## Overview of the service

The provider is an acute NHS foundation trust providing services across the Bristol and greater Avon area. The trust also provides specialist care to people from across the South West Region.

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What we found overall

We found that University Hospitals Bristol NHS Foundation Trust was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we suggested that some improvements were made.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:
- Care and welfare of people who use services
- Cooperating with other providers
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 18 May 2011, 19 May 2011 and 27 May 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider’s records, and looked at records of people who use services. Our inspection team was made up of three Compliance Inspectors and a Clinical Advisor who is a Consultant Histopathologist.

The trust had declared non-compliance with outcome 14: Supporting workers because of concerns about the levels of staff appraisal and also because of the levels of safeguarding training which have been undertaken by staff within the trust. The trust had implemented action plans to ensure compliance with this outcome.
The trust had declared non-compliance with outcome 21: Records due to the quality of clinical record keeping raised as part of the Care Quality Commission review of outcome 5 relating to nutrition; and due to the changes in definitions regarding information governance toolkit the where the trust was red-rated for this. The trust had put in place action plans to ensure compliance by 31 December 2011.

We did not gather further evidence as part of this review about these areas of non-compliance and will be addressing this separately with the trust.

**What people told us**

We carried out this review to follow up on the concerns raised following the publication of the Histopathology Independent Inquiry Report which published in December 2010 and also in response to an additional case of misdiagnosis which was reported to us by the trust. We have also had concerns raised by members of the public about the provision of histopathology services at University Hospitals Bristol NHS Foundation Trust.

This review was focused on the delivery of histopathology services and the diagnosis of cases through the multi-disciplinary team (MDT) meetings.

We found that the trust had implemented an action plan following the Histopathology Independent Inquiry Report which they had made progress with. However, further actions were still to be implemented.

We spoke with 14 patients within the Haematology and Oncology Centre about the care that they had received, their pathway through diagnosis, the discussions they had had with clinicians and other healthcare professionals, information they had received about their treatment and diagnosis and if they had any concerns about the service.

People told us that they were very satisfied with the care that they had received from diagnosis through to their treatment. People told us that they had received adequate information about their diagnosis and treatment and that staff of all levels had been willing to answer any questions that they had. However, one person told us that their appointments with the consultant could be quite rushed not leaving time for all of the questions they had to be answered. Most people told us that they are given options for treatment which they were able to discuss with their consultant.

We were told by patients that there was plenty of literature to assist in increasing their knowledge about their condition and we saw evidence of this in place within the Haematology and Oncology Centre.

We spoke to a variety of staff (17 in total) including Cancer Nurse Specialists, Consultant Surgeons, Consultant Oncologists, Consultant Radiologists, Consultant Histopathologists, Matrons and members of the senior management team of the trust.
They told us that they all felt supported in their role and that they had all received appraisals.

We found that there were systems in place within the trust to assess and monitor the quality of services and that the trust had recently commissioned two reviews of governance systems by Audit South West and by an independent consultant. These reviews made recommendations for improvements which the trust were acting upon.

We found that core members of the multi-disciplinary team (MDT) meetings were not always in attendance as required by trust policies. The trust is monitoring the attendance at MDT meetings.

We found that the trust works in cooperation with other trusts to ensure that people receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

We found that staff in the Histopathology Department had high workloads. We reviewed the Consultant Workload Data for the year 2010-2011. We reviewed the figures against the Royal College of Pathology guidance on staffing and workload within histopathology and cytopathology departments (June 2005). The data showed that most consultant histopathologists within the department were working in excess of the number of unweighted specimens recommended by the Royal College.

We found evidence that staff are supported in their role and had access to professional education and continuing professional development. We found that staff had received appraisals but that some were more detailed and meaningful than others.

We found that Histopathologists are undertaking External Quality Assurance (EQA) Schemes which are appropriate to their practice.

We saw that histopathology reports were documented in line with that expected. The trust is also reviewing the style of histopathology reporting in order to ensure best practice. We found that records of second opinions on the reporting of histopathology specimens were recorded in the pathology computer system.

What we found about the standards we reviewed and how well University Hospitals Bristol NHS Foundation Trust was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

- Overall, we found that University Hospitals Bristol NHS Foundation Trust was meeting this essential standard but, to maintain this, we suggested that some improvements were made.
Outcome 6: People should get safe and coordinated care when they move between different services
- Overall, we found that University Hospitals Bristol NHS Foundation Trust was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
- Overall, we found that University Hospitals Bristol NHS Foundation Trust was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
- Overall, we found that University Hospitals Bristol NHS Foundation Trust was meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
- Overall, we found that University Hospitals Bristol NHS Foundation Trust was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 21: People’s personal records, including medical records, should be accurate and kept safe and confidential
- Overall, we found that University Hospitals Bristol NHS Foundation Trust was meeting this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We spoke with 14 people on the outpatient units at the Haematology and Oncology Centre. 13 of the people were very satisfied with the care they had received since diagnosis through to their treatment. One person said, initially they did not feel they were being listened to but they said this could have been due to their anxieties about having a diagnosis of cancer. They said there had been delays in appointments but this did not relate to University Hospitals Bristol NHS Foundation Trust but another hospital, with delays of up to two hours in appointment times.

Most people (13 out of the 14 we spoke with) said they had sufficient information about their diagnosis and their treatment. Most people said their treatment plans were clearly mapped out for them on an appointment card and this was seen as positive by the people that we spoke to.

Two patients told us “Good experience - with nurses taking time to explain treatment. There were no surprises” and “My diagnosis and treatment was explained. I have made choices about my treatment”.

Another told us “Every time I see the oncologist I am given options, involved in
discussion and am able to ask questions. I am given information and have access to
advice and treatment."

Another two patients told us they were given information to make a decision about
treatment and the different options available and had been “Given a lot of
information about proposed surgery including leaflets”.

There was one patient who felt that they had not been told about all options
available and felt they were not prepared.

One of the individuals we spoke with said that there had been delays in the initial
diagnosis but this was more with the GP than the hospital. However, once referred
to the consultant treatment commenced promptly.

People told us that all levels of staff were willing to answer questions. One person
said that they felt their appointments with the consultant could be rushed not leaving
sufficient time to answer all the questions that you may have. Everyone said that
there was plenty of literature to assist in increasing their knowledge of their
condition. We were also told that there was a 24 hour support line that patients can
contact where their questions can be answered.

People we spoke to said that the nursing staff were knowledgeable and would
answer their questions. They told us the nursing staff always explained the
treatment that they are receiving.

People we spoke to said that the staff were approachable. Two of the people we
spoke to said that they felt the outpatients unit was short staffed but this did not
directly affect the care that was delivered.

We observed staff supporting people in the outpatients units in a respectful manner
and all the patients we spoke with confirmed that the staff were very supportive and
accommodating.

Comments included “Staff listen to you”, “They explain every step of the treatment”,
“Nurses are first class and very respectful” and “Can’t say enough about the
nurses”.

A member of a patient’s family felt communication between the hospital’s
departments could be improved as their relative was also accessing treatment from
other areas. It was felt that in this instance a more “holistic” approach towards their
relative’s care would have improved their experience.

People told us about the process they had gone through to get their diagnosis.
All the people we spoke with had been referred by their doctor to the hospital in
order to follow up investigations. This included meetings with consultants, and
surgeons where they were involved in discussions about their individual diagnosis.
All of the patients spoken with told us they felt involved, and had been listened to.

We asked the people we spoke with if they knew about any changes that were happening within the service or the Trust and if they had been asked to be involved in them. They all responded that they did not know of any changes while two people told us they had been involved in a project related to their treatment.

We asked the people we spoke with if they could tell us if there was anything they could change about their experience. One person said they would have been better prepared from seeing specific equipment before their treatment. They also said there had been one occasion when their treatment had not gone to plan and they had suffered a side effect. They said this had now been rectified.

We were told by two patients that they felt frustrated having to wait for prescriptions after they had received their treatment and that this could mean a further two hour wait.

Another person told us they had concerns about other general patients being admitted to the oncology ward. That they had picked up a virus while on the ward and felt that due to their vulnerability other general patients should not be admitted. They had reported this concern to a member of the nursing staff but felt they had not been responded to appropriately.

This was reported to the Chief Executive during feedback at the end of our first visit. We were told that there had been some occasions when this had occurred when there had been increased demand of beds during the winter months.

Although these specific comments were raised with us, it was evident that all the patients felt they that they were treated well and were satisfied with the service.

**Other evidence**

The trust has told us that it is compliant with this outcome and declared compliance at transitional registration in April 2010.

We reviewed the Histopathology Independent Inquiry Report (December 2010) and the most recent update to the action plan (10 June 2011) that the trust had developed in response to this. Although the inquiry report states that the service provided by the trust is safe, a number of recommendations were made which the trust had addressed within their action plan and was in the process of implementing these actions. This included the implementation of a double reporting policy (which we saw) that had been developed, implemented, reviewed and updated since the report. This policy covers both University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust and had been finalised and disseminated to all staff in May 2011.

The trust told us that they had agreed that another recommendation (that patients should not be given information contained in histopathology reports until the reports have been considered by the MDT) could lead to a delay in patient being given
information concerning their diagnosis and could put clinicians in the position of having to withhold important information from patients. The trust also believed that their ability to run ‘one-stop clinics’ would also be compromised by this. Instead the trust has proposed that patients should be given information appropriate to their care, with an explanation of the diagnostic and treatment decision process by the multi-disciplinary team. The trust had also developed and was piloting an information leaflet for patients to ensure that they are aware that a diagnosis given prior to an MDT may be refined at the MDT meeting following further consideration.

The trust told us that they were disappointed with their results of their National Cancer Patient Experience Survey from 2010. Although the trust scored in the top 20% for patients being given a choice of different types of treatment and ensuring that there was always or nearly always enough nurses on duty, the trust scored in the bottom 20% for 16 scores. The broad themes for these areas relate to compassion; dignity and respect; Clinical Nurse Specialist support and communication and information. The trust had put an immediate action plan into effect to improve these scores/patient experience.

We were shown around some areas of the Bristol Haematology and Oncology Centre. This included the reception and information & support centre situated on the ground floor. We saw the area provided people with relevant information through leaflets and booklets. We were told information could be accessed in different languages if asked for and interpreters could be accessed if people could not speak English. A WRVS coffee shop provided refreshments and we found the recently decorated centre provided a calming atmosphere for prospective patients.

At the entrance to the oncology unit there was an information centre where people/carers and professionals can obtain further literature and support. Staff were available to speak to people confidentially about living with their diagnosis including help and support groups. Everyone we spoke to said they were aware of this service.

We were told by staff that training is given to nursing staff on areas of consent and what to do if a person is assessed as lacking capacity. They told us that staff have access to advocacy services, specialist nurses with skills and knowledge to support people with a learning disability or dementia and the care of the older person.

Much of the information that we saw was in English. Staff said that most of the literature was available in different languages and could be requested. However this was not clearly advertised at the information centre. Staff told us that interpreters can be made available to ensure that people understand and can communicate effectively with staff. We were told that this sometimes can happen in person or via a three way telephone network.

We were told that each person visiting the outpatient unit for chemotherapy had a named nurse to support them during their treatment. We were told that the first appointment more time was allocated to the patient to enable the nursing staff to
complete an assessment and discuss the treatment being given and any anxieties
the person may have. This was confirmed in discussions with a person who was
having their first treatment.

We observed two Multi-Disciplinary Team (MDT) Meetings (one Lung MDT and one
Breast MDT). Both were run in accordance with their operational policy. However,
there was no Consultant Oncologist in attendance at the Breast MDT. This was due
to a communication failure as one oncologist was on leave, one had a personal
appointment and one was not due to attend the meeting that week as their job plan
had changed. We raised this with the trust and have been told that those concerned
have since committed to more robust communication of their attendance or non-
attendance at MDTs with each other.

We reviewed attendance records for core members of all the MDTs held in the trust
between 30 March 2011 and 18 May 2011. We found that there was only one MDT
which had no absences of core members for all MDTs during this period other
MDTs had variable attendance and at meetings and that this was across clinical
specialities (Surgeons, Physicians, Oncologists, Radiologists and
Histopathologists).

We saw evidence of two memorandums sent to MDT leads and MDT coordinators
within the trust (and copied to Divisional Leads and Managers) during March 2011
from the Chief Executive which identified that the all histopathology specimens to be
discussed should have been reported on by a suitably qualified histopathologist
prior to the meeting; that a suitably qualified histopathologist must be in attendance
at the meeting; that core membership of the MDT should be identified and
attendance at meetings recorded and that the advice to obtain or seek a second
report should be acted upon and findings taken into account.

The second memorandum identified the responsibilities of the MDT and the MDT
lead. This includes: a named core histopathologist and radiologist (or cover) being
present at the meetings; ensuring the MDT meeting is quorate; the information
which should be recorded for each patient as part of the MDT discussion; a review
of the waiting list information for patients.

We found that despite the memoranda sent by the chief executive, core members of
the multi-disciplinary team did not always attend the MDT meetings. However, we
found that decisions about patients care were validated and documented
appropriately.

Each patient case was presented at the MDT by the Consultant Surgeon or
Physician and histopathology slides and radiology scans were viewed and
presented by the Consultant Histopathologist and Consultant Radiologist. We
observed discussion and debate between the multidisciplinary team members about
each case which involved all present including Consultant Oncologists (where
present) and Cancer Nurse Specialists.

We observed that the MDT coordinator recorded notes of the discussion, decisions
made and the agreed diagnosis and pathway in the Somerset Cancer Network
Database. Where further clarification was required the MDT Coordinator requested
We saw evidence of other MDTs referring cases across to the Lung MDT and also that there was the opportunity for clinicians to add additional patient cases to the MDT at the end.

Throughout the MDTs the leads clarified that all in attendance were satisfied with actions and decisions and people were encouraged to challenge and speak up within the meetings. We observed that the waiting times and breach dates for each patient was included in the MDT information.

The staff that we spoke with all agreed that they felt supported within the MDTs and felt able to speak up, challenge and be included in the MDTs. We were told that there were good working relationships within the MDTs and that other clinicians can be contacted at any time if further information is required from them. Staff told us that they did not feel that any one individual dominated the MDT and that all clinicians (surgeons, physicians, oncologists, radiologists, histopathologists and other healthcare professionals) listened and they all work as a team. Staff told us that they were happy with the level of communication within the MDT.

Staff told us that the MDT coordinators are a hugely valuable resource within the trust. They ensured that cases were added to the agenda and that the record of the MDT is maintained and will ask whether everybody validates the decision about cases reviewed. Staff told us that the coordinators cover more than one MDT and that they are thinly spread as a result. This sometimes results in not being able to add cases to an MDT at the last minute, although we observed cases being discussed at the MDT which were not on the agenda.

We visited the Histopathology Department and Laboratories. We observed that work was booked in and processed in accordance with their operating procedures and with what would be expected in any laboratory.

We found that Consultant Histopathologists are allocated work as per their speciality and each consultant covers one or more speciality areas.

We were told that Consultant Histopathologists dictated reports using a digital recording system. We were told that typing of reports has been outsourced and is undertaken in the UK and uses NHS trained typists. This was introduced in 2006 due to secretarial staffing difficulties and the trust has told us that this has improved typing accuracy and the turnaround time of reports.

Our judgement

People were satisfied with the care that they received from the trust and that they get the information that they need about their diagnosis and treatment. The delivery of people’s care is planned in order to meet the service user’s needs, however not all healthcare professionals were involved in the planning of this care as they were not always in attendance at multi-disciplinary team (MDT) meetings.
Outcome 6: Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
• Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

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The trust leads a number of regional multi-disciplinary team MDT meetings where cases are reviewed from a number of trusts including Royal United Hospitals Bath, Weston Area Health Trust and North Bristol Trusts. We were told us that histopathology slides are made available from all of these trusts.

Staff told us that although the MDT coordinators request histopathology slides and radiology scans in advance for discussion at the regional MDTs the do not always arrive in time. If this happens then the patient’s case is deferred to the next MDT meeting.

We were told by staff that they have good working relationships with clinicians in other trusts and that where there is shared regional working there are standard practices in place. We were told that staff from other trusts are invited to join the
regional MDT and that the trust is investigating the possibility of remote link up between these trusts in order to facilitate this further.

We were told that staff were also able to attend and be involved in MDT meetings at North Bristol NHS Trust when the care of the patient is shared between both trusts.

There were concerns raised by staff regarding referrals to University Hospitals Bristol MDTs which are sometimes delayed at other trusts and can result in waiting times being breached. Where this occurs the University Hospitals Bristol MDT investigates this. We drew this to the attention of the senior managers within the trust as part of our feedback, who were going to be acting on this.

We were also told that there is a virtual Teenager and Young Adult MDT which works in partnership with the trusts and hospitals across the South West which share care for these patients. Although this group is referred to as an MDT it is brings together adult and paediatric services in order that they can add value to what already exists within patient care. This involves recruitment to clinical trials (where appropriate) and links with the voluntary sector in order to improve outcomes for patients.

We were told that the trust was looking to improve inter-trust working between University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust Histopathology Departments. The first stage of this was to appoint a joint Clinical Lead for Cellular Pathology which had been done. The joint clinical lead is looking to improve working in this area in line with the recommendations of the Histopathology Independent Inquiry Report (December 2010) and the Bristol Pathology Review which is ongoing in conjunction with NHS Bristol, North Bristol NHS Trust and Weston Area Health NHS Trust.

There had been a number of appointments to the histopathology department at University Hospitals Bristol NHS Foundation Trust over the last six months. The trust told us that these have all been joint appointments with North Bristol NHS Trust including the role of Joint Clinical Lead for Cellular Pathology. All Histopathologists at both North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust had been awarded honorary contracts in the reciprocal trust in order to facilitate cross trust working.

The trust had implemented a number of policies, procedures and protocols over the last six months with respect to histopathology in conjunction with North Bristol NHS Trust. These include a double reporting of histopathology specimens protocol and a raising concerns protocol in respect of histopathology reporting.

Our judgement
The trust works in cooperation with other trusts to ensure that people receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.
Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We did not speak with people who use services about this outcome.

Other evidence
The trust has told us that it is compliant with this outcome and declared compliance at transitional registration in April 2010.

The trust told us that it has an organisational “Workforce Strategy 2007-2012” the purpose of which is to ensure that the trust has “sufficient numbers of staff with the appropriate capabilities to deliver high quality services over the period 2007 – 2012”.

In addition there are annual workforce plans for each division. These have been provided for the year 2009-2010. It is not clear from this whether the planned increase in consultant staff within the workforce plan for the Diagnostics and Therapies Division relates to the Histopathology Department.

The action plan in respect of the Histopathology Independent Inquiry Report (10 June 2011) identified that were a number of actions relating to staffing as a result of the recommendations of the report, many of which had been completed. These included; honorary consultant contracts and the continued development of cross site
working in specialists areas.

In addition to the joint clinical lead there have been two new adult Pathology Consultant joint appointments in March 2011 across both trusts. All new cellular pathology appointments are to be joint between both of the trusts.

We reviewed the Consultant Workload Data for the year 2010-2011. We reviewed the figures against the Royal College of Pathology guidance on staffing and workload within histopathology and cytopathology departments (June 2005). The data showed that most consultant histopathologists within the department were working in excess of the number of unweighted specimens recommended by the Royal College.

Staff told us that they felt that there had been difficulty in recruiting to histopathologist clinicians and that where this had occurred locums had been employed who had been very good. We were also told that it is sometimes difficult if the pathologist is away for a long period of time and raised concerns about what would happen if somebody was ill and unable to work for a period of time.

We were told that staff within the Histopathology department were working under a certain amount of stress due to large volumes of work and the publicity surrounding the Histopathology Independent Inquiry.

We were told that there are some vulnerabilities within the staffing one of which is that there are too few staff for specialist reporting at the trust. We were told that there are ongoing discussions with Histopathology staff about their workloads in order to develop plans for the department moving forward.

Staff told us that their workload was in transition following the departure of some colleagues and that posts have been covered with the assistance of locums. Staff told us that workload distribution within the department was being reviewed.

The trust is in the process of reviewing consultant histopathology staffing levels in accordance with the Royal College of Pathologists’ “Guidelines on staffing and workload for histopathology and cytopathology departments” (2nd Edition, June 2005) in order to adjust staffing where necessary to ensure they are sufficient for a safe, timely and reliable service. This is due to be completed by the end of August 2011 and progress was being made on this by the Joint Clinical Lead for Cellular Pathology having review discussions with staff.

The trust had identified areas of urgent staffing need and had put measures in place to manage the current workload in the trust. This includes the outsourcing of work as necessary to an appropriate third party

The trust had made efforts to recruit and permanently appoint to a paediatric and perinatal pathology post which was vacant. They were unable to make an appointment in February 2011 but have recently undertaken a further round of recruitment to this post. The trust told us that they have implemented an interim
outsourcing arrangement in order to provide cover for this service. The trust was also working with two other teaching hospitals to set up joint working arrangements for this service.

**Our judgement**
The staff within the Histopathology Department have high workloads which could impact on the needs of the service. However, the trust has identified alternative arrangements to maintain suitable numbers of staff.
Outcome 14: Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant
with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
People we spoke with told us that staff were approachable and knowledgeable about their condition and treatment when they asked questions of them.

Other evidence
As part of this review we only looked at supporting workers in relation to histopathology and the clinicians involved in the diagnostic pathway.

We reviewed 12 appraisals of a selection of consultants within the trust. All of these appraisals had been completed within the last year. We found that most of the appraisals we reviewed contained detailed information about the performance, continuing professional development and areas for development for the professional. However, in two cases we found that the appraisals were quite scant in information and did not provide detail of the appraisal discussion or the professional's performance.

The staff we spoke with told us that they had all received an appraisal within the last year.

The trust has provided evidence of the involvement of histopathology clinicians in
EQA (External Quality Assessment) schemes.

All of the Consultant Histopathologists have undertaken EQA schemes where available in the last year these include the South West Regional General Histopathology EQA; South West Regional Breast EQA; National Gastro-intestinal EQA; Bone and Soft Tissue EQA; Paediatric Pathology EQA; Gynaecological EQA; Specialist Dermatopathology EQA; Head and Neck EQA; Urology EQA. In addition to this there is a Lung Histopathology Scheme (run by clinicians from another trust) which is not Royal College of Pathology Accredited that clinicians from the trust take part in. This has not been run since August 2010. There is no national Lung Histopathology EQA scheme accredited by the Royal College of Pathologists. There is no Bone Marrow EQA scheme but clinicians attend an annual conference in order to maintain their knowledge.

The latest version of the action plan regarding the Histopathology Independent Inquiry Report (10 June 2011) states that EQA (external quality assurance) scheme involvement had been reviewed for all Consultant Histopathologists at University Hospitals Bristol and that all specialist Consultant Histopathologists have participated in an appropriate EQA programme.

The Joint Clinical Lead for Cellular Pathology for both trusts was in the process of developing joint EQA and CPD (Continuing Professional Development) programmes across the two trusts. This was to be in place by the end of August 2011.

The trust had implemented processes to ensure that histopathology trainees have supervised involvement in the full range of specimens, including the most complex cases, which reflects their seniority within the department. Training plans had been adjusted accordingly.

The trust had put systems in place to ensure that staff affected by the Histopathology Independent Inquiry are able to access support where necessary. They had also held an externally facilitated event in January 2011 for histopathologists from both University Hospital Bristol and North Bristol Trusts to attend. There are further team development activities for staff at both trusts being planned.

Consultants of all specialities told us that the MDTs which they attend are included within their job plans and that now this has been formalised.

All of the staff we spoke with told us that they feel supported in their role now although some said that in the past they had not felt so supported. They told us that they had been given sufficient time and support for professional education and continuing professional development. One consultant was not clear about the amount of funding which was available for educational days. The trust told us that it would clarify this with all consultants. Other clinicians told us that they had never had any problem in gaining funding for training.

Cancer Nurse Specialists told us that although their role can be quite isolating that they felt supported, not only from their manager but from other people within the organisation. They told us that they received supervision and that they also felt a responsibility to pursue their supervision.

Histopathologists we spoke to told us that it was always nice to have colleagues
within the department with at least equal or more experience within the trust but that they are happy to gain additional support from colleagues outside of the trust if they have a particularly difficult case. There was variety in opinion about whether all histopathologists within the department are keen to seek a second opinion. Some felt that everybody was keen to gain a second opinion and others felt that some people were more hesitant. We were told that it is easy to get a second opinion from colleagues within the department if required.

Our judgement
People can be assured that there are suitable arrangements in place within the Histopathology Department to ensure staff are appropriately supported in relation to their responsibilities and received appropriate professional development, supervision and appraisal.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not speak to people who use services about this outcome.

Other evidence
The trust has told us that it is compliant with this outcome.
The trust has told us that it has systems in place to assess and monitor the quality of service provision. These include: national and local clinical audits; national and local patient surveys; monitoring of national performance targets; ISO systems in Radiology etc; CHKS tracking/benchmarking; Hospital Standardised Mortality Ratio; monitoring of complaints; reporting and analysis of patient safety incidents; NHS Litigation Authority Risk Management Standards; plans for Quality Accounts; Board Assurance Framework; Board Performance Report, annual board governance self-certification. The trust has implemented board and divisional level quality dashboards for 2010/11 which are being further developed for 2011/12. These contain a range of quality metrics and the board receives exception reports where individual metrics are not achieving the set threshold. For 2011/12 the board has set up a new Non-Executive Quality and Outcomes Committee and has revised its governance of management arrangements for quality monitoring. In 2011 the trust...
instigated a new Quality Intelligence Group to monitor outlier data from external organisations including the Care Quality Commission.

The trust told us that it monitors clinical incidents which feed into the Patient Safety Group (which replaced the Clinical Risk Assurance Committee in May 2011) and the Clinical Quality Group.

The trust told us that it achieved compliance with NHSLA Acute Risk Management Standards at Level 2, gaining ten out of ten for governance and safety standards in June 2011.

The trust identified that it has a risk strategy in place which was last updated in August 2010 and identified how risks are to be escalated and de-escalated through the trust and also identifies the roles and responsibilities within the organisation. There are a number of risk and governance committees within the organisation which make up the risk management structure.

The risk strategy also identified how risks are to be categorised and how they are added to the risk register and how risk training will be undertaken.

The trust had policies for the management of incidents and serious untoward incidents (SUls). These policies identify the procedures for reporting incidents and also positions the culture of reporting incidents within the trust in order to encourage staff to report incidents and signposts staff to the “speaking out” policy for reporting concerns about malpractice within the trust. The policies also identify the roles and responsibilities and escalation procedure through the organisation in respect of incidents. The serious untoward incident policy had not been updated to reflect reporting to CQC.

There were also parallel reporting systems in place within the pharmacy department and within the laboratories. This was identified in the external evaluation of governance that was commissioned by the trust and reported in April 2011. The laboratory staff (spoken to by the external consultant evaluating governance in the trust) say that their system for reporting “non-conformities” is better than the clinical incident reporting system but these are entered into the trust system if something occurs which affects the patient. The system is managed by the quality managers within the laboratories who meet every 2-3 months to review the non-conformities. It was said that the feedback from this system is immediate and actions are followed through, for example, staff training.

The external evaluation of governance was provided to us by the trust as evidence. The trust commissioned this evaluation of their internal clinical governance systems and processes to ensure that they were working effectively.

The external evaluation found that “risk and governance were part of the natural language of the trust” and from the discussions we had with staff, of how incidents were followed, up it was clear that the incident reporting system and conducting of route cause analyses were generally well managed by managers and nursing staff within divisions.

The report identified that there were some important lessons to be learned regarding
the engagement of medical staff and regarding the ownership of and leadership of incidents, root cause analyses and complaints. The trust had implemented a new computerised reporting system which most staff felt had improved the ability to report although some are more confident than others in doing this.

There were also recommendations about linking incident reporting to the risk register and reviewing parallel reporting systems for incidents.

The trust also commissioned an Internal Audit Report of the governance systems within the trust divisions (carried out by Audit South West). The overall audit assurance opinion is that there was good practice within the trust but raised some recommendations for the trust to address including processes for review, dissemination of information to some staff, updating of risk registers and monitoring the implementation of action plans.

The trust provided us with a copy of the action plan which was put in place to address the issues raised in this internal review.

The trust had a whistle blowing policy in place and provided a copy of this as evidence which, we have reviewed. There is a protocol in place for raising concerns about histopathology. This is a cross trust protocol for both North Bristol NHS Trust and University Hospitals NHS Foundation Trust. This formalises the process for raising concerns between UH Bristol and North Bristol NHS Trust Histopathology Departments and concerns raised by other clinicians about these departments and was implemented in May 2011.

In addition to the policy the trust had recently implemented a confidential hotline for staff to raise concerns anonymously.

Staff told us that told us that they would feel comfortable to raise concerns about a colleague’s practice either through the lead clinician in the MDT or via their line managers. One member of staff said that they had raised concerns in the past about a colleague and that they had been listened to and supported. They felt that the outcome in that particular case was appropriate to all involved.

Consultants told us that they were clear about the process to raise concerns within the trust and that they had easy access to both the Medical Director and the Chief Executive, however, that it had not been necessary for them to do so.

We were told that complaints are reviewed at the MDT. We were also told that sometimes results get changed at the MDT which are recorded in the MDT record. We were told that these are not necessarily reported as a Serious Untoward Incident but would be reported through the surgical team, although they weren’t clear about whether an individual would be charged with the reporting of the incident/near miss. Clinicians told us that they were confident that they would be logged as an incident or near miss and that they felt that the trust had worked quite hard to encourage this. Clinicians told us that reporting a change of diagnosis would depend upon the situation, for example, the patient outcomes and the indicators for the case.
We were told by clinicians that there had been a large amount of research carried out within the trust about the running of MDTs and that they have tried a number of different ways of running them.

Histopathologists told us that if they pick up any discrepancies they have no qualms in discussing them. We discussed the process for managing adverse incidents with histopathologists. They told us that if an incident had led to the incorrect management of a patient then this would be flagged up by another clinician or within the MDT. We were told that there is a protocol in place for dealing with discrepancies and that clinical incident forms are completed and that incidents are discussed in regular consultant meetings. We were told that there was not a blame culture within the department and that it was felt that this was the case throughout the trust.

We observed that diagnoses were refined and validated as part of the MDT meetings and that it may be difficult to determine when a change in diagnosis at the MDT meeting should be highlighted for reporting through the clinical incidents system.

The trust has told us that there is a clinical audit plan in place for all divisions across the trust, which we reviewed. The plan included five audits for histopathology including: an audit of the double reporting protocol; an audit of reporting systems; review of supplementary reports following the multi-disciplinary team meeting and two clinical speciality audits. The Histopathology Independent Inquiry Report Action Plan Version 13 identified that a joint audit plan for histopathology has been developed between both trusts.

The Trust had provided a copy of their updated action plan (10 June 2011) relating to the Histopathology Independent Inquiry Report (published December 2010) which showed that actions had been completed and that progress had improved since the Joint Clinical Lead for Cellular Pathology had been appointed.

There was a process in place to inform patients within the trust of errors in their care. This was identified within the “Staff Support and Being Open Policy 2009”. This policy was being updated to ensure that the process for informing patients of diagnostic errors is made more explicit.

Our judgement
The trust has suitable arrangements in place to assess and monitor the quality of services provided. However, there is a lack of clarify about some aspect of the reporting systems. The trust had systems in place to ensure that concerns can be raised by staff and also by staff from other trusts.
Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
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<tr>
<td>The provider is compliant with outcome 21: Records</td>
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<table>
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<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>We did not speak to people who use services about this outcome.</td>
</tr>
<tr>
<td>Other evidence</td>
</tr>
<tr>
<td>As part of this review we only looked at histopathology reports.</td>
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<tr>
<td>The Histopathology Independent Inquiry Report (December 2010) identified that “many “histopathology reports “are in a style reminiscent of reports one reads when reviewing cases that were reported 10 or 20 years ago”. We reviewed some histopathology reports within the trust. We found that they were set out in accordance with what would be normally expected.</td>
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<tr>
<td>The most recent action plan regarding the Histopathology Independent Inquiry Report (10 June 2011) stated that the Bristol Cellular Pathology Forum, as part of their work programme, are to review and discuss the style of reporting in order that any changes which are deemed appropriate may be implemented.</td>
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<tr>
<td>We have been told by the trust that it is looking at improving the system of recording</td>
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when a second opinion has been obtained in reviewing a case or specimen. This is to be very clearly recorded in the text of each report. The electronic system does have the capacity to record both consultants review and this is being explored further by the trust. We saw evidence that where a case had be seen by a second pathologist a record was made on the pathology computer database.

We found that where cases were sent to the trust for reporting, requests are usually received by fax or email. The case usually dispatched the same day as it is reported, the reporting consultant needs to authorise the release of the case, unless they are on annual leave when another consultant can authorise the release. We found that cases are logged and tracked by the computer system and in the day book within the department. We reviewed the standard operating procedure for this and found that processes were being followed.

Our judgement
Systems were in place, in the Histopathology Department, to ensure that accurate records are kept and also kept under review.
Improvement actions

The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tr>
<td>Treatment of disease, disorder or injury; Surgical procedures; Diagnostic and screening procedures; Maternity and midwifery services</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
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<tr>
<td>Core members of the multi-disciplinary team (MDT) meeting are not always in attendance at meetings and therefore not all professionals have an input into the plans for all patient cases.</td>
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<tr>
<td>Treatment of disease, disorder or injury; Surgical procedures; Diagnostic and screening procedures; Maternity and midwifery services</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
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<tr>
<td>Staff within the Histopathology Department have high workloads which would seem to be in excess to the maximum figures recommended by the Royal College of Pathologists.</td>
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<td></td>
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<tr>
<td>Treatment of disease, disorder or injury; Surgical procedures; Diagnostic and screening procedures; Maternity and midwifery services</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
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<tr>
<td>There is a lack of clarity within Clinicians about when changes in diagnosis should be reported as incidents or serious untoward incidents and who takes responsibility for this, particularly surrounding multi-disciplinary team (MDT) meetings.</td>
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The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent within 14 days of this report being received.
CQC should be informed in writing when these improvement actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.