University Hospitals Plymouth NHS Trust

Derriford Hospital

Quality Report

Derriford Road
Crownhill
Plymouth
Devon
PL6 8DH
Tel: 01752 202082
Website: www.plymouthhospitals.nhs.uk

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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

Summary of findings

Letter from the Chief Inspector of Hospitals

We conducted a follow-up inspection on 11 and 18 December 2018. We did not review ratings as part of this inspection. This inspection was focused solely on the improvements required as detailed within two warning notices. These warning notices were issued to the trust on 13 August 2018, with the requirement to make significant improvements regarding the quality of healthcare by 26 October 2018. The following areas of concern were identified in the warning notices:

Medicines and Pharmacy

- Significant improvements were required to ensure systems and processes for safely managing medicines were operating correctly both within the pharmacy services and across the trust. These processes also needed to be effectively governed so people were given the medicines they needed, when they needed them and in a safe way.
- Routine pharmacy input to clinical areas had been frequently limited due to staffing and capacity issues.
- The delivery of a high-quality service provision was not assured by the leadership, governance and culture.

Diagnostic Imaging

- Significant improvements were required to ensure patients suspected of having cancer had timely access to initial assessment, test results and diagnosis.
- The diagnostic imaging service was not meeting internal or national targets for the imaging of patients.
- Leaders did not have the necessary capacity to lead effectively. This included both service management and modality leadership.
- There were consistent low levels of staff satisfaction and high levels of work overload. Staff did not feel valued, supported, or appreciated by the rest of the trust.

We found the trust had not fully addressed or sufficiently acted on some of our concerns in the warning notice. The full warning notice and the actions taken needed better executive oversight. The detail of the warning notice had not been appropriately reviewed and acted on. However, we recognised the trust was making some progress and that a cultural shift would take time, which was relevant to both areas inspected.

In Medicines and Pharmacy we found:

- There was progress in addressing the concerns in the warning notice, although some areas had not been well considered or implemented quickly enough.
- There was no consistent assurance that patients were discharged with their medicines to take away (TTAs), posing a risk to patient safety.
- Processes to review TTAs left on the ward following a patient discharge had still not been rolled out. The trust had therefore made insufficient progress in the timeliness of addressing this issue.
- There were still no safeguards to ensure medicines had been delivered to patients using the trust transport service and patients were adequately counselled on their medicines.
- The monitoring of refrigerator temperatures on wards across the trust was still not functioning effectively, increasing the risk of unsafe storage of medicines.

Summary of findings

- There was a level of instability in the pharmacy department and a reduced resilience amongst the team. Progress had been made recruiting staff, however, there was a lot of pressure and stress on staff due to capacity and workload.
- Clinical pharmacist vacancies were reducing; however, gaps were still apparent with specialist pharmacists.
- The dispensary and supply team particularly felt the pressures of workload because of the vacancies they were experiencing.
- We were not assured sufficient priority or resources had been allocated by the board to address and rectify issues in pharmacy.
- There was a lack of capacity with leadership. Adequate support had not been provided to the interim director of pharmacy to ensure a continued presence of support in the department.
- The current pharmacy department staffing risks were not included on the pharmacy risk register. This was not recorded for the pharmacy leadership team or pharmacy staff.
- The gap analysis against the Royal Pharmaceutical Society's Professional Standards for hospital pharmacy did not adequately link to risk management.
- Culture was improving in the department, but there was still a division, with mixed feelings from pharmacy staff. There were still staff who were upset and felt morale was low.
- Improvements were needed in the level of engagement provided to pharmacy staff.
- A more robust check and challenge of the warning notice action plan, through the governance structure, was required to ensure areas of the warning notice had been fully met.

However:

- The chief operating officer recognised there was still not enough resource to allow the trust to address the full CQC warning notice and the trust action plan. Choices were being made to deliver sustainable solutions, and they were working to get resilience around clinical support in the department. The service model required review and a new workforce model would be developed.
- The clinical pharmacy service had improved their access to clinical areas for routine pharmacy input. The service had been reinstated on 1 October 2018, reducing several risks identified in our warning notice from a previously restricted service.
- Governance structures for pharmacy had been changed since our last inspection, although they were not yet embedded to enable us to evidence their effectiveness.

In Diagnostic Imaging we found:

- Insufficient progress had been made in addressing the concerns in the warning notice.
- The diagnostic imaging service was still not meeting the seven-day internal target for the imaging of patients suspected of having cancer.
- In MRI there were still a number of scans breaching the two-day internal reporting cancer target.
- Some modality leaders still did not have the capacity to lead effectively.
- We found limited improvement, and some areas of deterioration, with progress on the cultural concerns within the diagnostic imaging department.

Summary of findings

- Staff consistently described a culture from some modality leaders of poor attitudes and behaviours which bullied, belittled and humiliated junior staff. Radiographers felt unable to raise this with their managers or with their freedom to speak up guardians.
- Some consultants said the workload had not reduced and most reported working harder than at the time of the last inspection.

However:

- There was improving performance for patients waiting longer than six weeks for a routine scan.
- There were plans to improve process and efficiency with booking appointments.
- There was improved management of governance within the imaging department.
- There had been an internal review of risks on the risk registers and actions were progressing well.
- Improvements had been made in the management structure for senior staff in the imaging department.
- The department was now consulted when new appointments and service developments were made throughout the trust.
- In CT the most urgent scans were reported on in a timely way.

Following this inspection we told the provider it must take some actions to comply with the regulations, and it should make other improvements, even though a regulation had not been breached, to help the service improve. We also served the trust with a section 29A warning notice requiring the trust to make significant improvements within the diagnostic imaging department. Please see details at the end of this report.

Importantly, the trust must:

Pharmacy and Medicines

- Ensure there is a clear process rolled out trust wide, within wards, pharmacy and transport, to safeguard patients receiving their critical medicines if discharged. Ensuring patients are being appropriately counselled on their medicines.
- Ensure the trust have assurance and can evidence processes, through review of data, that patients being discharged without their critical medicines receive them in a timely manner.
- Review staffing establishment and skill mix for the pharmacy department to ensure staffing meets capacity and demand.
- Review training and competency of staff and ensure staff are not working above their role and competencies.
- Ensure capacity for leadership and ongoing support is available in the pharmacy department.
- Ensure risks are identified, recorded and mitigated, with a clear record for this.
- Ensure there is robust oversight of governance for pharmacy and medicines trust-wide.

Diagnostic Imaging

- Ensure that 85% of patients suspected of having cancer are scanned within seven days as per the trust target.
- Ensure the management team addresses poor leadership and manages attitudes and behaviours shown by some of the team.
- Ensure staff satisfaction improves, and that staff are confident to raise concerns with managers.

Summary of findings

In addition, the trust should:

Pharmacy and Medicines

- Encourage pharmacy staff to consistently report incidents.
- Confirm all areas within the hospital with refrigerators are recording the minimum and maximum temperatures, along with current temperature, daily.
- Adapt the ward TTA trust pilot form to ensure a clear auditable trail of TTAs being collected by patients.
- Explore ways to engage with the pharmacy department to keep staff well informed at a time of unsettlement.
- Continue to focus on the culture within the pharmacy department.
- Develop the strategy for pharmacy so there is clear direction for the service, and ensure this is supported by a contingency plan.

Professor Ted Baker

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		This was a focused follow-up inspection. Therefore, we did not rate this service. There was progress in addressing the concerns in the warning notice, although some areas had not been well considered or implemented quickly enough for medicine and pharmacy services.
Outpatients and diagnostic imaging		This was a focused follow-up inspection. Therefore, we did not rate this service. We found insufficient progress had been made in addressing the concerns in the warning notice for diagnostic imaging.

Derriford Hospital

Detailed findings

Services we looked at
Medical care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Derriford Hospital

University Hospitals Plymouth NHS Trust

University Hospitals Plymouth NHS Trust (formerly Plymouth Hospitals NHS Trust) is the largest hospital trust in the south west peninsula. It is an NHS teaching trust and works in partnership with the Peninsula College of Medicine and Dentistry. The trust provides healthcare to people living in the south west peninsula, visitors to the region, and provides training and education for a wide range of healthcare professionals.

The trust is organised into four 'care groups' of; surgery, medicine, women and children, and clinical support services.

The trust has an integrated Ministry of Defence Hospital Unit on the Derriford Hospital site, which has a tri-service staff of approximately 220 military personnel working within a variety of posts. This includes consultants, doctors, nurses, and trainee medical assistants.

Derriford Hospital has just over 1,000 inpatient beds, of which 41 are for children, and 167 day-case beds. There are around 1,800 outpatient clinics and 336 community clinics held each week. The trust operates a high dependency and intensive care unit for both general and neurological patients, and a cardiac critical care unit and cardiothoracic service. It provides acute and community maternity services, runs 31 operating theatres, and has 36 inpatient wards. It has a fully equipped diagnostic imaging department operating seven days a week, an eye infirmary, and a recently commissioned acute assessment unit.

The trust employs around 6,300 whole-time-equivalent staff (7,127 headcount).

Inspection and Enforcement

In April and May 2018, we conducted an announced inspection of the trust. We identified serious concerns in terms of safe care and treatment and good governance for medicines and pharmacy, and diagnostic imaging. We took enforcement action, serving a warning notice under section 29A of the Health and Social Care Act 2008, and the trust was required to submit an action plan setting out how it would make improvements. This inspection was undertaken to review the progress made against the trust's action plan and the concerns identified in the warning notice.

Our inspection team

Our inspection team included four CQC inspectors with specialisms in pharmacy and diagnostic imaging. The inspection team was overseen by an inspection manager and Mary Cridge, CQC Head of Hospital Inspections.

Detailed findings

How we carried out this inspection

The inspection was announced at short notice, to enable the trust to supply data to the inspection team and to plan for meetings. We visited the trust on 11 and 18 December 2018.

We used evidence provided to us prior to the inspection, as part of the trust's action plan in response to the section 29A Warning Notice, and requested additional data for review.

During the inspection we spent time talking to managers and staff in pharmacy and diagnostic imaging, and we visited a random sample of wards across the trust. During our visit we spoke with 106 staff, across the two services inspected.

Medical care

Safe	
Well-led	
Overall	

Information about the service

As part of this inspection we inspected medicines and pharmacy services.

The trust's pharmacy department supplied medicines to wards and patients during their stay in hospital, and to take away when discharged. Pharmacy services included clinical pharmacists, dispensary and supply, production, logistics, procurement and IT. The trust also had external contracts to be the main supplier of medicines to the community hospitals across Devon and Cornwall.

During this inspection we spoke with 60 staff. This included the chief executive, chief nurse, chief operating officer, a non-executive director, the interim director of pharmacy, interim pharmacy general manager, pharmacy management staff, pharmacy non-management staff, 'tiger team', ward nurses, and freedom to speak up guardians. We visited six wards, including the maternity delivery ward, Merrivale, Meldon, Shaugh, Sharp and Stannon. These were different inpatient wards across the trust where patients would be discharged. We reviewed documentation and data, and the trust's action plan in response to the warning notice.

Summary of findings

This was a follow-up inspection focused solely on the concerns identified in a warning notice issued under section 29A of the Health and Social Care Act 2008, relating to medicines and pharmacy. The inspection was to assess whether the trust had made sufficient progress against the warning notice. Therefore, we did not rate the service.

We identified progress had been made in addressing the concerns in the warning notice, although some areas had not been well considered or implemented quickly enough.

During this inspection we found:

- There was no consistent assurance to ensure patients were discharged with their medicines to take away (TTAs), posing a risk to patient safety.
- Processes to review TTAs left on the ward following a patient discharge had still not been rolled out. The trust had therefore made insufficient progress in the timeliness of addressing this issue.
- There were still no safeguards to ensure medicines had been delivered to patients using the trust transport service and that patients were adequately counselled on their medicines.
- The monitoring of refrigerator temperatures on wards across the trust was still not functioning effectively, increasing the risk of unsafe storage of medicines.
- There was a level of instability in the pharmacy department and a reduced resilience amongst the team. Progress had been made recruiting staff, however there was a lot of pressure and stress on staff due to capacity and workload.
- Clinical pharmacist vacancies were reducing, however gaps were still apparent with specialist pharmacists.

Medical care

- The dispensary and supply team particularly felt the pressures of workload because of the vacancies they were experiencing.
- We were not assured sufficient priority or resources had been allocated by the board to address and rectify issues in pharmacy.
- There was a lack of capacity with leadership. Adequate support had not been provided to the interim director of pharmacy to ensure a continued presence of support in the department.
- The current pharmacy department staffing risks were not included on the pharmacy risk register. This was not recorded for the pharmacy leadership team or pharmacy staff.
- The gap analysis against the Royal Pharmaceutical Society's Professional Standards for hospital pharmacy did not adequately link to risk management.
- Culture was improving in the department, but there was still a division, with mixed feelings from pharmacy staff. There were still staff who were upset and felt morale was low.
- Improvements were needed in the level of engagement provided to pharmacy staff.
- A more robust check and challenge of the warning notice action plan, through the governance structure, was required to ensure areas of the warning notice had been fully met.

However:

- The chief operating officer recognised there was still not enough resource to allow the trust to address the full CQC warning notice and the trust action plan. Choices were being made to deliver sustainable solutions, and they were working to get resilience around clinical support in the department. The service model required review and a new workforce model would be developed.

- The clinical pharmacy service had improved their access to clinical areas for routine pharmacy input. The service had been reinstated on 1 October 2018, reducing several risks identified in our warning notice from a previously restricted service.
- Governance structures for pharmacy had been changed since our last inspection, although they were not yet embedded to enable us to evidence their effectiveness.

Medical care

Are medical care services safe?

At our last inspection we were concerned routine pharmacy input to clinical areas had been frequently limited due to staffing and capacity issues. Significant improvements were required to ensure the systems and processes for safely managing medicines were operating correctly, both within the pharmacy services and across the trust.

During this inspection we found:

- There was no consistent assurance to ensure patients were discharged with their medicines to take away (TTAs), posing a risk to patient safety.
- Processes to review TTAs left on the ward following a patient discharge had still not been rolled out at the time of our inspection. The trust had therefore made insufficient progress in the timeliness of addressing this issue.
- There was a lack of awareness of a process in pharmacy for the return of TTAs following a patient being discharged without their medicines.
- There were still no safeguards to ensure medicines had been delivered to patients using the trust transport service and that patients were adequately counselled on their medicines.
- The monitoring of refrigerator temperatures on wards across the trust was still not functioning effectively, increasing the risk of unsafe storage of medicines.
- There was a level of instability in the pharmacy department and a reduced resilience amongst the team. Progress had been made recruiting staff, however there was a lot of pressure and stress on staff due to capacity and workload.
- Clinical pharmacist vacancies were reducing, however gaps were still apparent with specialist pharmacists.
- There was still no medication safety officer actively in post. There was no deputy in place to cover absence for this key role.
- The dispensary and supply team particularly felt the pressures of workload because of the vacancies they were experiencing.
- The staffing establishment had not yet been reviewed, and was planned to be completed in the new year.
- A review of training and competency to carry out roles had not yet been completed.
- Pharmacy staff still required encouragement to report incidents.

However:

- The clinical pharmacy service had improved their access to clinical areas for routine pharmacy input. The service had been reinstated on 1 October 2018, reducing several risks identified in our warning notice from a previously restricted service.
- The risks associated with poor label printing had been resolved.
- The timeliness of production of chemotherapy medicines had improved.
- Maternity services had improved their storage of medicines within grab bags for home births.

Environment and equipment

- The risks associated with poor label printing had been resolved. The label printer had been replaced in pharmacy, so labels could now be easily read by staff and patients.

Pharmacy staffing

- There was a level of instability in the pharmacy department and a reduced resilience amongst the team. Progress had been made recruiting staff, however there was a lot of pressure and stress on staff due to capacity and workload. This was evident when talking with staff. We reviewed the pharmacy department risk register and there was no risk recorded for pharmacy staffing.
- Clinical pharmacist vacancies were reducing, however gaps were still apparent with specialist pharmacists. In May 2018 there were 13.32 whole time equivalent (WTE) vacancies. In August and October 2018 this had improved to 6.07 WTE vacancies, and at the time of our inspection there were 5.9 WTE vacancies. Current vacant pharmacist posts included education and training (one WTE), lead governance and patient safety (one WTE), cancer services (0.4 WTE covered by locums), neuroscience (one WTE), HIV specialist (0.5

WTE), formulary and medicines information (one WTE), admissions (one WTE) and pre-registration pharmacists (two WTE). However, some of these posts had plans, for example recruitment, to fill the vacancies so the team would be in a better position. Additionally, there was sickness or long-term absence which meant people were not actively in their post. Some staff were sharing roles to cover the gaps, for example four specialist clinical pharmacists were covering medicines information services, and one advanced specialist clinical pharmacist was also providing governance support.

- There was still no medication safety officer actively in post at the time of our inspection. There was no deputy to enable absence to be covered of this key role. This role was being covered by the interim director of pharmacy.
- The dispensary and supply team particularly felt the pressures of workload because of the vacancies they were experiencing. They had four assistant technical officer vacancies, however two were due to start in post and the remaining two posts were due to be advertised. There was one technician vacancy which was planned for interview. When talking with staff from this team they spoke about the lack of capacity in the department. Data between September 2017 and November 2018 showed an increase in the time taken to complete to take away medicines (TTAs), reflecting the capacity pressures this team were under.
- Several staff raised concerns about dispensary staff working beyond their 12-hour shift to meet the needs of patients. The backlog of work and requests for TTAs coming down to pharmacy late meant staff were consistently working past their finish time. There was a perceived expectation from the hospital for staff to stay and ensure this was completed. Some staff felt the low staffing and high workload risked human error occurring, which was unsafe. We were unable to establish if the pharmacy department was capturing data to identify the time TTAs were arriving in the department to see if this was impacting on staff working hours. However, staff were recording their extra hours and concerns with this had been escalated to the interim director of pharmacy, who was due to review the staffing establishment.
- Other services were in a better position. In production there were 1.84 WTE vacancies. The logistics team had a vacant post for their band four pharmacy logistics support manager. The procurement and IT team had one storekeeper vacancy, which was due for interview.
- The staffing establishment had not yet been reviewed, although this was planned to be completed in the new year. This was required to assess the staffing in line with the higher workload taken on over the previous years. For example, increased hours of the pharmacy service and external contracts. There had been no recent review of skill mix or benchmarking against similar sized services to ensure staffing levels were correct. This would be captured as part of the review of the staffing establishment.
- A review of training and competency to carry out roles had not yet been completed. At our previous inspection some staff felt they were asked to work above and beyond their grade. There was still some staff who felt this was happening due to covering vacant posts.
- Appraisals had been completed for pharmacy staff. Current compliance was at 80%. The appraisal process was audited in October 2018, reviewing a sample of 65 appraisals to identify the discussions and areas covered. The process was to be reviewed in line with findings.

Medicines

- There was no consistent process in use to ensure patients were discharged with their medicines to take away (TTAs). This posed a risk to patient safety. There was still no clear system or process to ensure appropriate advice was provided to those patients who left hospital without their medicines. Further, there was no clear process to follow-up those patients who did not return to collect their medicines, if that was agreed.
- Processes to monitor the number of patients discharged without their critical medicines were not robust, despite this being a known risk to the trust. On 11 May 2018, a pharmacy department risk assessment stated: “An unknown number of patients currently leave hospital without their discharge medication, with risk of adverse events, two serious untoward incidents resulting in death in the last 12 months have occurred due to discharge without TTA”. A monthly report was provided

to the safety and quality committee for identifying patients discharged without their TTAs who required them to be transported to their place of residence. Between January and November 2018 there were an average of 124 patients a month who required TTAs to be transported. However, there was no data captured for patients who returned to the hospital to collect TTAs who did not receive these, or to look at TTAs containing critical medicines.

- Processes to review TTAs left on the ward following a patient discharge had still not been rolled out at the time of our inspection. The trust had therefore made insufficient progress in the timeliness of addressing this issue. There had been a time lag in addressing these issues despite two serious incidents resulting in death.
- A lead nurse had been asked to focus on the TTA process and review practice trust-wide. It was identified there was variable practice on wards and largely the processes for managing TTAs on wards was ineffective. A two-week pilot was completed on two wards, starting on 22 September 2018. One ward held their TTAs in patient lockers and one ward held their TTAs in a central location. Clear instructions were provided to the wards on what critical medicines were and the actions ward staff should take if left on the ward, which included informing pharmacy and contacting the patient to arrange collection, or the GP if the patient was not available. This was recorded on two different forms to evidence the follow-up. Following this trial, the process in the medicines management policy had been updated to include holding TTAs centrally and completing a form. At the time of this inspection, the policy was with the medicines utilisation and assurance committee for approval. Trust-wide roll out of this process was planned for the end of the 2018/19 financial year.
- We reviewed some completed forms from the pilot. It was not clear from the forms whether the patient had collected their medicines. Although staff would be able to see if the TTA was no longer present in the cupboard the following day, there was no oversight and assurance built into the process. The lead nurse for the pilot told us they would update the form so this could be clearly recorded.
- There was a lack of awareness of a process in the pharmacy department for the return of TTAs following a patient being discharged without their medicines. Some staff were unaware of a process, while other staff told us there was one individual in pharmacy who was responsible for checking the returned TTAs for any critical medicines. However, we were told this individual did not work two days a week, and staff did not think there was contingency around this. We discussed with the supply manager who informed us there were a few individuals trained in returned drugs, although recognised this was not enough staff. We spoke with one of these trained individuals to discuss the process. There was a process, which was a safety net, and this was to review all returned medicines, contact the ward for the reasons for return, and to log this on an electronic form. This was required to be completed within three days of return, which posed a risk to patients, as they would miss doses in this time. It was the ward's responsibility to ensure the patients returned to pick up their medicines or their GP was informed if there were critical medicines. There was a returned drugs standard operating procedure, however this did not include specifically the importance of recognising TTAs which contained critical medicines, and ensuring the ward took on responsibility for confirming discharged patients received these critical medicines.
- There were still no safeguards to ensure medicines had been delivered to patients using the trust transport service and that patients were adequately counselled on their medicines. A process for the transport of TTAs after discharge was to be used in exceptional circumstances, although data showed it was currently used for approximately 120 patients a month. This was a courier service and therefore medicines were delivered to the patient with no counselling.
- The monitoring of refrigerator temperatures on wards across the trust was still not functioning effectively, increasing the risk of unsafe storage. We found wards were recording the current refrigerator temperatures daily, with some omissions in daily checks. However, they were not always recording the minimum and maximum temperatures. This was not in line with trust policy. We sampled nine wards across the trust and found six wards were not recording fully. These

included maternity delivery, Meldon, Sharp, Burrator, Marlborough and the clinical decision unit. We did identify good practice on Merrivale, Shaugh and Sharp wards, where the full recordings were complete for minimum and maximum temperatures. This identified a lack of oversight and assurance against the concern included within the warning notice. We found the refrigerator monitoring concerns were not included on the trust's action plan.

- Refrigerator temperature monitoring data was obtained, but it was evident this was not being captured correctly and did not provide assurance of minimum and maximum temperatures. As part of the matron inspection audit, there was a check whether the medicines refrigerator temperature was checked every 24 hours (electronic). This was recorded at 93.3% for the period 1 January to 11 December 2018. However, this did not identify the minimum and maximum temperature recordings were being completed.
- On our second visit to the trust, we were informed a safety alert had been sent to staff to remind them of the processes for refrigerator temperature monitoring. We were told this would be audited to confirm the correct process was being followed by all areas in the hospital.
- The clinical pharmacy service had improved their access to clinical areas for routine pharmacy input, to reconcile inpatient prescription charts and screen them for prescribing errors. During our previous inspection the service had been severely restricted. As a result, there was no routine, basic pharmacy service to most clinical or ward areas.
- At the time of this inspection, pharmacy services had been reinstated. Pharmacists had returned to inpatient wards via a phased roll out from 1 October 2018. This reduced some of the risks which were present at our previous inspection and identified within our warning notice. Furthermore, there were plans to extend the role of the pharmacist to include ward rounds and multidisciplinary team participation from February 2019, and for this to become normal practice.
- The timeliness of production of chemotherapy medicines had improved since our last inspection. Data was collected daily on the number of products, the percentage on-time and the percentage later, with reasons for being late attributed to pharmacy, prescriber, supplier or other. Data showed the percentage on-time had been improving, and between 3 September and 29 November 2018 this was at 88% for the 59 days which had data recorded. Service improvement for haematology and oncology had been a focus within the department.
- Maternity services had improved their storage of medicines within grab bags for home births. The grab bags no longer contained medicines. Medicines were now held in a box at a suitable temperature in the refrigerator, and these would be taken from the refrigerator when needed. We checked two home birth medicine kits in the refrigerator and all medicines were in date.

Incidents

- Pharmacy staff still required encouragement to report incidents. At our previous inspection we were told by pharmacy staff incidents were not being reported, and staff did not always feel supported to report incidents. During this inspection, there was still a mixed message as to whether staff were reporting incidents. For example, staff spoke about requests for to take away medicines (TTAs) coming down late, which resulted in them having to work late, however they did not incident report this. Some staff told us they did not have time to report incidents. There were incidents being reported for the pharmacy department, and for medicines trust-wide, however it was difficult to establish whether this reflected all incidents that were occurring.

Are medical care services well-led?

At our last inspection we were concerned the delivery of high quality service provision was not assured by the leadership, governance and culture. Significant improvements were required to ensure the systems and processes for safely managing medicines were effectively governed.

During this inspection we found:

- We were still not assured sufficient priority or resource had been allocated by the board to address and rectify issues in pharmacy.
- There was a lack of capacity with leadership. Adequate support had not been provided to the interim director of pharmacy to ensure a continued presence of support in the department.
- With no assistant directors of pharmacy for clinical or operational roles actively being in post, there were no clear line management reporting structures for some departmental management pharmacy staff.
- A strategy for pharmacy had not yet been developed. Multi-stakeholder work programmes were being undertaken to develop a three-year pharmacy strategy.
- The current pharmacy department staffing risks were not included on the pharmacy risk register. This was not recorded for the pharmacy leadership team or pharmacy staff.
- The gap analysis against the Royal Pharmaceutical Society's Professional Standards for hospital pharmacy did not adequately link to risk management.
- A comprehensive key performance indicator framework had still not been developed. This would be reviewed through strategy and signed off by the board in 2019.
- Culture was improving in the department, but there was still a division, with mixed feelings from pharmacy staff. There were still staff who were upset and felt morale was low.
- Improvements were needed in the level of engagement provided to pharmacy staff.
- A more robust check and challenge of the warning notice action plan, through the governance structure, was required to ensure areas of the warning notice had been fully met.

However:

- The chief operating officer recognised there was still not enough resource to allow the trust to address the full CQC warning notice and the trust action plan. Choices were being made to deliver sustainable solutions, and they were working to get resilience around clinical support in the department. The service model required review and a new workforce model would be developed.
- Contingency planning for pharmacy services was being reviewed both at trust level and within the Devon Sustainability and Transformation Partnership.
- Governance structures for pharmacy had been changed since our last inspection, although they were not yet embedded to enable us to evidence their effectiveness.
- A 'tiger team' was created for pharmacy. This was a multidisciplinary team with a focus to make improvements to the service and support the interim director of pharmacy in doing so.
- There was an increased staff awareness of the trust's freedom to speak up guardians.

Leadership

- We were still not assured sufficient priority or resource had been allocated by the board to address and rectify issues in pharmacy.
- There was a lack of capacity with leadership. We did not feel adequate support had been provided to the interim director of pharmacy to ensure a continued presence of support in the department. The interim director of pharmacy had a dual role and was also responsible for a local community-based organisation, spending 80% of their time engaged with University Hospitals Plymouth and 20% of their time for the community organisation. There were currently no assistant directors of pharmacy, clinical or operational, actively in post to support the interim director of pharmacy. During our follow up inspection, the interim director of pharmacy was also absent, leaving the service without key leaders. We spoke with representatives of the board about their plans to ensure adequate support was being provided to the interim director of pharmacy. We were told they would review their options to help provide this.
- With no assistant directors of pharmacy for clinical or operational roles actively being in post, there were no clear line management reporting structures for some departmental management pharmacy staff. Some management staff also felt they required managerial support to help them successfully manage their staff

and to be enabled to do their role. They were informed initially human resources (HR) would provide the support but did not feel there had been an HR presence in the department.

- There was a newly appointed interim general manager who was providing support with day to day operations. This individual had previously been working as a general manager in another department.
- Following our previous inspection and concerns identified by the trust, a 'tiger team' was created for pharmacy. This was a multidisciplinary team focused on making improvements to the service and supporting the interim director of pharmacy in doing so. The team included personnel with skills in nursing, improvement and process mapping, high level governance, clinical support, and workforce. However, the team had only been in existence for approximately six weeks before being disbanded. Some members continued with areas of pharmacy work, but were required to return to their trust roles.
- We spoke with the chief nurse about the board visibility and support within the pharmacy department. They said they spent some time in the department initially for some executive caring and to touch base. There was an informal connection using social media. They also met with the interim director of pharmacy on a regular basis to check they felt supported. However, this did not demonstrate ongoing visibility and support across the whole department at a time of unrest when there was limited leadership capacity.

Vision and strategy

Culture

- A strategy for pharmacy had not yet been developed. Multi-stakeholder work programmes were being undertaken to develop a three-year pharmacy strategy.
- Staff were unaware of the vision for the pharmacy department and services provided across the trust due to being in a state of unsettlement.
- Culture was improving in the department, but there was still a division, with mixed feelings from pharmacy staff. There were still staff who were upset and felt morale was low. This was impacted by the stress of a high workload with limited capacity. However, there were also many staff who spoke positively about the improvements in the service, the change in culture and team morale.
- There was an increased staff awareness of the trust's freedom to speak up guardians. We spoke with freedom to speak up guardians who told us about their increased profile, particularly to promote pharmacy staff coming forward to speak to them if required. This was kept on their radar and executives were aware of concerns which were raised through freedom to speak up guardians, while maintaining anonymity. Since our previous inspection the freedom to speak up guardians had heard less concerns. The concerns raised tended to be historic, and those who remained in contact were more positive in their engagement.
- The pharmacy department had held development days, including leadership (76% attendance) and team (93% attendance) development days as part of the cultural change programme.
- The NHS staff survey was planned to be used to measure improvement and identify areas for further work. It had recently been completed, therefore results were not available at the time of our inspection.
- A pulse survey was completed to gain feedback on staff views and experiences. However, there was only a 31% response rate. This survey would be repeated in three months, to provide a comparator and to review progress.
- Some management staff felt disempowered in leadership, they felt those they managed would bypass them as managers and go directly to the interim director of pharmacy. There were mixed opinions across pharmacy staff about leadership styles and this linked with the culture within the department.
- Some staff shared sincere concerns about the pressures their colleagues were under and how this was impacting on their well-being. Several staff raised how they had been close to, or were close to having

time off work due to stress. Some of these staff had seen the positive change in the department which had prevented them from taking time off work, while others were still struggling.

Governance

- Governance structures for pharmacy had been changed since our last inspection, although they were not yet embedded to enable us to evidence their effectiveness. A new governance reporting structure for pharmacy included the medicines utilisation and assurance committee (MUAC). This committee reported to the safety and quality committee, and the pharmacy board reported to the trust management executive. Both the safety and quality committee and trust management executive reported to the trust board.
- The new pharmacy board had executive presence. It was chaired by the chief nurse, although they had only attended one out of three meetings. We were told dashboards and appraisals would be a standard item on the agenda. Terms of reference had been drafted and the pharmacy board planned to meet monthly.
- The main programme of work for the pharmacy board, as stated in the first meeting minutes held 24 September 2018, was to oversee and ensure implementation of the CQC action plan. The second meeting held on 22 October 2018 was not quorate, but it did discuss elements of the warning notice and current progress. A third meeting had been held in November 2018 and we reviewed the draft meeting minutes. Although this meeting was quorate, there were several absences.
- Talking to department managers in pharmacy, they did not feel they had a clear route or voice for governance. They were aware of the pharmacy board but had not had any involvement or feedback about the areas discussed. However, this board was in an initial phase of being developed.
- A more robust check and challenge of the warning notice action plan, through the governance structure, was required to ensure areas of the warning notice had been fully met. This was the responsibility of the safety and quality committee, to "confirm all pharmacy related recommendations from the CQC have been fully implemented", as stated in the trust board assurance framework. The meeting minutes of the safety and quality committee on 15 October 2018 stated ""invited questions on the action plan. There were none. The chair (committee chair) stated that the plan appeared to be complex and comprehensive." However, there were no embedded documents within the action plan for appropriate check of evidence, and areas of the warning notice had not been included within the action plan. In addition to oversight by the safety and quality committee, progress was also presented to the trust management executive and trust board.

Management of risk, issues and performance

- We saw limited evidence of risks being identified and discussed within the new governance structures, to enable the updating of risks on the risk register. The trust's CQC action plan stated: "Risk will be discussed at Medicines Utilisation and Assurance Committee, Safety and Quality Committee, Pharmacy Board and Trust Board." The new governance arrangements were in their infancy and therefore the identification and management of risk needed to be embedded.
- The current pharmacy department staffing risks were not included on the pharmacy risk register. This was not recorded for the pharmacy leadership team or pharmacy staff. Risk item 5852 identified the "potential risk of harm to inpatients due to a reduced clinical pharmacy service", however the last record of action was 5/10/18 where it stated, "reintroduction of ward based pharmacy service". There was no recognition on the risk register about the current gaps in staffing and within the leadership, and the workload and capacity challenges staff were facing. However, the pharmacy board minutes for 24 September 2018 stated a current risk: "the number of temporary senior staff in pharmacy". We reviewed the board assurance framework and under safe staffing it was identified there were staffing risks in some areas, including pharmacists. However, this did not include other areas of pharmacy.
- The gap analysis against the Royal Pharmaceutical Society's Professional Standards (RPS) for hospital pharmacy did not adequately link to risk management. We reviewed the copy last updated 8 October 2018. We were unable to evidence this was working effectively to identify pharmacy risks. For

example, the status for standard six (leadership) and standard eight (workforce) had areas of red, yet there were no risks associated. Despite this, the trust action plan for the warning notice stated: "risk identification and mitigation is now supported by the RPS Standards – informing and management of the Risk Register."

- Risk register item 5844 was with regards to "patient harm through missed doses/no counselling when discharged without TTAs". This was added to the risk register on 15 February 2017 but had not been updated since our last inspection.
- A comprehensive key performance indicator framework had still not been developed. We were told by the interim director of pharmacy this would be reviewed through strategy and signed off by the board in 2019.

Engagement

- Improvements were needed in the level of engagement provided to pharmacy staff. At our previous inspection we were told communication was an issue and pharmacy staff told us there was a "complete disconnect" between pharmacy and the board, and from the operational teams. During this inspection we were told there was limited staff engagement, or clear messages. This led to staff uncertainty about the future and speculation. There were some ongoing processes which could not be openly communicated to staff, but there was a possible disconnect between what was happening and what was being communicated.
- We saw evidence of some improved communication between pharmacy and wards. When the pharmacy service was reinstated communication was sent to trust-wide staff. An update was added on the staff intranet and emails sent explaining the phases of the roll out. We saw evidence of this communication.

Learning, continuous improvement and innovation

- The chief operating officer recognised there was still not enough resource to allow the trust to address the full CQC warning notice and the trust action plan. Choices were being made to deliver sustainable solutions, and they were working to get resilience around clinical support in the department. The service model required review and a new workforce model would be developed.
- Contingency planning for pharmacy services was being reviewed both at trust level and within the Devon Sustainability and Transformation Partnership, to also support other organisations at times of crisis in the workforce.

Outpatients and diagnostic imaging

Responsive	
Well-led	
Overall	

Information about the service

As part of this inspection we inspected diagnostic imaging services.

The trust provides a wide range of diagnostic imaging services, called a modality, including non-obstetric and obstetric ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, breast imaging, interventional radiology and plain film X-ray.

There are five CT scanners in the trust, four MRI scanners and an additional mobile scanner is available if required. There is a plain film X-ray service for both inpatients and outpatients. This includes those attending the trust's emergency department. Mobile X-ray machines are used on wards, in theatres and in some other departments. There is also an ultrasound department with access to portable ultrasound units in outpatients, wards and theatres. CT, MRI and plain film X-ray offers a 24-hours, seven days a week, imaging service for emergency admissions and those with life and limb threatening injuries or conditions.

Diagnostic imaging services are provided at University Hospitals Plymouth NHS Trust from several locations. We only inspected Derriford Hospital. However, the trust offers a peripheral plain film X-ray and ultrasound services from other departments within the region:

- The Cumberland Centre
- Launceston General Hospital
- Liskeard Community Hospital
- South Hams Hospital
- Tavistock Hospital

During this inspection we spoke with 46 staff. We also reviewed documentation to corroborate our findings, and the trust's warning notice action plan.

Summary of findings

This was a follow-up inspection where we focussed solely on the concerns identified in the warning notice for diagnostic imaging, to assess whether the trust had made sufficient progress in response to the warning notice issued under Section 29A of the Health and Social Care Act 2008. Therefore, we did not rate this service.

We identified insufficient progress had been made in addressing the concerns in the warning notice for diagnostic imaging.

During this inspection we found:

- The diagnostic imaging service was still not meeting the seven-day internal target for the imaging of patients suspected of having cancer.
- In MRI, there were still a number scans breaching the two-day internal reporting cancer target.
- Some modality leaders still did not have the capacity to lead effectively.
- We found limited improvement, and some areas of deterioration, with progress on the cultural concerns within the diagnostic imaging department.
- Staff consistently described to inspectors a culture from some modality leaders of poor attitudes and behaviours which bullied, belittled and humiliated junior staff. Radiographers felt unable to raise this with their managers or with their freedom to speak up guardians.
- Some consultants said the workload had not reduced and most reported working harder than at the time of the last inspection.

However:

- There was improving performance for patients waiting longer than six weeks for a routine scan.

Outpatients and diagnostic imaging

- There were plans to improve process and efficiency with booking appointments.
- There was improved management of governance within the imaging department.
- There had been an internal review of risks on the risk registers and actions were progressing well.
- Improvements had been made in the management structure for senior staff in the imaging department.
- The department was now consulted when new appointments and service developments were made throughout the trust.
- In CT the most urgent scans were reported on in a timely way.

Are outpatient and diagnostic imaging services responsive?

At our last inspection we found the diagnostic imaging service was not meeting some national or internal targets. These included the seven-day internal targets for the imaging of patients suspected of having cancer in CT, MRI or ultrasound, the 10-day target for the imaging of patients suspected of having cancer requiring a CT colonoscopy, and the two-day internal target for reporting of images for patients suspected of having cancer. The diagnostic imaging service was also not meeting the six-week diagnostic test national standard.

During this inspection we found:

- The diagnostic imaging service was still not meeting the seven-day internal target for the imaging of patients suspected of having cancer including those requiring CT, MRI or ultrasound.
- In MRI there were still a number scans breaching the two-day internal reporting cancer target.

However:

- There was improving performance for patients waiting longer than six weeks for a routine scan.
- There were further plans to improve process and efficiency with booking appointments, including the introduction of additional booking and coordination staff.
- In CT the most urgent scans were reported on in a timely way.

Access and flow

- Although there had been improvement, the diagnostic imaging service was still not meeting the seven-day internal target for the imaging of patients suspected of having cancer in CT, MRI or ultrasound.
- The trust had set an internal target of 85% of patients to be seen within these timeframes. However, modalities continued not to meet this target. This increased the risk of delayed diagnosis and treatment and compromised patient safety. No month since the last inspection met the 85% target:

Outpatients and diagnostic imaging

- The trust's warning notice action plan identified in November 2018 only 55% of ultrasound patients were scanned within seven days. Although this was a 34% increase since the last inspection, it was still significantly lower than the trust target.

- The trust's warning notice action plan identified in November 2018 only 55% of CT patients were scanned within seven days. Although this was a 33% increase since the last inspection, it was still significantly lower than the trust target.

- The trust's warning notice action plan identified in November 2018 only 62% of MRI patients were scanned within seven days. Although this was a 13% increase since the last inspection, it was still significantly lower than the trust target.

- There was improving performance for routine scans being completed within six weeks. All modalities were meeting their improvement trajectory which was set by NHS Improvement. In October 2018, 250 MRI patients were waiting longer than six weeks compared to a planned trajectory of 600 patients. In CT, 50 patients were waiting longer than six weeks compared to a planned trajectory of 100 patients. In non-obstetric ultrasound, 20 patients were waiting less than six weeks compared to a trajectory of 550 patients.
- The department had significantly improved capacity within the service. In CT, a new scanner had been made operational and a second had been upgraded to improve capacity. Further capacity had been gained through using a mobile van to reduce backlogs.
- In ultrasound, a new room was added with new equipment to increase sonographer capacity. Although this had been filled with locum staff, others were returning from maternity leave who would fill this room.
- In MRI, additional capacity was gained through outsourcing to external companies. Also, a capital investment project had been signed off to upgrade the existing scanner. This would improve capacity in the department.
- Compliance with the two-day internal reporting target had improved but still required further improvement. Because of the increased capacity to improve the seven-day internal cancer imaging target and the six-week routine target, the number of scans requiring reporting also increased. This had increased the workload of staff in position.
- In CT, the most urgent scans were reported on in a timely way. However, due to the increase in capacity, the size of the backlog had not significantly reduced (266 scans in July 2018 and 250 in November 2018). The number of breaches in the two-day target had significantly reduced from 769 in July 2018 to six in November 2018.
- However, in MRI there were still a number scans breaching the two-day internal reporting cancer target. Due to the increase in capacity, the size of the backlog had not reduced, and instead had slightly increased (328 in July 2018 and 331 in November 2018). There were still 240 breaches in reporting in November 2018.
- The medical director and radiologists had agreed to 'in-source' scans based on a fee per scan payment. This was working well for the radiology workforce and had increased imaging capacity. Additional reporting capacity had also been gained through outsourcing and radiologists reporting at home.
- Prior to the inspection the trust had increased the appointment booking team by three staff to have oversight of bookings. There were further plans to improve process and efficiency with booking appointments. Financial approval had been gained for a further three booking clerks, with a focus on booking scanning appointments. Funding had also been agreed for an urgent scan booking coordinator. There were improved processes to escalate where a patient booking may be difficult or breach through an escalation email address. These emails were picked up by the senior managers to mitigate risks and make decisions, to ensure patients were scanned in an appropriate time.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

At our last inspection we were concerned leaders did not have the necessary capacity to lead effectively. There were consistent low levels of staff satisfaction and high levels of work overload. Staff did not feel valued, supported, or appreciated by the rest of the trust.

During this inspection we found:

- Some modality leaders still did not have the capacity to lead effectively. The department recognised this was not going to be resolved quickly due to substantial staffing shortfalls.
- We found limited improvement, and some areas of deterioration, with progress on the cultural concerns within the diagnostic imaging department.
- Staff consistently described a culture from some modality leaders of poor attitudes and behaviours which bullied, belittled and humiliated junior staff.
- Radiographers felt unable to raise this with their managers or with their freedom to speak up guardians.
- Some consultants said the workload had not reduced and most were working harder than they did during the last inspection.

However:

- There was improved management of governance within the imaging department.
- There had been an internal review of risks on the risk registers and actions were progressing well in relation to a never event and patient satisfaction action plans.
- Improvements had been made in the management structure for senior staff in the imaging department to improve their capacity to lead.
- The department was consulted when new appointments and service developments were made throughout the trust.

Leadership

- The department had worked to implement initiatives to engage staff. However, these had not been effective. Band five radiographers felt unable to raise these concerns with their managers or with the trust's freedom to speak up guardians. Staff described examples where staff had raised concerns about these band seven radiographers before and felt they had been "named and shamed" and "thrown under the bus" by the radiographers in question. Several members of staff said they wished they could raise their concerns but did not want to see what had happened to others happen to them. Some staff said they felt undervalued, humiliated and demoralised about coming to work. Following the inspection, we had multiple whistle-blowers contact CQC with further examples.
- Improvements had been made in the management structure for senior staff in the imaging department to improve their capacity to lead. The department had appointed a project manager to oversee progress with the CQC warning notice. This individual was subsequently appointed as the substantive care group manager for clinical support services. There had also been additional recruitment to the imaging management team. Managers said this had "given the team the headspace to focus on the capacity issues".
- Some modality leaders still did not have the capacity to lead effectively. However, the department recognised this was not going to be resolved quickly due to substantial staffing shortfalls. Due to staffing shortages, modality leaders were still regularly being pulled from non-clinical work to perform operational duties and were included as part of the on-call rota. Modality leaders were still sometimes away from the department several days a week, which limited the support for junior members of staff. Managers told us improvements would not be seen until new staff were in position and following alterations of duties for some staff. The department had recently recruited 18 radiographers who were newly-qualified. However, they would not be in position until August 2019. The delay in the staff starting was because they were graduate radiographers who would not be able to work until August 2019.
- Work was ongoing to build capacity into the modality leads' non-clinical time, although this had been limited. Questionnaires had been sent to all modality leaders within the department requesting a self-assessment of the time they had to deliver non-clinical tasks and what time they needed to do this. Time had also been spent

in other hospitals to discuss their approach to non-clinical time. Additionally, a business case was going through the trusts business planning process identifying short, medium and long term actions.

- There was more time for the modality lead weekly meeting. During our previous inspection, we found these were not given sufficient priority and they were not minuted. During this inspection we found they were minuted and there was senior management attendance. Senior managers in the department felt these improvements meant "for the first time we are all in the room together, feeling part of the group".
- Band five radiographers consistently felt some modality leadership was poor. Some radiographers said they argued amongst themselves and were not managed appropriately by more senior staff. One radiographer said "interprofessional working was a massive part of my training, however the people in these roles don't champion this". Some radiographers said some modality leads "gatekeep tasks" to control the unit.

Culture

- We found limited improvement, and some areas of deterioration, with progress on the cultural concerns within the diagnostic imaging department. At our last inspection, we highlighted staff concerns around workload and job satisfaction. During this inspection, we found this had deteriorated.
- Although this may have been due to promotion with the service, some staff described the situation as "getting worse for plain film as staff are getting pulled into modalities". Another staff member in plain film said, "staff don't get recognised for the hard work they do". Some radiographers felt where there was poor management the "band five staff had to fill the cracks" to ensure patients were scanned efficiently. Another said, "the workload has not got any less".
- A medical workforce stress survey had been introduced to identify the stress levels of the department. This planned to identify areas where radiologists were struggling to manage workload and plans to address this. However, this had only started the month prior to the inspection.
- Some consultants we spoke with said the workload had not got any less and most were working harder than they did during the last inspection. One said, "there is no give in the system" and another said they were "all 100% stretched, all day, every day". Some described how they were considering retiring early or leaving the trust because of the pressures of work.
- Staff consistently described a culture from some modality leads of poor attitudes and behaviours which bullied, belittled and humiliated junior staff. Staff felt that some of the band seven staff working in the department displayed attitudes and behaviours which were not appropriate. We were given multiple examples which included airing private conversations with peers, embarrassing staff in public and name calling. We were also given examples of senior staff humiliating radiographers to get them to use unsafe equipment. We were given examples where staff felt intimidated to accept additional shifts and some examples of childish behaviour from senior staff when they had to take additional shifts. One radiographer said, "it's not fair when you're told you can't take your annual leave".
- We were given an example of a senior radiographer mocking a patient behind their back, which upset the radiography staff present. They said this was inappropriate behaviour but did not escalate it due to fear of repercussion.
- We immediately escalated feedback given by radiographers to the department's senior manager and the trust's chief executive during feedback at the end of the inspection. Following the inspection, we spoke with the freedom to speak up guardian and the department manager who described further conversations and focus groups they had held with staff to begin to address the concerns raised.
- Band five radiographers felt learning from incidents was not shared with them and one said, "there is no sharing of incidents, they are a way to blame people, not as an opportunity for learning"
- The department was now consulted when new appointments and service developments were made throughout the trust. Senior managers said they now felt part of the trust and were given sufficient resources to achieve what they needed to. Managers described how imaging was now considered with developments to the trust. An example was given with the development of plans for a new fracture clinic.

Outpatients and diagnostic imaging

Governance

- Senior leaders in the diagnostic imaging department had better capacity to lead and this was reflected in improved management of governance.
- During our last inspection, we found actions from key action plans were not completed in a timely way and there were risks on risk registers which had not been updated or actioned for some years. During this inspection, we found there was a re-focus of the oversight of risks and actions were mostly being completed in a timely way.

Management of risk, issues and performance

- There had been an internal review of risks on the risk registers. In August 2018, an exercise for risk owners to review and update their risks was completed. All moderate and serious risks underwent scrutiny from care group managers to ensure they were correct. Throughout the past three months there had been work to ensure risk registers were maintained and updated appropriately. Although some actions were still overdue, there was better oversight and management of those risks to ensure they progressed. These included actions which were out of their control and required further trust wide progress.
- Actions were progressing regarding the never event action plan. At our last inspection we found many actions were overdue. During this inspection, we found the never event action plan had been reviewed and updated. Actions which were overdue during the last inspection, such as a review of the World Health Organisation safer surgery checklist, had now been completed. As a further level of assurance, any failed checklists were reviewed by the department's governance manager who asked for a report and feedback regarding non-compliance. Quality compliance audit results for October 2018 were 100% for general anaesthetic cases (22 checklists, all of which were compliant) and 100% for non-general anaesthetic cases (104 checklists, all of which were compliant).
- Actions were progressing with regards to a patient experience improvement action plan which was created following a patient survey conducted in 2017. During the last inspection we found many actions which were overdue. During this inspection we found the patient improvement plan had been reviewed by the department's project director and service line manager in September 2018. The action plan was reviewed, some completion dates were revised, and others updated to ensure they were achievable. The action plan was circulated to the modality leads in September 2018, but feedback was limited.
- Actions relating to the radiation protection action plan were progressing, although the department recognised there was still some improvement required. At our last inspection, we found many actions which were overdue. During this inspection we found the radiation protection plan had been reviewed by the governance manager and the radiation physics team to ensure risks which were no longer relevant or duplicated were removed. A revised action plan was provided to the department's project director and actions were planned to be reviewed further in upcoming radiation safety committees.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Pharmacy and Medicines

- Ensure there is a clear process rolled out trust wide, within wards, pharmacy and transport, to safeguard patients receiving their critical medicines if discharged. Ensuring patients are being appropriately counselled on their medicines.
- Ensure the trust have assurance and can evidence processes, through review of data, that patients being discharged without their critical medicines receive them in a timely manner.
- Review staffing establishment and skill mix for the pharmacy department to ensure staffing meets capacity and demand.
- Review training and competency of staff, and ensure staff are not working above their role and competencies.
- Ensure capacity for leadership and ongoing support available in the pharmacy department.
- Ensure risks are identified, recorded and mitigated, with a clear record for this.
- Ensure there is robust oversight of governance for pharmacy and medicines trust-wide.

Diagnostic Imaging

- Ensure that 85% of patients suspected of having cancer are scanned within seven days as per the trust target.
- Ensure the management team addresses poor leadership and manages attitudes and behaviours shown by some of the team.
- Ensure staff satisfaction improves, and that staff are confident to raise concerns with managers.

Action the hospital SHOULD take to improve

Pharmacy and Medicines

- Encourage pharmacy staff to consistently report incidents.
- Confirm all areas within the hospital with refrigerators are recording the minimum and maximum temperatures, along with current temperature, daily.
- Adapt the ward TTA trust pilot form to ensure a clear auditable trail of TTAs being collected by patients.
- Explore ways to engage with the pharmacy department to keep staff well informed at a time of unsettlement.
- Continue to focus on the culture within the pharmacy department.
- Develop the strategy for pharmacy so there is clear direction for the service, and ensure this is supported by a contingency plan.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users; There was not a clear process rolled out trust-wide, within wards, pharmacy and transport, to safeguard patients receiving their critical medicines if discharged, and to make sure patients were being appropriately counselled on their medicines.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) Systems and processes must be established and operated effectively to ensure compliance with the requirements in this Part; The trust did not have assurance and could not evidence processes, through review of data, that patients being discharged without their critical medicines received them in a timely manner. There was a lack of capacity for leadership and ongoing support available in the pharmacy department to positively impact governance. Risks for pharmacy and medicines were not always clearly identified, recorded and mitigated. The trust did not have robust oversight of governance for pharmacy and medicines trust-wide.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

The pharmacy staffing establishment and skill mix had not been reviewed to ensure staffing met capacity and demand in pharmacy services.

Training and competency of pharmacy services staff had not been reviewed to ensure staff were working in accordance with their roles and competencies.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
To ensure patients suspected of having cancer have timely access to initial assessment, test results and diagnosis in diagnostic imaging.	The diagnostic imaging service was not meeting the seven-day internal target for the imaging of patients suspected of having cancer in CT, MRI or ultrasound. This increased the risk of delayed diagnosis and treatment, and compromised patient safety. Radiographers consistently told inspectors that some managers within diagnostic imaging were not addressing poor behaviours or attitudes displayed by some modality leaders. This affected the culture in the department, which risked impacting on patient care and safety. Band five radiographers consistently felt unable to speak with departmental managers or freedom to speak up guardians to escalate their concerns due to fear of repercussion.