Cambridge University Hospitals NHS Foundation Trust

Addenbrooke's and the Rosie Hospitals

Quality Report

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Unannounced inspection 23rd February.
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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
Surgery	**Requires improvement**
Maternity and gynaecology	**Requires improvement**
Outpatients and diagnostic imaging	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focussed follow up inspection on 9th and 10th February with an unannounced inspection on 23rd February. This inspection was to follow up specific concerns in surgery, maternity and gynaecology and outpatient and diagnostic services that were identified at our inspection in April 2015.

Cambridge University Hospitals NHS Foundation Trust is one of the largest in the UK with around 1100 beds. The trust provides a major trauma centre for the east of England and specialist services in immunology, foetal medicine, IVF, neurosurgery, ophthalmology, genetics and metabolic diseases, specialised paediatric, cancer and transplant services.

The trust also provides district general hospital services to patients predominantly coming from Cambridgeshire, Essex, Suffolk and Hertfordshire. The demographics vary during the year due to the large student population of approximately 24,488.

The clinical departments are clustered together into five divisions:

Division A: Musculoskeletal; Digestive Diseases and ICU/ Periops

Division B: Cancer; Laboratory services; Imaging and Clinical support

Division C: Acute Medicine; Inflammation/Infection; Transplant

Division D: Neuroscience; ENT/ Head and neck/ Plastics; Cardiovascular-Metabolic

Division E: Medical Paediatrics; Paediatric Critical Care and Paediatric Surgery; Obstetrics and Gynaecology

During this inspection we inspected all key questions in maternity and gynaecology, outpatients and diagnostic imaging and the responsive question only in surgery. We found improvement in each area we inspected compared to our previous inspection in April 2015 with a particular focus on leadership and safety. The organisation had been through a significant change in senior leadership which had resulted in a number of governance changes within the organisation. However, the trust was continuing the implementation of an improvement plan in response to concerns found at our previous inspections.

Our key findings were as follows:

- Nitrous oxide scavenging systems had been installed and monitoring had shown them to be effective at reducing environmental nitrous oxide. Other equipment within the unit was all serviced and had been appropriately maintained.
- There had been a review of midwifery staffing which had led to an increase of nine midwifes and six health care support workers in the unit.
- Governance in maternity had improved with clear view of the unit's risks and key performance data now being collected. However, there was no long term plan in maternity to manage capacity and demands on services.
- Neonatal early warning scores were still not being consistently completed or recorded.
- The outpatients department had risk assessed and reviewed all patients records with an outstanding appointment to ensure patients were seen in a timely way based on relative clinical risk. However, there continued to be a backlog of appointments within outpatients.
- There was a general improvement in referral to treatment times (RTT) and against other waiting time standards. However the trust was still failing to meet agreed RTT, some diagnostic test waiting times and was just below the national standard on one measure of cancer waiting times.

Summary of findings

- New leadership within the outpatients department had a clear view of the risks within the department and a strategy for addressing these. A new governance and management structure gave full oversight of the trusts improvement plan.
- There was on-going cancelled surgery though the number was on a downward trajectory and represented improved performance since our last inspection in April 2015.

Importantly, the trust must:

- Ensure that staff in maternity are compliant with mandatory training including safeguarding
- Ensure that neonatal early warning observations are completed, recorded and responded to according to protocol and clinical need.
- Ensure that all staff receive feedback on incidents in their area or relevant to them in their work.
- Ensure all staff are aware of their responsibilities under Duty of Candour.

In addition the trust should:

- Review the provision of information technology for the community midwifery teams.
- Review the provision of consultant hours on the delivery suite in relation to national guidance.
- Ensure that data in relation to delayed induction of labour is collected and acted on.

This inspection was to gain assurance that Cambridge University Hospitals NHS Foundation Trust had taken action to address our most serious concerns identified at our inspection of April 2015 and was not to determine if the trust should be removed from special measures. A full follow up inspection has been announced for September 2016.

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?
Surgery	Requires improvement	Responsiveness in surgery required improvement because performance remained below the nationally average for referral to treatment times (RTT). Whilst the trust had improved within the incomplete referral pathway the admitted pathway was below the England average of 78% at 57%. Bed occupancy rates were higher than the target ranges set by the trust. However, the trust had implemented a number of actions as part of its improvement plans to address issues in relation to cancelled operations, waiting times, and theatre utilisation. The trust team were working collaboratively across specialities and teams to reduce bed occupancy on a daily basis and had implemented a pilot home for assessment scheme including fast tracks for discharge. We saw the hospitals electronic records system was widely used by staff. Staff told us the new system was extremely beneficial in the day-to-day work enabling staff to access live patient data to guide theatre use, discharge to wards and equipment allocation.
Maternity and gynaecology	Requires improvement	Maternity and Gynaecology services were rated as requires improvement because staff were not completing or calculating neonatal early warning observation scores on babies which we identified at our previous inspection in 2015. Records showed that observations were not routinely carried out on babies with high risk factors such as high temperatures or increased respirations. Mandatory training, including safeguarding training, was not in line with the trusts target of 90% for medical staffing but was for nursing and midwifery staff. We found particular poor compliance in medical staffing. A lack of mobile connectivity in the community meant that community midwives could not access electronic records, nor upload data at the point of contact. Handheld notes remained available, while other data is entered onto Epic later. Consultant obstetric cover in the delivery

Summary of findings

suite was 60 hours which did not meet the standard as outlined by The Royal College of Obstetrics and Gynaecology (RCOG) guidance which would equate to 98 hours for a unit of this size.
However since our last inspection. The trust had completed installation of scavenging systems in the birthing unit and delivery suite. Midwifery staffing across the unit had been reviewed with the recruitment of nine whole time equivalent (WTE) midwives and six health care support workers. Key performance data was now being collected, analysed and on-going work with the computer system (Epic) was continuing to improve data collection and enable timely and accurate audit. The maternity service and the Maternity Services Liaison Committee (MSLC) worked well together to improve care to women. This provided an opportunity for midwives to meet with a set agenda and to discuss new guidelines and practices relating to care delivery. There was no forward plan to manage the ongoing capacity issues within the unit.

Outpatients and diagnostic imaging

Requires improvement

We rated outpatients and diagnostic imaging as requires improvement overall. At our inspection in 2015 we found that the trust had significant numbers of patients awaiting appointments who had not been clinically assessed or received treatment in line with their clinical need. At this inspection in 2016 we found that the trust had taken action to ensure that patients awaiting appointments were being risk assessed to determine the correct time for them to be reviewed in clinic. However, some backlogs of appointments remained in some specialties. The trust had risk assessed all patients awaiting an appointment. Not all staff received feedback about incidents that happened in their area and whilst progress had been made with equipment, not all had been maintained in line with trust plans. Staff received appraisals and there was effective multidisciplinary working within the department. Since our last inspection there had been an improvement in patient records and notes being available through Epic.

Summary of findings

Staff were caring and patients and carers spoke positively about the care and compassion shown by all clinic staff. However, friends and family test data showed only 72% of patients would recommend the service on a poor response rate.
The trust was failing to meet referral to treatment time in10 of the 18 specialties. However, this was an improving performance since our last inspection. The number of clinics cancelled had increased in the six months to December 2015 and there were waits of longer than six week for some diagnostic tests. However, there had been improvement with appointment slot issue's (ASI's) and did not attend (DNA) rates since our inspecting in April 2015.
Since our last inspection there had been a change in the governance and management structure with the addition of new, dynamic leadership in the department. However, this still required embedding into daily practice. There was clear monitoring of performance indicators and understanding of the main risks in the department including the backlog of appointments and referral to treatment times. A comprehensive improvement plan was in place and being effectively monitored. Staff morale was noticeably improved and there were new initiatives to gain patient feedback.

Addenbrooke's and the Rosie Hospitals

Detailed findings

Services we looked at
Surgery; Maternity and gynaecology; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Addenbrooke's and the Rosie Hospitals

Sites and locations

Cambridge University Hospitals (CUH) comprises 12 locations registered with CQC. Addenbrooke's Hospital and the Rosie Hospital (Women's Hospital) in Cambridge provide healthcare and specialist services such as transplantation, treatment of rare cancers and neurological intensive care**.** The trust became a NHS Foundation trust in December 2004. The trust has around 1096 beds covering a wide range of specialties.

Population served:

Patients predominantly come from Cambridgeshire, Essex, Suffolk and Hertfordshire.

The demographics vary due to the large student population of approximately 24,488. The 2011 census has the usual population of Cambridge at 123,900 people in the non-metropolitan area. The town is the 167th most populated in the UK. Within the urban area, the estimated population is 130,000; the county area of Cambridgeshire has an estimated population of 752,900 people.

Deprivation:

The Indices of Multiple Deprivation indicates that Cambridge District is the 130th least deprived borough

out of the 326 boroughs in the UK. (1st being the most deprived.) Deprivation is lower than average, however about 15.7% (2,600) children live in poverty. Hip fractures in people aged over 65 years as well as hospital stays due to self-harm, drug misuse, and sexually transmitted infections are above the England average for Cambridge.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

The team included seven CQC inspectors, one assistant inspector, a consultant gynaecologist and three senior nurses.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Detailed findings

• Is it well-led?

The inspection took place on 9th and 10th February 2016 with an unannounced inspection on 23rd February 2016. Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England and the local Healthwatch.

We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists.

We talked with patients and staff from all 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 Addenbrooke's and the Rosie Hospitals

Key figures

• **Beds**: 1090

– 1014 General and acute

– 74 Maternity

• **Staff**: 7775

– 1137 Medical

– 2695 Nursing

– 3942 Other

• **Revenue**: £707,688,000

• **Full Cost:** £724,577,000

• **Surplus (deficit)**: (£16,889,000)

Activity type

Outpatient (total attendances; July 2014 to June 2015) 794, 405

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Surgery

Responsive	Requires improvement
Overall	Requires improvement

Information about the service

Adult surgery services at Addenbrooke's hospital are provided across 13 surgical wards, including day surgery units. Provision includes general surgery, trauma and orthopaedics, ear, nose and throat (ENT), urology, ophthalmology, oral surgery, plastic surgery, and neurosurgery.

There are 35 operating theatres, including the main theatres and ophthalmology. The trust had recently commissioned two new operating theatres as part of their strategic plan in order to increase patient access to surgery. Plans are in place to move neurosurgery to the two recently commissioned theatres whilst maintenance work is carried out in the older neurosurgery area. There are also pre-assessment and day case surgery areas as well as an ambulatory care area. The hospital saw 34,123 patients within surgery during July 2014/June 2015, 39% were day cases, 31% were elective and 30% were for emergency surgery.

During our inspection we visited surgical areas, day surgery discharge lounge services and 5 wards. We spoke with four senior managers, 31 staff and other health care professionals who were on the hospital wards at the time of our inspection. For example, domestics, housekeepers, and reception staff. We spoke with nine patients, seven relatives, and friends of patients and looked at six patient records on the electronic patient record system.

Summary of findings

Responsiveness in surgery required improvement because performance remained below the nationally average for referral to treatment times (RTT). Whilst the trust had improved within the incomplete referral pathway the admitted pathway was below the England average of 78% at 57%. Bed occupancy rates were higher than the target ranges set by the trust.

However, the trust had implemented a number of actions as part of its improvement plans to address issues in relation to cancelled operations, waiting times, and theatre utilisation. The trust team were working collaboratively across specialities and teams to reduce bed occupancy on a daily basis and had implemented a pilot home for assessment scheme including fast tracks for discharge. We saw the hospitals electronic records system was widely used by staff. Staff told us the new system was extremely beneficial in the day-to-day work enabling staff to access live patient data to guide theatre use, discharge to wards and equipment allocation.

Surgery

Are surgery services responsive?

Requires improvement

Responsiveness in surgery required improvement because:

- Performance remains below the national average for referral to treatment times (RTT) for both incomplete and admitted pathways.
- Whilst the numbers of cancelled operations are reducing this is still in excess of the trusts target of less than 1% at 1.34%.
- Bed occupancy rates were higher than the target ranges set by the trust. For example, we saw bed occupancy in urology was at 100% during inspection. Therefore the trust continues to struggle to admit and treat patients due to high bed occupancy rates.

However, we also found:

- The trust had implemented a number of actions as part of its improvement plans to address issues in relation to cancelled operations, waiting times, and theatre utilisation.
- The trust team were working collaboratively across specialities and teams to reduce bed occupancy on a daily basis and had implemented a pilot home for assessment scheme including fast tracks for discharge.
- We saw the hospitals electronic records system was widely used by staff. Staff told us the new system was extremely beneficial in the day-to-day work enabling staff to access live patient data to guide theatre use, discharge to wards and equipment allocation.
- The trust had implemented changes in practice to ensure adults and children were no longer shared the same recovery areas or bays to promote their privacy and dignity.

Service planning and delivery to meet the needs of local people

- The day surgery unit had made improvements to its discharge process and environment in order to meet the needs of the patients. We saw that the number of patients being discharged daily had increased since 1 December 2015 and was over 50 per day until 9 February 2016. The day surgery discharge lounge had been modernised with new furniture, a large screen TV and art work to try to reduce patient anxiety and improve their comfort. Staff utilised a hand held electronic tablet to gather patient feedback. A comments book for patients and relatives to record their feedback on the service was also available.
- Changes had been made within surgical areas to ensure that children and adults were no longer cared for in the same recovery area. We saw staff used screens and partitions to promote patient dignity and privacy at all times.
- Patient referral to treatment times (RTT) target of within 18 weeks (incomplete pathways) had improved since the trust was last inspected in 2015. However the trust whilst remaining below the 90% England standard. RTT had improved from 84% in March 2015 to around 88-89% in the six months prior to our inspection. This reflected the actions taken by the trust as part of their improvement plan. For completed pathways, this is where patients received their treatment, 57% of patients had received treatment within 18 weeks. This was lower than the England average of 78%.
- Patients are pre-assessed for treatment before attending for ophthalmic surgery. However, one consultant requested patients attended for their treatment at 07:30am on Fridays, this was their usual day in theatre. It is unnecessary for patients to arrive this early because they have already had their pre-assessment completed.

Access and flow

- We found during the first part of 2014/ 2015 that cancelled surgery was endemic within surgery with nearly 1.76% of all operations cancelled. However, since this high the trend shows a downward trajectory and a reduction in the number of patients having their surgery cancelled and the percentage over the year is now 1.36%. In January 2015 the trust declared a significant internal incident as capacity was significantly reduced. This meant that figures for cancelled operations in January rose to 78. However, the trust had made significant headway towards reducing the number of operations cancelled due to their Improvement Plan activities.
- Staff we spoke with were engaged with the trust improvement plan and had a grasp of the issues that were being faced and were working collaboratively to achieve performance targets. Cancelled operations on

or after the day of admission were increased at 1.24% in January, with 78 cancellations. The highest reason for cancellation in January was due to no operating time available with 34 cases (43%). This was predominantly in neurosurgery and orthopaedics, but also in vascular surgery due to higher clinical priority cases.

- Staff we spoke with told us that patients were sometimes held in adult recovery longer than clinically required due to the lack of beds available within the speciality services required to meet the patients post-operative needs. We saw that staff completed electronic notifications when patients that are clinically well enough to leave the recovery area are held there longer than necessary. Between 12 December 2015 and 9 February 2016, the trust made 6 notifications regarding 9 patients being held in recovery longer than clinically necessary due to bed shortages onwards. Staff recognised the issues they were facing and were working collaboratively with other colleagues ward areas, services to enable the trust to monitor flow though theatres, and reduce future occurrences of patients being delayed in recovery.
- During the period 1 November 2015 to 31 January 2016 there were 1222 clinically based transfers from inpatient surgical wards to other clinical areas, excluding transfers to theatres, endoscopy, or the discharge lounge. 94 patients within the same period were transferred for nonclinical reasons; for example, to create a side room, create critical care bed or specialist bed. The trust monitored the reason for moving patients between wards and could clarify whether the moves were made for clinical reasons.
- The average length of stay for inpatient surgical wards in November 2015 was 4.5 days and in December 2015 / January 2016, the average was 4.3 days which is better than the England average of 7 days.
- From 1 November 2015 to 1 January 2016, 20 patients had their operation cancelled and their treatment was not rescheduled within 28 days. This was below the England average of 5% of patients and showed improvement over time.

Meeting people's individual needs

- Staff were familiar with and knew how to access translation services. Staff we spoke with told us they could access the services by phone at any time to support patients who may need support with their communication needs.
- Patients were offered food and drink when it was clinically safe to do so. We spoke with a patient in the day surgery discharge lounge who told us "They brought my cereal, but they had obviously put the milk on a long time before serving and the cereal was mushy and inedible. The toast was cold and I had to wait a long time."
- The ambulatory care unit and ward J3 had link nurses for various areas of expertise in order to support patients and other staff via advice in infection control and prevention, tissue viability, falls, pain, moving and handling, pharmacy, diabetes, venepuncture and safeguarding.
- There were dementia and learning disability nurses who were champions within surgery to support staff with any specific patient issues. Staff we spoke with told us the champions helped in the assessment of individual patients needs and provided guidance to enable patients to access support and treatment appropriate to their needs.
- Information within the reception and ward areas was clear and up to date. Materials on notice boards were age appropriate and leaflets were available for a range of services and conditions to offer guidance to patients, relatives, and family members. For example, we saw information on surgery aftercare, who to contact for advice on complaints and concerns.

Learning from complaints and concerns

- Staff we spoke with were aware of the trust policy on complaints and how to access this via the hospital intranet system. Staff told us that dealing with complaints was about being open and honest, talk to the complainant straight away, look into it what happened and feedback quickly to reassure them the complaint has been taken seriously.
- Information on complaints and the patient advice and liaison services (PALS) was routinely displayed throughout the wards on notice boards and in leaflets giving advice on how to make a complaint formally or

informally. Staff we spoke with knew how to deal with complaints and refer patients, relatives or friends to the PALS if they were unable to deal with the complaint themselves.

- Staff we spoke with were aware of the duty of candour and how this would apply within their roles. We were given an example of an incident that occurred in ophthalmic day surgery where a small metal fragment had become lodged in a patient's eye due to a medical device failure. The patient had been informed immediately of the occurrence by the trust and what actions would be taken. We saw the incident form and records of conversations between the trust and medical device providers to establish the cause and minimise any future events.
- A senior nurse told us that complaints were discussed in team briefings and meetings so that lessons learned could be shared and staff made aware of complaints that were being dealt with. We saw a record of team meetings and noted that complaints were discussed. Staff we spoke with saw learning from complaints as a positive part of the service and told us that managers kept them informed of events and incidents within their respective areas of work.
- We spoke with a patient who said, "I would give the hospital 10 out of 10, I was told what to do if I want to make complaint and given all the information needed to understand everything."

Maternity and gynaecology

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

Information about the service

The Rosie Hospital is a purpose built women's and maternity hospital which is located adjacent to Addenbrooke's Hospital in Cambridge. The Rosie Hospital serves the local population of Cambridgeshire, extending to parts of North Essex, East Hertfordshire, Suffolk and Bedfordshire. Specialist services, including high risk obstetrics and foetal and maternal medicine, are provided to the whole of the eastern region. Women's and maternity services are provided under one directorate, led by a divisional director, supported by a divisional lead midwife and associate director of operations, divisional finance lead and a divisional workforce lead.

Women's services include general, emergency and specialist gynaecology services delivered from an in-patient gynaecology ward (Daphne ward) and numerous outpatient gynaecology clinics. Maternity services include the early pregnancy unit, maternal and foetal medicine outpatient department, maternity assessment unit, antenatal ward (Sara ward), delivery unit, birthing centre, two theatres, post-natal ward (Lady Mary ward), ultrasound department and an obstetric physiotherapy department.

There are 74 beds dedicated to the women's and maternity directorate and during April 2015 and March 2016 the hospital had 5729 deliveries.

During this inspection we visited all areas with the exception of physiotherapy and the In Vitro Fertilisation unit, which is provided by the trust at another location. We spoke with seven people who used the service and 40 members of staff including student midwives, midwives, senior managers, service lead, consultants, sonographers and governance staff. We also reviewed 12 people's care records.

An unannounced inspection took place on 23rd February 2016. We inspected the delivery unit, High dependency unit and post-natal ward (Lady Mary). We reviewed 14 sets of care records, focusing on Neo natal early warning scores (NEWS).

Maternity and gynaecology

Summary of findings

Maternity and Gynaecology services were rated as requires improvement because staff were not completing or calculating neonatal early warning observation scores on babies which we identified at our previous inspection in 2015. Records showed that observations were not routinely carried out on babies with high risk factors such as high temperatures or increased respirations. Mandatory training, including safeguarding training, was not in line with the trusts target of 90% for medical staff though nursing and midwifery were meeting this target. We found particular poor compliance in medical staffing. A lack of mobile connectivity in the community meant that community midwives could not access electronic records, nor upload data at the point of contact. Handheld notes remained available, while other data is entered onto Epic later. Consultant obstetric cover in the delivery suite was 60 hours which did not meet the standard as outlined by The Royal College of Obstetrics and Gynaecology (RCOG) guidance which would equate to 98 hours for a unit of this size.

However since our last inspection. The trust had completed installation of scavenging systems in the birthing unit and delivery suite. Midwifery staffing across the unit had been reviewed with the recruitment of nine whole time equivalent (WTE) midwives and six health care support workers. Key performance data was now being collected, analysed and on-going work with the computer system (Epic) was continuing to improve data collection and enable timely and accurate audit. The maternity service and the Maternity Services Liaison Committee (MSLC) worked well together to improve care to women. This provided an opportunity for midwives to meet with a set agenda and to discuss new guidelines and practices relating to care delivery. There was no forward plan to manage the ongoing capacity issues within the unit.

Are maternity and gynaecology services safe?

Requires improvement

Maternity and gynaecological services were rated as requires improvement in safe because:

- Consultant obstetric cover in the delivery suite was 60 hours a week which was less than the Royal College of Obstetrics and Gynaecology (RCOG) guidance of 98 hours a week for a unit this size.
- Mandatory training compliance for medical staff was poor, particularly in relation to safeguarding. This was raised with the trust at the time of the unannounced visit.
- Compliance with the Neo Natal early warning system (NEWS) was poor, with failure to complete records, inadequate management plans and non-compliance with timings of observations. This was escalated with the trust during the unannounced inspection
- There was a high sonographer vacancy rate of 3.4 whole time equivalent (WTE).This meant that constraints on staffing had impacted on staff breaks and administration time. The data from October 2013-May 2015 provided a ratio of one whole time equivalent (WTE) midwives to 33 births which was below that national standard of 1:28 births.

However there had been improvements made following the previous inspection in April 2015:

- Installation of a scavenging system for the birthing unit and delivery suite had now been completed.
- Equipment in clinical areas was serviced, visibly clean, and daily checks were completed. Additional resource of two new ultrasound machines had been purchased.
- Safety thermometer data was being recorded and displayed in clinical areas. There was on-going work within the audit department to review data and establish themes and trends
- The gynaecology referral to treatment time (RTT) had improved from 89% to 97% from the previous inspection in September 2015 to February 2016

Incidents

- Between February 2015 and February 2016 there had been four incidents recorded relating to baby falls

within the post-natal ward. This risk was clearly identified on the risk register. Each episode had been thoroughly investigated, with a number of changes implemented to attempt to reduce the risk of reoccurrence. Changes included clear multidisciplinary working with the falls coordinator and consultant, patient advice documentation regarding co sleeping arrangements, and a record on Epic for midwives to sign that they had provided information to women. A post falls protocol was in draft process, and work was on-going with Epic to build this into the computer system. This was being monitored though the safety subcommittee. Cots that can attach to the bed were being considered, with the input of the falls coordinator and the infection control team.

- There was evidence that learning from incidents occurred and changes in practice took place. For example, in 2015 a baby received the incorrect breast milk from the milk fridge located within the nursing area on the post-natal ward. Following this incident "dedicated" labelled storage tubs with tamper sealed bottles had been introduced. There were clear instructions for women using this facility, with staff supporting those who require it. A risk assessment had been completed as the milk fridge remained unlocked in order to be accessible to women. There had been no further incidents reported since.
- Serious incidents (SIs) were reviewed at the divisional governance meeting, divisional board meeting and at executive level. SIs were presented at the weekly Multi-disciplinary team meeting, and lessons learnt were shared in the quarterly "maternity risk matters" newsletters.
- There had been three SIs relating to Cardiotocograpghy (CTG - monitor of foetal heart rate and contractions of uterus). The previous inspection in 2015 showed that guidelines in relation to foetal heart monitoring were not always followed. In response the trust had implemented additional training for CTG .This included both ELearning and face to face training (a Royal College of Obstetricians and Gynaecology (RCOG) and Royal College of Midwives (RCM) online course and an in-house two day training programme to be completed yearly).
- CTG recordings from the incidents were used as part of the internal training provided to staff. A weekly "fresh eyes" audit (in which CTG are reviewed by more than one person) had commenced in February 2016, in which five sets of notes were reviewed every Monday to ensure there was no misinterpretation of CTGs.

Safety thermometer

- On the previous inspection maternity services did not use a specific Maternity NHS safety thermometer (data collected to record harm free care and number of harms women experience). A specific maternity thermometer was now completed once per month, in line with national guidance, and displayed within all areas.
- Staff had been advised on how to access the thermometer data, and there was on going work with the audit department to be able to start establishing trends and themes as well as working with midwives to decide what data was most useful. This was in progress at the time of inspection.
- The quality and safety dashboard data included results for MRSA, Clostridium difficile (C. diff), falls and pressure ulcers (PU).From January 2015 to January 2016 there were no reported Clostridium difficile infection or MRSA Bacteraemia.

Cleanliness, infection control and hygiene

- The ward areas, in maternity and gynaecology, were visibly clean and tidy. This included store rooms, sluices and medication rooms.
- Monthly hand hygiene audits were in place. Minutes from the divisional meeting in December 2015 showed 100% hand hygiene compliance
- There was a clear process in place for the cleaning of the birthing pools on the birthing unit. A record of the cleaning of the pools was logged in a pool cleaning folder. Which was completed accurately and consistently
- Staff adhered to trust policies and guidance on the use of personal protective equipment (PPE), and to 'bare below the elbow' guidance, to help prevent the spread of infection. There was adequate provision of gloves, aprons and visors throughout both maternity and gynaecology areas.

Environment and equipment

- Security systems were in place within the maternity inpatient areas with access via a buzzer entry system. Visitors had to use the intercom and identify themselves upon arrival before they accessed the ward. Staff had a swipe card access
- Emergency resuscitation equipment was in line with national guidance and checked daily.
- On the birthing unit there was a completed daily checklist and weekly audit record for all equipment. On the delivery unit there was a dedicated midwife who would check resuscitaires at each shift, and also after use.
- The January 2016 medical device dashboard showed that the trust had met compliance targets for planned equipment maintenance. High risk devices for February were 98% compliance against trust target of 97%, medium risk devices at 76% compliance against trust target of 75% and low risk devices at 73% against trust target of 50%
- Staff on the delivery unit stated that the equipment services appeared to have improved significantly and were accessible and visible in the clinical areas.
- New scavenging systems had been installed in the birthing unit and delivery suite, to ensure that Nitrous Oxide levels did not exceed the Work Exposure Level (WEL). The trust provided evidence that the birthing unit had Nitrous Oxide levels checked in December 2015 and levels were within the recommended guidance. Testing for the delivery suite had been undertaken however the results were pending at time of inspection.
- Two new ultrasound machines had been purchased in November 2015, with a further machine on order waiting to be delivered as part of the on-going capital programme. Staff stated that they had been involved in the trial process, and the new equipment had made a significant difference to service delivery. Staff confirmed that they had received training on the new equipment and felt confident to use it.
- Equipment reviewed during the inspection had been PAT (Portable Appliance Testing) tested. For example the patient hoist on the birthing unit had a sticker stating it had been checked in November 2015. Lithotomy legs (bed stirrups) were checked on the birthing unit and found to be intact and in working order.
- Staff in the equipment library had been given training by the appropriate manufacturers to ensure that repairs, particularly in relation to lithotomy stirrups were completed correctly in line with manufacturer guidelines.
- The pool room on the delivery suite had been upgraded to emulate the pool rooms on the Rosie birth centre with charitable funds. This improved the dignity, privacy and satisfaction to women using the facility.
- The delivery suite has received funding for a centralised CTG system, with a six to eight week lead time prior to installation.

Medicines

- Medications were reviewed across the directorate, in medication rooms, fridges and resuscitation equipment. All reviewed were found to be in date and stored securely.
- Fridge temperatures where checked daily and results recorded. Staff confirmed that if fridge ranges were not within limits then this would be reported to pharmacy
- The drug fridge on the post-natal ward remained unlocked, although behind a locked door. This had been risk assessed and deemed appropriate as it contained medication for emergency use.
- Venous Thromboembolism (VTE) assessment was 94% compliant across the directorate. There was central monitoring of VTE, discussed in both the maternity and gynaecology divisional meetings and the divisional executive meetings. VTE assessment was completed at booking and on assessment. Community midwives complete a paper assessment; Ward clerks check the computer system and flag any patients that still require VTE assessment to the midwives. On the ante natal ward for January 2016 compliance was at 98%, on the post-natal ward data provided showed compliance of 98%. This was escalated to the Director of Nursing.

Records

- The community midwife team did not have full access to the Epic system. This meant that information could not be recorded at the time of the patient contact; blood test results cannot be accessed. Paper records are completed and then transferred onto Epic by non-clinical administration staff.
- Restriction within the community had been put in place by GPs and health clinics, meaning that internet access was being withdrawn and community staff could not

access the system remotely. This was on the trust risk register and had been updated to a status of high risk in January 2016 when the restrictions had been made. The lead for the action plan was senior managers in the eHospital and maternity teams. We were not provided with any evidence or action plans relating to how this problem would be resolved at the time of inspection.
- Four sets of notes were reviewed in gynaecology for women undergoing termination of pregnancy. All HSA1 forms had been completed appropriately

Safeguarding

- There are three levels of safeguarding children training. Level 1 provides a baseline understanding, Level 2 provides greater knowledge for those working regularly with children and Level 3 provides high level of knowledge for staff working in complex situations and who have to assess, plan, intervene and evaluate needs of children (Working together to safeguard children:HM Gov 2015).
- A red, amber, green (RAG) rating was in place to indicate staff compliance with mandatory training and data showed that child safeguarding training for medical staffing needed improvement. Obstetrics and Gynaecology medical staff were amber for level 1 child safeguarding training and green (compliant above the trusts 90% target) with level 2. However, neo natal medical staffing were found to be amber for level 1, and red for both Level 2 and 3 training which meant that they were non-complaint with the trusts recommended target of 90%. This was escalated at the time of the unannounced inspection to the Director of Nursing and being monitored through the trusts improvement plan and monthly oversight group.
- Compliance with child safeguarding in nursing and midwifery staffing was significantly better. There was 100% compliance with level 1 in all areas, 14 out of 16 areas were compliant with level 2, in the two areas that required level 3 training one was compliant whilst the other was amber.
- There was a dedicated midwife identified for teenage pregnancy. This individual was part of the safeguarding team, which also included a named midwife and lead for safeguarding across the trust, mental health midwife and substance misuse midwife.
- The trust had introduced Mental Capacity Act and Deprivation of Liberty training across the directorate in December 2015, with a 90% compliance rate to be achieved by March 2016 for all clinical staff Data from February 2016 showed that four areas had reached the 90% target, this included nursing / midwifery staff and additional clinical service staff. The remaining areas compliance ranged between 40-93%
- Safeguarding alerts to children services from September 2015 – December 2015 identified three main areas for referral were: substance misuse (10%), domestic violence (16%) and parent mental health. (13%)
- Minutes from January and February 2016 safeguarding meetings showed that meetings were well attended by the multidisciplinary team including mental health, midwife, teenage pregnancy midwife, lead for safeguarding midwife and social worker. There was evidence that serious safeguarding concerns were discussed with clear actions at each meeting.

Mandatory training

- Data provided from the trust for December 2015 showed that Nursing and Midwives were overall compliant with mandatory training, with 14 out of 16 areas showing as “green” over 91% compliance (against the trusts target of 90%) and two areas rated as “amber” at 85%. Two areas were highlighted as requiring greater compliance in relation to Moving and Handing and Fire training. This had been minuted in the December 2015 divisional meeting and the Clinical Lead and Head of Midwifery had been identified to address gaps with relevant individuals.
- Data provided from the trust for December 2015 showed that obstetrician and gynaecology medical staff were only compliant in three areas of mandatory training, amber in three and red in seven. This gave an overall compliance rating of red at 79%. Neo natal medical staff were only complaint in one area, amber in 10 and three in red. This gave an overall rating of 82%.This had been minuted in the December 2015 divisional meeting and the Clinical Lead and Head of Midwifery had been identified to address gaps with relevant individuals .
- Practice Development midwives were employed by the service to facilitate training and maintain records of staff completing the training

Assessing and responding to patient risk

- Maternity services are required to complete MEOWS (Modified Early Obstetric Warning Score) scoring for women at every set of observations. Gynaecological services are required to complete MEWS (Modified Early

Warning Score) scoring for every woman at every set of observations. During the inspection it was identified that the MEOWS scores were not being recorded on the computer system, in a timely manner, if entered by a maternity support worker, and obstetricians could not view observations on the flow sheets. This was escalated and the trust responded promptly with escalation to the risk manager, entry made onto the risk register, urgent investigation into system commenced. There was communication to staff regarding situation and the mandatory requirement of obstetricians to ensure they have settings to view MEOWS. The outcome was that the information was recorded but medical staff were looking in the wrong place for it. Refresher training was identified as a requirement. This mitigated any risk of not having timely observations. The trust advised that once the work is completed that further training and updates would be provided to staff.

- Three sets of MEOWS scores were reviewed in maternity. One patient had "triggered" on the MEOWS score. The patient had been seen by the medical staff in a timely manner, and had a clear, documented plan of care in place. The staff had carried out required interventions such as administration of Intravenous fluids, antibiotics and preparation for theatre.
- Two sets of MEWS scores were reviewed on the Gynaecological ward and both had been completed appropriately
- Audit data received from the trust for January 2016, which looks at compliance in frequency, recording accurately and escalation taken if score above three (as per guidelines) for the gynaecological ward, post-natal and ante natal ward, showed below than 100% compliance overall. This was discussed with the lead midwife, who stated that a new rolling audit programme had been introduced to monitor MEOWS compliance. Ward managers were asked to investigate, identify reason and produce an action plan if non-compliance was found on their wards.
- In maternity services the Neonatal Early Warning Score (Neonatal EWS) system is used for baby observations. During the unannounced inspection, 14 sets of records were reviewed. Seven records showed that the babies did not require any observations (predominantly those babies delivered in the birthing centre). However the other seven sets of records showed inconsistencies in the completion of the NEWS scoring and the frequency of observations, which were not in line with the minimum of four hourly observations, or in line with escalation plans.
- An example of this was one record of a baby who was receiving intravenous antibiotics. There had been two "red flag" observations in relation to elevated heart rate and elevated respiratory rate. NEWS had not been completed, there had been no escalation and there was no documented plan of care. Records for another baby showed observations had been completed at 19.00pm, with one "red flag" of an increased respiratory rate. No NEWS had been completed; no escalation and a further set of observations had not been repeated until 23.00pm.The midwife on the delivery unit reviewed these records with us and confirmed the findings, which were escalated to the Director of Nursing. .
- In theatres there was a designated "red hat wearer", who was solely dedicated to overseeing patient safety, and this ensured that staff have an identifiable point of contact to raise concerns. The co-ordinator ensures that incident forms are completed, provides team brief to staff in relation to any changes or communications, escalates any concerns or issues and ensures that staff are complying with the WHO (World Health Organisation) checklist.
- The Morecambe Bay Investigation was commissioned by the Secretary of State for Health, to examine concerns raised by the occurrence of serious incidents in maternity services in a different provider in the UK. The trust responded and completed their own gap analysis and benchmarked themselves against the findings.
- The trust provided evidence of the report that had been presented at the Quality committee in July 2015.There was evidence of actions that had been taken, for example, reference to the Francis and Kirkup reports regarding role definition. The Trust had ensured that there was clear definition between the Supervisor of midwives and line managers in the management of investigations, by ensuring that supervisor of midwives did not carry out investigations on their own supervisees. Reference was made to the introduction of "skills and drills" training, which was substantiated when speaking to staff in the clinical areas. The practice development midwives kept a record of staff who had attended the training.

- A number of medications were available and stored appropriately on the post-natal ward for patients to take home. This enabled women to be discharged in a timely manner, and not have to experience any potential delays in waiting for medication

Midwifery and nurse staffing

- Data from October 2013-May 2015 showed the midwife to birth ratio was 1:33, which is worse than the England average. A staffing establishment review had been completed since the last inspection, which identified the need for an increase of nine whole time equivalent (WTE) midwives, and six WTE support workers. This had been agreed by the Board. One Midwife had taken up post, with a further four due in February 2016, five in March and one in April. Five support workers had been recruited and were awaiting start dates. This would bring the midwife to patient ratio to 1:30, with on-going recruitment planned to achieve 1:29.5 ratio, to bring the trust in line with the Royal College of Midwives (RCM, 2010) guidance.
- Whilst staffing shortages remained within the unit, ward managers had dates for new starters. For example the post-natal ward had one new midwife started, with a further two due. On the 23rd February 2016, the post-natal ward had two health care assistants' vacant shifts on the day shift and one midwife on the night shift. Staff on the birthing centre stated they felt that staffing levels were improving. On the ante natal ward all vacant posts were out to advert.
- Staff were able to contact a designated coordinator if staff were moved, or if there were shortages in other areas. For example on the birthing unit, there was a dedicated community midwife for the night shift, who would call into the birthing centre for a second midwife who would go out to support with a home birth. This would be escalated to the designated bleep holder, who would review staffing across the unit and move staff accordingly. Where staffing levels remained short, bank staff would be requested.
- On the ante natal and post-natal wards, staff stated that the use of agency staff was minimal, and that bank staff were normally known to the unit. Figures provided from the trust showed that between November 2015 and January 2016, 7693 hours of bank/agency staff had been used. These figures were not broken down any further to separate bank from agency staff.
- The trust had implemented a twice yearly maternity staffing review using the Birthrate Plus tool, which forms part of the trusts staffing strategy. Monthly data is gathered to measure staffing levels against the 1:30 ratio. This is recorded in the monthly maternity dashboard and discussed at the divisional executive group. There was evidence from the December 2015 divisional meeting that staffing had been discussed. Fill rate for November 2015 across the directorate was 98%, reflecting that the use of bank and agency staffing were filling vacant shifts.
- The delivery of 1:1 care during established labour was not achieved. November 2015 data showed 95.8% and December 2015 data 95.3% compliance. This reflected the shortages in staffing across the unit. Staffing shortages were recorded on the risk register. There was a clear plan for escalation, via a midwifery manager on call and the unit would divert in an acute increase in either acuity or activity.
- Expected levels and actual levels of staffing were displayed on boards within the clinical areas.
- There was a shortage of sonographers with a 3.4 WTE vacancy rate. This was recorded on the Risk Register. The trust were attempting to address this in a variety of ways including recruitment, internal development and a recruitment and retention incentive. One agency post had been advertised, with agreement to be used indefinitely whilst staffing vacancies remained.
- The Gynaecology ward (Daphne ward) data for November 2015 fill rate, showed an average of 92% Nurse/Midwife and 103% Health Care support workers. The ward was fully established with no whole time equivalent vacancies.

Medical staffing

- Consultant obstetric cover in the delivery suite was 60 hours a week The Royal College of Obstetricians: safer childbirth: minimum standards for organisations and delivery of care in labour (2007) state that a unit that has more than 5000 births a year (the trust has on average 5,700 births per year) require 98 hours of consultant cover presence by 2008.Therefore the 60 hours consultant presence did not meet the guidance, however we did not see any impact of this on the care of women.

- Staff stated that a business case had been proposed for 72, 84 and 96 hours of consultant cover, with the minimum of 84 hours cover being met within the next 12 to 24 months with an additional two consultants.
- During weekday mornings there was an allocated consultant for elective caesarean section.
- The medical staffing skill mix was overall higher than the national average for whole time equivalent at 47%, compared to national average of 35%, Consultants at 17% compared with national average of 8%, registrar group 49% lower than the national average of 50% and juniors at 11% higher than the national average of seven.

Major incident awareness and training

- The trust had a clear major incident plan, which included the management for diverting woman regionally as well as to specialist centres in the case of a major incident. This information was available to staff on the trusts intranet. Staff we spoke to knew how to access this information.

Are maternity and gynaecology services effective?

Good

Maternity and Gynaecology services were rated as good for effective because:

- Audit at both local and national level occurred, with action plans that were embedded into practice.
- Consent to care and treatment was in line with relevant legislation and guidance, and policies and procedures were reviewed and based on evidence based practice.
- Since the last inspection in 2015, the maternity Dashboard and Maternity Safety Thermometer was published and displayed. 100% of Midwifery/Nursing staff had received an appraisal
- There was evidence of good multi-disciplinary working
- In November 2015 the Rosie Hospital had been accredited level two “Baby friendly status” from UNICEF and the World Health Organisation

However we found that:

- The trust was not compliant with the National Clinical Institute of Effectiveness (NICE) guidelines CG192 in relation to the provision of antenatal and post-natal mental health: clinical management and service guidance.

Evidence-based care and treatment

- Minutes were provided from the Perinatal Mortality meeting group from December 2015 and January 2016. There was evidence of case reviews and learning points. There was reference to a report from MBBRRACE (Mothers and babies-reducing risk through audits and confidential enquires).The trust had identified the need to benchmark itself against the findings and to learn from the key points. An example of this was to increase the awareness of reduced foetal movements to expectant mothers, through the use of the Rosie website and ante natal care records.
- There was a wide range of trust wide evidence-based polices which staff were aware of how to access. Minutes from the January 2016 policies and procedure group, rag rated guidelines that were overdue. In January 2016 four guidelines were out of date by more than six months and three were over three months. Each guideline had a clear action in place. Seven polices were noted to have been reviewed and amendments made.
- There was an audit programme for maternity and gynaecology which was comprehensive including participation in national and local clinical audits. The trust provided audit reports from the NHS screening programme key performance indicators (audits to measure how well screening programmes are performing).Two examples of these were the newborn hearing audit 2015 and the consent audit 2016. Both clearly demonstrated recommendations and learning, for example the consent audit, which had very high compliance rate, identified improvements that could be made in the time recorded on consent forms and using the most up to date version of consent forms. All reports had been circulated within the division to the relevant staff.
- Minutes from the December 2015 gynaecology meeting showed that audit data was presented. This assured us that audits were thorough and improvements required were recognised.
- There was clear protocol for midwifery led discharge, for example women who had a normal or forceps delivery

Maternity and gynaecology

Pain relief

- On the birthing unit women said that they had received pain relief when required. However some women, on the post-natal ward, stated that sometimes pain relief could be delayed due to staffing shortages. The self-administration pilot has been launched and commenced on the ante natal ward, and was due to be rolled out across the directorate once the pilot was completed. This would enable women to self-administer pain relief and other medication and negate any delays in receiving medication, which at the moment had to be administered by a midwife of trained nurse.
- There was an anaesthetic consultant on call for the maternity services 24 hours a day, seven days a week, providing epidurals when requested, which meant that patients received pain management in a timely manner
- Information leaflets were available for choices of pain relief before, during and after labour.
- We reviewed three records on the birthing unit, which showed that women had had the option to discuss pain relief in their birthing plans.
- Community midwifes could obtain certain controlled drugs for pain relief at home births from the local General Practitioner

Nutrition and hydration

- Data for breast feeding initiation rates were 71.1% for October 2015, 75.5% November 2015 and 81% December 2015, against a benchmark of 80%. The data indicated an improving picture with breast feeding initiation rates. However the trust was unable to corroborate all of the figures at the time of inspection due to on-going issues with the Epic system.
- There was a dedicated infant feeding midwife. This allowed support to be given to women, offering advice and motivating women if they were experiencing feeding problems. Woman said that staff were very supportive in assistance in feeding, either by breast, expressing or bottle. In November 2015 the Rosie Hospital had been accredited level two "Baby friendly status" from UNICEF and the World Health Organisation. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding. This award meant that all staff had been educated to implement the baby friendly standards, for example supporting mothers to breastfeed. The assessors are planning to return in 2017 for stage 3 assessment.
- In the post-natal ward there was a dedicated dining room. Woman could help themselves to tea, coffee and toast and there was use of a microwave, so that meals could be brought in and families eat together if they wished to do so.
- A choice of meals was available and patients completed menu choices for the day. There were set mealtimes to ensure women had regular nutrition and a variety of choice. Water was available at all times.

Patient outcomes

- During the last inspection in April 2015 the trust was unable to provide a maternity dashboard. The maternity dashboard is a tool used to plan and improve maternity services and reviews performance against locally agreed standards. The overall areas monitored are activity, workforce, clinical outcomes, complaints and incidents The trust had now produced a dashboard, which had a clear rag rating system and covered a number of indicators including results on Commissioning for Quality and Innovation (CQUIN) and proportions of delivery methods.
- Recent data in relation to the trusts caesarean section rate (CS), showed that in November 2015 the trust result was 24.6% (below the 25% threshold), but this had increased in December 2015 to 26.1%. To address this the trust had several actions including a steering group which focused on reducing the CS rate, a project board to review the lower segment caesarean section (LSCS) workforce and induction of labour, a daily review of women who have undergone CS and a review by a consultant midwife for those women requesting CS. No data was available for CS for non-clinical induction however the trust was working with Epic to obtain this data.
- The maternity service was not indicated as an outlier for maternal readmissions, neonatal readmissions or severe maternal infections diagnosed within 6 weeks of birth. An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected.
- Proportions of delivery methods from April 2015-December 2015 were as follows: elective caesarean 13.4 % higher (worse) than the national average of 11%, emergency caesarean 14.5% lower

(better) than the national average of 15.2%, normal vaginal delivery 57.9% lower (worse than) the national average of 60.1%, low forceps 8.1% lower (worse than) national average of 3.5%, ventouse 4.1% higher (better than) national average of 5.8%.

- Data for women who have experienced 3rd or 4th degree tears from April 2015 to December 2016 showed: normal vaginal delivery 3.6% (against benchmark of 4.0%), forceps delivery 9.8% (against benchmark of 9.0%) and ventouse 3.8% (against benchmark of 2.5%)
- There were 30 still births delivered in the hospital between April 2014 and April 2015.
- The ante natal ward has five dedicated beds for induction (labour commenced artificially). Complaints on this ward were normally in response to the induction being delayed and the woman sent home. Every woman waiting for induction was discussed at the morning management meeting, and at the 11.00am meeting on delivery suite. The trust could not provide any data regarding the numbers or reasons for delays in induction, but stated that from the 1st February 2016, that data would start being collected, and would form part of a monthly audit. These results would be discussed at the induction labour pathway group. A multi-disciplinary working party met on a monthly basis and had developed new guidelines in the management of inductions, which were pending ratification This included the change in medications administered, which would reduce the number of times women would have to return to the unit, and improved communication in the form of leaflets. All delays in inductions were captured as a "red flag "event and sent to the senior midwife for review.

Competent staff

- Records confirmed that 100% of nursing and midwifery staff had completed an appraisal within the last 12 months. Compliance for clinicians and specialty leads was 88.3%
- The action plan from the Local Supervising Authorities (LSA) Audit 2015 stated that all student cohorts have a Supervisor of midwives (SOM) attached. It was documented that there were monthly service and education meetings held, with the clinical service manager, Higher Education Institute (HEI) and wider members of the trust team.
- A number of student midwives were spoken to across the directorate. All stated that they had felt supported within their clinical placement, although said that some areas were at times short staffed.
- Additional training opportunities included a CTG study day with external speaker in November 2015, with a further day planned for November 2016, as well as a "baby life line "study day planned for March 2016

Multidisciplinary working

- There were good working relationships between medical, nursing and midwifery staff. The unit held a "Just 5" meeting at the beginning of the day on the delivery unit to discuss any patient safety concerns, or any other issues or communication, for example reinforcement of the importance of maintaining patient confidentiality. These discussions were recorded in a communication book.
- During the inspection there was a planned doctor's strike. Staff were aware of contingency plans and knew who would be providing medical cover on the ward.
- The obstetrician and gynaecology consultants stated that they worked well together, and that there were weekly meetings with the obstetricians and monthly meeting with obstetrics and gynaecology. The monthly governance meetings were multi-disciplinary.
- Monthly minutes were provided from the multi-agency safeguarding meetings
- Daily ward rounds were undertaken on the post-natal ward and supported by the wider team including a paediatrician The minutes were comprehensive and clearly showed actions in relation to specific cases.

Seven-day services

- There was a supervisor of midwives (SOM) available 24 hours a day, seven days a week through an on call rota. The role of the supervisor of midwives is to offer support, guidance and supervision to midwives. Each midwife must have a supervisor and the supervisors are accountable to the local supervising authority.
- There was a dedicated community midwife rostered for the night shift
- There was an anaesthetist and consultant available 24 hours a day 7 days a week for both maternity and gynaecology services

- The early pregnancy scanning operated a weekend clinic from 08.30-14.00. This service could be accessed by women for gynaecological emergencies or pregnancy related pain and bleeding for women whose pregnancy is under 12 weeks and 6 days
- Paediatric over was provided seven days a week with on call arrangements during out of hours and night shift
- There was a dedicated midwife on every early shift on the post-natal ward to carry out Newborn and Physical Examination (NIPE)
- On the post-natal ward there was ward clerk cover Monday through to Sunday.

Access to information

- In the reception area of the Rosie there was a dedicated board which identified and displayed photographs of the supervisor of midwives, including their contact details. This information was also available on the staff intranet
- We reviewed the Supervisors of Midwives Annual Report to the Local Supervising Authority from June 2015. There were a number of initiatives that had been taken to ensure information was communicated to midwives such as a quarterly newsletter and breakfast meetings with the supervisor of midwives.
- In all ward areas the white board which contained women's names, was located in an area that was not visible to the general public
- Staff, within the hospital, stated that Epic had improved and that they found it helpful to be able to access women's notes, blood results and other information all in one place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust was not compliant with the National Clinical Institute of Effectiveness (NICE) guidelines CG192 in relation to the provision of antenatal and post-natal mental health: clinical management and service guidance. The trust had one specialist midwife working part time for perinatal mental health care. Recently the community consultant with a perinatal mental health interest had retired. The concern had been escalated to the obstetrician consultants and was on the trusts risk register as a high risk.
- On the Gynaecology ward (Daphne Ward), consents for Terminations of pregnancy (TOPS) were reviewed and completed appropriately.
- HSA1 (Notification of Abortion form, Department of Health) were correctly filled in and arrangements in order for 1st and 2nd signatures. Nurses were able to undertake consent training.
- Mandatory training had been introduced for all staff to complete Mental Capacity Act and Deprivation of Liberty training. Staff had until the end of March 2016 to complete this training.

Are maternity and gynaecology services caring?

Good

Maternity and Gynaecology services were rated as good for caring because:

- People were treated with dignity, kindness and respect. Women described staff as "fantastic", "very caring" and "supportive".
- There were numerous systems in place to support women's emotional needs and a number of midwives with specialist skills such as bereavement and teenage support.
- Partners were welcomed and felt supported throughout their stay which was important to them.
- Friends and Family test results recommending birth services were better than the national average.

Compassionate care

- The maternity patient feedback survey was collected using an iPad device or comments card. Results provided for Gynaecology and the delivery unit were overall positive.
- Results of the patient feedback survey for ante natal for the period June 2015-December 2015 was 71.6%, and post-natal 77.7%. The main areas affecting the scores were around shortages in staff, communication, discharge and quality of food. On the post-natal ward a new information booklet had been produced following the results, which meant that the trust was responding to the survey results and working to improve patient's experiences.
- Staff interactions with women were observed to be compassionate and caring.

Maternity and gynaecology

- The results from the friends and family test (FFT) results recommending birth services were better than the national average.

Understanding and involvement of patients and those close to them

- One woman stated that she had received excellent care during her birth. Her baby developed some medical complications after the delivery, which meant the baby had to be transferred to the neo-natal intensive care unit. There had been good communication throughout this time by both the midwifery and medical staff, and she felt confident during the time the baby was transferred.
- Two sets of birth plans were reviewed. There was evidence that women had been given the opportunity to discuss their plans of care, and that the birth partners had also been involved.

Emotional support

- Birthing partners were encouraged to stay with women during birth and in the post-natal ward to provide extra support and enable early bonding as a family unit.
- There was a confidential "listening service" which women could access which offered support after the birth. Access was provided either through the midwife, contact number or email address.
- The PETALS charity worked alongside clinical staff and specialised in counselling services at the Rosie. Women can use the service for a number of reasons such as the loss of a baby, trauma post-delivery and IVF support.
- The chaplaincy team was available to patients, families and staff 24 hours per day seven days per week

Are maternity and gynaecology services responsive?

Good

Maternity and Gynaecology services were rated as good for responsive because

- Women were given informed choice about where to give birth depending on clinical need.
- There was a clear escalation process in place in which outlined actions prior to closure or transfer of women or babies.
- Two dedicated rooms had been refurbished for women undergoing termination of pregnancy and there was a separate entrance to the delivery unit, so woman undergoing termination did not have to enter through the delivery unit.
- The service was responsive to learning from complaints and concerns.

However:

- The service had to divert 15 times between April 2015 and February 2016 due to capacity and shortages in staffing. Senior staff were aware of the concerns around capacity but there was no strategy to reduce these incidents.
- Triage ward 23, allowed women to self-refer however delays in medical review could occur but no data was collated to measure the extent or impact of these delays.

Service planning and delivery to meet the needs of the local people

- During the 2015 inspection concerns were raised regarding the "3 year divisional business plan 2015-2018", which was being delivered without an appropriate review of workforce analysis. The trust had made changes to the 2016-2019 business plan which included workforce analysis as part of the plan.
- In 2013 the Rosie went under a multi-million pound extension, leading to a modern facility to serve the local population. The facilities are state of the art, with ensuite and double bed facilities in the Rosie birthing centre, a number of birthing aids, such as birthing balls, slings and a communal kitchen where birth partners could get refreshments.
- Women were given informed choice about where to give birth depending on clinical need. The unit had a number of birthing aids, such as birthing pools, and women were offered the choice, subject to any health risks, to give birth at home, on the birthing unit or delivery suite
- The community midwives had an overnight on call service to support mothers who planned for a home birth
- There was a dedicated midwife for teenage pregnancies. The midwife would complete home/hostel visits to

actively encourage and support teenage mothers to attend ante natal services and to prepare for birth. The midwife was also trained to provide contraceptive advice and implants.

Access and Flow

- Data provided showed that bed occupancy had varied over the last eighteen months and had been higher than the England average between October 2013 and September 2014 when it had reduced to below the national average until July 2015. Bed occupancy at time of inspection was 55% for Quarter 3.
- The delivery unit had partially closed for high risk deliveries for a total of 344 hours between April 2015 and March 2016 This was due to either capacity issues or staff shortages. During this period 46 women had been transferred, for either medical intervention or neo natal support. Staff stated that women, with low risk pregnancies, could still access the unit at such time. Women of higher risk, requiring obstetric care, or when the neo natal unit had no capacity then transfers could be required.
- Capacity was affected by the choose and book system, as 30% of women who were out of area chose to deliver at the unit. There was a clear escalation process in place in which outlined actions prior to closure or transfer of women or babies. Discussions were held with the obstetrician, consultant and director or on call director. The Clinical Commissioning Group (CCG), Local Supervising Authority (LSA) and ambulance trust were also informed.
- Triage ward 23, allowed women to self-refer. Staff stated that priority was given to those with the highest clinical need. The protocols and management plans were clear, with rapid response to clinical concerns. Complaints received through this service were predominantly in relation to the length of time waiting to be seen by a doctor; however, no data was collated to measure the extent of delays. Incident forms were not completed regarding delays, and staff stated that women were expected to "understand "as the unit runs similar to an accident and emergency department.
- During the previous inspection in 2015 there was concern regarding women undergoing Termination of pregnancy (TOPS) on labour ward for foetal anomalies, as the two dedicated rooms were being refurbished. These rooms had now been newly converted and said to be sound proof, which meant that women would not hear others in labour, or crying babies.
- There was a separate entrance to the delivery unit, so woman undergoing TOP did not have to enter through the delivery unit. Reclining chairs were available in the rooms to allow partners to stay. The trusts updated TOP policy had been approved by the perinatal board and signed off by the clinical director.
- The trust guideline stated that all women are seen within 15 minutes to auscultate the foetal heart rate. This is monitored by the intrapartum foetal monitoring audit committee which commenced in January 2016.Data was not available at the time of inspection as in the process of being collated
- In gynaecology services the Referral to Treatment Time (RTT) for December 2015 was 97.1% This was an improvement on the previous 89%.
- The trust had introduced an outpatient service for induction (clinic 23), however the numbers were low as there was stringent criteria for woman to meet, to avoid any potential risk

Meeting people's individual needs

- On the post-natal ward there was evidence of meeting patients' individual needs. One patient had a physical disability, she praised the staff on how they had taken time to provide advice on positioning baby, feeding and changing baby. There had been good communication through the patients stay, and extra support had been sought from the physiotherapist.
- On the birthing unit the rooms were large, with the availability of a double bed, to allow partners to stay. One woman who had recently undergone a caesarean section with twins had her husband stay to support her, whilst another woman with a mental health condition also had her husband stay.
- On the post-natal ward there was a dedicated disabled side room, which enabled two beds to be in the room, and had a large shower. At the time of inspection the room was in use by a couple as the woman was wheelchair bound.
- Staff advised that they could access the translation line for women who could not speak English.

Maternity and gynaecology

- A DVD was available for new mothers and shown as a teaching aide and provided information such as feeding, post-natal care and general advice on what to expect at home. Women stated that they found this helpful and made them feel prepared for going home.
- There were clear guidelines on the management of extremes of Body Mass Index (BMI) in pregnancy. This included the medical management of women, equipment requirements and weight limits. Staff on the delivery unit were aware how to source the equipment if required.
- The Supervisors of midwives, student supervisor of midwifes and Chair of Doula (a Doula provides continuous emotional and practical support, for mothers and couples, through pregnancy, birth and immediately postpartum) had collaborated in development of an information leaflet for service users.
- There were a number of specialists, including bereavement, safeguarding, teenage and alcohol and drug midwives. These specialist roles offer vulnerable women continuity of care, access to other agencies and the health and wellbeing of the woman themselves and their babies

Learning from complaints and concerns

- On the birthing unit one woman stated that she had received a positive experience on delivery, but felt that she had not received adequate pain relief during a procedure following delivery, and that the lighting had been faulty. These comments were relayed to the lead midwife who investigated immediately. It was found that escalation to medical staff regarding pain management could have been improved and the faulty lamp was reported. The early escalation for pain control was to be fed back to the midwife involved for learning and reflection.
- There were posters displaying how to make a complaint and comment boxes in most areas.
- There were "you said we did" display boards, which demonstrated that the service learnt from complaints and concerns. An example of this was on the ante natal ward. Women had raised concerns that there was no shelving to place shampoo bottles or shower gel when washing. The ward had responded by purchasing some "holders" so that women could easily place their bottles in and hook onto the shower, to avoid the difficulties in having to bend down.

Are maternity and gynaecology services well-led?

Requires improvement

We rated the maternity and gynaecology services as requires improvement for well led because:

- The leadership team had put in place a number of new processes to ensure good governance practices since our previous inspection. We saw that whilst these were having the desired effect this required embedding into daily practice.
- There was no long term plan to address the capacity issues that resulted in unit closure and patients having to be transferred.
- At our inspection in 2015 neonatal early warning scores had not been completed correctly. Leadership within the maternity service had failed to address this robustly as we found further incidence of this on this inspection.

However we also saw that:

- Issues that had been identified in the previous inspection in 2015 had been addressed. These included the staffing review and recruitment of midwifery staff, the resolution of the Nitrous Oxide in the birthing unit and delivery suite, and the production of the maternity dashboard and maternity safety thermometer to ensure key performance data was being collected and analysed.
- The risk register was up to date, with clear ownership and mitigating actions.
- Senior staff appeared more visible in clinical areas, and staff stated that they felt that the agreement for more staffing had improved morale within the unit.
- There was a clear business plan for the number of consultant hours to be increased.

Vision and strategy for this service

- The trust vision and strategy was visible throughout the wards and corridors.
- There were clear plans in relation to strategy, staffing, capital, education, service development and innovation. Examples were the newly refurbished pool room on delivery suite, recruitment and retention payment for ultrasound staff and the centralisation of the CTG monitors on delivery unit

- The trust had responded to concerns from the inspection in 2015 and a specific maternity work stream was included in the trust improvement plan and a workforce analysis in the "3 year Divisional Business Plan 2015-2018".
- There was no long term plan to address the concerns of closing the unit to high risk women and the capacity issues within the directorate, particularly in relation to accepting patients out of area

Governance, risk management and quality measurement

- Maternity dashboards were available with key performance data robustly collected and analysed. The trust were continuing to work with Epic in data and intelligence monitoring. The dashboards were rag rated and displayed within the clinical areas. Staff were able to discuss the dashboard and the results, for example in relation to patient outcomes and the increased acuity of patients. However there was further work required to streamline the data collected on the dashboard and make it useful and meaningful to staff. The trust was continuing to work with the audit department on the dashboard.
- Local risk registers were in situ across the maternity and gynaecology service. All risk was reviewed at the monthly divisional patient safety sub-committee which then fed into the monthly executive quality and performance meeting. Risks were monitored and reviewed with clear action plans in place and review dates.
- . Senior managers had completed a full review against the Morecombe Bay investigation report, benchmarking themselves against 17 of the recommendations that were relevant to their service. 11 recommendations were compliant with 2 being taken forward once national standards have been drawn up and the further 4 in progress, such as staff recruitment. An action plan was in place that had been reviewed and updated once actions had been completed.
- The gynaecology governance meetings in November and December 2015 were reviewed. There was evidence that incidents, complaints, infection control and morbidity and mortality reviews were completed.

Leadership of service

- Staff throughout the unit stated that local leadership was very good, and that managers were approachable. Ward managers demonstrated clear leadership skills and professional behaviour and ensured that communication was fed down into their teams. This would be through team meetings, emails, notices displayed in staff rooms and at one to ones with staff.
- Staff stated, that since our previous inspection in 2015, they felt that they were listened to, in particularly regarding the shortages of staff, and were pleased that recruitment was underway
- The Associate Director visited the maternity areas and was visible and accessible to staff. Staff could attend open meetings with the Associate Director and Divisional Director. Staff in the ward areas felt pleased that senior managers, and more recently the Director of Nursing, attended the wards,
- The senior nursing staff stated that the Leadership courses for managers were very good and that they had the opportunity to develop and network across the hospital, which promoted best practice by sharing of ideas, as well as support for each other

Culture within the service

- Staff were open and honest and informed the inspection team what worked well, what did not and the visions they had to improve their own areas
- Leaders within the service celebrated success. On the trusts website the directorate celebrated the success of a Maternity Care Assistant (MCA) receiving a "you made a difference" staff award in January 15. The award was for the MCA making a difference in bereavement services, which included "memory making" for those woman who had lost babies., which provided emotionally support to bereaved families
- Consultants stated that there were good multi-disciplinary working relationships, including the sharing of learning which took place at the CTG case review meetings and review of the monthly dashboards.

Public and staff engagement

- The Maternity Services and Liaison Committee (MSLC) held regular monthly meetings. The minutes from October 2015 showed that the group was made up of user representatives, Doula and a general practitioner (GP). There was reference to the recent Rosie Hospital open day, with reference to how the MSLC can support the "healthy start" published by the Public Health Report, relating to assessment of women by 12 weeks and 6 days and initiation of breastfeeding.

Maternity and gynaecology

- The Supervisor of Midwives (SOMS) held regular breakfast meetings in which staff could drop in to discuss any issues.
- The Rosie has support of the Addenbrooke's Charitable fund, which had recently provided funding for the upgrade of the birthing pool room in the delivery unit

Innovation, improvement and sustainability

- The senior team had developed business cases, which had been approved, to address the issue of nursing and midwifery staffing and increased obstetric cover to ensure that staffing guidelines would be met.
- The trust are planning to make a joint submission with another partner to develop a ten bed regional mother and baby mental health suite, which would be on the Addenbrooke's site. This was still in the planning stage.
- Installation of the centralized CTG monitoring system on the delivery unit was planned to be completed by the end of April 2016 to improve patient safety

Outpatients and diagnostic imaging

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

Information about the service

The outpatient's services at Addenbrooke's Hospital covered many specialities including dermatology, orthopaedic, ophthalmology, respiratory, and oncology. The diagnostic and imaging department carried out routine x-rays as well as more complex tests such magnetic-resonance imaging (MRI) and computerised tomography (CT) scans. We inspected services that were solely provided from the hospital site. Services at the hospital saw adults and children and there was a separate children's outpatient's department.Outpatient and diagnostic imaging services were available Monday to Friday. Some clinics and CT and MRI scanning were available at weekends and in the evenings. However there was an on-site radiologist available 24 hours a day seven days a week as well as specialist on call cover. Patients were referred by their GP, consultant's private practice or as self-referrals. The trust had 794, 405 appointments between July 2014 and June 2015.In April 2014, the service began a redesign project called 'centralisation', to combine all outpatient clinics under one management structure. During this inspection we found the process to be almost complete.

We:

- inspected the main outpatients department and radiology
- visited 8 clinic areas,
- spoke to 23 members of staff including diagnostic and imaging staff, consultants, nurses, and support staff
- observed care,
- looked at eight patient records and
- Spoke to 15 patients and those close to them.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging as requires improvement overall. At our inspection in 2015 we found that the trust had significant numbers of patients awaiting appointments who had not been clinically assessed or received treatment in line with their clinical need. At this inspection in 2016 we found that the trust had taken action to ensure that patients awaiting appointments were being risk assessed to determine the correct time for them to be reviewed in clinic. However, some backlogs of appointments remained in some specialties. The trust had risk assessed all patients awaiting an appointment. Not all staff received feedback about incidents that happened in their area and whilst progress had been made with equipment, not all had been maintained in line with trust plans. Staff received appraisals and there was effective multidisciplinary working within the department. Since our last inspection there had been an improvement in patient records and notes being available through Epic.

Staff were caring and patients and carers spoke positively about the care and compassion shown by all clinic staff. However, friends and family test data showed only 72% of patients would recommend the service on a poor response rate.

The trust was failing to meet referral to treatment time in10 of the 18 specialties. However, this was an improving performance since our last inspection. The number of clinics cancelled had increased in the six months to December 2015 and there were waits of longer than six week for some diagnostic tests. However, there had been improvement with appointment slot issue's (ASI's) and did not attend (DNA) rates since our inspecting in April 2015.

Since our last inspection there had been a change in the governance and management structure with the addition of new, dynamic leadership in the department. However, this still required embedding into daily practice. There was clear monitoring of performance indicators and understanding of the main risks in the department including the backlog of appointments and referral to treatment times. A comprehensive improvement plan was in place and being effectively monitored. Staff morale was noticeably improved and there were new initiatives to gain patient feedback.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

Outpatient services were rated as requiring improvement because:

- In 2015 the trust was not aware of the risks within the backlog of appointments and we saw impact of delayed appointments on patients. At this inspection all patients within the backlog had been risk assessed to determine their clinical need and priority for appointment. However a large backlog remained in some specialities.
- At this inspection we saw that improvement had been made in the tracking and maintenance of equipment but there were outstanding 'medium' and 'low' risk devices that required attention.
- Not all staff we spoke with received feedback form incidents including serious incidents. Serious incidents continued to be reported following the review of all patients in the appointment backlog as part of that process.
- Staff we spoke with were not aware of all of their responsibilities under the Duty of Candour requirement.
- Not all medicines were securely locked, in one clinic a large number of prescription only eye drops were not secured because there were no adequate facilities to do this.

However, we also found:

- Staff used appropriate hand hygiene and the environment was visibly clean.
- Records were electronic with limited duplication with paper records. We were told that the quality of discharge and GP letters had improved.
- Most staff had completed mandatory training.
- Staffing had been reviewed and increased in a number of clinic areas though some gaps remained for nursing and medical staff.

Incidents

- In 2015 seven members of staff we spoke with out of 65 were unclear about the requirement to report patient safety incidents or near misses. A few staff we spoke with could not describe the incident reporting system or find it on the trust's internal systems when asked. At this inspection we found that not all staff received feedback about incidents that they had reported. Seven members of staff confirmed this and that they were not aware of a number of serious incidents that had occurred in the department.
- In 2015 four other staff said they had not reported incidents that they had witnessed due to the working pressures within the department generally. At this inspection staff told us that they all reported incidents they had witnessed or been involved with.
- In 2015 information the trust provided to us demonstrated that there had been 12 serious incidents within the department in the previous year. However when we asked staff to describe how an incident had led to service improvement or learning they were unable to provide an answer. At this inspection, seven members of staff could not describe the serious incidents that occurred in the department. However, most staff could describe learning from an incident that happened in their area.
- In 2015 there was significant confusion within the department of what constituted a serious incident and how these should be managed. The ophthalmology clinic told us that they had reported 21 serious incidents but no record of these could be found. Therefore the department was not assessing and responding to the risk of harm to these patients. At this inspection we found that there was consistency in reporting serious incidents by the department, senior managers and the trust even though some junior staff were not aware of a serious incident
- In 2015 we looked at the root cause analysis investigation reports for three serious incidents and saw that appropriate investigation took place. However the processes for follow up and ensuring lessons were learnt and embedded were not followed. At this inspection we reviewed root cause analysis and serious incident investigations as part of our monitoring of the trust. These investigations were properly completed and action plans showed that learning had been identified and changes made to systems and processes in response to this.
- In 2015 there was however a good incident reporting culture in diagnostic imaging services. Staff were aware of how to record and report incidents on the electronic reporting system. Staff demonstrated an awareness of what types of incidents needed to be recorded and who they needed to be reported to for example, the

Radiation Protection Advisor (RPA) or CQC as appropriate. At this inspection there remained a good incident reporting culture within radiology for both local and national reporting.
- Learning from incidents in radiology could be evidenced through radiation safety committee minutes.
- At this inspection not all staff were aware of Duty of Candour. Whilst all staff we spoke with had heard of it and said it meant being "open and honest", eight staff did not know what triggered the duty or the requirement to offer an apology or record any subsequent meetings.

Cleanliness, infection control and hygiene

- In 2015 all the outpatient and diagnostic imaging areas we visited were found to be generally clean. At this inspection we found that the environment was visibly clean and well maintained.
- At this inspection the majority of staff in clinical areas observed 'bare below the elbow' guidance and adhered to the hospital's infection control guidance. Staff carried out appropriate hand hygiene and wore personal protective equipment (PPE) where necessary.
- In 2015 there was a good supply of alcohol hand gel dispensers.
- Infection prevention and control policies were accessible to all staff on the intranet, and staff we spoke with knew how to find them. At this inspection all staff we spoke with were aware of infection control policies and guidance and could access them on the intranet.
- Waste management systems were in place for the disposals of clinical and non-clinical waste. At this inspection these processes were in place and information showed subject to regular audit.
- In 2015 the trust gave us a number of audits for February 2015 which demonstrated regular cleaning checks took place and that actions for improvement were highlighted and action taken. At this inspection, regular cleanliness audits were completed for the outpatients department that showed regular compliance with the target of 95%.
- In 2015 the environment within the maxillofacial and oral clinic was not working to best practice. There were no separate clean or dirty areas for contaminated dental equipment. We asked to review a risk assessment and noted that the risk was being managed with use of colour coded boxes to separate dirty and clean equipment. This risk had however been ongoing for five years, with no plans to find a permanent solution. At this inspection the maxillofacial and oral clinic was still not meeting best practice with regards the separation of clean and dirty dental equipment. However, a plan was in place and work due to commence to rectify this.

Environment and equipment

- In 2015 there was an inconsistent approach to the maintenance of equipment within the clinic settings that we visited. However, equipment such as blood pressure monitors and defibrillators in other clinics had been regularly serviced tested and appropriately cleaned. At this inspection audit data showed that some improvement had been made in the regular maintenance of equipment within the department. Whilst only 2% of high risk devices were overdue maintenance this rose to 45% of medium risk devices and 39% of low risk devices. Information showed this was being audited and was subject of an ongoing improvement and action plan.
- Where electrical testing was completed, we saw labelling on equipment to demonstrate that testing had been completed and on which date. At this inspection equipment was properly portable appliance tested (PAT) in line with legislation.
- In 2015 we looked at a sample of resuscitation equipment across the departments. We found that checks were not being carried out regularly. For example, an adult resuscitation trolley had not been checked for three days (should be daily) prior to our inspection. We also found that an oxygen cylinder on the paediatric resuscitation trolley had passed its expiry date by six weeks. We informed the trust about this during our inspection. At this inspection we found checks were carried out in line with trust policy on the resuscitation equipment and other emergency equipment that we checked.
- There were radiation warning signs outside any areas that were used for diagnostic imaging. The preparation of radioactive materials was carried out behind keypad coded locked doors to ensure safety.
- Policies and procedures were in place for all scope equipment including separate guidance for the cleaning of radiographic equipment.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks

based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protect patients against unnecessary exposure to harmful radiation.

- Specialised personal protective equipment such as lead aprons for staff and lead shields for patients were available in the radiology department and it was confirmed these were checked on a daily basis and screened annually for damage.
- The radiology manager kept an inventory of equipment and we saw that this was kept up to date with the addition of new equipment as necessary.

Medicines

- In 2015 we checked the storage and management of medicines and found effective systems in place. We found that refrigerator temperatures were monitored with the exception of one fridge in clinic 9, which we found did not have any records to confirm that appropriate temperature checks had taken place. At this inspection medicines in refrigerators had temperatures monitored and recorded. However, we also found in one clinic a large volume of prescription eye drops that could not be secured and were regularly left unattended in clinic rooms. Staff told us they had completed a business case to enable secure storage.
- Drugs and lotions were stored safely with all medicine cupboards we checked being locked. All medicines we checked were within their expiry date.
- Staff were aware of the trust's medicines management policy and it was available in departments for staff to refer to.

Records

- In 2015 an electronic records management system called Epic had been introduced into the service in October 2014 and the department was aiming to be paper free by October 2015. At this inspection the department was in the vast majority of cases, paper free for the administration of patients medical records and associated paperwork.
- However during the 2015 inspection we noted that there were inconsistencies in how paper records were being managed although records were available for patients attending the outpatients departments. In one clinic we saw that a room storing confidential patient records was unattended and had been wedged open by a door stop in a publically accessible area. At this inspection patient records were found to be properly secured and confidential information was protected.
- In 2015 in the fracture clinic, we noted that requests for follow up appointments were being written on notepads. There is a risk that these requests for follow up appointments could become lost; meaning that patients could be placed at risk because of delays or appointments. The trust stated that all patients' records are signed off before the patient leaves the clinic this would include any follow up arrangements. At this inspection we saw that appointments were now made on the electronic patient record system
- In 2015 we spoke with stakeholders prior to our inspection who told us that there had been ineffective discharge letters sent out by the trust. These included a lack of information about treatments or diagnoses people had received or missing information in relation to medications. This meant that there was a risk of people receiving inappropriate follow up or after care due to inaccurate records produced by the trust. The trust confirmed that they had experienced some issues with sending out letters but recovery plans were now in place. At this inspection trust performance with regards discharge letters had improved I terms of timeliness and content in line with the trust improvement plan.
- In 2015 the standard of record keeping in the outpatient neuropsychology assessment service was good.

Safeguarding

- There was a safeguarding lead at the hospital and staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff knew who the trust's safeguarding lead was and how to contact them.
- In 2015 staff working in the outpatients department were provided with mandatory safeguarding training to level 2. Data we received demonstrated that the majority of staff were up to date with this training however improvement was needed in relation to administrative and clerical staff in trauma and orthopaedics clinic where uptake of level 1 training where only 75% against a target of 90% was being achieved.
- Staff were able to talk to us about the insight and knowledge they had gained from this training.

- At this inspection information showed that outpatient staff were up to date with safeguarding training with the exception of children safeguarding level 2 which had a compliance of 80% against a trust target of 90%. Staff we spoke with were knowledgeable about safeguarding and were aware of how to make a safeguarding referral.

Mandatory training

- Staff mandatory training was evidenced by a paper based table indicating that the majority of staff of clinic staff were up-to-date with mandatory training with figures of above the trusts 90% target being reported.
- In 2015 this was not the case in a small number of outpatient areas for example dermatology department was not up to date with training in conflict resolution, fire and manual handling. Medical outpatients training required significant improvement with only 40% of nursing staff being up to date with resuscitation training, fire training and manual handling training.
- At this inspection information showed that compliance with mandatory training across the department was at 97% including life support, moving and handling and conflict resolution. Six member so staff we spoke with told us they had completed mandatory training.
- At this inspection information showed a variable compliance with Mental Capacity Act (MCA) training. HIV and Clinic 8 were the only areas above the trust target of 90% with some, including clinic 10 and nuclear medicine reporting 0% staff completion as at November 2015.

Assessing and responding to patient risk

- In 2015 there was a significant backlog of patients waiting for ophthalmology appointments. At the time of our inspection the total number of patients waiting for a follow up appointment was 6,911 and 2,500 new patients were waiting for a first appointment. We asked on numerous occasions to be provided with a risk assessment or evidence which demonstrated that the service had assessed and prioritised patients at risk of harm. This is important because in spite of the backlog, the service could have seen patients with the most serious eye problems first. We were not provided with evidence that any such patient assessment had been undertaken. At this inspection the trust had addressed these concerns in that all patients' records had been reviewed by a clinician to identify any patients who required an immediate appointment, who could wait longer and who could be discharged based on a risk criteria and profile. The trust continued to have backlogs in specialties There was a clear improvement plan in place to address these backlogs however it indicated that whilst the majority of patients had been risk assessed this had not been completed for all specialties. Senior managers within the department told us that this had now been completed.
- In 2015 we found that a serious incident reported in July 2014 had determined avoidable harm had come to an ophthalmology patient whose follow up appointment had been delayed by 6 weeks. As part of the investigation we saw that a further 21 patients had been identified as at potential risk with even more serious incidents envisaged. We asked to review a copy of this risk assessment however; this was not provided to us. The trust provided a summary of actions taken of the 21 patients. Two had come to harm and one was awaiting medical treatment prior to ophthalmology treatment. At this inspection the trust had reported two further serious incidents following our last inspection related to patients who has suffered harm due to delays in appointments though these had been highlighted by the remedial work and subsequent improvement plan implemented by the department and trust. There were clear risk assessments in place for ophthalmology and other specialties to address these concerns as part of a wider improvement plan.
- In 2015 we found this also be the case within dermatology where a backlog of 1, 800 patients was reported. Again no patient risk assessment could be provided to us to demonstrate that patients would be prioritised based on clinical need. At this inspection all patients had been reviewed either in person or by review of their records to determine the level of risk and when patients should be seen by a clinician. Ongoing work with commissioners in relation to managing demand was in place.
- In 2015 we escalated these concerns immediately following our inspection. The trust had recovery plans in place but had not successfully covered medical staffing to reduce the waiting times in the ophthalmology service. Within the dermatology service a new template had been designed and a Fellow had been recruited to cover some appointments however most actions were on hold, delayed or in progress. We were not assured

that patients were being protected from avoidable harm in these services. On this inspection we found the actions identified to be completed or in progress in line with the trust improvement plan.
- If a patient deteriorated, systems were in place to contact an emergency response team. There were also a number of resuscitation trolleys across outpatients which were available.

Nursing staffing

- In 2015 Staffing was low within the Ophthalmology department. Staff told us, and we saw from records, that they were being asked to cover extra shifts and sometimes were required to cover two clinics when there should be one member of staff present at each.
- At this inspection information showed a low vacancy rate in the eye clinic and cataract clinic. There were vacancies in the audiology clinic and large number of vacancies for band 4 staff (4 whole time equivalents (WTE) in post against a budgeted number of 14 WTE). Overall there were 55 vacancies across all of the department though this included 20 staff for a call centre yet to be created and also included an uplift of staff in some clinics. Information showed that a number of these vacancies had been recruited to.

Medical staffing

- In 2015 there was a shortage of consultants employed by the trust with outpatient commitments. Data provided by the trust showed that across outpatients there were 21 vacancies for consultants who had direct outpatient commitments. The trust provided evidence which showed that they were recruiting to fill these vacancies. At the time of our inspection, eight posts had been filled and start dates confirmed At this inspection, whilst a number of posts had been recruited to there were shortages in some specialties that impacted on clinic time including cardiology. The trust had identified a need for a number of additional consultants to meet the increasing demand in outpatients.
- In 2015 we were told that locum cover was being provided where necessary. However, managers and clinicians acknowledged that due to the implementation of Epic it was difficult to use new locums who were not familiar with the trusts systems. At this inspection Epic had been used consistently for a longer period. Two locum consultants we spoke with told us they had received training on the system and were competent to use it. They were aware of the support available if they required help with the system.
- In 2015 we spoke with consultants who told us that clinics often overran or were over booked. For example, morning clinics often exceeded their allotted time. This meant that they had less time for ward rounds and other commitments as morning clinics exceeded the allotted time. At this inspection we saw that several clinics overran during our inspection.

Major incident awareness and training

- There was an internal major incident policy in place which contained plans to assist staff in dealing with circumstances such as loss of staff, loss of information technology or data, loss of utilities, denial of access to property or parts of, supply chain failure, or acute pressures in capacity.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate the effectiveness of outpatients services though we found:

- There was evidence based care and treatment within outpatients and diagnostics. Diagnostic imaging had been reaccredited by the Imaging Services Accreditation Scheme.
- The trusts follow up to new ratio was now below in the England average.
- The majority of staff had received appraisals and had access to training and development.
- There was continued multidisciplinary working and some an increase in the number of clinics available in evenings and weekends.
- Access to information had been improved and there were no occasions recently when patient notes and records had not been available.

Evidence-based care and treatment

Outpatients and diagnostic imaging

- Waste management procedures were in place for the disposal of radioactive waste which complied with the Environment Agency's Environmental Permitting Regulations 2010.
- In 2015 diagnostics and imaging conducted patient dose assessments and audits to ensure that patients received the correct level of radiation dose when receiving x-rays. Part of this work used national guidelines to inform their practice. At this inspection audits were regularly undertaken and any concerns identified from audit data fed into the governance framework for review.
- We saw reviews against IR(ME)R regulations were undertaken and that learning was disseminated to staff through team meetings and trainings. This included auditing radiotherapy services and diagnostic x-ray services. Learning and investigation had taken place where improvements had been identified regular follow up took place through the radiation safety or medical exposures committees .
- At this inspection the trust had developed radiation safety policies and procedures in accordance with national guidance and legislation. The purpose of the policies was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable. At this inspection we saw that these were imbedded within the department, five staff we spoke with were aware of the policies and procedures and how they directed their practice.
- The trust had a radiation protection advisor to lead on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R regulations.
- At this inspection there was a comprehensive audit plan for the department based on issues identified through the risk register and NICE guidance amongst others. Each audit had a named professional to lead and an estimated completion date.

Patient outcomes

- In 2015 the diagnostic imaging was part of the Imaging Services Accreditation Scheme (ISAS) and was into year two of three of accreditation. ISAS is a patient-focused assessment and accreditation Programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. At this inspection we saw that ISAS accreditation had again been awarded in October 2015.
- In 2015 there was lack of local initiatives within the outpatient department generally to monitor and report on patient outcomes. For example, there was a lack of local audits identified on the department's audit plan which demonstrated all specialities were using audit as a way to monitor and improve outcomes for patients. In 2016 there was a comprehensive audit plan in place. Audits were included that would identify best practice and patient outcomes including in rheumatology and management of type 2 diabetes in acute hospitals amongst others.
- In 2014 the trusts follow up to new rate was consistently worse that the England average for the period July 2013 and June 2014. At this inspection, for the period of November 2014 to June 2015 the trusts follow up to new ratio was below the England average.

Competent staff

- In 2015 there was a mixed response from staff with regards to appraisals. Some staff told us that they had not received an appraisal in the last year. When we asked managers about appraisals rates we were told on numerous occasions that appraisals were being booked to be completed by July 2015. The trust data we received showed us that the majority of staff within the directorate had received an appraisal within the last year. At this inspection the trust was meeting the target for appraisal completion. All staff we spoke with had had an appraisal in the previous year.
- In 2015 junior medical staff had good support from consultants and told us they always responded or came in when they were on call to provide support in complex cases. At this inspection we were unable to speak with junior medical staff due to an ongoing industrial dispute.
- In 2015 staff had good access to learning and development courses to help support them in their roles. At this inspection staff told us that they were able to attend relevant courses to the area they worked. One member of staff told us they had attended wound care training so that they could be more effective in the clinic.
- An up to date equipment competency log was kept for all staff working within the radiology department.

Outpatients and diagnostic imaging

Multidisciplinary working

- Good internal team working was reported between services for example, between clinics and diagnostic imaging services and the pathology department.
- In 2015 there were outstanding examples of MDT working given by the infectious diseases clinic. A social worker was assigned to work with the clinic in order to support patients who were newly diagnosed with HIV and their families. At this inspection we saw that this arrangement continued, supporting patients and their families.
- Virtual meetings were held as part of the Regional HIV Network in order to share learning and provide professional development across professionals in the region caring for patients both as inpatients and outpatient.
- At this inspection virtual clinics were in place for patients with age related macular degeneration. All investigations would be completed, the case discussed at regional MDT as required and then the patient called at home for a consultation to discuss outcomes and arrange treatment.

Seven-day services

- Outpatient services were not available seven days a week. In order to deal with appointment backlogs some outpatient services were being made available in the evenings and some clinics were available Saturdays between 9:00am and 5:00pm. At this inspection ophthalmology clinics were being held on some Saturdays to manage the backlog of patients.
- CT scanning was available on a Saturday and MRI scanning on Saturday and Sunday. There is an on-site radiologist 24 hours a day, seven days a week. There are three consultant radiologists providing specialist on-call cover who also provide reporting services on Saturday and Sunday

Access to information

- In 2015 a selection of administrative and clerical staff told us of the impact of Epic on the work that they undertook. At this inspection staff were more positive about the system. They told us that they normally had all the information they required for clinic and had become more familiar with the system. Audits showed that in November and December 2015, all patient notes were available for outpatients.
- In 2015 we saw that letters were prepared in an unformatted way and were told that information such as laboratory results, took a long time to appear on the system. This sometimes meant healthcare professionals did not have access to the most up to date and accurate information for their patients. At this inspection information was formatted within the Epic system though there remained some delays in getting investigation results. We were told that this was not due to Epic but delays in the processing of the samples.
- In 2015 prior to the inspection we spoke with the Local Medical Committee and been contacted by numerous GP's concerned at the lack of information provided following discharge since October 2014. Concerns included insufficient information on patients' diagnoses and care and long delays in discharge and clinic letters being received by GP's. At this inspection we again contacted the LMC and were told that GP's had other concerns and there had been no recent contact about these concerns. CQC had received no further correspondence from GP's about these issues since the publication of our last report in September 2015.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for consent before any examination or procedure was carried out. Six patients we spoke with told us they had been asked for their consent before they received treatment.
- Consent forms for some procedures were available and two records we reviewed showed that they had been completed properly and that risks associated with a procedure had been clearly identified.
- We heard a staff interaction with a patient who was asked for verbal consent before a minor procedure was carried out. The member of staff clearly explained what they were doing and kept the patient informed at all times.
- Mandatory training had been introduced for all staff to complete Mental Capacity Act and Deprivation of Liberty training. Staff had until the end of March 2016 to complete this training.

Are outpatient and diagnostic imaging services caring?

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging as good for caring because:

- We observed staff being friendly, caring and compassionate in their dealings with patients. Patients clearly appreciated the volunteers who directed or guided them to clinics.
- All patients we spoke with were positive about their experience of care in outpatients and x- ray.
- Patients and their carers told us they were kept informed of their care and involved in decision making.
- Emotional support was available for patients either within the hospital or, on occasion, via referral to external organisations.

However, we also found:

- Friends and Family Test results were below the England average at 73% on a very low response rate of 0.4% compared to the national average of 6%.

Compassionate Care

- Throughout our inspection we observed care being provided by nursing, medical and other clinical staff. We saw examples of staff being friendly, approachable and professional. For example, when people became lost staff would accompany people to the area in which they should be. We witnessed people being spoken to with respect at all times.
- We spoke with 14 patients about the care and treatment they received. All were positive about the care and compassion they received from staff.
- In 2015 patients complained about long waits due to clinics running behind schedule. Five patients we spoke with at this inspection made the same comment and a further 14 contacts before and after the inspection raised this as a concern.
- In January 2016, Friends and Family Test (FFT) data showed that 73% of patients would recommend the service against an England average of 92%. This was against a comparatively low response rate of just 146 completed responses for the month of January against 37, 556 patients eligible to take part in the survey. This was a response rate of 0.4% compared to the national average of 6%.
- In 2015 staff we spoke with were aware of their responsibilities to ensure privacy and dignity was maintained for people. At this inspection we saw that staff were mindful of patient's privacy and dignity including awareness of chaperoning policies.

Understanding and involvement of patients and those close to them

- At this inspection all the patients we spoke with told us that they understood their plan of care and had been involved in making decisions about their care.
- In 2015 we spent time in the reception area of the outpatient departments observing patients being greeted and booked into the department. We saw patients were greeted in a warm and welcoming manner and given clear instructions by the receptionist regarding which waiting area to sit in and any delays there were in the clinics. At this inspection patients were welcomed into the department by reception staff and volunteer services and assisted to their clinic. We observed patients being put at ease by these staff through the use of humour.
- 14 patients and 3 relatives said they felt listened too and that their concerns regarding their health and that they had been properly considered when developing their plan of care.
- We observed numerous positive staff interactions with patients, their carer's and relatives for example, explaining what was happening and how long they would have to wait to be seen or receive test results.

Emotional support

- In one clinic we saw that patients had been referred for specialist support in the community following a difficult diagnosis, ensuring patients were properly supported and received any counselling therapy they may need.
- Patients spoke highly of the emotional support they received in the oncology and hematology clinics. Staff told us of the support available within the hospital.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Outpatients and diagnostic imaging required improvement for responsive because:

- The trust was failing to meet referral to treatment times (RTT) for 9 out of 18 specialties. There were approximately 3866 patients with an incomplete pathway longer than 18 weeks in January 2016, though this represented an improving performance.
- The number of cancelled clinics had increased between July and December 2015.
- The two week wait for cancer patients was meeting target at 98% of patients being booked in that time though the 62 day measure for urgent treatment with reallocations was missing target at 83% for February 2016 though there was an improved performance overall.
- There were waits longer than 6 weeks for some diagnostic imaging, particularly in MRI.
- Telephone calls were only answered on approximately 50% of occasions.

However, we also found:

- Appointment slot issue's (ASI's) had fallen considerably since our last inspection and were monitored frequently. Did not attend (DNA) rates had also fallen and each DNA followed up by the clinic coordinator.
- There was evidence of service planning to need the needs of local people including an additional virtual clinic in ophthalmology and rapid access clinics.
- Translation services were available for patients and there was written information for patients, their relatives and carers.
- At this inspection we found that the department and staff were more aware of the themes of recent complaints and how they had led to service improvement or change in practice.

Service planning and delivery to meet the needs of local people

- In 2015 staff working within the outpatient department told us patients could use the 'choose and book' system to enable them to choose an appointment in a hospital location close to their home. A booking team was available to assist patients with the provision of letters to inform them of their appointment date and time.
- Rapid access clinics were available in cardiology, breast and rheumatology.
- Virtual clinics had been set up in a number of areas. We heard about this in detail from the fracture clinic who had recently developed this service. The virtual clinic consisted of a multidisciplinary team of staff including nursing and consultant grade staff. The purpose of the clinic was to review patient x-rays and notes to make treatment decisions without the need for the patient to attend an appointment. Patients were then called and explained treatment options over the phone. At this inspection virtual clinics were also available in ophthalmology.
- In 2015 whilst we noted patients had access to water in many of the clinic areas, hot beverages were not accessible in many of the areas we visited. The main outpatients department was situated next to a reception area where there were facilities to purchase food and drinks. However patients risked missing being called for their appointment in some areas if they wished to visit the shops for food and drink, as some clinic were situated quite a distance from these facilities. We spoke with one patient who told us they had been waiting in excess of an hour for their appointment and had not been offered a hot drink. At this inspection staff offered beverages to patients waiting in overrunning clinics. Two patients we spoke with had been offered refreshments whilst awaiting their appointment.
- Extra clinics were being provided at weekends to meet demand. For example, ophthalmology clinics were being provided on a Saturday due to increased numbers of patients. At this inspection, additional clinics were continuing to be provided at weekends to meet patient needs and demand on the service in line with the trust and department improvement plan.
- Television screens were present in the majority of clinic areas we visited which kept patients up to date on waiting times in clinics. At this inspection, we saw that these were kept up to date.
- In clinics that also saw children, there were designated areas for children to play and wait for appointments. We observed that they were well used by families. There was however a lack of facilities to cater for adolescents such as age appropriate magazines.

Access and flow

- In 2015 the entrance to the outpatients department was very confusing. There was a reception desk which dealt with transport and travel and we heard that many people reported to this desk believing it was an outpatient's reception desk. At this inspection a

volunteer station had been created in January 2016 which helped patients with directions and assisted them to clinics if needed though the entrance to the department remained busy and confusing.

- In 2015 signage was also not clear. We observed many patients becoming confused or lost and having to ask people in corridors for help way finding. We spoke with a volunteer of the hospital who told us that many of the people they assisted were those requiring direction. At this inspection, signage was still not always clear but the provision of volunteers to assist patients helped mitigate the poor signage.
- At this inspection data showed that clinic cancelled within 6 weeks of the clinic had risen from 6% in September 2015 to 9% in December 2015. For clinics cancelled over 6 weeks the rates were 8% and 12% for the same months. However in January 2016 the percentages of cancelled clinics had dropped to 9%.Over time the number of cancelled clinics was improving.
- In 2015 there was a significant backlog of patients waiting for ophthalmology appointments. At this inspection we saw that the number of patients in ophthalmology who were breaching their 'see by' date (new and follow up patients) had fallen considerably from 6195 in July 2015 to 4354 in December 2015. Other specialties also saw a decrease in the number breaching 'see by' dates including cardiology, trauma and orthopedics, ENT, physiotherapy and urology amongst others. Rheumatology breaches remained consistent for the same period and dermatology, diabetes medicine gastroenterology amongst others had seen an increase. Overall, it was an improving performance with 4000 less breaches in December 2015 against July 2015.
- In 2015 some clinic managers we spoke with were unclear about the numbers of patients that had been waiting for excessive amounts of time for appointments. At this inspection, two clinic managers we spoke with had a better understanding of the number of patients waiting longer periods for appointments and the improvement plan in place to address this.
- In 2015 there was a significant problem with the choose and book appointment slots issues (ASIs). For example, there was a backlog of 227 ophthalmology and 233 dermatology patients waiting a call back at the time of our inspection and a total of 605 across all specialities. At this inspection there had been an improvement in ASI's with an average of 145 per week in December 2015, with a significant reduction in ophthalmology ASI's to 12 for the whole of December 2015. Operational taskforce meeting minutes showed that ASI's were closely monitored and referred to the appropriate specialty in the event of concerns.
- At this inspection did not attend (DNA) rates were monitored for each specialty. Protocols showed that DNA's were highlighted and sent to the relevant clinic coordinator to escalate or rebook as required. Clinic coordinators we spoke with could explain how this worked in practice and the decision making involved. Data showed that the trust DNA rate was lower than the England average.
- In 2015 all bookings made to the designated appointment centre were to the next available slot. This meant that at the time of booking patients were not being booked into slots which enabled them to be seen in line with their referral criteria for example within two or 18 weeks. However the trust confirmed that all referrals are clinically triaged and appointment priorities changed accordingly. At this inspection we found that this process continued and that all patients were appropriately assessed to determine when their appointment should be.
- In 2015 at the time of our inspection the trust had seen a fall in performance against the two week wait for cancer diagnoses. In December 2014 and January 2015 the trust saw a small percentage fall to 92% against a projected target of 92% but a more significant dip to only 89% during February 2015. The figures for March were not available however we were told that the trust was forecasting a further performance dip to only 60%. At this inspection, data showed an improvement in two week wait cancer appointments with the trust above target at 98% for December 2015.
- In 2015 we asked to review a recovery plan but this was not provided to us, therefore we could not be assured appropriate action was being taken in order to improve services. However we were told that the trust had made a commitment to the local CCG to be meeting performance targets by July 2015. At this inspection we found that there was a full recovery and improvement plan for cancer waiting times as part of the outpatient's improvement plan which was regularly reviewed by the trust and other stakeholders.
- In 2015 the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was worse than the England average. The

percentage figures had significantly fallen in the first part of 2015, meaning that patients were waiting longer for urgent treatment. Latest figures for the 62 day to treatment for urgent cases without reallocations showed that 83% meant this standard for December 2015 and 78% for January 2016 as opposed to the desired target of 85%. For 62 days from urgent referral to treatment with reallocations, the figure as 85% for December 2015 meeting target but was below target at 83% for January 2016. Further work needs to be done to ensure the target is consistently met. There was a general increase in performance across the other measures for cancer patient waits.

- In 2015 since the implementation of Epic the trust had seen a serious decline in its 18 week referral to treatment (RTT) performance. At the time of our inspection, 14 out of 18 specialties were not meeting the required target of 92% of patients waiting no more than 18 weeks from referral. Whilst recovery plans were in place for each specialty, sustainable improvement monitoring systems were not evident. At this inspection RTT recovery was part of the outpatient's improvement plan. Data showed that the department was continuing to miss the 95% standard for 18 weeks referral to treatment in October 2015. Operational taskforce meeting minutes showed an improvement in performance against RTT but was still missing the standard with 89.9% of patients being seen within 18 weeks in February 2016 with six specialties well below the standard Median waiting times for appointments was around 6 weeks with the highest being in trauma and orthopeadics where the median times was 10 weeks.
- Managers told us that some clinics were putting on additional services during the evenings and weekends to try and meet the service demand and see those patients who had been waiting a long time. At this inspection additional clinics were being arranged for some specialties including ophthalmology to meet demand.
- In 2015 a recent audit had identified that only 50% of calls being made to the outpatient department were being answered. We noted that there were plans to recruit 20 staff to the booking centre to improve this. At this inspection outpatients department meeting minutes showed that calls being made to the department were answered in only 50% of instances.
- In 2015 the trust was also not meeting its 6 week diagnostic performance target with over 1000 breaches being reported between January and March 2015. Again a recovery plan was in place and it was noted that the figures reported in March 2015 were significantly lower than those in the preceding two months. In January 2016, 58 (3.9%) patients waited longer than 6 weeks for an MRI, 1 person waited longer than 6 weeks for a CT and 16 (1.1%) for an ultrasound. The worst performance was in neurophysiology where 162 (38%) waited longer than 6 weeks for investigation. The average wait for CT scan was 5.5 weeks, for an MRI 8.6 weeks and ultrasound 6.7 weeks in December 2015. The wait for an MRI showed an improved performance over the preceding 6 months.

Meeting people's individual needs

- In 2015 in general the clinics we visited met people's individual needs. Most services were accessible via lifts and ramps were available where appropriate to assist with people's physical disabilities At this inspection we found one clinic to be accessible via a ramp. However the ramp was very steep with a door at the top. We were told that the ramp could become slippery and was on the department risk register. However, no changes had been made to the design.
- We were however concerned with the cataract clinic location, this was not easily accessible via lifts and signage was not appropriate. For example, there was no contrast in colour and fonts were small.
- There was a chaperone policy in place. This information was clearly on display throughout the service.
- At this inspection translation services were available in outpatients and diagnostic imaging. Translators were available via the phone or could be booked for face to face appointments.
- Staff spoke with considerable knowledge about their service and the support that was available to patients both within and without the hospital.
- There were good links with to the local mental health teams and the internal referral processes were clear.
- In 2015 there was excellent practice within the allergy clinic. This clinic was dynamic and comprehensive. A one stop allergy service had been implemented which provided a service for the diagnosis and management of a wide range of allergic disorders, including hay fever, perennial rhinitis; allergic or non-allergic, asthma, eczema, urticaria and angioedema, anaphylaxis, food

allergies and drug allergies, including allergy to anaesthetic agents, NSAIDs, antibiotics and local anaesthetics. At this inspection we continued to hear very positive comments about this service before and after the site inspection.
- Information was available to patients regarding support groups they could contact for specific conditions. We saw information relating to support groups for visually impaired people and for infectious conditions.

Learning from complaints and concerns

- Information was accessible on the Trust web site including the complaints policy. We saw posters distributed at multiple locations across the departments.
- Staff we spoke with were familiar with the complaints process and were able to tell us that what they should do if a patient raised a concern.
- In 2015 we were not be provided with evidence which demonstrated that complaints were used to inform learning and improvement locally. At this inspection we saw meeting and divisional governance meetings that demonstrated complaints were actively considered and any learning identified.
- In 2015 staff we spoke with could not describe a compliant which had led to service improvement. At this inspection seven staff we spoke with told us about complaints that had been received that had led to service improvement; this included the more frequent communication of clinic delays. They also told us that complaints were discussed locally in team meetings and huddles. Minutes of these meetings in three clinics confirmed that this happened.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated outpatients and diagnostics as requires improvement for well led because:

- Although a new management and governance structure had been had been put in place and the management team had been strengthened with the addition of a new out-patient manager and clinical leadership this was not yet embedded.
- The centralisation programme, though nearing completion was not fully implemented.
- Local meeting minutes varied in terms of quality and consistency which failed to provide continuity of information across outpatient services.
- Some issues which were raised at our inspection in 2015 still required addressing.

However, we also found that:

- There was a noticeable change in the morale and motivation of staff with the out-patient service beginning to develop its own identity.
- There was also evidence of effective monitoring of key performance indicators, risk and quality measures with clear progress against the improvement plan.
- In addition, there were clear routes for the escalation of issues and a cohesive senior management team who were all sighted on the current performance of the department.
- There were new initiatives to gain staff and patient feedback about their experiences in outpatients.

Vision and strategy for this service

- In 2014 the outpatients department started on a project of 'centralisation' to combine all outpatient clinics under one management structure. At the time of our 2015 inspection this project had stalled leaving the service disjointed and staff feeling confused about their place within the service structure.
- During our 2016 inspection we found that the trust had reinvigorated focus on the centralisation project and the majority of the outpatient clinics had been merged into one outpatient department.
- Vision and strategy for the service was short term focused with the aim of embedding centralisation and creating a unified outpatient service.
- We were told that longer term planning and service sustainability would be built on once centralisation had been complete. This was formalised in a strategy document which looked at the services plans between 2016 and 2019.

Governance, risk management and quality measurement

Outpatients and diagnostic imaging

- At our previous inspection the trust had not fully developed or implemented governance processes for outpatient services. This was an area of priority in the trusts recovery plan and by February 2016 substantial progress had been made.
- At this inspection a clear governance structure was in place and regular meetings were being held. We reviewed the minutes of the last two governance meetings together with the outpatient board minutes. These demonstrated that there was oversight of the outpatient departments' performance, risk, quality and key milestones.
- Improvement was being made with the services risk management systems but further work was needed. We reviewed a copy of the directorate's risk register and noted that whilst regular monitoring was now taking place key risks, although being managed, had not been triangulated to the register. For example, the backlog of patients in ophthalmology or dermatology.
- At this inspection further improvement was also required with the continuity of local meetings. We reviewed a sample set of minutes and noted that these varied in consistency and content. In order to ensure an effective governance and information sharing culture it is important that there is continuity in the messages being delivered and discussed.
- Minutes of meetings demonstrated that there was an emphasis on discussing and learning from incidents however, staff we spoke with on the front line were still unsure of what they should be reporting as incidents and could not articulate any recent learning.
- An audit plan was in place with 44 projects on-going within the department. Sustainability of the audit plan and the consequential learning and improvement could not however be tested during this inspection due to improvement being in the early stages.
- Governance systems for diagnostic and imaging services were well established. A radiation committee was in place as well as regular governance meetings and reports including a bi- annual Radiation Protection Adviser's / Radiation Waste Adviser's Report (April to September 2015).

Leadership of service

- In 2015 there was a lack of leadership for the outpatients department. The majority of staff we spoke with felt unclear about who had overall responsibility for the service and where issues would be escalated to. Clinical staff told us that management did not listen and that they felt they were running the service outside of the trust's leadership structure. At our inspection this had improved.
- We spoke with the Divisional Director and the Associate Director of Operations for outpatients. It was evident from our discussions that the trust board had continued to focus on improving out-patient services. This included the concentration to centralise the outpatient department and the work continuing to strengthen senior and middle management. Work had also begun on engaging stakeholders and patients to seek further areas of improvement.
- Roles and responsibilities were clearly defined and there was a sense of unity in the understanding of what was to be achieved within the service. There was consistency from all of the management team that we spoke with in terms of key achievements and the key risks and challenges.
- An outpatient manager had been appointed since our last inspection. This role, working alongside the clinical lead, had brought out improved over-sight of the service. Information such as, waiting times, clinic cancellations, ASIs and DNAs was readily available and we were shown that this was frequently monitored. This is a significant difference from our last inspection when there was no function within the trust that regularly reviewed and monitored this information.
- Staff told us that the leaders of the service were supportive and welcoming.
- The outpatient management team were visible to staff on the ground, regularly visiting clinics to support staff and resolve issues.

Culture within the service

- Culture within the service was much improved. All members of staff we spoke with felt that the service was becoming more open and transparent. We heard that access to managers was regular and feedback was becoming more frequent.
- Staff told us that they felt they could now approach management and feel listened to. An example of a representative quote was "My management structure is now much clearer and I feel confident to raise issues."
- A notable change in morale was within the booking centre, which had undergone significant positive

change. Staff in this department had implemented daily team "huddles". The members of the team we spoke with all agreed this has impacted on ensuring they felt up to date and empowered to do the best job possible.
- There was also an improvement in the morale of the administrative and clerical staff although further work was needed to ensure that they felt they were listened to and felt valued.

Public and staff engagement

- During our inspection in 2015 there was a lack of patient experience initiatives in place and management were unaware that the service had taken part in the friends and family test.
- At this inspection, improvement on seeking and acting upon patient feedback was in the early stages. However, initiatives had been started and there was evidence of analysis of patient feedback and consideration of changes in response to feedback. Feedback was collected via electronic kiosks and comment cards amongst others.
- The service had implemented touchscreen patient feedback kiosks in some of the clinics. We were provided with data which demonstrated the results were being monitored and analysed. We also noted that regular monitoring of the system was being undertaken at the outpatient's governance meeting. An action plan demonstrated that key themes were identified from the data and planned remedial action.
- At this inspection a new outpatients experience group had been set up which would include to ensure an overview of the patient experience within this department. We were also told of plans to invite service users to the department's quarterly governance meetings in order to feedback about their experiences.
- Staff we spoke with agreed that email communication was becoming more informative and relevant. This meant that they felt enabled to voice their opinions and input into service design and delivery.
- New outpatient services lanyards had been given out to staff. We heard how this made staff feel engaged with the service within which they worked and gave them a sense of identity.

Innovation, improvement and sustainability

- There was lack of innovation and sustainability during our 2015 inspection as staff did not feel empowered in their roles. We did however see the use of virtual clinics and heard about the vision to set up patient self-check-in stations.
- At this inspection there had not been much improvement in terms of visible innovations however the service had seen significant improvement throughout.
- The management systems had been strengthened, staff morale had been improved and the service was being well led by an experienced and committed leadership team. These improvements had led to the creation of an outpatient department with a platform for innovation and more sustainability than that of the one which we saw in April 2015.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that staff in maternity are compliant with mandatory training including safeguarding.
- Ensure that Neo Natal Early Warning observations are completed, recorded and responded to according to protocol and clinical need.
- Ensure that all staff receive feedback on incidents in their area or relevant to them in their work.
- Ensure all staff are aware of their responsibilities under Duty of Candour.

Action the hospital SHOULD take to improve

- Review the provision of information technology for the community midwifery teams.
- Review the provision of consultant hours on the delivery suite in relation to national guidance.
- Ensure that data in relation to delayed induction of labour is collected and acted on.