Bradford Teaching Hospitals NHS Foundation Trust

St Luke's Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Medical care	Good
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Bradford Teaching Hospitals NHS Foundation Trust is an integrated trust, which provides acute, and community in-patient health and children's services. The trust serves a population of around 500,000 people from Bradford and the surrounding area. The acute services are provided in two hospitals, Bradford Royal Infirmary and St Luke's Hospital. The trust also has four community hospitals; Westwood Park, Westbourne Green, Shipley and Eccleshill.

The community hospitals are part of the elderly and intermediate care service in the division of medicine at the trust and provide a less acute environment. These services are aimed at avoiding the need for patients to be admitted to an acute hospital for rehabilitation and restoring functional abilities following an acute hospital stay. At the time of the inspection only two community hospitals had in-patient services operating: Westwood Park and Eccleshill.

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

We inspected the trust from 21 to 24 October 2014 and undertook an unannounced inspection on 4 November. We carried out this inspection as part of the Care Quality Commission's (CQC) comprehensive inspection programme.

Overall, we rated St Luke's Hospital as requires improvement. We rated medical care services as good. We rated outpatients as inadequate. We rated the hospital good for being caring and effective but inadequate for safety, and requires improvement for responsiveness and being well-led. The ratings within the report were based on the evidence gathered at the time of the inspection.

Our key findings were as follows:

- We had serious concerns over the very large back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. A patient could have multiple pathways if they are accessing several services for the same referral simultaneously . The trust had taken steps to address this and was validating the information on patients in the back log. However, we had concerns over the length of time it had taken to put in suitable actions and the time it would take to assess the impact on individual patients.
- Following the inspection we requested further information from the trust in accordance with Section 64(1) of the Health and Social Care Act 2008 (HSCA) regarding this backlog. The trust's response indicated that actions were in place and that the backlog was reducing. The timescale for completing the review of all these patient pathways was March 2015.
- There were no concerns over mortality at this hospital.
- There were concerns regarding the access to out-of-hours medical advice. There was no on-site medical cover provided overnight, on Sundays or on bank holidays and the most senior nurse on the wards during these times was a band 5 staff nurse. This put patients at risk, due to possible delays in accessing treatment.
- Most staff were clear about the vision and strategy for the service. Changes to the risk management processes were in place, but required further embedding in practice.

We observed areas of good practice including:

- There were arrangements in place to manage and monitor the prevention and control of infection. There was a dedicated team to support staff and ensure policies and procedures were implemented. We found all areas visited visibly clean.
- Care and treatment followed best practice and national guidance.
- Patients received appropriate hydration and nutrition. Patients were supported to eat and drink and this was accurately recorded.
- The wards at St Luke's Hospital were suitable environments to provide care. Improvements had been made to make the wards more dementia friendly. Decoration had been improved to aid reminiscence and generate conversation.

Summary of findings

- Patients and relatives told us that they had been treated with compassion and that staff were polite and respectful. However, patient information was not readily available in languages other than English.
- In diagnostic imaging, all ultrasound sonographers were independent reporters. There was a high proportion of advanced practitioners which had helped improve access to services.

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

Importantly, the trust must:

- Ensure that the significant backlog of outpatient care pathways is promptly addressed and prioritised according to clinical need.
- Ensure there is access on the wards to sufficient numbers of suitably skilled staff, particularly medical staff, at all times.

In addition the trust should:

- Review the referral system of patients to the ward services to ensure it is fit for practice and maintains an audit trail.
- Share with staff information regarding audits and reviews of practice so that trends and good practice can be identified.
- Review the approach and uptake of clinical supervision.
- Review access to patient information in languages other than English.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Good 	We rated medical care as good overall with some areas of patient safety requiring improvement. Systems were in place to report and learn lessons from incidents. Wards monitored safety and harm free care and results were positive overall. We had concerns regarding the access to out-of-hours medical advice. There was no on-site medical cover provided overnight, on Sundays or on bank holidays and the most senior nurse on the wards during these times was a band 5 staff nurse. This put patients at risk, due to possible delays in accessing treatment. Wards were clean and staff were observed adhering to infection control principles. Records were completed accurately. Policies and guidelines were available to staff. Audits were undertaken. There was limited feedback, particularly to nursing teams to monitor the effectiveness of the care provided. Most staff were clear about the vision and strategy for the service. Changes to the risk management processes were in place, but required further embedding in practice. Patients and relatives told us that they, or their relatives, had been treated with compassion and that staff were polite and respectful. Patients were supported to eat and drink and this was accurately recorded. Patient information was not readily available in languages other than English.
Outpatients and diagnostic imaging	Inadequate 	We rated outpatients and diagnostic imaging services as 'inadequate' for safety, responsiveness and well led. There was a significant backlog of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. A patient could have multiple pathways if they are accessing several services for the same referral simultaneously This meant that some patients were waiting considerable amounts of time for follow-up appointments, which resulted in delays for patients. The trust had recognised the full extent of the issue in May 2014and had put some measures in place to address this. However, significant action had not been taken until additional staff were recruited in October 2014 and

Summary of findings

there had been little done to risk assess the impact on individual patients. The Board were not made formally aware until October 2014. This represented a significant failing in governance and reporting arrangements.
Outpatients and diagnostic imaging services were caring. Systems were in place to capture concerns and complaints raised within both departments, review these and take action to improve the experience of patients.
We saw that trust policies were based on and included nationally recognised good practice guidance. Staff in both departments were competent, and there was evidence of multidisciplinary working. Staff in diagnostic imaging stated that they were well supported by their managers. However, there were significant concerns raised by some medical secretaries/ administration staff and outpatients' staff who did not feel empowered or listened to.

Requires improvement

St Luke's Hospital

Detailed findings

Services we looked at
Medical care (including older people's care) and Outpatients and diagnostic imaging

Contents

Detailed findings

Background to St Luke's Hospital

St Luke's Hospital is part of the Bradford Teaching Hospitals NHS Foundation Trust. It is situated in Bradford and serves a population of around 500,000 people in the local area. The hospital has approximately 80 beds. St Luke's Hospital provides general medicine services for adults and outpatient services for adults and children as well as rehabilitation and therapy services.

St Luke's Hospital had three medical wards: Ward F6 stroke rehabilitation, Ward F5 care of the elderly rehabilitation and Ward F3 'step down' rehabilitation.

There was a virtual ward based at St Luke's Hospital. This team delivered care in the community setting and aimed to keep patients at home, where possible. The team consisted of nurses, therapists, rehabilitation support workers, an advanced nurse practitioner and medical consultants. The virtual ward had 50-60 patients referred to them each month.

Bradford Teaching Hospitals NHS Foundation Trust provided a wide range of outpatient clinics, predominantly at St Luke's Hospital and Bradford Royal Infirmary. Between 2013 and 2014, 577,619 patients attended outpatient clinics across the two sites, with 227,435 of these patients attending outpatient clinics at St Luke's Hospital.

Since 29 September 2014, outpatient services at the trust are managed within the new directorate of outpatients and patient administration within the Division of Diagnostic and Therapeutic Services Currently, some outpatient activity is managed by other clinical divisions, such as trauma and orthopaedics, ophthalmology and ear, nose and throat. Other specialties were managed within the outpatient department with their own staff rotating between this hospital and Bradford Royal Infirmary.

Outpatient services were delivered at Horton Wing within St Luke's Hospital. This hospital also provided diagnostic imaging, including radiology (plain film), general ultrasound, bone densitometry, computerised tomography (CT) and magnetic resonance imaging (MRI) scans.

The children's community nursing team, child development service and children's outpatients' clinics were also based at St Luke's Hospital.

The inspection team inspected two of the eight core services at St Luke's Hospital:

- Medical care (including older people's care)
- Outpatient services

At the last CQC inspection in February 2014, the hospital had not been compliant with the Health and Social Care Act 2008 regarding meeting nutritional needs (Regulation 14). An action plan had been submitted and the trust planned to be compliant by July 2014.

Our inspection team

Our inspection team was led by:

Chair: Michael Marrinan, Executive Medical Director, Kings College hospital, London

Head of Hospital Inspections: Julie Walton, Care Quality Commission

A team of 46 included CQC inspectors and a variety of specialists including medical consultants, junior doctors, senior managers, nurses, allied health professionals, and experts by experience who had experience of using services.

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?

Detailed findings

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

organisations to share what they knew about the hospital. These included the clinical commissioning

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Bradford on the 20 October 2014, where 21 people shared their views and experiences of the Bradford Teaching Hospitals NHS Foundation Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone. We also attended additional local groups to hear people's views and experiences. We carried out the announced inspection visit between 21 and 24 October 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, allied health professionals including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients and staff from the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about St Luke's Hospital

- The trust gained foundation trust status in April 2004
- The trust's revenue: £356.6m
- Full Cost: £360m
- Surplus (deficit): £3.8m
- The Bradford area sits within the 10% most deprived local authorities in the country, due to this they have a higher level of chronic disease than neighbouring areas. Areas of particular concern are cardiovascular disease, diabetes and respiratory disease.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

St Luke's Hospital had three medical wards: Ward F6 stroke rehabilitation, Ward F5 care of the elderly rehabilitation and Ward F3 'step down' rehabilitation.

There was a virtual ward based at St Luke's Hospital. This team delivered care in the community setting and aimed to keep patients at home, where possible. The team consisted of nurses, therapists, rehabilitation support workers, an advanced nurse practitioner and medical consultants. The virtual ward had 50-60 patients referred to them each month.

We looked at the care records of seven patients. We spoke with four patients and their relatives and 18 members of staff, including medical and nursing staff and therapists. We visited all three wards plus the virtual ward team. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

We rated medical care as good overall with some areas of patient safety requiring improvement. Systems were in place to report and learn lessons from incidents. Wards monitored safety and harm free care and results were positive overall.

We had concerns regarding the access to out-of-hours medical advice. There was no on-site medical cover provided overnight, on Sundays or on bank holidays and the most senior nurse on the wards during these times was a band 5 staff nurse. This put patients at risk, due to possible delays in accessing treatment. Information from the trust showed that over an eight week period in July and August 2014, 18 patients had required transfer to Bradford Royal Infirmary, due to deterioration in their condition.

Wards were clean and staff were observed adhering to infection control principles. Records were completed accurately. Policies and guidelines were available to staff. Audits were undertaken. There was limited feedback, particularly to nursing teams to monitor the effectiveness of the care provided. Most staff were clear about the vision and strategy for the service. Changes to the risk management processes were in place, but required further embedding in practice.

Medical care (including older people's care)

Patients and relatives told us that they had been treated with compassion and that staff were polite and respectful. Patients were supported to eat and drink and this was accurately recorded. Patient information was not readily available in languages other than English.

Are medical care services safe?

Requires improvement

Systems were in place to report and learn lessons from incidents. Wards monitored safety and harm free care and results were positive, overall.

We had concerns regarding the access to out-of-hours medical advice. There was no on-site medical cover provided overnight, on Sundays or bank holidays and the most senior nurse on the wards during these times was a band 5 staff nurse. This put patients at risk, due to possible delays in accessing treatment. Information from the trust showed that over an eight week period in July and August 2014, 18 patients had required transfer to Bradford Royal Infirmary, due to deterioration in their condition.

Wards were clean, with arrangements in place for the prevention and control of infection. Patients' records were completed accurately. Patients were supported to eat and drink and this was accurately recorded.

Not all staff were up to date with mandatory training and attendance at safeguarding training was well below the trust target of 95%.

Incidents

- There had been 88 incidents reported over the previous four months on the medical wards at St Luke's Hospital. The most common reported incidents related to patient falls and pressure ulcers.
- There were systems in place to report incidents. Incidents were reported using an electronic 'Datix' system. Staff told us they were aware of how to use the system and were encouraged to report incidents.
- Staff reported they received verbal feedback regarding incidents.
- Reviews of mortality and morbidity were considered as part of specialty clinical governance meetings.

Safety Thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. All the medical wards recorded the Safety Thermometer information.

Medical care (including older people's care)

- Over the previous year, the percentage of harm free care across the medical wards at St Luke's Hospital averaged between 87% to 96%.
- Information regarding the results of the Safety Thermometer was displayed on the wards for patients and visitors to see.

Cleanliness, infection control and hygiene

- There had been two attributable cases of MRSA for the medical division since April 2013. The target was zero trust-attributable cases.
- Clostridium difficile (C. difficile) rates for the trust had been higher than the England average since December 2013. A total of seven out of sixteen cases reported cases of C. difficile reported in April and May 2014 where attributable to medical wards. A post-infection review was held for each case and actions were identified, implemented and reviewed.
- Monthly infection control audits were undertaken. Data from July and August 2014 for the medical division showed good compliance with, for example: hand hygiene, dress code, insertion of central venous catheters, peripheral intravenous catheters and urinary catheters. The ongoing care of peripheral intravenous catheters was an area that fell below the trust target of 95% compliance in August 2014, reaching just over 90%.
- Ward areas appeared clean.
- Personal protective equipment and alcohol hand sanitising gel was available at the entrance to, and throughout, the wards.
- We observed that staff wore personal protective equipment and staff applied the principles of infection control.
- Equipment was cleaned after use and labelled as clean.

Environment and equipment

- The wards at St Luke's Hospital were suitable environments to provide care. Improvements had been made to make the wards more dementia friendly. Decoration had been improved to aid reminiscence and generate conversation. St Luke's Hospital was shortlisted for the Building Better Healthcare Awards 2014 for the best internal environment project.
- Day rooms were used for meal times, for those who were able and wanted to sit at the dining table.
- Equipment was available. Specialist equipment was ordered as required.
- Resuscitation equipment was available and checked regularly.

Medicines

- Ward staff confirmed that they had regular visits from the pharmacy team.
- We saw that medicines were stored appropriately and drug fridge temperatures were recorded.
- An audit of controlled drugs was undertaken monthly. The trust reported the results were satisfactory. We looked at the storage, recording and administration of controlled drugs on the wards. No concerns were identified.
- We reviewed a sample of medication administration records on the wards we visited. We found medication had been administered as prescribed and at appropriate times.

Records

- We found that patient records were completed appropriately.
- Risk assessments were completed in all the patients' notes we reviewed.
- Records were stored appropriately.
- Following the previous inspection visit, the documentation had been streamlined and we saw the standard of record-keeping had improved.
- Hydration and nutrition charts were completed appropriately.
- Staff within the virtual ward undertook peer reviews and audits of records to check the computer records and paper-based records matched.

Safeguarding

- Across the medical division, at July 2014, 90% of staff who required training were trained to safeguarding Level 1, 31% trained to Level 2 and 41% trained to Level 3. This was against a trust target of 95% for each level. The safeguarding lead reported sufficient training sessions, but these were undersubscribed.
- Staff we spoke with were aware of who to contact regarding safeguarding concerns. Guidance information was readily available.

Mandatory training

- Staff spoke positively about mandatory training and 'sweeper days', which incorporated required training.

Medical care (including older people's care)

- We saw that trust figures for the medical division for July 2014 showed that 60% of staff were in date with their mandatory training against trust target of 75%.

Assessing and responding to patient risk

- Every ward used the national early warning score system (NEWS). Patients observations were recorded appropriately and concerns were escalated in accordance with the guidance.
- Due to the lack of medical cover after 5pm and on Sundays and bank holidays, nursing staff reported that, when a patient's condition deteriorated, they either called medical staff at Bradford Royal Infirmary or, if the patient's condition required urgent medical input, staff called '999' for an emergency ambulance. Guidance for which option to use was available on the early warning score system, but was not detailed. Staff on one ward told us they telephoned '111' (the NHS advice line) for non-emergency out of hours cover. Staff expressed concern about the lack of medical cover outside of normal working hours.
- Information from the trust showed that, over an eight week period in July and August 2014, 18 patients had required transfer to Bradford Royal Infirmary, due to deterioration in their condition. Nine patients were transferred directly to wards. The remaining nine patients were sent to the emergency department (ED).

Nursing staffing

- The hospital has used the Safer Nursing Care Tool to determine the required levels of nurse staffing for each ward. This was last completed in March 2014.
- At the time of the inspection, September 2014, there were 62 whole time equivalent (WTE) registered nurse vacancies for the medical division. Recruitment was in progress and a number of appointments had been offered, leaving 27 WTE posts unfilled.
- Information on planned versus actual staffing numbers was displayed at the entrance to ward areas. These figures were reported to the board monthly and submitted nationally, in accordance with requirements.
- In August 2014, the actual number of staff on duty for both day and night duty was around or above that planned, with the exception of registered nurses on day shifts on Wards F5 and F6.
- On Ward F5, there were three occasions when staffing levels were identified as being less than required. On a further four occasions, when staffing levels were identified as being less than required, shifts were downgraded to be filled by unregistered staff.
- On Ward F6, there was one occasion when staffing levels were identified as being less than required.
- There was no on-site senior nurse cover at night or weekends. At night and weekends, the most senior member of nursing staff was frequently a band 5 staff nurse. Staff contacted the manager of the on-call team, or the medical teams at Bradford Royal Infirmary if they had concerns.
- Staff who worked within the virtual ward team told us that, occasionally, they were asked to support staffing on the elderly medicine wards, particularly on night shifts. Staff would take their phones with them and if one of their patients called they would attend to them immediately, which meant the ward would be left short staffed.
- The trust employed their own bank staff. Bank staff said they had received their mandatory training and had a ward induction. Agency staff were infrequently used.
- Formal handovers between shifts were in place, which included a safety brief.

Medical staffing

- There was on-site medical staffing cover from Monday to Friday until 5pm at St Luke's Hospital. There was medical cover on Saturday between 7.30 am and 10.00 am and between 2.00pm and 7.30 pm.This was provided by doctors who had qualified and were on a two-year, general postgraduate medical training programme (F1 or F2). However, there was no medical cover provided overnight or on Sundays and bank holidays. Nursing staff called medical staff at Bradford Royal Infirmary for advice. If the patient required urgent medical input, staff called '999' for an emergency ambulance. Patients were transferred to Bradford Royal Infirmary if required. Staff on one ward told us they telephoned '111' (the NHS advice line) for non-emergency out of hours cover.
- We were made aware of a recent incident that was being investigated where a patient required emergency transfer to Bradford Royal Infirmary.
- Consultant-led ward rounds were held at least weekly.
- For the virtual ward, out-of-hours medical cover was provided by the medical team based at Ward 3 at Bradford Royal Infirmary.

Medical care (including older people's care)

Major incident awareness and training

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

Are medical care services effective?

Good

Treatment was provided in accordance with national and best practice guidance. Policies and guidelines were available to staff and practice was audited. Where shortfalls had been identified, action plans had been put in place. However, there was limited feedback, particularly to nursing teams, when it came to monitoring the effectiveness of the care provided.

Pain relief, nutrition and hydration needs were met. Individualised goal setting was used to monitor patient outcomes. These were agreed with patients and their families, as appropriate, at multidisciplinary meetings. The trust participated in national clinical audits.

Appraisal rates for the medical division in August 2014 averaged 73% for non-medical staff and 95% for medical staff. Staff reported very good working relationships within the multidisciplinary teams. Multidisciplinary team meetings were held regularly and often involved the patient and their relatives.

Evidence-based care and treatment

- Policies based on National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines were available to staff and accessible on the trust intranet site.
- Care pathways were available and implemented such as the stroke pathway, which was in accordance with NICE guidance. Pathways, such as a home intravenous antibiotics pathway, were used by the virtual ward team.
- We saw evidence-based care for the prevention of venous thromboembolism (VTE). For example, for patients who had suffered a stroke, mechanical prophylaxis in the form of compression sleeves was used.
- Audits were undertaken to monitor compliance with guidance, such as hand hygiene audits. Results seen showed good levels of compliance.
- There was a trust-wide nursing audit timetable for ward sisters to complete. Staff confirmed they completed the audits and submitted these electronically. Staff told us that they were aware of their results, but these were not formally collated or presented. Staff did not have information that could identify trends or demonstrate good practice. There were no action plans available; although staff reported that if there were issues they would be contacted and additional monitoring would be put in place.

Pain relief

- We saw that pain was assessed and patients were provided with analgesics, as prescribed.
- Patients confirmed they were provided with pain relief, when required.

Nutrition and hydration

- Protected meal times were in place and we observed these were adhered to.
- Patients were assessed regarding their nutritional needs and care plans were in place.
- Care and comfort documentation had recently been introduced. We saw this was completed and that patients were attended to regularly to ensure they received appropriate food and drink. We saw drinks were readily available for patients.
- Food and fluid intake was recorded appropriately.
- Patients spoke positively about the food they were offered.
- Dietetic support was available for patients with specific nutritional needs.
- Food to meet individual requirements, such as 'soft' diets, or food in accordance with a patient's faith or religion was available.

Patient outcomes

- During 2013/2014, Bradford Teaching Hospitals NHS Foundation Trust participated in 97.2% of national clinical audits and 100% of national confidential enquiries, which it was eligible to participate in according to their Quality Accounts.
- Bradford Teaching Hospitals NHS Foundation Trust achieved an overall rating of 'D', on a scale of A – E with E being the worst, in the Sentinel Stroke National Audit Programme (SSNAP) for January to March 2014. This

had improved on the previous quarter. An action plan was in place, which included access to specialist staff. The most recent audit report was due to be considered in full at the stroke business meeting in October 2014.
- Performance in the National Diabetes Inpatient Audit (NaDIA) in September 2013 showed the trust performed better than England and Wales average in 11 out of 22 indicators. Of the ten indicators that performed below the national average, these predominantly related to staff knowledge and the suitability, timing and choice of meals. No data was available for involvement in a treatment plan.
- The average length of stay for patients at the trust was below England average for 2013/2014.
- Emergency readmissions to the trust within 28 days of discharge from medical wards averaged around 14% over the previous three months. This is higher than the England average.
- Individualised goal setting was used to monitor patient outcomes at St Luke's Hospital. These were agreed with patients and their families, as appropriate, at multidisciplinary meetings. The Barthel Index was also used for patients who had experienced a stroke. The Barthel Index, which was developed for use in the rehabilitation patients with a stroke, measures the extent to which somebody can function independently and has mobility in their activities in the course of daily living, such as feeding, bathing and grooming.

Competent staff

- Appraisals rates for the medical division in August 2014 averaged 73%. This ranged from 50% of staff appraised in some areas to 100% in others. Trust-wide work had commenced to simplify the appraisal process, improve the quality of appraisal and to ensure there was a direct link with corporate objectives.
- A report to the board in May 2014 showed that 95% of doctors in the medical division completed an appraisal in 2013/2014. Sixty-two recommendations were made by the trust in relation to 'revalidation' to the GMC between 1 April 2013 and 31 March 2014. All recommendations were completed on time.
- Senior nursing staff we spoke with said they did not undertake formal clinical supervision with their staff.
- Staff within the virtual ward team expressed concerns that when they assisted on the ward they may not have the necessary skills or knowledge to care for the patients.

Multidisciplinary working

- There was good multidisciplinary team working. Multidisciplinary team meetings were held regularly and often involved the patient and their relatives.
- Speech and language therapists and podiatrists were employed by another NHS trust and worked according to an agreed service level agreement with Bradford Teaching Hospitals NHS Foundation Trust.
- The virtual ward held daily board rounds and multidisciplinary team meetings three times a week to discuss patients. These included the consultant and the social worker. The team reported they had good relationships with the local authority, community long-term condition teams and with the patient's GP. When patients had complex health and social care needs, one of the practitioners in the team took the lead and undertook the visit and assessment.
- Mental health input was provided by the local mental health care trust. Staff reported delays in patients being seen.

Seven-day services

- There was access to radiology services 8.30am-5.00pm from Monday to Friday. Outside of those hours patients are transferred to Bradford Royal Infirmary for examination.Discharge prescriptions were dispensed from Bradford Royal Infirmary. This meant discharge medication had to be ordered 48-72 hours in advance. Staff managed this to avoid unnecessary delays in discharge. An on-site outpatient pharmacist was available.
- Physiotherapy staff were available five days a week. There was no physiotherapy support for other medical areas of the trust at weekends, including for patients who had suffered a stroke. No rehabilitation assistants were available during the weekend.
- The virtual ward team worked 24 hours a day; seven days a week and patients had access to them throughout these times.

Access to information

- Staff reported adequate response to information such as test results. These were accessible electronically.

Consent, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)

Medical care (including older people's care)

- Staff had a good understanding of consent, the MCA and Deprivation of Liberty Safeguards.
- Staff had recognised the potential need for Deprivation of Liberty Safeguards and we saw examples where these had been applied for and had been implemented appropriately.
- Processes were in place to assess a patient's mental capacity in accordance with the MCA 2005.
- Divisional information showed that, up at July 2014, no staff were overdue training in the MCA. Staff confirmed they had received this training.

Lone working

- Within the virtual ward, staff told us there was a lone working policy. Individual risk assessments were undertaken and the evening and overnight staff visited people at home in pairs. Staff also had lone worker devices and there was a system to contact each other after visits.

Are medical care services caring?

Good

Patients and relatives told us that they, or their relatives, had been treated with compassion and that staff were polite and respectful.

The percentage of patients who would recommend the service was consistent with, or higher than, the national average in September 2014. The trust performed around the same as other trusts in relevant questions in the inpatient survey.

Patients were aware of what treatment they were having and understood the reasons for this and, in some cases, had been involved in the decisions. Patients said they felt supported by staff.

Compassionate care

- The NHS Friends and Family Test response rate was consistent with the England average. The percentage of patients who would recommend the services was consistent with, or higher than, the national average in September 2014.
- The trust performed around the same as other trusts in relevant questions in the inpatient survey for 2013 with the exception of one question. This was regarding whether patients felt they received enough emotional support during their stay.
- The cancer patient experience survey results for 2012/2013 for inpatient stay showed the trust was in the top 20% for three indicators and consistent with other trusts in 33 indicators. They scored in the bottom 20% of trusts in eight indicators. This included provision of information and being provided with enough care.
- Throughout the inspection, we observed patients were treated with compassion and respect and their dignity was preserved.
- We spoke with four patients and their relatives throughout the inspection. All patients and relatives told us that they, or their relatives, had been treated with compassion and that staff were polite and respectful.

Understanding and involvement of patients and those close to them

- Multidisciplinary meetings were held that included the involvement of the patient and their families in goal setting.
- Family meetings were held to ensure smooth transitioning and discharge.
- We saw that staff explained procedures and involved the patients to ensure their understanding.
- An interpreter service was available. We saw that an interpreter was booked to attend during a ward round to ensure the patient was involved and understood the discussions about their care.

Emotional support

- Patients said they felt supported by staff.

Are medical care services responsive?

Good

Patients were predominantly admitted from Bradford Royal Infirmary to St Luke's Hospital as part of their pathway. Referral to treatment times were better than the England average and the trust had consistently achieved their performance targets for national cancer waiting times.

Medical care (including older people's care)

Staff worked to meet the needs of individual patients. Physiotherapy staff provided training for nurses to enable them to meet individual patient needs. The elderly care wards had developed practices and the environment to meet the needs of patients living with dementia. However, patient information was not readily available in languages other than English. Staff received information about the current themes regarding complaints to enable learning to occur.

Access and flow

- Bed occupancy for the trust was 74% or below for the trust over the previous financial year.
- Patients were predominantly admitted from Bradford Royal Infirmary to St Luke's Hospital.
- Estimated discharge dates for patients were planned. Discharge teams were available to support the discharge of patients with complex needs. An early supported discharge scheme for patients with a stroke had started in June 2014. This team attended the multidisciplinary team meetings.
- Over the previous 12 months, referral to treatment times were better than the England average. Some services, such as general medicine, geriatric medicine, neurology and dermatology achieved 100% against the 18-week target.
- No patients were waiting longer than six weeks for diagnostic tests with the division at July 2014.
- Figures for April to August 2014 showed the trust had consistently achieved their performance targets for national cancer waiting times.
- Medical outliers were managed at the trust. There were no outliers affecting patients at St Luke's during the inspection.
- Eighty-one percent of patients were not moved to another ward at St Luke's Hospital as part of their hospital stay (though they may have moved between hospitals). Fourteen percent of patients had one ward move while the remaining 5% had two or more ward moves during their stay.

Meeting people's individual needs

- Translation services were available and staff knew how to access these. We saw these were used.
- We noted that information leaflets were available for patients, but these were not readily available in languages other than English.
- The elderly care wards had developed practices and the environment to meet the needs of patients living with dementia. Dementia Friends Champions were in place to support meeting the needs of individuals.
- Physiotherapy staff provided training for nurses to enable them to meet individual patient needs.
- Staff reported an increase in caring for patients with complex needs, such as those suffering from delirium.
- The lack of psychology input had been noted on the Sentinel Stroke National Audit Programme (SSNAP). Access to psychological services is recognised as good practice, due to the prevalence of cognitive and mood difficulties in patients who have had a stroke.

Learning from complaints and concerns

- Staff were aware of the complaints process.
- Staff reported that they received information about the current themes regarding complaints, to enable learning to occur.

Are medical care services well-led?

Good

There had been very recent changes to the leadership of the medical division as part of a wider trust restructure. Staff were generally positive about the leadership and the recent appointments. Most staff were clear about the vision and strategy for the service.

Clinical governance meetings were held at speciality, directorate and divisional levels. There was, generally, good clinical engagement and attendance. Changes to the risk management processes were in place but required further embedding in practice.

The trust was better than average for staff engagement when compared with trusts of a similar type; however, the data for the division of medicine showed that this division was the lowest scoring part of the trust. Some staff we spoke with said they felt the culture had improved over the last few years. There were examples of innovation and improvement.

Vision and strategy for this service

- Most staff were clear about the vision and strategy for medical services overall and for the trust.

Medical care (including older people's care)

- Staff told us they were proud to work for the organisation.
- Staff within the virtual ward team told us they had recently presented to the British Geriatrics Society about the service they provided to patients. However, staff felt there was uncertainty and lack of knowledge within the trust about the virtual ward.

Governance, risk management and quality measurement

- Clinical governance meetings were held at speciality, directorate and divisional levels. A standardised agenda template had recently been introduced across the trust to aid with consistency. We reviewed notes of meetings and saw there was, generally, good clinical engagement and attendance.
- A risk register was in place for the medical care services division. This had recently been completely revised. A process had been put in place to align the identified risks from the specialties to the division. There were some discrepancies noted between the divisional risk register and the corporate risk register. The senior management team identified that the processes still required embedding.
- Information on quality performance was collected. A monthly updated divisional dashboard was produced.
- Staff at St Luke's Hospital reported more involvement in clinical governance and quality initiatives over the last 12 months. Staff attended the speciality clinical governance meetings.

Leadership of service

- There had been very recent changes to the leadership of the medical division as part of a wider trust restructure.
- Staff were, generally, positive about the leadership and the recent appointments. Staff knew who to contact if they had concerns.
- At ward level, there was clear leadership of the services.

Culture within the service

- Staff we spoke with were positive about the culture at the hospital.
- Staff felt proud to work at the hospital and felt supported by senior staff.

Public and staff engagement

- Managers told us how they had engaged with the public regarding ward developments. For example, developments on the care of the elderly wards had been informed by meetings held with carers.
- The trust displayed the NHS Friends and Family Test results on the wards.
- Information from the 2013 national NHS staff survey showed that staff engagement was better than average when compared with trusts of a similar type; however, the data for the division of medicine showed that this division was the lowest scoring part of the trust in relation to staff engagement.
- Staff in the virtual ward told us they were proud of the feedback they received and this was discussed at the monthly team meetings.

Innovation, improvement and sustainability

- There had been improvements to the wards to make them dementia-friendly.

Outpatients and diagnostic imaging

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

Information about the service

Bradford Teaching Hospitals NHS Foundation Trust provided a wide range of outpatient clinics, predominantly at St Luke's Hospital and Bradford Royal Infirmary. Between 2013 and 2014, 577,619 patients attended outpatient clinics across the two sites, with 227,435 of these patients attending outpatient clinics at St Luke's Hospital.

Since 29 September 2014, outpatient services at the trust were managed within the new directorate of outpatient and booking services, diagnostic and therapies. The trust was currently transitioning to a centralised patient booking service. By December 2014, all outpatient bookings will have transitioned into the centralised model. The patient booking service is located at St Luke's Hospital. By March 2015, all outpatient bookings will have transitioned into the centralised model Currently, some outpatient activity is managed by other clinical divisions, such as trauma and orthopaedics, ophthalmology and ear, nose and throat. Other specialties were managed within the outpatient department with their own staff rotating between this hospital and Bradford Royal Infirmary. As part of the divisional restructure, responsibility for outpatient nursing and outpatient clinic environments will fall within the remit of this directorate. Detail of the moves and phasing were being developed by the trust at the time of our inspection.

Outpatient services were delivered at Horton Wing within St Luke's Hospital. This hospital also provided diagnostic imaging, including radiology (plain film), general ultrasound, bone densitometry, computerised tomography (CT) and magnetic resonance imaging (MRI) scans.

Outpatient clinics were held in one main area, which was divided into five smaller areas, all identified by numbers. There was one main reception and waiting area, in addition to some smaller separate waiting areas. We visited all outpatient and diagnostic imaging areas as part of this inspection and observed clinics in urology, rheumatology, care of the elderly, neurology and cardiology. We also observed phlebotomy clinics.

The children's community nursing team, child development service and children's outpatients' clinics were based at St Luke's Hospital. The children's community nursing team provided home-based care for children with continuing care needs. For example, for those who required 24-hour care. The team also provided short-term interventions either at the patient's home, or in the clinic. The children's development service saw children with developmental delays and complex health or disability needs. The health transition nurses supported young people whose care was being transferred from children's services to adult services.

During the inspection, we spoke with 43 patients, seven relatives, and 36 staff including consultants, divisional managers, radiologists, nurses and healthcare assistants. We checked the outpatient environment, equipment and looked at patient information, as well as five patient records.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging services as 'inadequate' for safety, responsiveness and well-led.

There was a significant backlog of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. A patient could have multiple pathways if they are accessing several services for the same referral simultaneously. This meant that some patients were waiting considerable amounts of time for follow-up appointments, which could have resulted in delays accessing treatment. These problems were not proactively brought to the attention of CQC before or during the inspection

There had been a serious failure of governance systems to identify, respond and address to the significant backlog of followup appointments. The trust had belatedly recognised this as a significant issue and had commenced plans on how to address this, but there had been little done to risk assess the impact on individual patients. The trust recognised the full extent of the problem in May 2014. Extra staff were recruited to address the backlog by the end of October 2014.

Outpatients and diagnostic imaging services were caring. Systems were in place to capture concerns and complaints raised within both departments, review these and take action to improve the experience of patients.

We saw that trust policies were based on and included nationally recognised good practice guidance. Staff in both departments were competent, and there was evidence of multidisciplinary working. Staff in diagnostic imaging stated that they were well supported by their managers. Staff and managers told us there was an open culture. However, most medical secretaries and some outpatients' staff did not feel empowered or listened to.

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated safety within outpatients and diagnostic imaging as being 'inadequate'. We had serious concerns over the very large back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. A patient could have multiple pathways if they are accessing several services for the same referral simultaneously This meant that some patients were waiting considerable amounts of time for follow-up appointments which resulted in delays for patients. The trust had recognised this as an issue and had commenced plans on how to address this, but there had been little done to risk assess the impact on individual patients.

Cleanliness and hygiene in both outpatients and diagnostic imaging departments were within acceptable standards, with high levels of compliance in infection control audits. There was sufficient clean and well maintained equipment to ensure that patients received the treatment they needed in a safe way.

There were policies and procedures in place to respond to, and assess, patient risk. There were sufficient well trained and competent nursing and medical staff within the department to ensure that patients were treated safely.

Incidents

- There had been six serious incidents recorded on the Strategic Executive Information System (STEIS) in 2013/2014 in relation to outpatients at this trust.
- At the time of the inspection there had been one patient identified where a delay in treatment had happened and another where a delay in a patient's follow-up had resulted in a potential delay in treatment. Both cases had been reported and identified as serious incidents. In December 2014, following an investigation, the trust confirmed that the incidents were not related to the non-RTT patients.
- The trust provided information on the 28 November 2014 about the incident reporting system and acknowledged that at that time the system did not

separate access and administration issues. A total of 509 access/appointment/ admission/discharge/transfer incidents have been reported but the trust's system did not identify risk through delayed follow up.

- Between July and October 2014, outpatients at this hospital had reported 69 incidents on Datix. The majority of these were low grade or 'no harm' and were in relation to cancelled clinics or appointments.
- Between July and October 2014, diagnostic imaging at this hospital had reported 15 incidents on Datix. All were low grade or no harm.
- Staff were aware of how to follow the trust's policies and procedures for reporting incidents.
- General incidents were reported and investigated in line with trust policies within diagnostic imaging. We looked at a copy of all reported trust incidents from 1 July 2014 to 9 October 2014 and saw incidents for the diagnostics division were categorised, described and included a record of any immediate and/or further actions taken to manage or minimise further similar events. The senior managers told us they encouraged a culture of open incident reporting across all of the diagnostic modalities.
- The trust had reported radiation incidents to the Care Quality Commission (CQC) under the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) during the past year.
- The Radiology Protection Advisor (RPA) report included reference to all of the radiation incidents reported in each modality and the report included confirmation of their involvement in the investigations of all radiation incidents.
- We looked at three incidents in outpatients and saw these were managed in accordance with the trust's incident management policies and the learning outcomes from each incident were documented.
- Managers within outpatients told us they provided staff with verbal feedback from incidents at the weekly Monday morning team meetings. Minutes from these meetings confirmed this. Staff confirmed that the manager fed back the learning from incidents and discussed how they could do things differently in order to improve.

Cleanliness, infection control and hygiene

- Clinical and non-clinical areas in both outpatients and diagnostic imaging appeared to be clean and tidy, with equipment stored appropriately.
- We saw staff adhering to the trust's bare below the elbows policy. We also saw that staff wore protective aprons and gloves, when required, and regularly used hand sanitising gel between patients.
- Hand washing signage was clearly displayed throughout the departments and there was sufficient supplies of hand sanitising gel available.
- Cleaning schedules were on display in all areas and completed correctly.
- The outpatient and diagnostic imaging departments completed infection control audits every month, which monitored compliance with key trust policies such as hand hygiene and dress code. Most areas within outpatients and diagnostic imaging demonstrated compliance of between 97% and 100% during 2014.
- Systems and processes were in place to manage patients with suspected communicable diseases and isolation facilities were available, along with access to the deep cleaning teams, within diagnostic imaging.
- The outpatients department had link nurses for infection control to promote continuous service improvements and who introduced and monitored best practice guidelines.

Environment and equipment

- All of the outpatients areas we visited appeared to have adequate seating, some with drinks and refreshment facilities nearby.
- We looked at equipment and found it was appropriately checked and cleaned in both outpatients and diagnostic imaging departments.
- Resuscitation equipment and defibrillation machines were checked daily in all areas that we visited in outpatients and diagnostic imaging.
- During the course of our inspection, we observed staff wearing specialised personal protective equipment, while working within radiation areas.
- In diagnostic imaging, the trust had maintained compliance with their annual programme of quality assurance testing of x-ray equipment throughout 2014 across all of the modalities and provided over 60 examples of the compliance testing carried out throughout 2013 and 2014. The managers told us there were systems and processes in place to respond to national medical equipment alerts. The RPA report

confirmed the trust's ongoing compliance with quality assurance testing of x-ray equipment and referred to appropriate actions taken in response to two applicable medical equipment safety alerts.
- We looked around the imaging departments at St Luke's Hospital and saw radiological protection/hazard signage displayed throughout the departments. Illuminated treatment room 'no entry' signs were clearly visible and in use throughout the department at the time of the inspection visit.
- The general environments in the diagnostic imaging department appeared to be clean, uncluttered, well maintained and directional signage to reception and the various treatment areas were clearly displayed. Patient waiting areas were clean and tidy. We saw private changing areas for patient use, along with single sex and disabled toilet facilities.
- Appropriate containers for the disposal of clinical waste were available and in use across the diagnostic imaging department. The RPA had assessed the trust as fully compliant with the legislation Environmental Permitting (England and Wales) Regulations 2010, commenting that: "All work with radioactive materials is carried out in accordance with the permits issued by the Environment Agency."

Medicines

- Medicines were stored and managed safely, including in locked cupboards and fridges, where required.
- Medicines fridge temperatures were checked daily and medication room temperatures were set and monitored.

Records

- All records were in paper format in outpatients. Outpatient clinics also operated a paper patient record for each visit, called a 'clinic outcome form'. These records included the patients' personal data, referral to treatment status and 'outcome' and 'future appointment' sections.
- Medical staff completed the consultation records along with the outcomes form, which was passed to the receptionist to arrange follow-up appointments and/or discharge, as determined by the medical staff.
- We found nursing staff were responsible for checking and recording each patient's height, weight and basic physiological signs, such as blood pressure and pulse rates. We saw these procedures were consistently completed before patient consultations.
- We looked at five patient records and saw they included comprehensive health records such as the patients' medical histories, consultation records, care and treatment interventions, medical and nursing notes, along with diagnostic test results.
- At the time of inspection we saw patient personal information and medical records was managed safely and securely in the diagnostic imaging department.

Safeguarding

- The trust had safeguarding policies and guidance in place for both children and adults. All staff we spoke with were aware of these policies and guidance and could describe how to report and escalate a safeguarding issue.
- Overall, in outpatients, 94% of appropriate staff had adults and children safeguarding Level 1, 62% had Level 2 and 3 adults safeguarding and 78% had Level 2 and 3 child safeguarding training within the trust.
- In diagnostic imaging, 100% of appropriate staff had safeguarding training at all levels for both adults and children within the trust.

Mandatory training

- Staff reported that mandatory training was delivered via e-learning and face to face. They reported that reminders were received from their managers when updates were required and that they were up to date with their mandatory training.
- We looked at staff mandatory training records for both outpatients and diagnostic imaging.
- Overall, in outpatients, staff had to complete 26 mandatory training courses. Mandatory training was at 81% completed to date for 2014, ranging from 12 % in safe administration of medicines to 100% in equality and diversity training for managers.
- In diagnostic imaging, staff had to complete 13 mandatory training courses. Mandatory training was at 80% completed to date for 2014, ranging from 0% at safe administration of medicines to 100% in moving and handling. There were plans in place to ensure relevant staff received safe administration of medicines training before the end of 2014.

Assessing and responding to patient risk

- We had serious concerns over the very large back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to

be reviewed. A patient could have multiple pathways if they are accessing several services for the same referral simultaneously. This was across all specialties. A briefing paper presented to the Quality and Safety Committee, dated 16 October 2014, stated that in September 2014, the trust had "had 205,257 patients on the patient tracking list with no active referral to treatment pathway" or who were not on a review waiting list. Of the 205,257 patients, "155,622 - do not have a follow-up appointment".

- In February 2015 the trust informed us that following validation, the actual number of patients who were overdue a follow up appointment due to the non RTT issue would be less than 5,500.
- There was a significant risk that decisions about treatment or diagnostics were delayed for some patients. At the time of the inspection there had been one patient identified where a delay in treatment had happened and another where a delay in a patient's follow-up had resulted in a potential delay in treatment. Both cases had been reported and identified as serious incidents. In December 2014, following an investigation, the trust confirmed that the incidents were not related to the non-RTT patients.
- We found that the issue had been escalated in May 2014 to the divisional general managers and divisional clinical directors and belatedly in October 2014 to the Quality and Safety Committee and Trust Board.
- On 26 November and 3 December 2014, the CQC formally issued a statutory request for information using its powers under Section 64 of the Health and Social Care Act 2008 with regard to the back log of patients on a non-referral to treatment pathway who did not have a follow-up appointment.
- The trust provided information that stated, "the cohort of pathways being validated was 200,000, this is not a total follow up backlog number but the total volume of non-RTT pathways on the system classed as 'not applicable".
- The trust commenced a validation process in October (a validation process checks and confirms whether information/or process is correct), which was expected to be a six month piece of work to identify which patients required a follow up appointment, whether this was in the past or whether it would be required in the future. The work would also include identifying pathways to close down or where there had been duplication.
- At the time of the trust response to the Section 64 formal request for information, 20,000 patients on the backlog had been validated. Of these 8,000 had their referral closed down, with no further action required, 1,000 had been added to the waiting list with an overdue review date. Of the patients whose due date had passed, 30 should have been seen before February 2014, 154 in March 2014 and the remaining between April and November 2014.
- The trust informed us that the validation team was fully recruited to at the end of October, which should increase the validation rate. The trust was expecting to complete the validation process by the end of March 2015.
- The validation process was commencing with an initial cohort of two specialities and at the time of the inspection the trust was not in a position to understand the level of potential harm to patients whose follow up care had been delayed or the numbers of patients affected.
- Patients attending outpatients had baseline physiological signs, such as blood pressure and pulse rates, taken before their consultation.
- Staff in both outpatients and diagnostic imaging told us that urgent care and resuscitation could be provided in cases of emergency. Patients would then be transferred to the accident and emergency (A&E) department at Bradford Royal Infirmary for further assessment and treatment.
- In diagnostic imaging, the trust's radiation protection annual report summarised radiation protection during the year April 2013 to March 2014. The report provided an overview of the work carried out by the RPA and the Radiation Protection Service.
- The manager confirmed that the RPA was an employee of the trust and the RPA report confirmed that, "Regular contact was maintained between the RPAs, medical physics experts (MPEs), departmental managers and the radiation protection supervisors (RPS) throughout the year in order to progress this work. This included visits to various departments, as well as telephone and email contact."
- The report highlighted the trust's "continued commitment to ensuring the health and safety of staff, patients and members of the public and to complying with relevant legislation in relation to work activities involving radiation. Staff appeared to be maintaining good standards of practice".

Outpatients and diagnostic imaging

- All of the managers we spoke with told us that all modalities had an appointed and trained RPS. The RPA had commented within their report that: "The trust was fortunate in having members of staff in all radiation-using departments who carry out the duties of RPS with great diligence."
- We were told that the trust had a range of policies and procedures in place in relation to radiation protection regulations. The changes in policies and procedures within the past year were referenced within the RPAs annual report: "The local rules for diagnostic x-ray were updated in March 2014. The local rules for diagnostic radiology were amended to incorporate trust-wide local rules in one document for all areas where x-rays are used. The magnetic resonance imaging local rules were also revised." The report also noted that a number of policies were reviewed and reissued in 2013, which included, "Ionising Radiation Protection, Magnetic Resonance Imaging, Patient Identification, and Telephone (including mobile phones). IRMER procedures for diagnostic radiology had also been reviewed and reissued along with amendments to the pregnancy checking procedures."

Nursing staffing

- There was a dedicated team of outpatient nurses, receptionists and administration staff. The nursing staff covered clinics across the two hospital sites.
- The number of patients who attended clinics held each week was used to calculate staffing needed for each clinic.
- Staff and patients confirmed that there were enough staff available to meet patient's needs during clinics.
- We reviewed staffing information for outpatients at this hospital and found that required staffing levels met the actual staffing for the month of September 2014.
- The overall staffing compliment for the imaging services was approximately 40 plain film members of staff. This number included staff at varying band levels: one band 8, three band 7, seven to eight band 6 and four band 4 staff members. The rest of the staff were students. The CT scanning team was reported to have one band 8a, three band 7, 2.5 band 6 staff members and one band 5 trainee. The radiological intervention team had a band 6 and two band 5 staff members, while the MRI scanning team had three band 7, two band 6 and two locum members of staff.
- There were systems and processes in place to request additional temporary staffing and the service did use temporary nursing staff (bank staff) when shortages were identified.
- Induction and competence training for staff in different roles was carried out to facilitate staff moving between departments.
- We found there were clear lines of management responsibility and accountability within the outpatients and diagnostic imaging services.

Medical staffing

- Medical staffing for outpatients clinics along with clinic capacity and demand were agreed and reviewed with each clinical division, such as medicine and surgery. The divisions reviewed and managed mandatory training, appraisal and revalidation for medical staff.
- There were no reported medical staff vacancies.

Major incident awareness and training

- There was a trust major incident policy and business continuity plans, which staff were aware of and could refer to.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We saw trust policies were based on, and developed to include, nationally recognised guidance such as NICE and the Royal College's guidelines.

Staff in both departments were competent, and there was evidence of multidisciplinary team working.

The main outpatients service operated a five day a week service. Radiology and imaging provided a 24-hour service, seven days a week.

Evidence-based care and treatment

- We saw that NICE guidance was disseminated to both outpatients and diagnostic imaging departments, with a lead clinician taking responsibility for ensuring it was implemented. Staff were aware of the NICE guidelines and other guidance that affected their practice.

Outpatients and diagnostic imaging

- We saw that the departments were adhering to local policies and procedures. Staff were aware of how policies and procedures had an impact on patient care.
- The diagnostic imaging department undertook a range of audits, these included compliance with the radiation regulations. The trust radiation protection annual report summarised radiation protection, which included outcomes from surveys and audits. The report concluded that "in most respects" the trust "complied with the Ionising Radiations Regulations 1999 (IRR99), Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000), Artificial Optical Radiation Regulations 2010 (AOR) and fully complied with the Environmental Permitting Regulations 2010 (EPR)."

Patient outcomes

- In May 2014, the trust identified a very high volume backlog of patients on a non- referral to treatment pathway who did not have a follow-up appointment. This was across all specialties. A briefing paper presented to the Quality and Safety Committee, dated 16 October 2014, stated that, in September 2014, the trust had had 205,257 patients on the patient tracking list with no active referral to treatment pathway or who were not on a review waiting list. Of the 205,257 patients, 155,622 did not have a follow-up appointment. The trust was validating all of these patients to determine the extent of the issue and the actual follow-up backlog.
- We found the issue had been escalated to the divisional general managers and divisional clinical directors, as well as the Quality and Safety Committee and Trust Board. Actions to manage the backlog were in progress and were ongoing at the time of inspection.
- Staff had not been putting due dates for appointments onto the system. It was confirmed that in October 2014 the trust had agreed to invest in additional staff for nine months to validate the required appointments.
- This backlog resulted in significant delays for some patients and may have affected the clinical outcome for those patients required treatments.
- When patients attended for their appointments, we saw that patients were kept informed of any delays to their appointment times and sufficient time was allocated for each patient's appointment.
- Patient outcomes in outpatients were monitored by clinic outcome forms, as well as a clinic utilisation activity record. Both forms were completed by nursing and medical staff for every patient to ensure that there was a follow-up treatment plan in place.
- Staff in the outpatient departments we visited told us that they took part in local and trust-wide audits. For example, infection control and environmental audits. All of these audits demonstrated high levels of compliance.
- The diagnostic department undertook a range of national statutory audits to demonstrate compliance with radiation regulations.
- Information from the national paediatric diabetes audit 2013, showed that St Luke's Hospital was worse than the England average for the HbA1c diabetic audit measure. Glycated haemoglobin (HbA1c) levels give clinicians an overall picture of what the patient's average blood sugar levels have been over a period of weeks or months. This, therefore, aids the clinician in the care and treatment of the patient.

Competent staff

- Competency-based assessments were completed prior to outpatient staff undertaking some duties. For example, healthcare assistants completed manual blood pressure, height and weight measurements.
- In diagnostic imaging, the manager told us that there were a number of advanced practitioners who were trained to undertake more specialised roles within each of the different modalities. For example, ultrasound sonographers were independent reporters, along with radiographers and mammographers.
- Managers in diagnostic imaging told us of the formal arrangements were in place for mentoring students and new staff and for continually assessing staff performance through supervisions and appraisal. Training alert updates for all staff were flagged to managers for action on the departmental training database.
- All new staff received a two week supernumerary induction into outpatients.
- Staff confirmed that they had received appraisals in the last year.
- Information sent to us showed that all doctors were up to date with their revalidation.
- To date, 63% of staff have had appraisals within outpatients for 2014.

Outpatients and diagnostic imaging

- To date, appraisal rates for staff in diagnostic imaging specialties ranged from 80% to 100% for 2014.

Multidisciplinary team working

- A range of clinical and non-clinical staff worked within the outpatients department and they told us they all worked well together as a team.
- There was access to multidisciplinary teams and clinical specialists within outpatient clinics.
- The trust provided nurse-led clinics and we spoke with one of the pain nurse specialists, who told us they provided a direct service to the patients and they were supported by the medical team.

Seven-day services

- The main outpatients service operated a five day a week service.
- Phlebotomy services were available from 9am to 5pm for people to have their blood samples taken. We saw that, during our inspection, the phlebotomy clinics were very busy.
- We found that, sometimes if clinics ran late, they did not have support from the phlebotomy service, as it had closed. This meant patients could not have their blood samples taken at the time of their outpatient appointment and would have to return to the hospital for this.
- We spoke with senior managers and they said some patients had complained about waiting times. The service was completing audit activity to determine the scale of this problem.

Access to information

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information appropriately.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Senior staff reported that, within the outpatients department, implied consent (as opposed to written consent) was routinely obtained from patients before any care and treatment interventions. For example, obtaining specimens, routine diagnostic tests and the checking of height, weight and basic physiological signs. The General Medical Council defined implied consent in their guidance Consent: patients and doctors making decisions together (2008) as: "Patients may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken."
- Staff reported that, if consent could not be safely obtained and/or the patient lacked capacity to consent, they would contact the hospital safeguarding team for advice.
- We spoke with a number of staff about their understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. On the whole, staff were able to explain to us what each involved.
- All relevant staff in outpatients had attended Mental Capacity Act 2005 training Level 2, and 95% of staff had attended Mental Capacity Act 2005 training Level 1.

Are outpatient and diagnostic imaging services caring?

Good

Outpatients and diagnostic imaging services were caring. During our inspection, patients and relatives commented positively about the care provided from all of the outpatients and diagnostic imaging staff. Staff who worked in the departments treated patients courteously and with respect.

Staff listened, and responded, to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.

Compassionate care

- We observed staff interacting and speaking with patients in a caring, courteous and friendly manner. Patients told us staff were "brilliant", "pleasant" and "helpful".
- We saw staff listened, and responded, to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.
- The environment in the outpatients and diagnostic imaging department allowed for confidential conversations.
- Chaperones were provided where required.

Outpatients and diagnostic imaging

- Since the beginning of October 2014, the outpatient department had commenced the NHS Friends and Family Test. Posters and collection boxes were on display and we observed staff asking patients to complete the appropriate cards. Results of this test had not yet been collated at the time of the inspection.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated they felt involved in decision-making about their care and treatment.
- We saw staff using information leaflets as supportive literature to explain to patients about their health problem.
- The outpatient departments completed patient surveys. The survey completed in February 2014 confirmed that between 85% and 96% of patients were treated with dignity and respect and that their privacy was respected. The survey did detail areas for improvement, including waiting times, efficiency of services and the provision of written information. An action plan was in place to address these areas and the survey was to be repeated in March 2015.

Emotional support

- We saw that staff were always nearby and/or in the consulting rooms to support the patients emotionally in the event of receiving difficult news. Staff spent time talking to patients.
- Clinical nurse specialists in areas such as pain management, neurology and vascular services were available to give support to patients.
- Patients were able to access counselling services.

Are outpatient and diagnostic imaging services responsive?

Inadequate

We rated responsiveness within outpatients and diagnostic imaging as 'inadequate'. This was due to a significant backlog of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed, an indeterminate number of which have yet to have their follow up appointment. This meant that patients were waiting considerable amounts of time for follow-up appointments, which could mean there were delays in treatment. Actions to manage the backlog were in progress and ongoing at the time of inspection. It was too early to determine the impact of these actions. 'Did not attend' (DNA) rates for this hospital were worse than the England average.

The lead within the child development service, told us that the wait for an autism assessment had been 24 months. This had been reduced recently to nine months, following additional clinics being held. However, there were concerns about the sustainability of the additional clinics. Information on the service risk register, which indicated that the child development service was under considerable pressure with access issues. The patient wait for their first outpatient's appointment was 15 weeks. Follow-up appointment capacity was booked up to April 2015.

All other referral to treatment (RTT) for admitted and non-admitted pathways were similar to, or better than, the England average. Cancer waits and diagnostic waiting times were the same as, or better than, the England average.

Mechanisms were in place to ensure that the service was able to meet the individual needs of people, such as those living with dementia or a learning disability, and for those whose first language was not English. Departments had systems in place to capture concerns and complaints raised, to review these complaints and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

- The trust was transitioning to a centralised patient booking service. By December 2014, all outpatient booking will have transitioned into the centralised model.
- Outpatient nursing staff rotate between this hospital and Bradford Royal Infirmary to help ensure the needs of local people were met.
- Staff told us that, when clinics were expected to be busy, extra staff routinely worked to try to ease the pressure.
- When clinics were running late, some clinics offered patients alternative appointments.
- Additional outpatient capacity was arranged when required, in order to ensure that patients were seen in an appropriate timescale.

Access and flow

Outpatients and diagnostic imaging

- In May 2014, the trust identified a very high volume backlog of patients on a non- referral to treatment pathway, who did not have a follow-up appointment. This was across all specialties. A briefing paper presented to the Quality and Safety Committee, dated 16 October 2014, stated that in September 2014, the trust had 205,257 patients on the patient tracking list with no active referral to treatment pathway or who were not on a review waiting list. Of the 205,257 patients, 155,622 did not have a follow-up appointment.
- Following a formal request by CQC for information under Section 64 of the Health and Social Care Act 2008, the trust provided further details on the patients affected and the progress on the validation process they had commenced in October 2014. The trust informed us that of the 20,000 validated by 23 November 2014 - 8,000 referrals had been closed, 1,000 had been added to the waiting list with an overdue review date, 10,000 have been added to the waiting list with a review date in the future and 1,000 patients required a case note review as there was insufficient information in the clinic letter available to determine what was required.
- The trust informed us that, within the 205,257 pathways there were 25,000 obstetric referrals that were being sampled by the consultant group to confirm all referrals could be closed. The work was expected to be completed by January 2015 due to the need for a software upgrade.
- We found the issue had been escalated to the divisional general managers and divisional clinical directors in May 2014 and belatedly to the Quality and Safety Committee and Trust Board in October 2014.
- Did not attend (DNA) rates for this hospital were worse than the England average, at 11%. The hospital had commenced using an SMS text-messaging system to help improve this.
- Referral to treatment (within 18 weeks) for admitted pathways was 90% for this trust, referral to treatment for non-admitted pathways was 97% and for incomplete pathways was 97%. This was similar to, or better than, the England average.
- At this trust, for all cancers, the percentage of patients seen by a specialist within two weeks of an urgent GP referral was 94%, for less than 31 days from diagnosis to first definitive treatment was 96%, and for less than 62 days from urgent GP referral to first definitive treatment was 87%. This was similar to, or better than, the England average.
- At this trust, diagnostic waiting times of six weeks or more were less than 1%. This was better than the England average.
- In 2014, 70% of patients were seen on time for their appointments at this hospital, 23% were seen within 15 minutes of their allocated time, and 2% and 3% were seen within 30 and 60 minutes, respectively.
- The managers told us that the majority of outpatient diagnostic imaging procedures were managed through planned appointments times. Inpatients were booked into time slots within the departments as required, and were based upon the acuity of the referral.
- We saw information on the service risk register, which indicated that the child development service was under considerable pressure with access issues. The patient wait for their first outpatients' appointment was 15 weeks, which met the 18 week referral to treatment times (RTT). However, at the time of inspection in October 2014, follow-up appointment capacity was booked up to April 2015, which meant for some children and young people they may have had to wait longer periods of time to be seen following their initial appointment.
- The lead within the child development service told us that the wait for an autism assessment had been 24 months. This had been reduced recently to nine months following additional clinics being held. However, there were concerns about the sustainability of the additional clinics. This meant that, potentially for some patients and their families, they were waiting considerable amounts of time for a multidisciplinary assessment to diagnose their condition.

Meeting people's individual needs

- Information signage was adequate within outpatients and diagnostic imaging and patients appeared to be able to make their way around both departments easily.
- Translation services were available for patients. The staff explained the systems and processes in place for arranging translation services.
- Volunteers were on hand within the outpatients department to assist people.
- A range of information leaflets were available, which provided patients with details about their outpatient appointment and clinical supporting literature to assist them in their understanding of their medical condition. Leaflets were not always available in different languages if needed.

Outpatients and diagnostic imaging

- We saw, in the children's outpatients department, information for patients and relatives about appropriate support groups. For example, there was information about an epilepsy support group, free training courses for carers and activities for young children and teenagers.
- We observed staff spending time explaining to patients about procedures they were to have as part of their outpatient and diagnostic imaging appointment.
- Staff told us that, when patients with learning disabilities attended the departments, they tried to give the patient priority to be seen. They were aware of additional support that was available within the trust, and also allowed carers to remain with the patient if this was what the patient wanted.
- Some staff told us they had attended training about dementia within the trust and were aware of how to support people at different stages of dementia. One of the sisters we spoke with told us that most patients living with dementia were accompanied by carers or relatives, and provision was made to ensure that patients were seen quickly.
- In the children's outpatients department at St Luke's Hospital, there was a specific waiting area for children which was brightly decorated and child friendly. One relative told us that, due to the seating arrangements, they had difficulty moving their relative around the area in their wheelchair. We spoke with a senior nurse in the department, who told us that there were plans to change the waiting area to make the environment more wheelchair accessible.
- A senior nurse told us that iPads had been bought for young people to use while they were waiting to be seen.
- One of the main themes that patients and public raised about the Trust at the CQC Listening event prior to the inspection was the issue of not getting appointments or delays in appointments.
- Local Healthwatch also reported that one of the main themes from their engagement with local people about the trust's services was the long waiting times for appointments.

Learning from complaints and concerns

- The outpatients and diagnostic imaging services had a process in place for managing informal complaints. Both formal and informal complaints and concerns were recorded through the trust's Patient Advice and Liaison Service (PALS), as well as informally by the department.
- Between August 2013 and July 2014, the outpatient department received 52 complaints, 22 related to clinical treatment, 12 related to communication and 10 related to appointment delays and cancellations.
- Between August 2013 and July 2014, diagnostic imaging received two complaints relating to communication and clinical treatment.
- Staff in both outpatients and diagnostic imaging were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the PALS, or make a complaint was available within waiting areas.
- Managers and staff all told us that complaints and concerns were discussed at team meetings and any learning was shared.

Are outpatient and diagnostic imaging services well-led?

Inadequate

The main concern we had was related to the poor management systems, which had not identified the significant back log of patients waiting for a review of their outpatient care pathway. It was not clear what monitoring and governance had taken place prior to this backlog being noted. The full significance of the backlog was identified following a recommendation from an external review of waiting times. The trust had recognised the full extent of the problem in May 2014, but it was not until October 2014 that the Board was formally notified and extra staff were recruited to address the backlog. This indicated there had been a significant failing in governance and reporting arrangementsAdditionally, these problems were not proactively brought to the attention of CQC before or during the inspection.

Almost all staff who worked in diagnostic imaging stated that they were well supported by their managers and that this service was well-led.. Staff and managers also told us there was an open culture.

However, within outpatients many administrative staff and some other outpatients staff did not feel empowered or listened to.

Vision and strategy for this service

- The majority of the staff we spoke with were aware of the trust's values and aims, which we saw were displayed throughout the hospital and departments. They reported that the CEO was visible and they were aware of the recent listening events undertaken by the CEO. Other members of the executive team and trust were reported to be less visible.
- Staff were aware of the decisions and actions taken to centralise the booking service for outpatients.

Governance, risk management and quality measurement

- In May 2014 the trust identified a very high volume back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed This was across all specialitiesThis was across all specialties.
- This represented a significant failing in governance and reporting arrangements. It was not clear what monitoring and governance took place prior to this issue occurring, as the briefing paper stated that it was the expectation of the trust that everyone needing an appointment received one. However, this had not happened.
- The trust informed us in February 2015 that the monitoring before March 2014 related to RTT patients. We were told that as part of the Trust's investigation into the non RTT issue, it became aware of a gap in the existing systems to ensure that any follow up appointments as directed by clinicians had taken place. As a result of this the Trust developed a new booking tool to ensure that this issue could not happen again.
- On 26 November and the 3 December 2014, the CQC formally issued a statutory request for information using its powers under Section 64 of the Health and Social Care Act 2008 with regard to the back log of patients on a non-referral to treatment pathway who did not have a follow-up appointment.
- The trust provided information detailing that in 2012 the trust had identified issues with RTT management and reporting. A turnaround team had been appointed and support from the Interim Management and Support service (IMAS) to validate pathways to deliver RTT performance. This entailed separating RTT and non RTT pathways, with a focus on RTT delivery. The trust informed us that this was signed off by the trust in March 2014. A recommendation had been made to invest in a formal Data Quality tool to support assurance mechanisms, with a second recommendation to review non RTT waiting times. Following procurement processes, the trust put in place the Data Quality tool in September 2014.
- In April and May 2014, following the recommendation in March a review was undertaken, which highlighted concerns about the volume of non-RTT pathways. This led to a recommendation for validation, which was presented to the Clinical Executive in August 2014, the Quality and Safety Committee in October and then escalated to the Board of Directors and MonitorThere had been a considerable time lag between the identification of the backlog problem and it being presented formally to the Board.
- It was five months before additional staff were in place to validate the backlog which added significant delay in delivering appropriate follow up appointments for patients waitingWe were informed by the trust that deciding priority for booking appointments would be through the validation process involving the clinical lead and the relevant consultant. The process would be rolled out to each speciality.
- In the trust's reply dated 5 December 2014 there was an non-RTT clearance graph which indicated that the backlog extended to pre 2007 for approximately 20-30,000 of the appointments. Validation of these was completed by 10 November 2014. This indicated that there had been system failure in identifying patients for a number of years.
- The trust provided information on the incident reporting system and acknowledged that at the present time the system does not separate access and administration issues. A total of 509 access/appointment/admission/discharge/transfer incidents have been reported; initial review of the narrative did not identify 'delayed follow up' as the risk. Of the 509 incidents, two incidents were rated as moderate, one related to administration and one to access. The two serious incidents reported identified potential harm. These were being investigated (28 November 2014 Trust Response Letter).
- The trust had put in place a number of changes including global newsletters reminding staff of the

processes, additional system training, refresher training sessions on the patient pathway to divisional teams and central booking teams. In addition, the trust has changed the clinic booking process.
- Outpatients and diagnostic imaging departments held monthly clinical governance meetings. The outpatient and booking services, diagnostic and therapies division also held monthly divisional meetings with attendance from all the relevant departments. Both meetings escalated issues to the trust's Quality and Safety Committee.
- Complaints, incidents, audits and quality improvement were discussed.
- Feedback from these meetings was given at weekly departmental meetings.
- Risk registers were in place for both outpatients and diagnostic imaging. These had controls and assurance in place to mitigate risk. These were regularly reviewed. However, we noted that the issue of the non-RTT backlog was not raised as a significant risk and did not appear on either the corporate risk register (September 2014 Board papers) or the out-patients' risk register, at the time of the inspection. There could be a serious risk to patient safety due to the initial delay, of more than six months, before significant action was taken. There is a lack of assurance that this risk is being effectively managed and could not be repeated.

Leadership of service

- Currently, some outpatient activity was managed by other clinical divisions, such as trauma and orthopaedics, ophthalmology and ear, nose and throat. Other service specialties were managed within the outpatient department, with their own staff rotating between this hospital and Bradford Royal Infirmary.
- Staff in diagnostic imaging stated that they were well supported by their managers. Almost all diagnostic staff felt that their local managers communicated well with them and kept them informed about the running of the department.
- However, there were significant concerns raised by some medical secretaries/ administration staff and outpatient's staff who did not feel empowered or listened to.

Culture within the service

- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well supported by the organisation.
- Staff told us that the chief executive was visible, although members of the executive team were less visible.
- All of the staff we spoke with were proud to work for the trust.

Public and staff engagement

- The outpatient department completed patient surveys. The survey completed in February 2014 confirmed that between 85% and 96% of patients were treated with dignity and respect and that their privacy was respected. The survey did detail areas for improvement, including waiting times, efficiency of services and provision of written information. An action plan was in place to address these areas and the survey was to be repeated in March 2015.
- Since the beginning of October 2014, the outpatient department had commenced the NHS Friends and Family Test. Posters and collection boxes were on display and we observed staff asking patients to complete the appropriate cards. Results of this test had not yet been collated at the time of the inspection.
- The trust was rated better than expected for overall staff engagement in the NHS staff survey key findings for 2013.

Innovation, improvement and sustainability

- Managers and staff in both outpatients and diagnostic imaging told us that they were supported to try new ways of working to improve the effectiveness and efficiency of their departments.
- In diagnostic imaging, all ultrasound sonographers were independent reporters. There was a high proportion of advanced practitioners, which had helped reduce waiting times.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

Action the hospital MUST take to improve

The hospital must:

- Ensure there is access on the wards to sufficient numbers of suitably skilled staff, particularly medical staff, at all times.
- Ensure that the significant backlog of outpatient appointments is promptly addressed and prioritised according to clinical need.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Share with staff information regarding audits and reviews of practice so that trends and good practice can be identified.
- Review the approach and uptake of clinical supervision.
- Review access to patient information in languages other than English.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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