

The Royal Orthopaedic Hospital Foundation Trust

The Royal Orthopaedic Hospital Foundation Trust

Quality Report

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2015
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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



Critical care

Requires improvement



Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this inspection 28 and 29 July 2015 as a focused follow-up to an inspection we completed in June 2014. At that inspection the core services of Critical Care, which was a High Dependency Unit (HDU) at this trust and Outpatients Department (OPD) both had an Inadequate rating in one domain. This was within Safe for HDU and Responsive for OPD. Both services were rated as Requires Improvement overall. The trust received a follow-up inspection of those services to provide assurance that improvements had been made. Although diagnostics and imaging forms part of the OPD inspection the main issues had been in OPD, therefore the focus of this report was there. The inspection took place at this trust's one site which has the same name as the trust.

At the end of 2014 there were some issues relating to staff and medications, which the trust shared with us at the time. This resulted in some changes in staffing in governance and a wholesale review and change of processes regarding controlled medication. For this reason a pharmacist inspector joined the inspection team. We wanted to review the governance and the controlled medication processes. We received some whistle-blower allegations prior and during the inspection which we also had an opportunity to review within the remit of this inspection.

A further visit was arranged to view documents relating to Duty of Candour (Regulation 20). During that visit on the 05 August we visited OPD, X-ray waiting area, and the previously private ward.

At this inspection the two core services were rated as Required Improvement. However, we did see improvements in both core services. We noted that the trust responded to our concerns raised at the previous inspection, but we found that other issues impacted on their ability to meet the regulations. This has been reflected in the ratings.

Within HDU all the ratings remained the same as the previous inspection. Although the issues identified were different this time they had a significant impact across a number of domains.

Within OPD the result for safe remained the same. The responsive domain had improved from inadequate to requires improvement. This demonstrated that the trust had worked hard to improve the services for people and where the rating is requires improvement there is still some improvement work to be done. We have recognised within the reports that the trust has identified work streams to address the on-going improvement work. As part of the improvement work within OPD the trust had upgraded the patient administration system, to ensure it was compatible with the planned management information system due winter 2015.

Our key findings were as follows:

- Staffing of HDU with regards to children was not suitable. We found that children were being cared for within the unit but not always by a paediatric trained member of staff, nor were the facilities suitable for children.
- Within both core services we found that infection control practices were well embedded, and staff followed trust policy and procedures.
- We found that although the trust and its staff worked to the essence of the regulations of the Duty of Candour, in being open and transparent when things went wrong, they did not meet all of the requirements of that regulation.
- Multi-disciplinary working was effective in improving patient experience within the hospital.
- 100% of staff in both core services had received their appraisals, which was higher than the hospital's overall rate.

We saw several areas of outstanding practice including:

- The unit manager had ensured that staff were both aware and understood the values of the trust. A post box had been put on the unit to enable staff to identify what the values meant to them in their work on HDU. Staff views on the values displayed on a noticeboard and had also been discussed during staff meetings.
- Within Outpatients we observed that some clinicians were dictating letters to GP's and other services onto an electronic system for same day delivery, in the presence of the patient before the patient left the clinic.

Summary of findings

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

- Safeguarding training compliance rate needed to be improved in OPD, for both adults and children only reaching the trust target for awareness training.
- Privacy and dignity was compromised with the unacceptable arrangements regarding the toilet and washing facilities available for patients in HDU. There was only one toilet available for patients (adults and children, staff and visitors).
- The trust needed to ensure it could upload the information in the Intensive Care National Audit & Research Centre, so it could be benchmarked against other similar trusts.
- Within OPD management reports needed to be available to monitor clinic wait times and cancellations. There needed to be an agreed process which all staff followed in the event of a clinic being cancelled.

We were very concerned about care of children in the HDU, therefore have followed our processes to ensure that the trust takes appropriate action to improve the situation we found at inspection. Our specific concerns relate to:

- Medical and nursing cover must be improved on HDU when children are accommodated.
- Children must be cared for in an appropriate environment when requiring HDU care.

Importantly, the trust must:

- The trust must improve local leaders' understanding of the processes involved in exercising the duty of candour, in particular what they should expect beyond ward level and at a practical level, including record keeping.
- The trust must ensure sufficient staff are trained in safeguarding adults and children in OPD.
- The trust must improve the flow through the OPD so patients are not kept waiting for appointments.
- The trust must embed management arrangements within the OPD to ensure a firmer grip on the process of clinic booking and patient flow to improve waiting times for patients.

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?

Critical care

Requires improvement



The safety domain of critical care services was found to be inadequate. Improvement was primarily needed to ensure that children received appropriate care by paediatrician nurses and doctors. However, there were appropriate medical and nursing staff available to care for adult patients.

The availability of one toilet within HDU meant that both males and females (adults and children) used the same facilities which was not acceptable. Patients were treated with compassion and respect. Whenever possible patients and relatives were consulted and informed about the treatment they or their relative would receive.

There were appropriate systems in place to highlight risks, incidents and near misses. Appropriate actions were taken to ensure lessons were learned. The HDU was clean and there were appropriate systems in place to minimise the risk of cross-infection. The availability and use of equipment was found to be suitable to meet patient's needs.

There were suitable arrangements for the safe administration and storage of medicines. Although a need to ensure locked storage for intravenous fluids was identified and had been addressed by the hospital since our inspection.

People received effective care and treatment that met their needs. However as the HDU had not started to contribute data to the Intensive Care National Audit & Research Centre (ICNARC) it was not possible to benchmark HDU against other similar units.

There were arrangements in place to ensure that both nursing and medical staff had appropriate training and development opportunities. Multidisciplinary working was in place although handovers and ward rounds were not multidisciplinary.

Outpatients and diagnostic imaging

Requires improvement



We found outpatients & diagnostic imaging services required improvement. There were systems in place and in use for; reporting and learning from incidents, hygiene prevention and control, safe management

Summary of findings

of medicines, management of patients records. Risks to patients were identified and safely managed. OPD and radiology services were appropriately staffed. However sickness levels among staff had risen to a high level in June 2015.

The CQC does not currently provide a rating for the effectiveness of outpatients & diagnostic imaging services. We found the trust could not show us how effective some of its OPD systems were for patients. It did not have a clear picture of clinic cancellations and waiting times for clinics were variable.

Compared to the other orthopaedic trusts, there was a high follow- up patient to new patient ratio in this trust at 4:73. The trust said this was caused by the complexity of surgery required by patients who were sent there from outside the West Midlands. Most patients told us they were satisfied with their consultations, their treatment and plan including pain relief. Skilled nursing, medical and therapy staff worked together to provide the services.

We found that outpatients & diagnostic imaging services were caring. There was a system in place for patients who needed or wanted a chaperone during their consultations and treatment and support for patients to check in. Patients told us all types of staff treated them with respect and dignity and took care over their privacy and personal information. Doctors explained test results and answered patient's questions. They discussed a clear treatment plan with each patient taking into account their personal circumstances.

We found that outpatients & diagnostic imaging services needed to improve how they responded to patient's needs. The OPD was a new building designed for outpatient's services and was very busy. Patients got help to find their way around and to book in from volunteers. Staff understood how to help patients with dementia and implementing dementia patient 'pathways' was planned by the trust. However, the particular help that patients with learning disability might need in the outpatients services was not in place. Most patients got appointments in the OPD in an acceptable length of time after their GP had asked for one. Patients could also get urgent and rapid appointments when they needed them. However, the clinic booking system was complicated and 'block booking' of patients for

Summary of findings

appointment slots was happening for some clinics. This led to different waiting times for some patients especially when doctors had not referred ahead for x ray. The cancer service was better organised and also MRI scan reports were ready same day. Patients were helped to complain about the service in the OPD if they needed to.

We found the trust needed to improve how outpatients and diagnostic imaging services were led and managed. The trust had a vision for its future and we saw this information displayed in the main entrance of the OPD for patients. Many changes had taken place since our last inspection but improvements were recent and needed more time to show if they would work. Governance arrangements had been made stronger. Some areas were still weak around how the OPD was able to check how good its services were and improve them safely. Some work to improve this had been started but the improvements around how consultants ran their clinic appointments was patchy and needed firmer management. The trust wanted to hear patient's views about the service. Staff enjoyed working for the trust and felt involved in making improvements in the OPD services.

The Royal Orthopaedic Hospital Foundation Trust

Detailed findings

Services we looked at

Critical care; Outpatients & Diagnostic Imaging

Detailed findings

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Detailed findings from this inspection

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Background to The Royal Orthopaedic Hospital Foundation Trust

The hospital was established in 1817. The trust became a foundation trust in 2007. The existing hospital is situated in the south of Birmingham.

The hospital is a tertiary centre treating not only local people but people from across the UK and internationally.

The trust specialises in planned treatments of joint replacement, spinal and hand surgery as well as paediatrics. Nationally recognised as a centre of excellence for the treatment of bone tumours and for having a specialist bone infection unit.

Our inspection team

Our inspection team was led by:

Team Leader: Tim Cooper, Head of Hospital Inspection, Care Quality Commission

Inspection Manager: Donna Sammons, Inspection Manager Hospitals Birmingham, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a Deputy Medical Director, two Consultant

Anaesthetists, a Head of nursing with critical care experience, a Head of Outpatients, a Consultant Radiologist, a Medical Director and Deputy Chief Executive and a Head of Clinical governance and quality.

There were three experts by experience who were part of the team; they had experience of using services and caring for a person who used services.

How we carried out this inspection

We analysed the information we held about the service, which included national data submissions and information which people had shared with us. In addition to this we reviewed the information the lead inspector had regarding the service.

We visited the service as part of an announced inspection. The trust had 12 weeks' notice of our inspection start date.

We spoke with patients and visitors during the inspection. We also spoke with staff both clinical and non-clinical. We

Detailed findings

interviewed the executive team about their roles and responsibilities and the strength and weaknesses of the trust. We spoke to staff individually and in focus groups arranged in advance.

To reach our ratings we also reviewed documents in use at the time of the inspection and documents sent to us both pre and post the inspection, plus our observations of staff practice.

To get to the heart of people who use services' experience 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?
- Is it well-led?

We carried out an unannounced inspection on the 05 August 2015.

Facts and data about The Royal Orthopaedic Hospital Foundation Trust

Population served

The trust treats patients from both Birmingham and West Midlands area as well as across the country, many of whom have been referred by other hospital consultants for second opinions or for treatment of complex or rare conditions.

Location

- 128 beds plus 20 day case beds
- 10 Operating theatres

Staff (WTE)

- 966 staff (862 WTE)

Intelligent Monitoring

Number of 'Risks' 1

Number of 'Elevated risks' 0

Overall Risk Score 1

Number of Applicable Indicators 54

Percentage Score 0.93%

Maximum Possible Risk Score 108

Activity summary Apr/14 to Mar/15

- 6,813 planned inpatients
- 301 emergency admissions
- 8,186 day cases
- 73,969 out patients appointments
- Income: £77,998 million
- Surplus /deficit: -£464,000
- Full costs: £78,431 million

Our ratings for this hospital

Our ratings for this hospital are:







	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	Requires improvement

Detailed findings

Notes

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

Critical care

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

Information about the service

The Royal Orthopaedic Hospital had a 12 bedded High Dependency Unit (HDU); there were four side wards and eight beds on the main unit. The unit was commissioned to provide up to 10 level two beds. (Level two beds are for patients who have high dependency needs but are not ventilated).

The HDU provided care and treatment for both adults and children. Generally children were allocated to the two side wards on the far end of the unit. Adults received care in the main unit and the two other side rooms when needed. Between 01 July 2014 and 30 June 2015 there were 1160 adults and 155 children admitted to HDU.

The trust was members of the regional critical care network.

This was a follow up inspection to our inspection undertaken in June 2014 which identified that critical care services at The Royal Orthopaedic Hospital required improvement. The trust completed an action plan following our inspection which confirmed that all required actions had been undertaken.

We visited the HDU during our announced inspection. We spoke with 6 patients, 3 relatives and 23 staff which included nurses, doctors, physiotherapists, domestic staff and managers. We observed care and treatment, and looked at the records of nine patients on the HDU. Before the inspection, we reviewed performance information about the hospital.

Summary of findings

The safety domain of critical care services was found to be inadequate. Improvement was primarily needed to ensure that children received appropriate care by paediatrician nurses and doctors. However, there were appropriate medical and nursing staff available to care for adult patients

The availability of one toilet within HDU meant that both males and females (adults and children) used the same facilities which was not acceptable.

Patients were treated with compassion and respect. Whenever possible patients and relatives were consulted and informed about the treatment they or their relative would receive.

There were appropriate systems in place to highlight risks, incidents and near misses. Appropriate actions were taken to ensure lessons were learned. The HDU was clean and there were appropriate systems in place to minimise the risk of cross-infection. The availability and use of equipment was found to be suitable to meet patient's needs.

There were suitable arrangements for the safe administration and storage of medicines. Although a need to ensure locked storage for intravenous fluids was identified and had been addressed by the hospital since our inspection.

Critical care

People received effective care and treatment that met their needs. However as the HDU had not started to contribute data to the Intensive Care National Audit & Research Centre (ICNARC) it was not possible to benchmark HDU against other similar units.

There were arrangements in place to ensure that both nursing and medical staff had appropriate training and development opportunities. Multidisciplinary working was in place although handovers and ward rounds were not multidisciplinary.

Are critical care services safe?

Inadequate



We found that children On the HDU there was inadequate paediatric trained nurses to care for children at all times. We also noted that the paediatric medical cover arrangements were not suitable, having paediatricians in the hospital twice a week.

We found that following our last inspection improvements had been made to ensure the appropriate availability of medical and nursing staff were available for adults cared for in HDU.

Limited space in the side rooms posed a potential problem if responding to an emergency situation due to lack of space. We noted that IV fluids were not securely stored in HDU; however following our inspection this was addressed.

There were appropriate systems in place to highlight risks, incidents and near misses, although the completion of the safety thermometer required improvement to ensure that all risks were appropriately identified. Performance reports showed a good track record and steady improvement in safety. When something went wrong, there was an appropriate review or investigation. Appropriate actions were taken to ensure lessons were learned.

The HDU was clean and there were appropriate systems in place to minimise the risk of cross-infection.

The availability and use of equipment was found to be appropriate to meet patient's needs. Resuscitation trolleys were accessible and had been checked and signed as being 'in order' on a daily basis, as per trust policy.

Incidents

- No never events were linked to the HDU from 01 May 2014 to 30 April 2015. A never event is a largely preventable serious patient safety incident that should not occur if the preventative measures have been implemented.
- There were no serious incidents reported to the Strategic Executive Information System (STEIS) from 01 May 2014 to 30 April 2015 which were linked to HDU.
- The trust had an established system for reporting incidents and near misses through an electronic reporting system. The HDU had reported 45 incidents

Critical care

from 01 March 2015 and 30 June 2015 of which of which nine related to medication, and eight to staffing. Each incident submitted was reviewed and graded by a senior nurse or consultant. The subsequent investigation was proportionate to the grading and any harm to the patient involved.

- Mortality rates were discussed within the monthly clinical governance committee meeting. There have been no mortality outlier alerts for high dependency services at the Royal Orthopaedic hospital.
- Senior nursing staff were aware of the 'Duty of Candour'; they told us it was about being honest if things went wrong. One band five nurse said: "It's about apologising if we get it wrong or make a mistake".

Safety thermometer

- The safety thermometer was displayed on the unit for patients and relatives to view. The information related to falls with harm and the number of patients who had pressure ulcers and infections.
- The hospital used a management tool which contained information about the HDU and 'key performance indicators (KPI) against agreed targets. It included: staffing information such as sickness and compliance with mandatory training, incidence of pressure ulcers, slips, trips and falls and patient feedback. We saw that 'not applicable' was recorded for the incidence of identified infections and no information was identified for the percentage of completed venous thromboembolism (VTE) risk assessments was recorded.
- Following the inspection the trust made us aware that the information displayed was incorrect. Where it said 'not applicable' it should have read 'nil'.
- From 01 January 2015 to 31 June 2015 there had been two grade two hospital acquired pressure ulcers reported by staff in HDU.
- There had been no falls with harm between 01 March 2014 and 31 March 2015.
- We saw that performance each month was rated: red identified as urgent action, amber as concern and green as acceptable. An update was completed by the matron on 'red' areas. Information in the matron's update identified the action they were taking in mitigation.

Cleanliness, infection control and hygiene

- The HDU was clean and well maintained. There were cleaning plans in place, which identified the frequency that cleaning should take place. A thorough 'deep clean'

took place every Monday morning when the unit had the lowest occupancy. We saw records to show that housekeeping staff had signed to confirm that they had cleaned identified areas. We saw that cleaning audits were undertaken to check the cleanliness of the HDU. The audits identified when areas required additional cleaning and confirmed that those required actions had been undertaken.

- The HDU submitted data to monthly central venous cannula (CVC), peripheral venous catheter (PVC) and urinary catheter insertion and on-going management audits. We saw that mostly HDU maintained the required standard (more than 90%) although in May 2015 the PVC audit identified 60% compliance and requirements for the on-going management of urinary catheters was 94%. We saw that this information had been shared with staff and required compliance was met in June 2015.
- Hand sanitising gel was available at the entrance to HDU, at each bed space and throughout the unit. Signs to remind both staff and visitors about hand hygiene were visible throughout the unit. Since our last inspection signs reminding people of the importance of hand washing was also on the floor and the walls. Bed spaces were clearly marked to ensure that when staff moved from one bed space to the next they were reminded to wash their hands.
- Staff compliance with hand hygiene was checked weekly by a senior nurse and was rated as 'green' (acceptable). We observed that the staff washed their hands appropriately and wore appropriate personal protective equipment (PPE). Effective hand washing alongside the use of gloves and aprons reduced the risk of cross-infection.
- There have been no cases of MRSA in HDU since May 2008, although one patient was admitted with MRSA in 2010. Staff told us and this was confirmed by records we looked at that patients admitted for planned surgery were screened for MRSA infection.
- Staff told us that side rooms were used, where possible, as isolation rooms for patients identified as having an increased infection control risk. These rooms could also be used to protect patients with low immunity.

Environment and equipment

- We saw that that there was limited space around beds and also that side rooms were small. Side rooms were

Critical care

often used for children. We observed that this was problematic when side rooms had an additional bed to enable a parent or carer to stay alongside the child or adult. There was a risk that in an emergency situation it may be difficult for staff with emergency equipment to access the patient.

- It is best practice for children to be cared for in a designated HDU. We observed and staff confirmed that when children were improving and ready for discharge they did walk around the unit accompanied.
- We found that there was very limited storage space. Equipment which included a linen trolley was stored in two (empty) bed spaces and an unused side room. Staff assured us that during the weekly deep clean all equipment would be moved out and the bed spaces thoroughly cleaned.
- The unit had both an adult and paediatric resuscitation trolley. We saw that the resuscitation equipment was regularly checked and, when needed, restocked. There was a record of when these checks had been undertaken. Completion of the audits of the resuscitation trolley was identified as part of the HDU performance information (KPI).
- Managers told us that there was a 'rolling programme' to replace equipment and recently non-invasive ventilators had been replaced.
- During our last inspection we found that the HDU did not have adequate equipment to ventilate a deteriorating patient. We identified that this might be problematic and unsafe should a patient require level three (intensive care) and need to be transferred to another hospital that provided level three care. A portable ventilator was purchased in response to our findings. Staff showed us that this ventilator was now available, and had received training in its use.
- Staff told us that they had sufficient equipment to meet patient's needs. We found that medical equipment identified had the required service dates.
- A buzzer system which visitors spoke into to gain access was used to enter the HDU, to ensure that patients were kept safe.

Medicines

- There were systems and processes in place to ensure that medicines were stored and administered safely.

- The medicines fridge temperatures, including the minimum and maximum temperatures were recorded daily. A regular check of temperatures provided assurance that medicines were stored safely, and their effectiveness was not adversely affected.
- We found that intravenous fluids were stored in unlocked drawers. Staff said that these arrangements had been risk assessed and because they might be required in an emergency these arrangements were appropriate. However this practice is contrary to patient safety guidelines. We discussed this with the matron and unit manager who agreed to identify secure storage for intravenous fluids. We spoke with the matron after our inspection who confirmed that required changes were made to secure and locked storage of intravenous fluids.
- We checked a total of five sets of patient medication charts. All the medication records we checked were found to have been completed correctly.
- Emergency medicines were available for use and there was evidence that these were regularly checked.
- The hospital had an on-site pharmacy and pharmacists were available during the day with a call out system in place for emergency cover out of hours.

Records

- The HDU used paper based patient records. Records were completed and filed in a consistent manner to enable staff to easily locate required information about the patient, their treatment and care needs.
- We looked at five patients records during our announced visit. We saw that the records were clear and identified the treatment that patients had received and any further treatment or follow-up plan within HDU.
- Within the HDU paper-based nursing documentation which included a record of observations and risk assessment was present at each bed space. Risk assessments included pressure ulcer risk, nutrition risk, coma scale, and delirium assessments. We saw that observations were checked and recorded at the required frequency and any deviation from expected results was escalated to medical staff.

Safeguarding

- The trust policies and procedures were in place for safeguarding children and people in vulnerable circumstances.

Critical care

- Staff that we spoke with knew how to access safeguarding policies and procedures on the trust's intranet.
- Records we saw confirmed that 100% HDU staff had received safeguarding vulnerable adult's level one training as part of their mandatory training. 87% had level two adults safeguarding training. 100% of staff had received level two safeguarding children training. Staff confirmed that they had received safeguarding vulnerable adults training, and confirmed actions that would be undertaken to keep people safe.

Mandatory training

- Mandatory training included a one day clinical and one day non-clinical training day. The trust documents we reviewed had two targets for mandatory training 85 and 90 %. Training information provided by the trust identified that HDU had met the required target.
- In addition to the clinical and non-clinical mandatory training staff also received resuscitation training. The trust target for this training was 90%. Within the HDU dashboard it demonstrated that with the exception of February 2015 when 93% of staff had received this training the trust target was not met with results between 81-85% (01 January – 30 June 2015).
- Mandatory training attendance for nursing staff was monitored by the matron unit manager and the practice development nurse.

Assessing and responding to patient risk

- The hospital used the modified early warning score (MEWS) to identify acutely ill adult patients. A paediatric early warning score (PEWS) was used to identify acutely ill children.
- A patient's MEWS was calculated from each observation recorded on the patient's records. The score then identified deteriorating patients who required input from the critical care outreach team/critical care doctor. The team/ doctor then assessed the patient and a decision was made in relation to their on-going management.
- The critical care outreach team provided advice to wards when they had concerns about patients who were deteriorating and ensured appropriate actions were undertaken and also followed up patients following their discharge from HDU.

Nursing staffing

- The required and actual number of nursing staff on duty for each shift was displayed on the critical care unit. During our visit the required number of staff were on duty.
- We found that nurse staffing numbers met core standards for intensive care units. The unit could accommodate up to 10 level two patients Monday to Friday requiring five nurses on duty. Over the weekend due to reduced patient numbers and dependency staffing numbers decreased to four trained nurses on a Saturday and then a further reduction on a Sunday to two staff. In addition a shift coordinator was on duty twenty four hours a day seven days a week. This met core standards for intensive care units.
- During our last inspection we found that there was not always a supernumerary nurse or 'shift coordinator' on duty. During this inspection we found that a supernumerary nurse was on duty 24 hours a day and seven days a week.
- When shifts could not be fully staffed from their own staff working their contracted hours, shifts were filled by bank (the hospital's own staff working additional hours) or agency staff.
- The ward manager confirmed that they did use agency nurses when required although they tried to book nurses who had worked on the unit previously. We saw that the unit had an induction checklist that provided agency nurses with essential information about the hospital and the unit.
- HDU employed 4.6 WTE paediatric nurses who provided care for children whilst they were on the unit. However there were insufficient children's nurses to ensure a paediatric nurse was always on duty when the unit accommodated children. (Adult) nursing staff told us that they had looked after children for a long time and felt confident and competent to provide care to children. Information provided by the trust following our inspection confirmed that there were not sufficient children's nurses to cover all shifts and that they ensured that an adult's nurse who had experience caring for children was on duty. Defining staffing levels for children and young people's services, RCN standards for clinical professionals and service managers (2013) identify that there should be a minimum of two registered children's nurses on duty at all times in all inpatient and day care areas. This standard was not met in the HDU.

Critical care

- Nursing handovers occurred at least twice a day, during which staff communicated any changes to ensure that actions were undertaken to minimise the risks to patients.

Medical staffing

- The trust had a service level agreement for paediatric consultant advice. A consultant from a local provider visited the hospital two mornings a week and if requested would visit children on HDU. In addition a paediatric consultant was also available on an on call basis 24 hours a day for telephone advice. There was a staff grade doctor available to provide care for children overnight. The clinical lead also told us that the HDU registrar visited the children's ward to check that staff had no concerns about the children on the ward.
- We found during our previous inspection that consultants were only available on the unit in the mornings. In addition they had other responsibilities in the hospital whilst they were rostered to work in HDU, such as in theatres. When we highlighted this to the trust they immediately ensured that consultants were available in HDU all day. During this inspection we found that consultants were on the unit from 8am to 6pm and did not cover any other speciality during that time.
- There was a rota of 18 anaesthetic consultants who worked in the HDU, some but not all had a critical care qualification. The HDU had a ratio of one consultant for up to 10 patients this met intensive care core standards of a ratio of not more than 1 to 15.
- The clinical lead for HDU was an experienced critical care consultant.
- At night, a middle grade doctor or equivalent anaesthetist was on duty with a consultant anaesthetist on call from home.
- In the event of sickness doctor shifts were covered by locum doctors who had previously worked on the unit.
- The doctors within HDU had twice daily handovers and a daily ward round. This meant that patients' health and recovery was assessed to ensure they received appropriate and timely treatment.
- New admissions to HDU were reviewed by a consultant within 12 hours of admission.

Major incident awareness and training

- The trust had a major incident plan to prepare for all emergencies. Staff told us that all band six and seven staff who carried the hospital bleep had received major incident training.
- Staff told us that there had recently been 'major incident practice' which was a major fire in the hospital. HDU managers told us that they had not been informed before the practice had taken place but that their involvement had gone well.
- We saw that emergency plans and evacuation procedures were in place and on display on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.

Are critical care services effective?

Requires improvement



The HDU had not started to contribute data to the Intensive Care National Audit & Research Centre (ICNARC) therefore it was not possible to benchmark it against other similar units. This had been identified at the last inspection but had not been fully resolved.

People's care had good outcomes because they received effective care and treatment that met their needs.

There were arrangements in place to ensure that both nursing and medical staff had appropriate training and development opportunities. Staff understood their responsibilities around the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Multidisciplinary working was in place although handovers and ward rounds were not multidisciplinary. Seven-day working was in place for medical, nursing staff and physiotherapists. There were appropriate care pathways and clinical audit programmes in place to monitor adherence with guidance.

Evidence-based care and treatment

- HDU used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society, Faculty of Intensive Care Medicine (FICM) and Nursing and Midwifery Council (NMC) guidelines to determine the treatment it provided. Local policies were written in line with these.

Critical care

- There were appropriate and timely arrangements in place for deteriorating patients to be reviewed by the critical care outreach team. The availability of the outreach team and timely review of patients meets the requirements of NICE guidance using the local guideline modified early warning score CG35 Prediction and Detection of Impending Critical Illness in Adults. Records we looked at showed that critical care outreach staff responded quickly to deteriorating patients.

Pain relief

- A pain scoring tool was used in HDU. The pain assessment included patients own scoring of their pain.
- The records we looked at confirmed that patients had regular pain relief. Patients we spoke with told us staff ensured they had the pain relief they needed and they were kept comfortable.

Nutrition and hydration

- Patients we spoke with said that the food was tasty and appropriate for their needs. We observed that drinks were accessible for patients and that, when needed, nursing staff provided appropriate assistance.
- Should the unit have patients who were at risk of dehydration or poor nutrition there were appropriate arrangements in place to highlight the risk and actions to be taken.
- Policies were in place to enable patients who were unable to take oral nutrition or fluids to be given specialist feeds until they could be seen by a dietician. This meant that patients were protected against the risk of malnourishment.
- Staff told us that there was a service level agreement with another trust to provide dietician support if required.

Patient outcomes

- During our last inspection we found that HDU did not contribute data to Intensive Care National Audit and Research Centre (ICNARC), to benchmark the service against other similar hospitals. However, Critical Care speciality orthopaedics does not have a clear benchmarking criteria dataset in order to assess effectively the treatment received by patients.

- Since our last inspection arrangements were in place for HDU to contribute information to ICNARC. Staff told us that the data was being collected and they were waiting for the electronic systems to enable them to upload the data to ICNARC.
- The HDU collected data for a local audit of central venous catheters (CVC). The results were displayed for staff, patients and their relatives and showed 100% compliance (satisfactory compliance was 95%).
- Between 01 January 2015 and 30 June 2015 there had been 30 unexpected readmissions to HDU. The trust identified that this was a 5.2% readmission rate which local leadership said was an improvement. For the same time period in 2014 the rate was 7.9%.
- Between 01 July 2014 to 30 June 2015 there had been 16 patients transferred to other hospitals for additional specialist care such as level three intensive care.
- HDU had been part of an antibiotic audit to review the prescribing and use of antibiotics. The results of the audit were positive and identified a high level of adherence to the trust's guidelines and had achieved (94%). As a result of the audit we saw that actions to further improve practice were identified, such as pharmacist review to identify when antibiotics should be stopped.

Competent staff

- The high dependency unit had 56% of nurses with a post registration qualification in critical care which met the required standard of at least 50% of nursing staff with this qualification. Managers told us that two additional staff members had been identified to attend the next course.
- All new nursing staff had a hospital and local induction in HDU. They had a four week supernumerary period (six weeks for newly qualified nurses). New staff were assigned mentors.
- All nurse competencies were checked against standards identified by the critical care network. Staff told us that the four paediatric nurses were attending a local specialist trust to review their paediatric nursing competencies. However adult nurses who provided care for children had not had the same paediatric competencies assessed to provide appropriate care for children. Following the inspection the trust informed us that it was planned for the paediatric nurses to cascade that learning.

Critical care

- Following the inspection the trust confirmed that both adult and paediatric trained nursing staff had training in paediatric early warning, medication and paediatric life support training.
- Following the inspection the trust confirmed that the middle grade doctors used are competent in advanced paediatric life support (APLS) or advanced life support (ALS) and are on the unit 24/7.
- HDU had a practice development nurse to support nurse training and development needs and ensure they were competent to perform their role.
- At the end of April 2015, 100% of HDU staff had had an appraisal. All staff we spoke with confirmed that they received an annual appraisal.
- Following our last inspection, all consultants who worked in HDU had attended another local hospital critical care unit to review and update their competencies to provide high dependency care.

Multidisciplinary working

- Physiotherapists provided support to identified wards which provided care to specific conditions such as the spinal ward, hip and knee ward or the children's ward. Physiotherapists told us that they were able to track their patients and would visit and treat their individual patients whilst they were in HDU. This meant that the physiotherapists were able to follow on their treatment both on HDU and when they returned to the main ward.
- Ward rounds generally were not multidisciplinary. However the nurse allocated to that patient was present for all professional reviews. Multidisciplinary working can improve patient outcomes and provide effective patient care.
- Staff told us that a microbiologist visited the unit when required to provide specialist patient care. At other times, staff could obtain telephone advice. This meant that advice was provided which reflected changing recommendations and immediate changes could be made in response to national guidelines.
- There were visits to HDU five days a week by a pharmacist during which the patients' medicine needs were reviewed.
- There was one critical care outreach team member available between 07.45am and 6pm Monday to Friday and 8am to 4pm on Saturday for the management of

critically ill patients in the hospital. Staff told us that the availability of the outreach team was determined to be the times of greatest need around planned theatre activity.

- There was no speech and language therapist employed by the hospital due to the case mix they would have difficulty maintaining their competency. However, staff told us that if required they could contact the speech and language therapist from another trust for advice or review of patients with swallowing and communication difficulties.
- The hospital had a service level agreement with a local specialist trust to provide advice on children's care at any time.
- The hospital had a service level agreement with a local acute trust to transfer patients requiring level three or intensive care.

Seven-day services

- The HDU was open seven days a week, 24-hours a day.
- There was an intensive care consultant present in the high dependency unit five days a week 8am – 6pm. Consultant cover outside this time was provided by the consultant on call. In addition to this, at the weekend the named consultants on call did undertake ward rounds on the unit both days.
- Physiotherapy was available seven days a week although there was a reduced presence the weekends. However, staff told us that the availability of specialist respiratory physiotherapists was problematic as the majority of physiotherapists were specialist orthopaedic physiotherapists. Due to the case mix of patients it would have been difficult for a specialist respiratory physiotherapist to maintain their competency. Following the inspection the trust confirmed they supported on-call physiotherapists to maintain their competence. Radiology services were led by a consultant who was available for urgent x-rays and scans seven days a week and during the evening and overnight.
- The hospital pharmacy was open five days a week; Staff told us that they were able to obtain patients' medicines seven days a week.

Access to information

- On the HDU documentation containing plans of care and results were kept at the patient's bedside and were accessible by staff at all times.

Critical care

- Staff could access electronic care and treatment policies and procedures at all times.
- The HDU manager attended senior sister meeting with the matron and shared the outcome of these meetings with staff. Staff meetings were held monthly when information was shared with staff in addition to email and face to face sharing of information.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff we spoke with were clear about their responsibilities in relation to gaining consent, including those people who lacked capacity to consent to their care and treatment.
- Nursing staff told us they had received some training about the Mental Capacity Act 2005, as part of their safeguarding vulnerable adults training. Staff understood their responsibilities under the Act and what actions to take in patients best interests.

Are critical care services caring?

Good



Patients received a caring service with good emotional support. Throughout our inspection we saw patients treated with compassion and respect.

Whenever possible patients and relatives were consulted and informed about the treatment they or their relative would receive.

Compassionate care

- Patients were positive about staff and the care they received on the high dependency unit. One patient told us, "They have been excellent and kept me informed. I cannot fault them". A child told us "The nurses are all very kind and friendly".
- Throughout our inspection, we saw patients being treated with compassion.
- Privacy arrangements for patients were acceptable. Privacy curtains were closed and staff were seen to ensure they remained closed to maintain patients' dignity.
- We observed staff talking to patients and relatives in a respectful and friendly manner.

- Between 6 May 2015 and 16 July 2015 113 patients had completed the HDU patient survey. 100% of them said they were satisfied with the care provided by staff.
- 96.8% of HDU patients between 01 January and 31 March 2015 who had completed the NHS Friends and Family Test said that they would recommend the service.

Understanding and involvement of patients and those close to them

- Patients told us that they had been informed of their care needs and options for their treatment. Patients said that staff had explained their treatment and they had been asked to provide consent to their treatment and staff had acted in accordance with their wishes.
- One parent of a child receiving treatment told us; "They have been excellent. They have kept me informed from the time of referral via both telephone and email".

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open and supportive way. Patients and relatives were given good emotional support.
- A chaplaincy service was available, which provided valuable support to patients and relatives.

Are critical care services responsive?

The responsiveness of HDU required improvement. The availability of one toilet meant that both males and females used the same facilities which was not acceptable and does not meet the NHS contract requirements. In addition the accommodation of both children and adults on the same unit was contrary to national guidance.

Changes to ensure that HDU was open and staffed seven days a week was positive to provide additional assurances should patients in the hospital require high dependency care.

Within HDU support for patients living with physical and learning disabilities, dementia, or those who had communication difficulties, was available, if needed.

Service planning and delivery to meet the needs of local people

- The HDU was a high dependency unit with 12 beds but staffed to accommodate up to 10 level two beds (high dependency beds, but non-ventilated patients) only.

Critical care

- HDU provided care for surgical patients who required high dependency care after their surgery and for patients who may deteriorate whilst on the wards.
- The HDU was staffed to accommodate patients seven days a week twenty-four hours a day.

Access and flow

- Prior to July 2014 the bed occupancy for HDU was reported as 100%. The matron explained this was due to incorrect collection of data (all admitted patients compared to number of beds occupied at 12 midnight). Q1 2015/16 average bed occupancy was 53%. The national average critical care bed occupancy was 86%. This meant that there were sufficient beds to meet patient's need.
- Staff told us that the majority of admissions to the unit was planned and related to their planned surgery. Potential admissions to the HDU were discussed with the consultant covering HDU prior to their admission.
- The trust was part of the critical care network and there were agreed protocols in place to transfer level three patients. From 01 April 2014 and 31 March 2015 there were 18 patients transferred to other hospitals from HDU due to clinical reasons such as requiring level three (intensive care). There were 13 patients transferred between 5pm and 8am or over the weekend. This meant that there were appropriate and timely arrangements in place to ensure patients received additional care when required.
- From 01 April 2015 to 30 June 2015 there had been no paediatric transfers from HDU. When patients were transferred out of the unit, they were accompanied by a suitably skilled healthcare professional to support them whilst in transit. When children were transferred out of the unit a specialist retrieval team would support.
- There was one operation cancelled due to the lack of availability of a high dependency bed between 01 January 2014 and 30 June 2015.

Meeting people's individual needs

- When we visited HDU we found that the unit had only one toilet for use by both male and female patients, staff and visitors, including both adult and paediatric patients. We told the trust our concerns about these arrangements. We contacted the matron after our

inspection. They told us there were plans for an additional toilet/ shower and a change of 'footprint' for the unit to be assured that appropriate accommodation was available.

- The Department of Health required all providers of NHS funded care to confirm by 01 April 2011 that they were compliant with mixed sex accommodation except where it was in the patient's best interests or reflected their choice. A breach of 'mixed sex accommodation' refers not only to sleeping arrangements but also bathrooms and toilets and the need for patients to pass through areas for the opposite sex to reach their own facilities. Staff told us that when patients no longer required high dependency care they were discharged from the unit within four hours and this avoided 'a mixed sex breach'. However, this situation was unacceptable practice.
- Support for patients living with physical disability, learning disability or dementia was available if needed. Staff told us that they usually received assistance from families. Staff told us that they 'planned ahead' for the needs of patients with complex needs and meetings had recently been held for a patient expected admission in three months' time. Staff said that this meeting was invaluable to enable them to understand the patient's needs.
- The HDU provided care for both children and adults. Generally children were cared for in two side wards on the far end of the ward, although staff told us there were occasions that older teenagers were cared for on the main unit. Paediatric intensive care standards do not advocate that children and adults are cared for on the same unit.
- There was a small visitors' room with tea and coffee making facilities available. Staff told us that parent could stay with their child and there was overnight accommodation available within the hospital. We spoke with one family who told us that they had accommodation within the hospital at minimal cost.
- Regular meetings were held with the patient and family members to ensure they were included in treatment decisions and, where necessary, interpreters/translation services were arranged.

Learning from complaints and concerns

- There had been no complaints about HDU between 01 June 2014 and 30 June 2015.

Critical care

- Staff told us that if a patient or relative wanted to make an informal complaint, they would be directed to the nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns could not be resolved locally.
- Complaints information was included on the specialty quality improvement and KPI dashboards, which were discussed at departmental meetings. On a monthly basis, senior leadership received a report detailing any complaints received.
- Information on how to raise concerns and make a complaint was on posters displayed within HDU and visitors room.
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Requires improvement



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Are critical care services well-led?

Requires improvement



We found that the trust had not managed the paediatric cover effectively with regards to both nursing and paediatric cover. There was a lack of oversight in relation to the needs of children within HDU and national guidance was not met.

The lack of completion of ICNARC data meant that the leadership were unable to fully reflect on the performance of the unit compared to other similar units.

The mix sex breaches relating to the toilet facilities needed to be addressed to prevent breach and enable adult patients, children, visitors and staff to have suitable facilities.

Staff working in HDU were aware of the trust's vision and demonstrated commitment to its objectives and values.

The leadership, governance and culture of HDU promoted the delivery of high quality person-centred care.

There was an effective process in place to identify, understand, monitor and address current and future risks. Performance issues were escalated to the relevant managers and quality assurance meetings and to the board through clear structures and processes.

The nursing leadership were knowledgeable about quality issues and priorities for adult critical care. Staff felt valued, respected and supported.

Vision and strategy for this service

- Staff were aware of and understood the vision and values of the trust and the behaviours that would achieve these values.
- Staff told us the unit manager had asked them all about what the trust values meant to them. A post box had

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been put on the unit to enable staff to include their views of the values. Staff views on the vision were displayed on a noticeboard and had also been discussed during staff meetings.

- There was a vision that all staff would have the skills and competence to care for level three patients in the future.

Governance, risk management and quality measurement

- There were monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were fed back to staff.
- The HDU managers encouraged staff to report incidents and staff confirmed that they received feedback on the incidents they reported.
- Managers were keen to tell and show us improvements made since our last inspection.
- Systems were in place to contribute to ICNARC data although this had not commenced at the time of this inspection. This meant that the hospital did not have full assurance of the performance of the unit in comparison with other comparable units. However, the trust expected to be in a position to upload data by December 2015.
- Risks inherent in the delivery of safe care were identified on the trust's risk register: the HDU risk register had 29 identified risks of which one was identified as high risk and identified inappropriate use of identified equipment. Another risk identified was a review of staff competencies, training needs and a need for additional paediatric nurses. We saw that there were control measures in place such as high dependency consultants visiting another hospital to review and update their competencies and progress was in place to minimise any identified risk. HDU risks were reviewed at the monthly team meetings. However we did note that the mix sex breach associated with the lack of toilet facilities for males, females and children was not present. Also the paediatric medical cover had not been identified as a risk.
- A root cause analysis was undertaken following each serious incident. Records of investigations which we saw detailed identified actions to reduce the risk of further, similar incidents in the future.

Leadership of service

- HDU had a consultant intensivist who had been appointed since our previous inspection and was medical clinical lead for HDU. This meets intensive care core standards.
- HDU had a modern matron (band 8) who had a specialist qualification in critical care in addition to a management qualification and had overall responsibility for the nursing elements of the services. This met core intensive care standards.
- The matron and unit manager had both commenced employment after our previous inspection.
- Our previous inspection found that a supernumerary band 6 or 7 nurse was not in charge of each shift on HDU. We found that all shifts had a supernumerary nurse or 'shift coordinator' on duty which met intensive care core standards.
- The leadership ensured that there was shared learning and support for all HDU staff.
- The leadership drove continuous improvement in patient care, sharing good practice and highlighting audit findings with staff and when improvements were needed. For example, staff had been responsive to a need to improve and identified improvements had been made.
- We saw that both medical and nursing leadership were actively involved in quality improvement. For example, the clinical medical lead was able to demonstrate since medical and nursing staffing arrangements had been improved the number and dependency of patient transfers from HDU to other hospitals had decreased.
- We found that the leadership were responsive to suggestions for improving care outcomes and ensuring requirements of the previous inspection had been met.

Culture within the service

- Staff spoke positively about working for the hospital and the unit. Staff told us they would recommend it as a place to work and that senior staff were supportive.
- Staff commented that they were "a good team".
- Managers told us that they were proud of their team and their commitment to high quality patient care.

Public engagement

- An on-going patient survey provided valuable feedback from patients and their experiences of care within HDU. We saw results from May to July 2015, where 100% of

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patients were satisfied with the overall level of care offered by staff. The lowest score for the same time period was 86% of patients thought they had been given an explanation of nursing care and procedures.

Staff engagement






- The trust used a combination of email, intranet messages and newsletters to engage with staff.
- Managers were visible on HDU and staff spoke positively about matrons and the support they provided.
- Staff told us that the executive team had also visited the unit and had been supportive.

Innovation, improvement and sustainability

- There were appropriate systems in place to review service delivery and, when needed, ensure that lessons were learned and appropriate actions taken. As a consequence of medication incidents, nursing staff involved had to complete a reflective practice summary and learning was shared by the team.

- HDU managers had requested a peer review of the service from critical care network which had been undertaken and identified improvements had been made. For example an improvement in medical cover consistency within the HDU rota.
- HDU had a quality improvement plan which demonstrated a commitment to quality care while obtaining best value for money.
- The clinical lead for HDU had ensured that all consultants who worked in HDU had visited another hospital to ensure their competencies to provide high dependency care had been updated.
- Paediatric nurses within HDU had a two week secondment at a local specialist trust to review and update their paediatric / high dependency care competencies.

Outpatients and diagnostic imaging

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

Information about the service

The outpatients department had 136,473 appointments from January to December 2014. This was in the lower range of comparison with all trusts in England. It represented; 78% as follow up appointments, 16% as first appointments and 5% did not attend their appointment (DNA). The number of first appointments were lower than other orthopaedic trusts and all England trusts. The follow up appointment rate was higher than both and the DNA'S were the same as other orthopaedic trusts (5%) and lower than all England trusts (7%).

The outpatients department (OPD) provided 26 treatment/examination rooms in new build accommodation and had 60 clinicians working at varying frequency running clinics.

Patients were referred to the Out Patients Services (OPD) at the Royal Orthopaedic Hospital from all over the country and many travelled a long distance and stayed overnight locally. (Throughout this document when we mention OPD we are referring to the OPD)

Clinics ran on a five week schedule averaging 104 clinics per week.

We undertook a Comprehensive Inspection of the trust in June 2014 and found that the OPD overall required improvement. Although 'caring' was rated as 'Good', safety and leadership were rated as 'Required Improvement'; responsiveness was rated as 'Inadequate' (CQC did not give a rating the effectiveness of OPD's at that time).

The trust was required to put in place an action plan for improvement and we had contact with it regularly to monitor the plan. Our inspection of 28 July 2015 was a follow up inspection of some services provided by the trust.

We visited the trust on 28 and 29 July 2015 announced and visited the OPD department again unannounced on 5 August 2015.

We spoke with 30 patients and followed 12 through their appointments in a variety of clinics, from arrival to leaving including the consultation. We spoke with 21 staff at different levels and in different roles.

Outpatients and diagnostic imaging

Summary of findings

We found outpatients & diagnostic imaging services required improvement. There were systems in place and in use for; reporting and learning from incidents, hygiene prevention and control, safe management of medicines, management of patients records. Risks to patients were identified and safely managed. OPD and radiology services were appropriately staffed. However sickness levels among staff had risen to a high level in June 2015.

The CQC does not currently provide a rating for the effectiveness of outpatients & diagnostic imaging services. We found the trust could not show us how effective some of its OPD systems were for patients. It did not have a clear picture of clinic cancellations and waiting times for clinics were variable. Compared to the other orthopaedic trusts, there was a high follow-up patient to new patient ratio in this trust at 4:73. The trust said this was caused by the complexity of surgery required by patients who were sent there from outside the West Midlands. Most patients told us they were satisfied with their consultations, their treatment and plan including pain relief. Skilled nursing, medical and therapy staff worked together to provide the services.

We found that outpatients & diagnostic imaging services were caring. There was a system in place for patients who needed or wanted a chaperone during their consultations and treatment and support for patients to check in. Patients told us all types of staff treated them with respect and dignity and took care over their privacy and personal information. Doctors explained test results and answered patient's questions. They discussed a clear treatment plan with each patient taking into account their personal circumstances.

We found that outpatients & diagnostic imaging services needed to improve how they responded to patient's needs. The OPD was a new building designed for outpatient's services and was very busy. Patients got help to find their way around and to book in from volunteers. Staff understood how to help patients with dementia and implementing dementia patient 'pathways' was planned by the trust. However, the particular help that patients with learning disability might need in the outpatients services was not in place.

Most patients got appointments in the OPD in an acceptable length of time after their GP had asked for one. Patients could also get urgent and rapid appointments when they needed them. However, the clinic booking system was complicated and 'block booking' of patients for appointment slots was happening for some clinics. This led to different waiting times for some patients especially when doctors had not referred ahead for x ray. The cancer service was better organised and also MRI scan reports were ready same day. Patients were helped to complain about the service in the OPD if they needed to.

We found the trust needed to improve how outpatients and diagnostic imaging services were led and managed. The trust had a vision for its future and we saw this information displayed in the main entrance of the OPD for patients. Many changes had taken place since our last inspection but improvements were recent and needed more time to show if they would work. Governance arrangements had been made stronger. Some areas were still weak around how the OPD was able to check how good its services were and improve them safely. Some work to improve this had been started but the improvements around how consultants ran their clinic appointments was patchy and needed firmer management. The trust wanted to hear patients views about the service. Staff enjoyed working for the trust and felt involved in making improvements in the OPD services.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We found that the arrangements for the trust to discharge its duty of candour, although understood by staff, were not thorough.

Safeguarding adults and children training levels were low and did not reach the trust target. Sickness levels among staff had risen to almost twice the trust target in June 2015.

There were systems in place and in use for reporting and learning from incidents, hygiene prevention and control, safe management of medicines and management of patient's records. OPD and radiology services were appropriately staffed.

We did note that the compliance rate for mandatory training was falling short of the trust target by a significant amount.

Incidents

- No serious incidents were reported by the outpatients department (OPD) from May 2014 to April 2015.
- The trust had an electronic system for staff to report incidents and we noted from records we saw that it was used.
- The sister for the OPD showed us that the incident reporting access appeared on the desktop page of the internal computer system. That meant all staff had instant access to it by clicking the icon and logging in without searching the intranet to find it.
- Local leaders told us incident reports were seen and acknowledged in writing by the matron, the directorate manager and the patient access team. We saw this when we looked at an example of a recent report.
- We noted on the electronic incident reporting form that there was a tab for duty of candour. However, when we tracked a recent example (10 July 2015) of when harm had resulted from a patient's care or treatment we found the procedure was incomplete.
- We were assured that lessons had been learned from the incident and the changes made in practice were explained to us.

- Local leaders told us if the harm was severe letters would be written by the patient advice and liaison service (PALS) and the incident would go to governance.
- However they could not tell us if governance put explanations and findings from investigations into writing to the patient as there had been no severe harm incident in the OPD to test the procedure at that time.

Cleanliness, infection control and hygiene

- The trust had policies and procedures for hygiene and infection control.
- There were hand sanitising dispensers on walls around the department. We noted however that some were not always visibly situated. For example they were behind people when they had walked into the main waiting area and around a corner in one of the 'pod' waiting areas outside clinic rooms. We saw no patients or visitors using them.
- We noted that all staff complied with the policy of 'bare below the elbow' and no neck ties were worn in clinical areas.
- We noted clinical staff washing their hands after consultations.
- Data provided on the OPD assurance dashboard showed that local leaders were expected to submit weekly staff hand hygiene audits. This had a high level of compliance during 2014 with the exception of December 2014 when compliance was rated at 'red'.
- We noted from the 2015 dashboard that this requirement had moved to monthly submissions and trust target compliance was 95%, this was achieved each month to June 2015.
- There was information about the Ebola virus on posters around the OPD.
- The environment was clean, tidy and uncluttered.
- Data provided on the OPD assurance dashboard showed that local leaders were expected to submit monthly environment hygiene audits. The OPD had complied with the trust's target of 85% from January to June 2015.
- Four patients remarked to us on how clean the hospital was and those from out of the region compared the cleanliness favourably with their own local hospitals.

Environment and equipment

- The environment was contemporary in design, spacious, light and airy and sign posting was good.

Outpatients and diagnostic imaging

- Patients we spoke with all commented favourably on the environment.
- We noted a system was in place for spot checks on OPD resuscitation trollies and we saw a sample of the records signed off by matron for December 2014 to February 2015.
- Data was collected against key performance indicators on the OPD assurance dash board monthly.
- The trust told us it had identified the MRI safety check as a positive example of proactive safety good practice. We were unable to check the effectiveness of this practice as there were no cases in the time period looked at.

Medicines

- We found no controlled drugs medication being stored within the OPD.
- We noted local leaders weekly spot check of medication records and storage on both floors of the OPD. We saw a sample of a drugs cupboard check for December to January 2015 signed off by matron with comments including one deficiency noted and signed as actioned.
- Data was collected against key performance indicators on the OPD assurance dash board monthly. The dashboard showed when checked in January- June 2015 that drugs competencies by staff already trained, or completion of competencies new to the skill, was 100% compliant.

Records

- The trust told us there was a procedure in place in the event of lost or missing notes.
- On the day of clinic, a search was undertaken until the deadline of the clinic appointment. This was escalated to senior member of team to perform.
- Temporary notes were raised, with copies of clinical letters and pathology/imaging reports taken from the I.T systems. Referrals letters were requested along with any other relevant documents from GPs or other referring trusts as appropriate.
- Clinicians were made aware that the notes were duplicate and they were clearly marked on the folder as such.
- The case note tracking system was flagged that there were temporary notes in existence to avoid confusion with the original volume.

- An incident was raised using the trust incident reporting system for investigation and a record was kept by the health records team leader to report to governance as part of the monthly key performance indicators (KPI).
- When missing notes were located the temporary set was merged to ensure completeness.
- We observed that patient's records were securely stored in locked portable trollies while they were needed in the OPD.
- We noted in a log of incidents reported from March to May 2015 that patient's notes had been reported as missing on six occasions.
- We noted local leaders weekly spot checked records for note storage using a simple audit tool.
- We observed that clear and well organised records were kept for patients and none were left accessible or visible to the eye outside of clinic rooms or left unattended.
- Data submitted via the assurance dashboard for the OPD showed that five sets of nursing notes had been checked each month by the sister during 2014 and to June 2015.

Safeguarding

- Within OPD documents supplied at the time of the inspection by the trust demonstrated that adult safeguarding rates were; awareness 100%, level one 73% and level two 18%. Child safeguarding training levels were; awareness 100%, level one 9% and level two 27%. The trust had identified three staff to undertake the level three child safeguarding which they had completed. The trust minimum requirement was 85%, this demonstrated that within level two for both adults and children more compliance was required.
- Staff understood their responsibilities to safeguard children and people in vulnerable circumstances, including noting any non-attendance at booked appointments, and confirmed the trust's policies and procedure that were in place to guide them.
- Local leaders gave us an example of how the OPD had been proactive in marshalling social care support for a patient who was homeless and presented to the OPD in a very poor state of health.

Mandatory training

- Staff that we spoke with told us they were up to date with their mandatory training.

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- We noted the white board tracker system in the sister's office that alerted when staff were due for a refresher course.
- Local leaders told us there were electronic records held for study days and training and staff get automated reminders when training is due.
- Data was collected against key performance indicators on the OPD assurance dash board monthly.
- It showed clinical mandatory training day attendance, resuscitation life support and manual handling training achieved the trust's target of greater than 90% compliance for the months January to June 2015.
- We noted local leaders monthly record of staff compliance with basic life support training between November 2014 and July 2015 was 90% to 100%.

Assessing and responding to patient risk

- Senior leaders told us the policy was to discharge a patient if they failed to attend (DNA) for an appointment. However clinicians received each DNA patient's notes and made the judgement on a case by case basis.
- The OPD acknowledged on its risk register in May 2014 a risk to patients from the service being provided over two separate floors and two main waiting areas and the emergency buzzers could not be linked. This was addressed by increasing staffing levels through the trust bank.
- Senior leaders told us a business case was made in December 2014 when this was reviewed to appoint a qualified nurse to cover each floor. We noted there was a qualified nurse on duty on each floor on the day of our inspection. Health Care Assistants that ran the clinics within the pods confirmed that there was a qualified nurse on each floor and they could see where the nurse was working from the roster. They gave us a recent example of when they needed to access a nurse to see a patient who was feeling faint after a clinic consultation.
- Trust policy is that paediatric patients were not anaesthetised in the MRI suite due to its isolated position. These patients were scanned at a local specialist trust or the local acute hospital. This policy ensured the safety of children who required anaesthetised MRI.

Nursing staffing

- A new acuity tool had been put in place and a business case developed for a nurse coordinator to act as a trouble-shooter around the department and deal with blockages in flow.
- Two registered nurses were on duty each day, one on each floor. Their role is to support patients, the healthcare assistants and doctors working in the clinic.
- The clinics were staffed by health care assistants and they worked within each pod to facilitate the clinics.
- The trust told us regular bank staff who knew the department and its processes were used to cover for leave.
- The OPD was clinically led by a sister. They confirmed that there was one agency nurse on the team at the time of our inspection, who had been block booked for consistency.
- Staff sickness rate data submitted via the OPD dashboard showed the service was well below the trust target rate of 4% in January, February and April but rose to 5% in March and 7.6% in June 2015.

Medical staffing

- Clinics were delivered by clinicians who included consultant teams, advanced nurse practitioners, extended scope physiotherapist and occupational therapists.

Are outpatient and diagnostic imaging services effective?

The CQC does not currently provide a rating for the effectiveness of these services.

We found the trust could not provide evidence of the effectiveness of some of its OPD systems, it did not have a clear picture of clinic cancellations and waiting times for clinics were variable.

Compared to the other orthopaedic trusts, there was a high follow up to new ratio in this trust at 4:73 and the trust accounted for this by the complexity of surgery required by patients who were referred from outside the region.

Some monthly audit activity was taking place such as compliance with the trusts policy and procedures on infection prevention and control on a monthly basis. This was reported through the assurance dashboard to governance.

Outpatients and diagnostic imaging

Most patients told us they were satisfied with their consultations, their treatment and plan including pain relief.

The trust had an annual audit plan and the OPD carried out a cycle of audits of some of its clinical outcomes for patients.

Nursing, medical and therapy staff provided a multidisciplinary approach to the services. Staff annual appraisal rates were good. Training in some specific skills was made available for non-qualified nursing staff.

Clinics ran on Monday to Fridays. Magnetic Resonance Imaging (MRI scan) services were available to the OPD seven days a week. Radiology worked with the OPD to provide a 'one stop' shop for oncology patients to speed up their treatment.

Most patients told us they were provided with enough information about their condition, treatment and care.

Evidence-based care and treatment

- The trust told us the percentage of patients seen without a full medical record being available was 0.01% but did not give the time scale for this data and it was not clear how this figure was arrived at.
- Compared to the other orthopaedic trusts, there was a high follow up to new rate in this trust at 4.73. The England average was 2.4 for January to December 2014.
- The trust says that the data supported the logic that there was a correlation between the distance from which patients were being referred, and the possible explanation for this was that more distant referrals were for more complex conditions that would require more complex surgery.
- We saw from records that data on key performance indicators, including compliance with the trusts policy and procedures on infection prevention and control was collected through a monthly dashboard. We saw from minutes this was reported to and discussed at monthly governance meetings.
- We followed 12 patients through from their booking in at reception to their consultation. Most patients told us they were satisfied with the outcome of their consultation and their treatment and plan.

Pain relief

During the consultations we observed that clinicians asked patients about their pain relief strategies and gave them advice on pain management where appropriate.

Patient outcomes

- We noted five local clinical audits planned during 2015/16.
- Three, monthly audits were conducted in respect of large joints work but the trust record indicates further information had yet to be submitted as requested for quarter one of the year.
- An audit of the use of ethyl chloride spray as an alternative to local anaesthesia injection for ultrasound guided percutaneous musculoskeletal injections was completed and due to report in October 2015.
- Therapy services were auditing micro discectomy surgery pathways and waiting times. This was noted on the trusts record as 'on-going' with the comment 're-audit in January 2016'; it is therefore not clear what the results of this audit were.

Competent staff

- Trust data showed that annual performance appraisal for OPD staff was at 92% in January and February 2015 with March to June 2015 hitting the trust's 100% target.
- Consultant teams, advanced nurse practitioners, extended scope physiotherapist and occupational therapists and psychologists delivered clinics.
- The OPD was led by a matron and sister.
- Two registered nurses were rostered on duty each day. The balance of qualified nurses to health care assistants was 40% nurses and 60% assistants.
- Unqualified staff that we spoke with told us they could access training opportunities on the trust's intranet. Two health care assistants for example, told us their most recent training events were on using a cannula and taking blood sugar levels.
- Leaders told us the trust was intending to train radiology staff to provide children's x ray imaging when it was needed in particular for patients with spinal deformity.
- We noted Radiology had a lead radiographer, an MRI radiographer lead and a consultant radiologist.

Multidisciplinary working

- Senior leaders told us oncologists attended weekly multi-disciplinary team meetings to identify urgent patients coming in to the OPD.

Outpatients and diagnostic imaging

- We saw through an incident we tracked, an example of good multidisciplinary working with community nurses. Community nurses had reported back an incident involving the wound dressing of a patient with compromised capacity and the OPD had worked with them to improve OPD practice and continue to support the patient.
- Radiology worked with the OPD to provide a 'one stop' shop for oncology patients, reducing wait times for imaging results, speeded up the care and treatment pathway. This demonstrated a real focus on the patient experience.
- Local leaders told us there was an MDT meeting each Tuesday for all oncology patients to coordinate activity for work.

Seven-day services

- Clinics ran on Monday to Fridays from 9am to 4pm. Not all types of clinics ran all day and not all clinics ran every day. In addition to this the trust offers some clinics on Monday, Wednesday and Thursday evenings.
- Magnetic Resonance Imaging (MRI scan) was available from 8am to 8pm Monday to Friday and from 9am to 5pm on Saturday and Sunday.

Access to information

- Most patients we spoke with told us they were provided with enough information about their condition, treatment and care.
- We observed a number of consultations and noted patient's case notes were provided by HCA's running the clinics and clinical staff had access to imaging results on their table top computer screens when they saw their patients.
- The incident reporting log for the OPD showed that case notes had been missing or incomplete sets or misplaced pages on at least six occasions between March and May 2015. There was a procedure for missing notes that included escalation to a senior staff member. Temporary notes were raised, with copies of clinical letters and pathology/imaging reports taken from the I.T systems.
- We observed that some clinicians were dictating letters to GP's and other services onto an electronic system for same day delivery, in the presence of the patient before the patient left the clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most patients we spoke with told us they were happy with the procedures and the outcome of their treatment.

Are outpatient and diagnostic imaging services caring?

Good



We found that services were caring. There was a system in place for patients who needed or wanted a chaperone during their consultations and treatment and support for patients to check in.

Patients reported that staff in all roles had treated them with respect and dignity and we observed good practice around privacy and confidentiality.

Clinical staff explained test and imaging results, answered questions and offered and discussed a clear plan with each patient taking into account their personal circumstances.

Outpatients were able to access the emotional support services provided by the hospital.

Compassionate care

- We noted the trust had a chaperone policy and we saw the system in place was well embedded in practice.
- All of the patients we spoke with reported that staff in all roles had treated them with respect and dignity.
- We noted that patient's privacy was respected throughout the checking in process and during consultations. For example we saw examinations took place in single rooms and staff closed the curtains.
- Patients who were unable to use the self-check in system received support from reception staff.

Understanding and involvement of patients and those close to them

- We noted that in the majority of consultations we observed, clinical staff explained test and imaging results, answered questions and offered and discussed a clear plan with each patient taking into account their personal circumstances. Most patients we spoke with

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told us this was the case but one patient said they 'sometimes' did not have enough time with their consultant and were unsure about whether they were being discharged and had been given little information.

- We observed one consultation where the clinician did not acknowledge what the patient was saying regarding their concerns about the treatment plan. This meant the patient had to keep repeating themselves. When the patient left the consultation they told us they felt the clinician was failing to recognise the level of understanding that they had about their own condition and its family history.
- Patients who were under 18 years were also asked their views by clinicians and their questions were answered.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We found the responsiveness of services required improvement. The OPD was a new build structure designed to accommodate outpatients services' needs locally and from other parts of the country. Provision was made for urgent and rapid access.

Although lower than the England average, the trust had a higher proportion of people waiting over six weeks for an appointment than the other Orthopaedic trusts from June 2014 to May 2015. X ray waiting times had showed some deterioration during the first half of 2015.

We found the reception process was well organised and nursing staff did their best to facilitate flow of patients. However, although some work was in progress to improve it, the clinic booking system remained complex. This led to variable waiting times for patients as some clinics ran up to an hour late, some of whom accepted a wait as inevitable

A lack of planning/coordination of the OPD with radiology led to inefficiency and poor patient experience. Oncology directly booked their imaging cases and provided a more responsive service. Patients using the 'one stop cancer appointment' told us this was a very good service.

Magnetic Resonance Imaging (MRI scan) was available from 8am to 8pm Monday to Friday and from 9am to 5pm on

Saturday and Sunday. The addition of an on-site van MRI scanner had increased the capacity of the service. Improvement was achieved in shortening the time to issue the scan reports with most being done on the same day.

There was variable practice among consultants, while some consultants forward booked for diagnostic tests other did not. The trust could not easily audit patient access and flow or cancellations in the OPD. We found that improvement in clinic booking and waiting times experienced by patients seemed to depend on the working culture of individual consultants.

There was support in place to ensure patients found the OPD, booked in and got to the right clinic. Chaperoning procedures were becoming well embedded. However arrangements for patients who did not speak or read English were not clearly understood by all staff and written information was available only in English.

Some processes were developing to support patients with dementia but there was no equivalent focus on identifying the particular needs of patients with a learning disability. The trust had reduced the number of patients that had to be declined an MRI scan at the time of their appointment because of contra indications.

The trust had moved to a system in November 2014 of routing concerns and complaints about the OPD through the patients access liaison service (PALS). Both 'formal' and PALS contact issues were discussed at monthly governance meetings and action plans were put in place to improve the service where formal complaint investigations had upheld the complaint.

The referral to treatment percentage within 18 weeks non-admitted was better than the other Orthopaedic trusts and the England average. The referral to treatment percentage within 18 weeks (incomplete pathways) was higher than the other Orthopaedic trusts and the England average. The trust performed better than the other Orthopaedic trusts, England average and the standard in the percentage of people seen by a specialist within 2 weeks. The 'did not attend' (DNA) rates were similar to the other Orthopaedic trusts. Both were lower than the England average.

Service planning and delivery to meet the needs of local people

Outpatients and diagnostic imaging

- The OPD was a new build structure designed to accommodate outpatient's service's needs, from 2011.
- The outpatients predominantly served adults, with the majority of children and young people seen in the outpatients attached to the children's ward.
- Although the OPD was very busy during our visit, the number of patients attending were accommodated.
- Being a specialist provider the trust took patient referrals from around the country.
- The trust told us there were two clinic slots each day for patients who needed to be seen urgently. The OPD senior nursing team and the Royal Orthopaedic Community team were able to book into these slots
- There were daily wound dressing clinics which provided rapid access for patients.
- The oncology team also provided rapid access via the oncology consultant nurse or clinical nurse specialist team.
- The 'did not attend' (DNA) rates were similar to the other Orthopaedic trusts. Both were lower than the England average.
- This trust had a higher proportion of people waiting over six weeks for an appointment than the other Orthopaedic trusts from June 2014 to May 2015; however this was lower than the England average.
- Local leaders told us not all consultants adhered to the six week target and this was escalated within the directorate.
- Local leaders told us 95% of MRI scan appointments were offered within six weeks of referral.
- The addition of an on-site van MRI scanner for eight days per month from 1st September 2014 until 31st August 2015 had increased the capacity of the imaging service.
- Local leaders reported they had made considerable improvement in shortening the time to issue of the scan reports with most being done on the same day.
- Patients using the 'one stop cancer appointment' told us this was a very good service. Patients were advised they would have to wait but they found the scan was taken in the morning and they were then seen by their consultant in the afternoon with the results.
- A trust audit showed the number of patients waiting under 30 minutes for x ray imaging had worsened from approximately 65% in January 2015 to 55% in May 2015.
- We found the clinic booking system was complex and this led to many patients waiting at clinics. Local leaders told us they were working with consultants to identify unnecessary complexity and attempting to streamline the process.
- We noted when patients arrived they were booked in at reception, given a number and asked to wait in one of two waiting areas.
- Patients told us the reception arrangements were well organised.
- Patients' notes were delivered to health care assistants (HCA) in the 'pod' where the clinic was taking place and they prepared them. HCA's electronically called patients by number through to the pod from the general waiting area, met and greeted them and asked them to wait in the area outside the pod.
- We observed that HCA's were proactive in ensuring that patients waiting in the main area were aware they had been called. When a patient did not show as booked in they went to reception staff to confirm this and did not register this patient as a DNA until the end of the clinic.

Access and flow

- Operational standards were that 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral.
- The referral to treatment percentage within 18 weeks non-admitted was better than the other Orthopaedic trusts and the England average.
- Operational standards were that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral. An incomplete pathway is when the patient's waiting time to see a consultant and start treatment is still running i.e. the appointment has not yet been completed.
- The referral to treatment percentage within 18 weeks (incomplete pathways) was higher than the other Orthopaedic trusts and the England average.
- The percentage of cancer patients waiting less than 31 days from urgent GP to first definitive treatment was higher (better) than the other Orthopaedic trusts, the England average and the standard, from March 2014 to March 2015. The trusts performance on the 62 day target (from urgent GP referral) was variable over the past 5 quarters. Data for Q1 2015/16 shows 77.8% compliance against the national standard. The national target was 95%.
- The trust performed better than the other Orthopaedic trusts against the England average in the percentage of people seen by a specialist within 2 weeks.

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- One clinic we observed had six patients out of twenty DNA that morning. Staff attributed this to the school holiday period and told us that some will have rescheduled. However they did not know that before the clinic started.
- Local leaders told us the OPD was operating a text message reminder system for new patients.
- We noted that some clinics were running in two or three rooms at once with a clinician in each.
- The trust was not able to audit the OPD access and flow performance as no data was collected. For example, when we asked for information prior to our visit, the trust could provide us with no information on the number of clinic cancellations and local senior leaders we spoke with confirmed this.
- Local leaders confirmed there was no senior sign off for consultants cancelling a clinic although it would usually be escalated to the directorate level who would ask questions about re provision.
- The trust told us a new electronic system to collect performance data was being introduced in the winter of 2015.
- The trust's Access policy was that patients should be given six weeks' notice of a clinic cancellation but staff told us this was not always complied with. Local leaders confirmed that not all clinicians gave patients this notice and there was an escalation process when this happened.
- The OPD had a standard operating procedure (SOP) for clinic delays and this was implemented on 01 July 2015. The SOP indicated that the electronic book in and call system was to be used to inform patients of delays starting at 15 minutes. The SOP advised staff that at 30 minutes of a delay occurring nursing staff or the clinic team would need to communicate directly with the patients and their carer/relative; why the clinic was delayed, how many patients were before them in the clinic, if there was more than one clinic happening in that area of work and what staff were doing to help resolve the situation. However, local leaders we spoke with told us that it was a one hour delay that triggered this response. This suggested that the SOP was not yet imbedded or clearly understood.
- We found during our visit that waiting times were variable among clinics and some people waited over one hour for some clinics.
- A patient who had attended for a number of appointments told us there were delays sometimes, but they were kept informed by the monitor in the reception area. Other patients said there were always delays without any reasons being given.
- We heard mixed accounts from patients about their experience of waiting times once they have arrived in the department. Many patients waiting for clinics did experience delays but seemed to accept them as inevitable.
- One patient said they had a five minute wait in the main outpatient's reception area and a two minute wait in the clinic waiting area, "The only problem is waiting for x rays, the wait was too long, they don't seem well organised."
- Another patient told us they were delayed for an hour in the reception area. We noted that this particular clinic developed an hour's delay by midday and continued the delay through the afternoon.
- Patients spoke very highly of this clinician's care and treatment but confirmed there were always delays in the clinic running time, 'there are always delays for Mr ... clinics but it's worth the wait'.
- A third patient told us they arrived at 08.45 having travelled overnight from the north of England, checked in, went to x ray and in to the clinic for assessment and consultation within 45 minutes, "compared with my hospital in ... this is fantastic."
- We noted that some clinics on the day of our visit had no appointment delay. The pain management clinic for example, was able to see patients earlier than their appointment time that morning if they had already arrived.
- Consultation actual times at other clinics were delayed between 20 minutes and one hour beyond the appointment time booked.
- For the shoulder clinic, a patient told us their appointment was for 10.40 and they were seen at 11.40.
- For the knee clinic a patient told us their consultation was 45 minutes later than booked.
- The percentage of patients waiting over 30 minutes to see a clinician according to the trust was 19.4% in June 2015, which was an improvement on the last recorded figures November 2014 at 27%. Following the inspection the trust shared with us that this data was identified at public listening events for both months.
- We heard that improvement in clinic booking and waiting times experienced by patients seemed to

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depend on the working culture of individual consultants. For example, staff told us that some services such as the Wards Admissions and Day Case Unit (ADCU) had improved its appointment system by staggering lists. This they said took a lot of pressure on consultants to effect this change. This included support from the clinical director and local initiatives on audit undertaken by junior staff, to make a compelling case against the consultants resistance, 'we work together as a team [now], there's a magnet board and it works now, everyone can see where every patient is now [in the process].

- Staff said that they had noticed a difference (improvement) in OPD clinic waiting times but "the OPD is different [to the ADCU], it's the number of rooms and consultant availability. Some only work one half day a week, so a patient's next appointment could be in seven months' time".
- One Friday morning clinic waiting times were improved, according to HCA staff, by the consultants/clinic secretary taking it upon themselves to change appointment times "and it works better now, there is hardly any drag, instead of two hours its [average wait] its 45 minutes. It's [about] getting the consultants to agree".
- A number of patients told us they were concerned about availability of car parking and parking charges within the hospital grounds. One patient said that if you arrived early in the morning there was no problem parking. Another told us their only complaint about the service was the parking fees.
- Some patients said there were not sufficient disabled driver parking spaces in the grounds near the outpatient's main entrance. One said they sometimes came at 7am to make sure they got a parking space for a morning appointment.

Meeting people's individual needs

- There was a transport access service situated in a kiosk in the ground floor waiting area.
- There was conspicuous way finding arrangements in place staffed by volunteers, to make sure patients got to what may in effect, be a number of appointments during their visit to the hospital.
- Local leaders told us the trust had access to a comprehensive interpretation service including by telephone which the Senior OPD sister arranged when

necessary. However some staff told us the OPD did not have access to translation services. Following the inspection the trust confirmed that they had circulated a new process to access them September 2015.

- We noted complaint and PALS leaflets were available only in written English.
- There was no dementia strategy document but there were some agreed processes in place and staff we spoke within the OPD described them to us.
- Local leaders confirmed that a dementia lead nurse was now in place and dementia awareness was now part of mandatory training.
- Staff said GP's did not always alert the OPD about a patient's dementia status or learning disability on referrals.
- Pre-operative staff screen patients for dementia when they were clerked and flagged this on their notes.
- Staff told us the OPD did not see paediatric patients with learning disability just 'a few' young adults of 18 to 19 year olds.
- We saw no evidence of a particular strategy to support patients with learning disability. Staff were aware that a patient 'pathway' system for patients with dementia was planned to minimise patients being moved around the hospital. Also that the trust had introduced open visiting hours for inpatients with learning disability to enable their families/carers to support them. However we heard nor saw evidence of a particular strategy to support patients with learning disability through their out patients experience.
- A chaperoning policy was in place. We saw for example, patients under 18 years, attending with a parent, were asked if they wanted a chaperone for their consultation instead of their parent being present.
- Local leaders told us the service had redesigned the clinician's referral form to include identification of contra indications for the MRI scanning. If this was not filled in ROH staff contacted patients directly for this information. The trust told us, prior to this initiative 0.6% of patients were unable to be scanned as expected when they attended. Where the department was using a 3T strength scanner this figure would be greater.
- We noted the X-ray waiting area was a small space which was used for both outpatients and inpatients. To maintain patient dignity staff put screens between the beds.

Learning from complaints and concerns

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- The trust had a PALS service which was widely advertised around the OPD and we saw leaflets available in main waiting areas.
- We noted from incident reports records sent to us by the trust that on one day in January 2015 two incidents were raised by a local OPD leader about long waits for clinics. One of these was brought to the attention of the manager by a patient as the manager was leaving the department for the day. The patient had waited over two and half hours.
- The investigation undertaken by the OPD leader into the second complaint found that the clinic slots were double or treble booked and the clinic start time was very late. It was attributed to poor communication about the starting times and low staffing numbers to support the clinic.
- We asked the trust after our visit, for evidence that the one hour delay in clinic start time we had observed on the morning of 29 July 2015 was incident reported and we found that it had been.
- Senior leaders told us the OPD had received no 'formal' complaints since November 2014 since that date complaints/issues were dealt with locally through PALS. The dashboard showed that five complaints were received between July and November 2014 and that all had action plans in place to improve the issue.
- It showed there had been three PALS 'contacts' between July 2014 and January 2015 and six between February and May 2015.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We found that many of the improvements had been recently implemented and were not fully embedded. Governance arrangements had been strengthened since our last inspection but significant weaknesses remained in the OPD's ability to assure quality and manage risk. Although some work had been done to improve this, there was little standardised practice in achieving improvement in key areas of patient experience such as waiting times in clinics. A new software patient flow information system was due to be implemented in the winter 2015. However the transitional arrangements had not been risk assessed at the time of our visit.

Governance monthly meetings included key local OPD leaders. However the OPD had an interim manager and there was heavy reliance on a Transformation team. There was patchy evidence of success in solving the access and flow problems and grip on individual consultant working culture that affected patient experience. The local leadership was good at a clinical level including in radiology.

The OPD had its first dedicated matron in post and professional relationships between nursing and medical staff were good. We saw the department had a vision statement and we saw this displayed conspicuously in the main entrance of the OPD.

The OPD was proactive in seeking people's views of their experience through the FFT and the trust had recently held a public listening event. Staff felt engaged in contributing to improving the quality of care and the trust acknowledged their contribution through award schemes.

Radiology responded to the needs of the OPD by adjusting and implementing innovative systems.

Vision and strategy for this service

- The trust had a vision statement and we saw this displayed conspicuously in the main entrance of the OPD.
- We noted staff were engaged in the vision for the trust and improving systems in the OPD.

Governance, risk management and quality measurement

- We noted governance arrangements had been strengthened since our last inspection. Some key performance indicators were scrutinised and there had been some improvement in reducing patients waiting times at the clinics.
- However weaknesses in governance remained as the trust could not collect some crucial access and flow data and audit performance.
- There was no responsiveness assurance dashboard for the OPD and all data was collected manually. This meant clinics were not aware of their efficiency.
- There was little standardised practice in achieving improvement in some areas of patient experience such as appointment booking and forward planning for diagnostic tests.

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- The OPD operated a risk register and incidents were reported by staff and investigated by leaders. However we noted risks associated with delayed clinics and appointments were not effectively addressed. The main control measure for example, was the sister dealing with these issues at local level through PALS. However on at least one day in January 2015 local managers were not aware that a clinic was keeping some patients waiting over two hours. Also the control measures in place did not prevent a delay of an hour from developing.
- The trust did not effectively monitor cancellations of clinics in the OPD. The process in place described to us by local senior leaders in the event of a consultant cancelling a clinic was not standardised by the patient access policy.
- The OPD reported to the Board monthly on its performance against key indicators. We noted however from minutes that there was no dashboard data available to the governance meeting of May 2015.
- Staff confirmed there was a leadership focus in the OPD on patient experience, particularly waiting times in clinics, chaperoning and notes security.
- Senior leaders told us the trust was trialling a new nurse led role of co-coordinator within the OPD. This was a practitioner who was able to move around the process and immediately deal with any blockages in patient flow, provide appropriate clinical skills and address risks as they emerged. They said the role was 50% filled at the time of our inspection.
- The trust had purchased and senior leaders were anticipating the implementation of a new software patient flow system that would enable the collection of robust access and flow information including by service and clinician. This was due to be implemented in the winter 2015. However the implementation plan was in its early stages, having four actions started at the time of the inspection with the majority still to commence and complete.
- The duty of candour requirement was integrated into some existing processes within the trust and we found its 'spirit' was understood within the OPD. However the process of exercising its particular principles beyond ward level was not fully understood and incomplete at a practical level particularly around record keeping.
- Most staff that we spoke with in all roles knew the name of the chief executive officer and confirmed that senior leaders conducted 'walk arounds' including in the OPD. They were aware of the CEO's monthly blog.
- The local leadership in the OPD and radiology was good at a clinical level. The OPD had its first dedicated matron in post. Radiology was a well-run department that responded to the needs generated by the OPD and developed innovative systems to improve safety and efficiency such as the turnaround of imaging reports for the one stop shop for cancer patients.
- Outpatient's bookings were not managed by the outpatient's manager but by a patient's access team. This function also managed the reception staff and a call centre and booking team.
- The OPD had an interim improvement manager at the time of our inspection and needed to provide stable, longer term support to the strong clinical management. The trust confirmed a few days after our visit, that it had made a permanent appointment to the post starting September 2015.
- There seemed to be heavy reliance on a Transformation team to improve systems through projects and patchy evidence of success in solving the access and flow problems through leadership.
- Clear lines of accountability were not embedded and there appeared to be a lack of in house preparedness for embedding the new software system that was imminent.
- Leadership from some parts of the executive resulted in a patchy grip on patient experience, for example where some consultants who forward booked for diagnostic tests and therefore reduced waiting times and others did not.
- The head of patient access was working on rationalising the 360 different clinic/consultant 'templates' used to inform appointments, down to one template, to deal with the block booking and waiting time problems. We heard no target time had been set for completion of this review.
- Nursing staff told us they had good professional relationships with medical staff and in the OPD they worked more closely with doctors than would be the case in other parts of the hospital. We noted good professional relationships between staff at all levels and role.
- Patients told us staff seemed relaxed and well managed.

Leadership of service

Outpatients and diagnostic imaging

Culture within the service

- Staff told us there had been a culture change within the OPD since our last inspection of June 2014. They said there was now greater emphasis on patient experience.
- We noted that a significant number of the adverse incidents reported up by staff were about communication.
- Nursing and health care assistant staff that attended one of our drop in sessions during our visit were very positive about working in the OPD. They told us, “Everyone says hello no matter what your position”.

Public engagement

- Local leaders confirmed the trust had held a public listening event in June 2015 that was attended by 400 people and the outcome from this had since ‘directed the executives thinking’.
- We noted Friends and Family Test (FFT) questionnaire cards were attached by nurses to patient’s notes as they were taken in to a clinic.
- In the clinic we observed that some clinicians prompted patients to complete the FFT card at the conclusion of the consultation.

- Local leaders told us that recent issues arising for the FFT were: x ray imaging delays; car parking and water fountains in the general waiting areas which had been put on order.
- We noted the trust had a car parking policy, due for review in December 2015. This included offering discounts to patients making multiple visits.

Staff engagement

- Staff confirmed the trust encouraged staff and teams to improve the service through awards schemes.

Innovation, improvement and sustainability.

- Radiology had redesigned the clinician’s referral form to include identification of contra indications for the MRI scanning.
- Oncology could book patients into the MRI directly so staff could coordinate with the OPD.
- Improvements we noted were very recent and not fully embedded.

Outstanding practice and areas for improvement

Outstanding practice

Critical Care

- The unit manager had ensured that staff were both aware and understood the values of the trust. A post box had been put on the unit to enable staff to identify what the values meant to them in their work on HDU. Staff views on the values displayed on a noticeboard and had also been discussed during staff meetings.

OPD

- We observed that some clinicians were dictating letters to GP's and other services onto an electronic system for same day delivery, in the presence of the patient before the patient left the clinic.

Areas for improvement

Action the hospital **MUST** take to improve

HDU

- Medical and nursing cover must be improved on HDU when children are accommodated.
- Children must be cared for in an appropriate environment when requiring HDU care.

OPD

- The trust must improve local leaders understanding of the processes involved in exercising the duty of candour in particular what they should expect beyond ward level and at a practical level including record keeping.
- The trust must improve the flow through the OPD so patients are not kept waiting for appointments.
- The trust must embed management arrangements over and within the OPD to assume a firmer grip on the process of clinic booking and patient flow to improve waiting times for patients.

Action the hospital **SHOULD** take to improve

HDU

- The performance tool should be fully completed to ensure all risks are appropriately highlighted.
- The contribution of data to Intensive Care National Audit and Research Centre (ICNARC) or similar, to benchmarked the service against other similar hospitals should be commenced.
- There should be appropriate single sex toilet and wash facilities available for patients and separate toilet facilities should be available for patients (adults and children), staff and visitors.
- Multidisciplinary ward rounds and handovers should take place to ensure effective patient care.

OPD

- The trust should review the location of hand cleansing stations within the OPD and further encourage patients to use them.
- The trust should review the car parking capacity for disabled drivers.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.</p> <p>(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—</p> <p>(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);</p> <p>(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;</p> <p>The trust was failing to meet this regulation in that;</p> <p>OPD</p> <p>The flow of patients through the OPD was not being effectively assessed and monitored to ensure patients were not kept waiting for appointments.</p> <p>There were not effective management arrangements in place over and within the OPD to assure a firm and consistent grip on the process of clinic booking and patient flow to improve waiting times and timely access to imaging services for patients.</p>

Regulated activity	Regulation
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This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.

(2) Systems and processes must be established and operated effectively to prevent abuse of service users.

The trust was failing to meet this regulation

in that;

Within OPD inadequate numbers of staff had undertaken appropriate safeguarding training for both adults and children including the correct levels dependant on the level of contacts.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

15. —(1) All premises and equipment used by the service provider must be—

(c) suitable for the purpose for which they are being used,

The trust was failing to meet this regulation

in that;

Children were being cared for on an adult HDU which did not have either the facilities or space required to meet their needs.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Requirement notices

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

The trust was failing to meet this regulation in that;

HDU required paediatric trained nurses to care for children for the full length of their stay.

The arrangements in place were not adequate regarding the medical cover for the deteriorating child. By not having a paediatric doctor on the premises apart from twice a week and telephone support. This meant that visual assessment was by a suitably qualified doctor was limited.