information handed over between clinicians to ensure that the health, safety and welfare of the patients was maintained.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1) (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014

Good Governance

1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.
2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—
 - A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
 - B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

The regulation was not being met because:

Incidents were not always reported, therefore, the trust could not assess, monitor, improve safety or mitigate risks.