Review of compliance

University Hospitals Bristol NHS Foundation Trust
University Hospitals Bristol Main Site

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<th>Region</th>
<th>South West</th>
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| Location address| Bristol Royal Infirmary  
|                  | Upper Maudlin Street  
|                  | Bristol              
|                  | BS2 8HW              |
| Type of service  | Acute services with overnight beds |
| Date of Publication | June 2012             |
| 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. |
Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

University Hospitals Bristol Main Site was meeting all the essential standards of quality and safety inspected.

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

Why we carried out this review

We carried out this review to check whether University Hospitals Bristol Main Site had taken action in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 10 May 2012, checked the provider's records, talked to staff and reviewed information from stakeholders.

What people told us

We carried out this review to follow up on the improvement actions served following our review of the Histopathology service at the trust published in September 2011.

We spoke with four consultant histopathologists, one consultant surgeon, one consultant radiologist, one consultant oncologist, four cancer nurse specialists and the Joint Clinical Lead for Cellular Pathology.

We found that the trust had made improvements and were now compliant with all of the outcomes reviewed.

Processes had been put in place to ensure attendance of the core members of the multidisciplinary team (MDT) at meetings and the trust had audited compliance with this. The audit of compliance demonstrated high levels of attendance of core members of the MDT between December 2011 and March 2012.

A new policy for the management of discrepancies in cellular pathology had been put in place to clarify the procedure and criteria for reporting incidents relating to discrepancies in opinion of histopathology reports. We saw that there were low levels of discrepancies and subsequent issue of supplementary histopathology reports between July 2011 and January 2012.
We saw that the trust had taken steps to reduce the workload of consultant histopathologists through the recruitment to vacant posts within the trust and the creation of a new consultant histopathologist post. We also saw that the trust had committed to review workload within the histopathology service with a view to further recruitment. Three out of the four consultant histopathologists we spoke with said their workloads were more manageable than last year. However, one consultant histopathologist said their workload had increased in number and complexity. The consultant histopathologist did not know whether their workload was within the Royal College of Pathologists guidance.

The trust was in a position to provide raw data to evidence the ongoing review of workload within the histopathology service. At the time of our inspection there was further work going on in this area and we will continue to monitor this with the trust.

What we found about the standards we reviewed and how well University Hospitals Bristol Main Site was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider was meeting this standard.

The provider had taken appropriate steps to ensure that there were sufficient numbers of qualified, skilled and experienced staff to meet people's needs.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Other information

Please see previous reports for more information about previous reviews.
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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the Guidance about compliance: Essential standards of quality and safety
Outcome 04:
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

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<td><strong>What people who use the service experienced and told us</strong></td>
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**Other evidence**
The trust provided us with a copy of their action plan following our review of the trust in May 2011. This identified that all of their actions had been completed.

The trust told us they had identified who the core members of each multidisciplinary team (MDT) were. They also told us they had reviewed the job plans for core members of the MDT and had ensured that attendance had been included. We spoke with one consultant who had taken a lead in developing team job plans within the trust. They told us this process was ongoing but that attendance at the MDT meeting was an essential part of the job planning process. An MDT meeting is where a group of professionals discuss the results of patients’ tests and their diagnoses which enables the appropriate planning and delivery of care and treatment.

The trust had developed a draft policy for MDT attendance/membership. This outlined the criteria for attendance at MDT meetings. This stated that the Manual for Cancer...
Standards guidelines for attendance of an individual clinician at an MDT was 67%. The trust had made a commitment to ensuring that every clinician may not be at the MDT each week but that across a specific professional group (Surgeon, Radiologist, Oncologist and Histopathologist) there would be 95% attendance of core members.

The trust had undertaken an audit of attendance of core members at MDT meetings between December 2011 and March 2012. This showed high levels of attendance of core members of the MDT at meetings (between 94% and 100%) with attendance increasing to 100% for all core members in March 2012. We were told that these audits would now be conducted every month.

Staff we spoke with said there had been additional focus on attendance within the trust. One member of staff said that they felt there was more support from the Trust Board of Directors for the MDT over the last year. They felt this was positive. Another member of staff told us they felt that staff felt empowered to cancel or postpone a MDT meeting if core members were unavailable. They cited an example of an MDT coordinator contacting MDT members several days before a meeting to say that there had been a number of apologies made for a meeting. The coordinator had asked whether the other members of the MDT felt there were suitable specialist planning to attend in order for the meeting to continue as planned.

We reviewed the report of the Independent Inquiry Panel revisit to the trust in February and March 2012. This recommended the trust “continue the review of MDTs to ensure that the teams are functioning reliably and effectively across the city”. The trust action plan demonstrates that the trust has committed to this continued review.

Two of the clinicians we spoke with said they had a continued focus on and involvement in the development of MDTs both locally and nationally.

The trust and Consultant Histopathologists also told us that the double reporting policy, which is a check on the robustness of clinical reporting that informs patients' diagnoses, had been further reviewed. The policy in place at the time of our inspection specified double reporting criteria in excess of that required by the Royal College of Pathologists guidance. The Joint Clinical Lead for Cellular Pathology told us that the trust would continue to review this policy and the outcomes of double reporting of histopathology specimens.

Our judgement
The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.
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
The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We did not speak with people who use the service as part of this review. This was because the improvement actions we were reviewing did not involve direct patient contact.

We did review information from stakeholders which included Local Involvement Networks, the Council of Governors for the Trust, service commissioners, other regulators and information we had received from members of the public.

Other evidence
We spoke with the Joint Clinical Lead for Cellular Pathology and four consultant histopathologists.

We saw evidence that the trust had taken steps to recruit appropriate staff and reduce workloads.

We saw that the trust had continued to recruit to roles in line with the recommendations of the Independent Inquiry Panel Report of December 2010 and the Bristol Pathology Review, where joint appointments were to be made between University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust.

The Joint Clinical Lead for Cellular Pathology told us that the trust had reviewed the workload of all of the consultant histopathologists in the trust (and at North Bristol Trust) since our last visit, based on the draft Royal College of Pathologists Guidance on
workload for histopathology and cellular pathology. This was in order to inform workforce planning and individual's job plans. The information within this draft guidance was changed between the draft guidance and the final guidance publication. As a result of this the trust was reviewing the workload figures again at the time of our inspection in line with the final published workload guidance.

As part of the original review of consultant histopathologists' workload, a case was made to both the boards of University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust for the recruitment of an additional four consultant histopathologist posts across the two trusts. The boards considered the proposal and agreed to fund two consultant histopathologist posts, one based primarily at North Bristol NHS Trust and one based primarily at University Hospitals Bristol NHS Foundation Trust. The recruitment process for these two posts was underway at the time of our inspection. In addition both trust boards agreed to review the staffing levels on an annual basis with a view to further recruitment.

We reviewed the report of the Independent Inquiry Panel revisit to the trust in February and March 2012. This recommended the trust "keep consultant staffing under review".

We also saw that the trust had made efforts to recruit to the posts which were vacant at the time of our last review in May 2011. We saw that two consultant histopathologists had been appointed over the last year at University Hospitals Bristol NHS Foundation Trust as specialists in Lung and Paediatric and Perinatal Histopathology. In addition there was an appointment of a trainee within the Paediatric and Perinatal team, which we were told by staff had also helped to reduce the workload within that team.

Three out of the four consultant histopathologists said that their workload had become more manageable over the last year. One said they had reduced the number of specialist areas they reported on. They went on to say that the number of cases they now reported had increased but the complexity of those cases had reduced. Another consultant histopathologist said the number and complexity of the cases they were reporting on had increased. However, they could not tell us whether this was in line with the Royal College of Pathologist guidance on workload.

We were also told by consultant histopathologists and the Joint Clinical Lead for Cellular Pathology that a review of the skill mix within the department had occurred. As part of this some specific tasks had been identified which could be undertaken by other members of staff to reduce the consultant histopathologists workload. We were told by one consultant histopathologist that this had helped to reduce their workload, with appropriate advice and support arrangements in place. We were also told that steps had been taken to standardise the wording of reports which had helped with the workload.

The trust was in a position to provide raw data to evidence the ongoing review of workload within the histopathology service. At the time of our inspection there was further work going on in this area and we will continue to monitor this with the trust.

The provider may be interested to note that staff across the professional groups noted an increase in the number of cases discussed at the MDT, which would indicate an increase in workload within the histopathology service. We were also told that the number of cases had increased in one specialty reporting area by two consultant histopathologists.
Our judgement
The provider was meeting this standard.

The provider had taken appropriate steps to ensure that there were sufficient numbers of qualified, skilled and experienced staff to meet people's needs.
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

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We did not speak with people who use the service as part of this review. This was because the improvement actions we were reviewing did not involve direct patient contact.

We did review information from stakeholders which included Local Involvement Networks, the Council of Governors for the Trust, service commissioners, other regulators and information we had received from members of the public.

**Other evidence**
We reviewed the notifications of incidents sent to us by the trust. There had been no notifications about incidents of misdiagnosis reported to us which had occurred since our last review of histopathology services at the trust. The trust had agreed to notify us of such incidents by exception in addition to reporting them via the National Patient Safety Agency.

The trust implemented a policy entitled “Management of Discrepancies in Cellular Pathology” dated August 2011, since our last review of the histopathology service. This policy defined a discrepancy as "a difference of opinion between the original interpretation and the interpretation at review". The policy also defined an error as "when the discrepancy is confirmed by two independent reviewers". These definitions were adopted from the Royal College of Pathologists.

The policy further clarified how a discrepancy and the outcome of the attempts to
resolve it must be recorded and when and how a discrepancy should be reported as an incident.

The policy also contained details of the mechanisms that had been put in place to monitor such discrepancies.

All of the clinicians we spoke with told us about this new policy for managing discrepancies. They all had a clear understanding of when a discrepancy should be reported as an incident.

We were provided with a draft copy of an audit of supplementary reports issued after MDT to identify discrepancies across all cancer specialties. The standards reviewed as part of this audit and the targets were taken from the Royal College of Pathologists guidance on the review of categorisation of discrepancies in histopathology (November 2008)

Although the collection of data for the audit occurred between July 2011 and January 2012 it was only possible to analyse the data relating to these criteria for January 2012. The audit demonstrated that in 99% of cases there was agreement between the original histopathology report and the MDT review of the case. The audit also demonstrated that in 3% of cases a supplementary report was issued because the original data was incomplete. In total only 41 supplementary reports were issued for the period between July 2011 and January 2012. During this time 15657 histopathology reports were prepared. This demonstrated that during this time only 0.26% of cases required a supplementary report to be prepared.

Our judgement
The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.
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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. 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.
## Information for the reader

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