Hull and East Yorkshire Hospitals NHS Trust

Castle Hill Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Castle Hill hospital (CHH) is one of the main hospital sites for Hull and East Yorkshire Hospitals NHS Trust. The trust operates services from two main hospitals – Hull Royal Infirmary and Castle Hill Hospital – with a minor injuries unit at Beverley Community Hospital. Castle Hill hospital has cardiac and elective surgical facilities, new medical research teaching and day surgery facilities (the Daisy Building), an ear, nose and throat (ENT) and breast surgery facility and outpatients as well as the Queen`s Centre for oncology and Haematology. In total, the trust had approximately 1,300 beds and 7,400 staff. The CHH site has over 600 beds.

This was a focussed inspection of the CHH as concerns had been identified both during a previous comprehensive inspection of Hull and East Yorkshire NHS Trust in February 2014 and concerns had also been highlighted through other information routes such as the public and staff which required following up. The follow up inspection of CHH was on 19 – 21 May 2015.

Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We inspected surgery and outpatients and diagnostics but did not inspect the other core services at CHH which were critical care and end of life services. Additionally not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected. Almost all medical care had transferred to Hull Royal Infirmary since the February 2014 therefore these services are covered in HRI report

At the inspection in February 2014 we found the trust was in breach of regulations relating to patient care and welfare, medicines management, staffing, staff support and governance.

Overall, at the May 2015 inspection we rated the CHH as 'requires improvement'. We rated it 'good' for being caring, but it requires improvement in providing safe and responsive care and in being well led. We inspected effective in out-patients & diagnostic imaging but we are currently not confident that we are collecting sufficient evidence to rate effectiveness.

We rated surgery as 'inadequate' and outpatient and diagnostic services as 'good'.

Our key findings were as follows:

- The trust had responded to previous staffing concerns and was actively recruiting to fill posts however there were areas where nurse staffing levels were impacting on patient care and treatment on the surgical wards. There were also staffing pressures in the electrocardiography department.
- Most staff had received safeguarding training and could demonstrate an understanding of their role and what action to take if they were concerned about a person.
- There were a number of areas of concerns in relation to infection prevention and control. These included breaches of national guidance for orthopaedic patients who were not 'ring-fenced' to prevent cross infections; patients who had undergone joint replacements had been placed in a bay with other surgical patients. The pack room for day theatres, which stored the stock used in theatres, had inadequate ventilation to maintain infection prevention and control standards.
- The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral.

In relation to Radiology discrepancies we saw that the peer review process was an outstanding example of governance. The peer review meetings focussed on openness and learning and displayed a sensible application of legislation.

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

Importantly, the hospital must:

Summary of findings

- ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly the histopathologists, the echocardiography team and surgical staff.
- ensure there is a sustainable action plan to improve the reporting performance of histopathologist service.
- address the breaches to the national targets for referral-to-treatment times to protect patients from the risks of delayed treatment and care. It must also continue to take action to address excessive waiting times for new and follow up patients with particular regard those waiting the longest.
- ensure use of best practice guidance, such as national guidance to "ring-fence" orthopaedic patients to prevent cross infections; the safer steps to surgery checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections.
- ensure the sustainability of the work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014).
- ensure there is the development of a long term clinical strategy for the surgery health group in line with the Trust's overarching strategy which meets the clinical needs of patients.
- ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation.
- ensure compliance with theatre engineering performance measures and annual servicing of ventilation systems for all theatres.
- review the results of IPC audits across all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres.

In addition there were areas where the trust should take action and these are highlighted at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Inadequate 	There had been three Never Events reported for the surgical health group between April 2014 and March 2015; two of these on the Hull Royal infirmary site and one a retained foreign object on the Castle Hill site. Within the surgical health group 21 serious incidents had been reported in the last twelve months. Incidents were investigated however external support was being put in place as there were delays in investigating incidents and securing clinical staff for panel members to investigate incidents. The rate of incidents reported in this trust was lower than the England average. There were a number of areas of concern in relation to infection prevention and control. These included breaches of national guidance for orthopaedic patients who were not 'ring-fenced' to prevent cross infections; patients who had undergone joint replacements had been placed in a bay with other surgical patients. We saw potential risks of contamination caused by inappropriate storage and ineffective cleaning protocols; inappropriate access to store rooms; temporary repairs to flooring in ward and clinical areas which may hinder effective cleaning processes. The pack room for day theatres, which stored the stock used in theatres, had inadequate ventilation to maintain infection prevention and control standards. The room used for pain procedures in the day unit had natural ventilation only, without the recommended ventilation air changes to prevent infections. Not all equipment was cleaned appropriately. There was a lack of assurance of the governance systems to maintain safety. There was a risk register and an integrated governance group however the group had not been quorate for two of three meetings we reviewed. Risks had not been addressed in a timely manner. The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral. National data indicated that the number of cancelled operations had been increasing and were above the national average. Staff told us that they had had to borrow essential pieces of equipment from other theatres on site and in other buildings at CHH and HRI and that on occasion theatre lists had been cancelled

Summary of findings

due to not having the correct equipment available. The design and space of the Day Surgery Unit was inadequate for the increase in the number of patients and this meant that the privacy and dignity of patients was compromised.
A number of issues affecting patient flow through the hospital had been identified. Overall no formal site management existed, however matrons rotated into a patient placement role on a daily basis. All winter escalation areas were closed at the time of the inspection.
There was a backlog of complaints across the Health group. Matrons were unable to attend the monthly Patient Experience Committee due to their clinical workloads. Integrated Governance Group meetings were held each month although attendance was poor for some meetings.
There were nurse vacancies on most wards. Nurse staffing levels on the wards varied from 70% to 98% fill rate against the planned establishment.
There was no clear long term strategy or vision for the service. Senior managers told us the health group's strategy was to make decisions affecting the present and medium term and not about the longer term. Members of staff were able to articulate the health group's operational plan objectives.
Members of staff said that health group managers were available, approachable, and that leadership of the service was good. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience as a priority. Medical staff stated that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings.
Staff reported there had previously been a culture of poor relationships between qualified and non-qualified staff groups. We were told senior managers were aware of this and had addressed it. Staff told us that an open and honest culture had been developed and significant change in the culture of the service had been achieved.

Outpatients and diagnostic imaging

Good

We rated this service as good overall for safety, however there were a small number of concerns noted.

Summary of findings

Incidents were reported and managed appropriately and actions and outcomes were disseminated to staff. Patient areas were clean and infection prevention and control procedures were adhered to. The environment was in good condition.

Decontamination and maintenance arrangements were in place for equipment. There was a replacement plan in place for ageing equipment in Radiology. Medicine management arrangements were in place. Records were almost always available for clinics and enough information was held electronically to see patients safely if notes were missing. There was no evidence available to demonstrate that the quality of patient records or the use of radiological intervention patient safety checklists or WHO surgical checklists were audited.

Staff knew their responsibilities with adult and children safeguarding, however there were some areas where training compliance needed to be improved. There were processes in place for staff to recognise and respond to changing risks for patients, including responding to the warning signs of rapid deterioration of a patient's health.

Staffing establishments and skill mix were being reviewed at the time of our visit and departments were adequately staffed with few staffing issues reported. The major staffing concern was in relation to consultant vacancies in the histopathology team. Five out of 13 posts were vacant and although there was some mitigation in place, this was adversely affecting reporting times.

Castle Hill Hospital

Detailed findings

Services we looked at
Surgery; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Castle Hill Hospital

Hull and East Yorkshire Hospitals NHS Trust was established in October 1999 as a result of a merger between Royal Hull Hospitals NHS Trust and East Yorkshire Hospitals NHS Trust. The trust operates from two main hospitals – Hull Royal Infirmary and Castle Hill Hospital in Cottingham.

The trust provides a range of acute services to the residents of Hull and East Riding of Yorkshire area, as well as a number of specialist services to North Yorkshire, North and North East Lincolnshire, and Hull Royal Infirmary is recognised as a Major Trauma Centre for the region and Castle Hill hospital has the regional Queen`s Centre for oncology and haematology. The trust also provides other clinical services, mainly outpatients at other locations within the Hull and East Riding of Yorkshire area, for example the Freedom Centre in Hull and East Riding of Yorkshire community hospital in Beverley.

The trust serves a population of around 600,000. Life expectancy for those in East Riding of Yorkshire is better than average, but worse than average for those in Hull. Kingston Upon Hull performs significantly worse than average for most measures on the local health profile. East Riding of Yorkshire performs similar to or better than the England average. Hull is one of the most deprived local authorities in the country. East Riding of Yorkshire is in the 2nd IMD quintile (where 1 is the least deprived).

The trust has not yet achieved foundation trust status. The trust's management structure is based on health groups, which are , surgery, medicine, family and women's health and clinical support along with the corporate functions.

Castle Hill Hospital was inspected in June 2013 and found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulation 13 (medication) for the regulated activities diagnostic and screening and treatment for disease, disorder or Injury. In October 2013, two further breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding), for the same regulated activities.

At the comprehensive inspection in February 2014 the CHH site was found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulations 9 (care and welfare), 10 (governance), 13 (medicines), 22 (staffing) and 23 (staff support) for the regulated activities treatment of disease, disorder or injury and diagnostic and screening procedures. Compliance actions had been set for all these breaches and the trust had action plans in place to become compliant by March 2015.

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Michael Wilson, CEO, Surrey & Sussex Healthcare NHS Trust

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

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

How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

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

However, as this was a focused inspection we did not look across the whole service provision; we focussed on the areas defined by the information that triggered the need for the focused inspection. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

The team inspected the following core services at CHH:

- Surgery
- Outpatient and diagnostic services

We did not inspect the core services critical care or end of life services at this inspection. Almost all medical services had been transferred to the Hull Royal Infirmary since the last CQC inspection.

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG), Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the local Healthwatch organisations.

We held a listening event in Hull on the 18 May 2015, where 52 people attended and shared their views and experiences of the Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 19 and 21 May 2015. During the inspection we held focus groups and drop-in sessions with a range of staff including nurses, junior doctors, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about Castle Hill Hospital

Castle Hill hospital is one of the main hospital sites for Hull and East Yorkshire Hospitals NHS Trust. The trust operates services from two main hospitals – Hull Royal Infirmary and Castle Hill Hospital – with a minor injuries unit at Beverley Community Hospital and some outpatient services in other locations.

Detailed findings

Castle Hill hospital has cardiac and elective surgical facilities, new medical research teaching and day surgery facilities (the Daisy Building), an ear, nose and throat (ENT) and breast surgery facility and outpatients. It has the regional Queen's Centre for oncology and haematology. Critical care is provided in two units, which support the cardiology and cardio-thoracic services. There are no accident and emergency services at this hospital: these are provided at Hull Royal Infirmary.

In April 2015 the majority of the medical beds at Castle Hill hospital moved to the HRI to bring together acute medicine and care of the elderly onto the one site.

Overall the trust has:

Beds approximately 1,300 including:

- General and acute 992
- Maternity 72 (none at Castle Hill hospital)
- Critical care 44

Staff (whole time equivalent establishment): 7,361.65

- Medical 1,024.38
- Nursing 3,004.73
- Other 3,332.54

Revenue (2014-15 projection): £522,330

Activity summary (Acute) – 2013/14

- Inpatient admissions 185,676
- Outpatient (total attendances) 617,971
- Accident & Emergency (attendances) 131,308 (N.B. no A & E at Castle Hill hospital)

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatient and diagnostic imaging services.

2. As this was a follow up inspection to the comprehensive inspection in February 2014 not all services or domains were inspected.

Surgery

Safe	Inadequate
Well-led	Requires improvement
Overall	Inadequate

Information about the service

Castle Hill Hospital provides a range of surgical services for the population of Hull and the immediate surrounding area and also services the population of the East Yorkshire. The hospital provides elective and non-elective treatments for urology, upper gastrointestinal surgery, colorectal surgery, ENT, breast surgery, cardiothoracic and orthopaedics. There were 19 theatres including day theatres at this site.

We visited a sample of the wards, theatres and recovery areas on site and observed care being given and surgical procedures being undertaken. We spoke with patients, relatives and members of staff and observed care and treatment and reviewed patient care records.

Summary of findings

There had been three Never Events reported for the surgical health group between April 2014 and March 2015; two of theses on the Hull Royal infirmary site and one a retained foreign object on the Castle Hill site. Within the surgical health group 21 serious incidents had been reported in the last twelve months. Incidents were investigated however external support was being put in place as there were delays in investigating incidents and securing clinical staff for panel members to investigate incidents. The rate of incidents reported in this trust was lower than the England average.

There were a number of areas of concern in relation to infection prevention and control. These included breaches of national guidance for orthopaedic patients who were not 'ring-fenced' to prevent cross infections; patients who had undergone joint replacements had been placed in a bay with other surgical patients. We saw potential risks of contamination caused by inappropriate storage and ineffective cleaning protocols; inappropriate access to store rooms; temporary repairs to flooring in ward and clinical areas. The pack room for day theatres, which stored the stock used in theatres, had inadequate ventilation to maintain infection prevention and control standards. The room used for pain procedures in the day unit had natural ventilation only, without the recommended ventilation air changes to prevent infections. Not all equipment was cleaned appropriately.

There was a lack of assurance of the governance systems to maintain safety. There was a risk register and an integrated governance group however the group had not been quorate for two of three meetings we reviewed. Risks had not been addressed in a timely manner.

Surgery

The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral. National data indicated that the number of cancelled operations had been increasing and were above the national average Staff told us that they had had to borrow essential pieces of equipment from other theatres on site and in other buildings at CHH and HRI and that on occasion theatre lists had been cancelled due to not having the correct equipment available. The design and space of the Day Surgery Unit was inadequate for the increase in the number of patients and this meant that the privacy and dignity of patients was compromised.

A number of issues affecting patient flow through the hospital had been identified. Overall no formal site management existed, however matrons rotated into a patient placement role on a daily basis. All winter escalation areas were closed at the time of the inspection.

There was a backlog of complaints across the Health group. Matrons were unable to attend the weekly Patient Experience Committee due to their clinical workloads. Integrated Governance group meetings were held monthly although attendance was poor for some meetings.

There were nurse vacancies on most wards. Nurse staffing levels on the wards varied from 70% to 98% fill rate against the planned establishment.

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Members of staff said that health group managers were available, approachable, and that leadership of the service was good. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience as a priority. Medical staff stated that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings.

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Surgery

Are surgery services safe?

Inadequate

We found a number of concerns relating to infection and prevention and control practices. We visited a surgical ward which cared for seven surgical specialities. Staff told us that there were orthopaedic patients who were not 'ring-fenced' to prevent cross infections; patients who had undergone joint replacements had been placed in a bay with other surgical patients. This was a breach of national guidelines: "Saving Lives: a delivery programme to reduce Healthcare Associated Infection 2006"

Other examples included: the flow of patients through breast surgery theatres was inappropriate as staff could externally access the layup and preparation room areas where access should be restricted; this therefore presented an infection control risk. The pack room for day theatres, which stored the stock used in theatres, had inadequate ventilation which did not promote infection prevention and control principles. The room used for pain procedures in the day unit had natural ventilation only, without the recommended ventilation air changes to prevent infections.

Recent audits showed compliance with hand hygiene protocols varied from 49% to 100% on surgical wards. Incidences of MRSA and the prevalence rate of Clostridium difficile (C.difficle) were similar to the England average. Cleanliness check sheets were available in areas to help ensure that equipment was clean and ready for use.

Staff told us that on occasion, they had to borrow essential pieces of equipment such and theatre lists had been cancelled due to not having the correct equipment available for a particular procedure. The design and space of the Day Surgery Unit was inadequate for the increased number of patients and this meant that the privacy and dignity of patients was compromised.

There had been one Never Event reported on the Castle Hill Site between April 2014 and March 2015 in relation to a retained foreign object. Within surgery, 21 serious incidents had been reported in the last twelve months. Incidents were investigated however external support was being put in place as there was a backlog in investigation of incidents and delays in securing clinical staff for panel members to investigate incidents. The rate of incidents in this trust was lower than the England average. Feedback was given on reported incidents and outcomes at staff meetings, or cascaded via email.

There were nurse vacancies on most wards. Nurse staffing levels on surgical wards at CHH varied from 65% to 98% fill rate against the planned establishment.

Safety thermometer information included information about all new harms, falls with harm and new pressure ulcers. The hospital was performing within expected levels for these indicators. Care records showed that risk assessments for these were being appropriately completed on admission.

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Incidents

- There had been three Never Events reported between April 2014 and March 2015; two of these on the Hull Royal infirmary (between December 14 and March 2015) and one at Castle Hill Hospital a retained foreign object. The trust had consequently commissioned an external review by the Royal College of Surgeons. At the time of the inspection the terms of reference were being agreed and the review had yet to commence.
- Within surgery, 21 serious incidents had been reported in the last twelve months.
- Incidents were investigated however a delay in investigations and a backlog of incidents requiring investigation had led to external support was being put in place as there were delays in securing clinical staff for panel members to investigate incidents.
- We saw that incidents were discussed at ward and clinic manager meetings from across the trust to promote shared learning. However there may have been delays in the learning from incidents due to the backlog of incident investigations.
- The rate of incidents in this trust was lower than the England average.
- Staff members were familiar with the process for reporting incidents, near misses and accidents, using the trust electronic systems, including those triggering Duty of Candour requirements..
- Staff said that they were encouraged to report incidents and were aware of how to use appropriate systems. Feedback was given on reported incidents and outcomes at staff meetings, or cascaded via email. Staff told us that there was low-level reporting as not many incidents had occurred.
- Mortality and morbidity meetings were held monthly in all relevant specialities. All relevant staff participated in mortality case note reviews and reflective practice
- There were some incidents recorded regarding infection control issues but these did not relate to the concerns we have highlighted in the paragraph below.

Duty of Candour

- We saw that information about duty of candour was displayed on the staff intranet.
- Staff we spoke with were aware of their responsibilities under the duty of candour requirements.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety Thermometer information was clearly displayed on boards on all wards and theatre areas visited.
- The Safety Thermometer displays included information about all new harms, new falls with harm and new pressure ulcers.
- The surgical health group across both CHH and HRI was reporting within expected levels for these measures; the numbers of falls (nine), pressure ulcers (27) and urinary tract infections (26) across the health group had all remained low in the twelve months to December 2014. This was reflected in information displayed within ward areas.
- Care records showed that risk assessments for these measures were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- A number of infection prevention and control concerns were identified. We visited a surgical ward which cared

for seven surgical specialities. Staff told us that orthopaedic patients on this ward were not "ring-fenced" in accordance with national guidelines (Saving Lives: a delivery programme to reduce Healthcare Associated Infection, including MRSA Screening for Methicillin-resistant Staphylococcus aureus (MRSA) colonisation: A strategy for NHS trusts: a summary of best practice 2006); patients who had undergone joint replacements had been placed in a bay with other surgical patients which did not protect them from cross-infection.

- We saw damaged floors and walls in some theatres which were in need of repair, for example, timber exposed and unsealed flooring (in the theatres for breast operations). Environmental damage makes effective cleaning in the theatres difficult to achieve and as such has the potential to increase infection risks to patient.
- There was limited access to preparation and lay-up rooms from external corridors thus reducing the separation of clean and "dirty" flow required to maintain infection prevention principles. The pack room for day theatres, which stored the stock used in theatres, had inadequate ventilation which did not promote sterility of the packs to be used during surgery. The room used for pain procedures in the day unit had natural ventilation only, without the recommended ventilation air changes to prevent infections.
- Patient and staff access through theatres has to be in an appropriate manner to maintain a clean to dirty flow. The flow of patients through breast surgery theatres was inappropriate as staff could externally access the lay-up and preparation room. Staff initially told us they accessed these rooms through the sluice areas, carrying stock for theatres. Although this was later rescinded we did observe staff using this door for access into theatres.
- We reviewed internal infection, prevention and control (IPC) assessments for March 2015. These indicated that some theatres were classed as inadequate (below 80%): these theatres were 7, 8 and 12 (73%) and day surgery theatre 3 (65%). Other theatres required improvements (scoring 80-88%) for theatres 3, 4 and 5 (83%), 6, 9 and10 (86%) 14, 15 and 16 (83%), 19, 20 and 21 (81%).
- A concern was noted as a risk by the trust in February 2013 regarding some patients being operated on in an environment that left them vulnerable to infection with regard to the insertion of implants (joint replacements in hand, metalwork and breast prostheses) because there was no laminar flow system in theatre 6. Patients were therefore at risk of infection from the air in the theatre. Some controls had been put in place to mitigate this: "Surgeons were aware and alert for infection risks; Rescheduling high risk cases into other theatres with laminar flow (when one was available); ensuring that if a laminar flow is required that this is requested at the appropriate point, i.e. on the waiting list form.
- Wards and patient areas were clean and we saw staff wash their hands when appropriate and use hand gel between patient contact and complying with bare below the elbow policies.
- Recent audits showed compliance with hand hygiene protocols at 100% on surgical wards. Staff were able to tell us the results of the cleanliness audits carried out in their areas and patients were encouraged to ask staff to wash their hands before contact. We saw these had been reviewed and actions noted.
- All elective patients undergoing surgery were screened for Methicillin resistant Staphylococcus aureus (MRSA) Bacteraemia and procedures were in place to isolate patients when appropriate in accordance with infection control policies.
- Nursing staff had received training in aseptic non touch techniques. This covered the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- Swab, pack surgical instrument and sharp count audits were completed within theatre and these were discussed at health group meetings and actions identified if required.
- Pre-assessment of patients was in accordance with British Association of Day-care Surgery (BADS) guidelines.
- Infection control information was displayed in all ward and patient areas.
- There were two cases of MRSA in the trust between April 2013 and March 2014 and the prevalence rate of Clostridium difficile (C.difficile) was similar to the England average (95 cases).
- Cork noticeboards were in use in some clinical areas and items of staff's personal property, such as handbags, were stored in theatres which was not in line with infection prevention best practice guidance (Health Building Note 00-09: Infection control in the built environment 2013).

- The surgical health group participated in the ongoing surgical site infection (SSI) audits run by Public Health England. Each case of SSI was identified, discussed at formal meetings and actions identified to avoid a repetition.
- Cleanliness check sheets were used in all areas ensuring equipment was clean and ready for use. A new disinfectant had been introduced and domestic staff reported this product was easier to use than the previous product. Staff told us that all circulatory areas (e.g. communal corridors and windows) had been deep-cleaned in the weeks prior to our visit.

Environment and equipment

- We observed checks for emergency equipment, including equipment used for resuscitation. Resuscitation equipment in all areas had been checked daily.
- There was adequate equipment in the wards to ensure safe care. However, staff told us that they had had to borrow essential pieces of equipment, such as orthopaedic and ear, nose and throat equipment, from other theatres on site and in other buildings at CHH and HRI and that on occasion theatre lists had been cancelled due to not having the correct equipment available.
- Members of staff told us that some theatre lists had been cancelled due to the correct equipment for a particular procedure being unavailable. We noted nine incident forms had been completed across the trust in relation to unavailability of equipment from December 2014 to March 2015. In addition, one example happened during the inspection was that of a patient who was admitted after 7:00PM and was listed for 8:30AM the next day. Staff told us equipment was not available at the required time for this patient and they had to locate the necessary equipment.
- Staff also told us that the repair of equipment was usually good.
- The Daisy surgery unit was purpose-built with a layout that supported effective patient flow and infection prevention principles.
- However, the other day surgery unit was not purpose-built. Staff told us it had been earmarked for demolition in the past and then reoccupied. The unit was serving two theatres plus one clean room and a minor procedure area running two general and two local anaesthetic lists equating to around 100 patients a day, however it only had five recovery beds. Recently pre-assessment clinics for 30-40 patients per day had been located in this day unit so the unit had lost some facilities. The limited number of recovery beds created a backlog of patients in the recovery area and in the ward environment. The layout was not appropriate to support effective patient flow and it compromised patients' privacy and dignity. This was compounded by a high throughput of pre-operative, post-operative and pre-assessment patients all in the same area. Some cubicle doors where patients got changed into gowns did not lock.
- One of the day theatres was small with limited room outside the ventilation tent, although staff told us that the room size was adequate for procedures undertaken.

Medicines

- Medicines and fluids used within theatres were stored correctly in locked cupboards or fridges where necessary.
- Fridge temperatures were checked and were within required limits.
- We observed that the preparation and administration of controlled drugs was subject to a second independent check. After administration the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Care pathways including enhanced recovery pathways were in use.
- Ward staff completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately and showed compliance with timescales for the completion of Early Warning Score documentation and undertaking of appropriate actions.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure patient confidentiality was maintained.
- Members of staff within the pre-assessment area described a complex patient record management process involving the completion of a 'problem board' and 'problem book'. Patient 'problems' identified

included MRSA screening and blood test results. Nursing staff reviewed these and checked whether identified issues were resolved prior to surgery. This was a time-consuming process and open to human error.

Safeguarding

- Members of staff were aware of the trust's safeguarding policies and procedures and had undergone training in this area. They were aware of the appropriate action to be taken in such cases, including contacting the safeguarding team for advice and support.
- Information provided by the trust showed 86% of staff requiring training in safeguarding adults and safeguarding children within the health group had completed this training. We did not receive figures by site but observed that on each ward there were training compliance rates available for staff. For example ward 15 had 80% compliance with safeguarding.
- Members of staff we spoke with were able to describe action they would take if they had any safeguarding concerns. A board in the ward area displayed safeguarding information, including the definitions of abuse and contact details.

Mandatory training

- Performance reports showed that most members of staff within the health group were up to date with their mandatory training; this was confirmed during interviews with staff. For example 83% of staff had attended Deprivation of Liberty Safeguards (DoLS) training, 82% had attended Mental Capacity Act (MCA) training and 86% had attended appropriate Safeguarding Vulnerable Adults training.
- Senior members of staff were aware of health group compliance with mandatory training and accessed relevant information to develop plans to meet expected compliance levels.

Assessing and responding to patient risk

- All wards used an Early Warning Scoring system for the management of deteriorating patients.
- There were clear directions for escalation printed on the observation charts and members of staff were aware of the appropriate action to be taken if patients' scores were higher than expected.
- We looked at completed charts and saw that staff had escalated correctly and repeat observations were taken within the appropriate time scales.
- Theatre lists were updated in 'real time' to reflect changing priorities and timescales.
- In day surgery, members of staff were aware of the need for some patients to have an overnight stay and were able to discuss with us the protocols for making that decision.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken recently by the trust to ensure that staffing establishments reflected the acuity of patients. The newly appointed chief nurse was reviewing staffing levels and how these were reported regularly to the Board.
- Information provided by the Trust prior to the inspection indicated that there were vacancies on all the surgical wards at this site: on average each ward area had three registered nurse vacancies. . We reviewed nurse staffing levels (April 2015) on wards visited and within theatres and found that the fill rates for qualified staff during the day ranged between 65.7% (Ward 15) to 96% (Ward 9)) against establishment.
- During the night the fill rates for qualified staff were between 70% (Ward 14) and 98% (Ward 9) against establishment. For non-qualified staff the fill rates were between 65% (Ward 14) and 247% (Ward 16) against establishment.
- At least three members of staff told us about a "vacancy holding/recruitment freeze" that had been in place for the previous six to seven months and had been lifted prior to our inspection. However, the senior management team informed us that no such vacancy controls had ever been in place. The Trust had been actively recruiting vacancies including an overseas campaign for both nursing and medical staff.
- Staff told us that staffing levels were 'very poor and patient dependency is increasing'. They also told us that they were often moved from their own work areas to work in other areas that were short staffed; they said that this increased stress levels for staff, as they could be moved to different clinical areas a few times in any week. When moved, to different areas some members of staff had not felt confident in the care and management of patients in that clinical area.
- Staff told us that morale in some areas had been poor due to these moves; however, they had seen an improvement over the last month: moves had been reduced.

Surgery

- The senior management team told us that occasionally wards ran with two instead of three qualified nurses due to staffing vacancies, but that this had not happened when the dependency of patients had indicated a reduction of staff numbers would be unsafe. We were told that none of the wards had raised concerns about staffing levels through the Datix system and that patient care had not been compromised. However, on reviewing incident forms we found 162 staffing issues trust wide reported on Datix Dec 2014 to April 2015.
- Overall no formal clinical site management existed, however matrons rotated into patient placement role on a daily basis.
- Safety briefings were held twice daily and included discussions about staffing, falls, risks, safeguarding, and the allocation of members of staff to other work areas. Staff felt that this made allocations fairer and agreed with its principle. We attended safety brief meetings and saw that staff were moved from wards to work in other areas because of changing patient acuity and staffing levels. The senior management team told us that moving staff caused anguish and was on their 'worry list'.
- Recruitment processes had been developed including recruitment from overseas and the use of generic band 5 staff nurse recruitment to address staffing issues.
- Bank and agency staff were used to help fill gaps in rotas.

Surgical staffing

- Consultants were available on call-out-of-hours and would routinely attend and take out "when required". The general surgical on-call team comprised the general consultant and a consultant vascular surgeon. Medical staff told us that every list in theatre had been covered and cancellations did not occur often in the day theatres.
- Patients who required unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant and the hospital published a rota for the provision of general surgical emergency provision.
- Consultants were available on-call out-of-hours and would attend when required to see patients at weekends. Medical staffing within the health group was made up of 44% at consultant level (England average 40%), 25% registrar level (England average 37%), 16% middle career (England average 11%), and 15% junior doctors (England average 13%).
- The health group's risk register identified a number of issues including insufficient junior doctor cover, availability of agency staff and difficulties in appointing consultants. It stated that there was insufficient junior/ middle grade doctor cover which potentially comprised patient safety in surgery. The risk had been reviewed and agreed that the risk rating should remain high. A business case had been resubmitted in February 2015 supporting phased recruitment of seven junior doctors for the year.

Major incident awareness and training

- Business continuity plans for surgery were in place. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

Are surgery services well-led?

Requires improvement

There was no clear long term strategy or vision for the service. Staff were able to articulate the health group's operational plan. Senior managers within the health group commented that the health group's focus was to make decisions affecting the present and medium term and not the longer-term.

The risk register had a number of risks that had been "open" for some time and whilst some controls had been put in place they had not been resolved. There was an Integrated Governance Group meeting held each month, although two of three recent meeting had not been quorate. We noted six procedural documents which were past their review date. Staff reported serious incidents and could describe the dissemination of issues and learning. We saw evidence of investigations and root cause analyses.

Surgery

During our inspection we were told of two serious incidents that had been subject to significant delays in reporting which may have resulted in a lack of timely action to investigate and take action from lessons learnt.

Staff said that health group managers were available and approachable, leadership of the service was good, there was good staff morale and they felt supported at ward level. Staff spoke positively about the service that they provided for patients and emphasised quality and patient experience as a priority and everyone's responsibility. We saw good team-working on the wards between staff of different disciplines and grades. Members of staff recognised the history of a "bullying culture" as documented in a recent report, however, they told us that they had never witnessed any bullying behaviours. Staff told us about a history of poor communication within the senior nursing team this had been addressed through recent appointments, which resulted in increased motivation amongst nursing staff. Senior nursing staff told us that the culture was now more positive and encouraged change. Directors had been appointed as links between clinical areas and the board. Staff told us that the link director had not visited all areas.

Vision and strategy for this service

- There was no clear long term strategy or vision for the service.
- There was a surgical health group operational plan for 2015/16-2016/17. Within it was a strategic aim: "The Health Group continues to work towards its strategic vision of splitting elective and non-elective activities, ensuring that patients are treated in the right place, at the right time, by the right people, first time and within budget."
- Members of staff were able to articulate to us the health group's objectives across the surgical wards.
- We met with senior managers within the health group, who told us that the health group's strategy was to make decisions affecting the present and medium term rather than the longer-term.
- Staff told us that they believed the health group management team was 'fire-fighting', had no time to develop longer-term strategies.
- The trust had developed a Theatres Transformation Programme in May 2015 to focus on maximising efficiency. Data provided by the trust showed the utilisation of theatres varied between 51.3% and 94.1%..

Governance, risk management and quality measurement

- We reviewed the information supplied by the trust regarding risks for the surgical health group. There were 38 "open" risks and a number that had been "open" for some time and not resolved. For example, national guidance states that all patients with head and neck cancers should have their curative surgical procedures on a single site and then stay in a bed on a single designated head and neck ward. This had been first recorded in April 2011. Some controls had been put in place to mitigate the risk; however it remained a moderate risk on the register. Other risks, whilst recorded showed limited evidence of effective controls in place.
- Integrated Governance Group meetings were held each month. Agendas and minutes showed audits, learning from complaints and PALS issues, learning from clinical risk management, peer review data, patient and public information involvement, infection control issues, alert notices, good practice, national service frameworks, clinical audits and research projects were discussed.
- We reviewed the minutes of the January - March 2015 Integrated Governance group meetings; two of the three meetings had not been quorate which may have added delay to any decision making processes. For example, in the March 2015 minutes some policies, "Urology surveillance and staging imaging requesting" and "Flushing of IV devices for patients receiving an anaesthetic" had not been approved. Staff commented that attendance was difficult due to clinical work pressures.
- There were six procedural documents where the review date had expired, For example, pre-operative fasting which had a review date of 2010 and decontamination policy review date February 2014.
- We requested data to review quality measurements. Not all of this data could be provided for us, for example, for the number of cancelled operations. The surgical senior management team may not have been fully conversant with any quality concerns or been able to respond in a timely manner. Following a further request after the inspection quality information was provided, including theatre utilisation performance dashboards and cancelled operations and other audit information.
- External support was being put in place as there were delays in securing clinical staff for panel members to

investigate serious incidents. Staff reported serious incidents and could describe the dissemination of issues and learning. We saw evidence of investigations and root cause analyses. There was a backlog of 32 incidents across both sites, the oldest one dating from 19 February 2015 with a classification as a moderate incident.

- Concerns were raised at the inspection regarding the protocols for radiological protection during breast surgery. The radiological protection lead changed the standard operating procedure during our inspection in response to an identified safety issue around disposal signage that was against trust policy.

Leadership of service

- Staff said that health group managers were available, visible within the health group and approachable, leadership of the service was good, there was good staff morale and they felt supported at ward level. However, some staff told us the governance structure within the group sometimes delayed decision-making.
- Nursing staff stated that they were well supported by their managers, although we were told one-to-one meetings were informal, and that nurse managers visited the wards and clinical areas regularly.
- Medical staff stated that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings.
- Staff told us about recent structural changes to line management, nurse management, health group nurse management and clinical leadership. We were told matrons had worked clinically for the previous eight weeks and this had had an adverse impact on support, complaints and incident management.
- Senior nursing staff told us that they had lost some of their supernumerary time and they felt that, because of this, they did not have adequate management time to ensure safety controls were as effective as they could be.

Culture within the service

- We saw good team-working on the wards between staff of different disciplines and grades. At ward and theatre levels we saw that staff worked well together and there was respect between specialities and across disciplines.
- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority and members of staff were aware of their responsibilities under Duty of Candour.
- Staff recognised the history of a "bullying culture" as documented in the CQC 2014 inspection report and the ACAS (Advisory, Conciliation and Arbitration Service) report commissioned by the Trust in 2014. Staff we spoke with reported they had not witnessed any bullying behaviours.
- They told us some areas now had "Bullying support" staff in place and that a professional and cultural transformation (PACT) training course which had been introduced for all staff.
- Staff told us that the trust is "more relaxed now and the leadership team is more visible'. Directors had been appointed as links between clinical areas and the board. This approach was not consistent; however, as some members of staff told us that the leadership team had not visited all areas.
- Staff told us recent changes had resulted in a more open and approachable board and information was now disseminated from ward to board effectively.
- Although staff told us about a history of poor communication within the senior nursing team this had been addressed through recent appointments, which had resulted in increased motivation amongst nursing staff. Senior nursing staff members told us that the culture was now more positive and encouraged change.

Public and staff engagement

- The hospital's Friends and Family Test (FTT) survey response rate was 40%, between December 2013 and November 2014, which compared favourably with the England average of 32% during that period.
- Staff told us that they had regular staff meetings and the Friends and Family Test results were shared with them.
- Friends and Family Test results were highlighted and displayed throughout the hospital.
- NHS staff survey data (2014) showed the trust scored as expected in 7 out of 30 areas and better than expected in one area (percentage of staff appraised in the last twelve months).
- Trust-wide there were 22 negative findings, e.g. percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (75%; national average 78%), percentage of staff suffering work related stress in the last twelve months (45%; national average 37%) and percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last twelve months (34%; national average 27%).

Surgery

- The senior management team told us that professional nurse meetings were held; ward nurses and specialist nurses were included in these meetings.
- The senior management team held weekly matron meetings which included the health group nurses, health group manager and Director of Operations.

Innovation, improvement and sustainability

- Staff had developed a urology emergency ambulatory care area, where patients could be assessed to determine whether admission or treatment was required.
- Members of the senior management team told us that they were very proud of the nurse-led services that they had developed in the division, such as the extended roles of nurses to cover consultant shortages.

Outpatients and diagnostic imaging

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

Information about the service

Castle Hill Hospital (CHH) is part of Hull and East Yorkshire Hospitals NHS Trust and provides outpatient services for a number of specialisms, including ear, nose and throat, chemotherapy, radiotherapy, women's health, cardiology and endoscopy. There were a total of 257,074 outpatient appointments at CHH between July 2013 and June 2014. The ratio of new appointments to review appointments was approximately 1:3.4. CHH had a DNA rate of 7%.

Appointments usually originated from GP referrals through a paper system or NHS Choose and Book, which is a national electronic web-based appointment system that offers patients a choice of where to receive health care.

The Trust's radiology services were mainly provided at the Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). The trust provided all types of imaging which included general and plain film x-rays, fluoroscopy which means the use of radiation where images are viewed on a television monitor during the examination, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, interventional radiological procedures and nuclear medicine.

We spoke with 30 patients and relatives/ carers using outpatients and diagnostic services and approximately 38 staff including; doctors, nursing staff, radiologists, non-clinical staff and managers. We visited cardiology, ear, nose and throat (ENT), haematology/ oncology and main outpatients as well as the radiology areas. Before our inspection, we reviewed performance information from, and about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

In February 2014 CQC carried out an announced comprehensive inspection and found the overall rating of the service was requires improvement. The service was good for caring. However, the responsive domain was rated as inadequate and the safe and well led domains required improvement. There was insufficient evidence to rate effective. Diagnostic imaging was not inspected in February 2014.

Outpatients and diagnostic imaging

Summary of findings

The outpatients and diagnostic imaging service was judged as good overall. The service was rated as good for safety, caring and being well-led. Responsiveness was rated as requires improvement and the effective domain was inspected but not rated. Throughout our inspection we witnessed good care being given. Most patients were happy with the care they received.

Incidents were reported and managed appropriately. Patient areas were clean and infection prevention and control procedures were adhered to. Medicine management arrangements were in place and records were almost always available for clinics. Staff knew their responsibilities for adult and children safeguarding. There were a small number of concerns noted regarding audit of records and vacant consultant histopathologist posts.

Staff had access to evidence based protocols and pathways. Internal and external audits of radiation regulations showed good compliance. Systems and processes were in place to monitor report and address any issues with patient outcomes. However there was little audit of waiting times within departments. Access to information was generally good for staff but patients reported some issues regarding accessing and timeliness of results. Turnaround for results times was acknowledged as an issue and there were some mitigating actions in place to improve this situation.

The trust had performed worse than the England average for the three waiting time measures for “all cancers” since April 2013. There were four reported breaches trust-wide of 52 weeks before completion of care pathways during January 2015. Improvements had been made to waiting times but there were still significant improvements needed, particularly with reviewing follow up patients.

Both staff and managers were clear about the vision and strategies for both the Trust and their own departments. Priorities, challenges and risks were well understood; there were governance structures and progress was being made against targets to improve services for patients and reduce waiting lists for both new and follow up patients. There were governance structures and clearly defined reporting structures in compliance with ionising and non-ionising regulations. We found evidence of good local leadership and a positive culture of support, teamwork and innovation.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated this service as good overall for safety, however there were a small number of concerns noted.

Incidents were reported and managed appropriately and actions and outcomes were disseminated to staff. Patient areas were clean and infection prevention and control procedures were adhered to. The environment was in good condition.

Decontamination and maintenance arrangements were in place for equipment. There was a replacement plan in place for ageing equipment in Radiology. Medicine management arrangements were in place. Records were almost always available for clinics and enough information was held electronically to see patients safely if notes were missing. There was no evidence available to demonstrate that the quality of patient records or the use of radiological intervention patient safety checklists or WHO surgical checklists were audited.

Staff knew their responsibilities with adult and children safeguarding, however there were some areas where training compliance needed to be improved. There were processes in place for staff to recognise and respond to changing risks for patients, including responding to the warning signs of rapid deterioration of a patient's health.

Staffing establishments and skill mix were being reviewed at the time of our visit and departments were adequately staffed with few staffing issues reported. The major staffing concern was in relation to consultant vacancies in the histopathology team. Five out of 13 posts were vacant and although there was some mitigation in place, this was adversely affecting reporting times.

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Incidents

- There were 130 incidents reported across outpatients and diagnostic areas within the Trust between December 2014 and March 2015. Of these 28 were attributable to outpatient departments (OPDs), two to medical physics, 16 to nuclear medicine and 84 were reported by Radiology. The main themes from the incidents were incidents relating to equipment issues & failure (14), extravasation (leakage of fluid from a vein) incidents (19) and issues with correct or incomplete documentation. The majority of incidents were low or no harm.
- There were six serious incidents report by this trust across all outpatient departments and locations. A root cause analysis was undertaken as part of incident investigations.
- The radiology and outpatient managers told us they encouraged a culture of open incident reporting across all areas and staff we spoke with confirmed they received appropriate feedback and reviewed learning outcomes from incident reports.
- Staff we spoke with across all departments were able to describe how they reported incidents and how they

used 'Datix', (the hospital incident reporting system). Staff said that incidents were discussed at departmental meetings and at radiation protection supervisor (RPS) group meetings. Staff in outpatients told us where changes were needed action plans were put in place. There was a good learning environment within the clinics, staff felt well informed and were keen to improve practices from lessons learned.

- The trust provided the radiology datix incident log 01/02/2014 to 31/03/2015 and we saw incidents were categorised with actions and feedback to staff along with completed dates.
- We also saw, from the quarterly RPS group meetings November 2014 and April 2015, radiology management team/ governance and strategy monthly meetings December 2014 to March 2015, non-clinical quality committee January 2015 and the radiation protection advisers' annual report 2014 dated 01/04/2015, that radiation incidents were reported, reviewed and the learning outcomes identified and shared.
- The trust reported radiation incidents to the Care Quality Commission (CQC) under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and responded to actions as determined by CQC. The trust provided information from two recent reported incidents 20/05/2014 and 19/01/2015 and we saw both incidents had been reviewed and the learning outcomes identified and shared. CQC had no concerns regarding the level or type of incidents reported.
- The blood sciences laboratory manager told us that all blood transfusion incidents were reported to SHOT (Serious Hazards of Transfusion) and SABRE (Serious Adverse Blood Reactions and Events) via an online reporting system. Incidents were investigated using root cause analysis and were discussed by the hospital transfusion team and the hospital transfusion committee.
- Incidents in the laboratories were recorded on the laboratory quality management system (Q-pulse), if the risk assessment showed that the risk rating was moderate or above then it would be entered onto the electronic trust incident reporting system (Datix).
- The manager also explained that anything which had an impact on a patient, such as blood samples needing to be taken again, would be rated as a moderate incident.
- There were no 'never events' reported in 2014, (never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented).
- The sister from one department told us it was not so easy to share lessons across other outpatient areas following a restructure as the regular outpatient sisters' meeting was no longer a formal, regular occurrence.
- Staff understood their obligations with regard to duty of candour and were confident in the systems in place to ensure patients were fully informed of the circumstances which led to any incident resulting in moderate harm.

Cleanliness, infection control and hygiene

- The outpatient areas were visibly clean and records of daily cleaning were visible on the doors.
- All OPDs had adequate supplies of personal protective equipment (PPE), hand gel and liquid soap.
- Waste was appropriately segregated using different bins.
- We noted that instruments from outpatient theatres and from interventional procedures were sterilised at the local sterilising and decontamination unit at HRI and returned to the relevant departments in individual sterile packaging. There were no reported problems with supply of equipment.
- There were adequate hand washing facilities and posters prompting hand hygiene were displayed.
- We observed staff using good infection control practices and they told us there were sufficient supplies of PPE. Staff were observed to be bare below the elbows in accordance with Trust policy. Hand washing practice and use of PPE was observed to be carried out between patients, using the correct technique, PPE, used linen and other waste was seen to be disposed of correctly.
- The radiology departments appeared clean, tidy and uncluttered overall. Patient waiting, private changing and toilet areas were also generally clean and tidy.
- Radiology staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control (IPC) standards. We were told that room cleaning schedules were available in all areas. We saw these schedules were available and up to date in the areas we looked at. We saw a number of radiology staff using PPE appropriately throughout our visit.
- Appropriate containers for disposing of clinical waste were available and in use across the departments.

- The trust provided evidence of Patient-Led Assessments of the Care Environment for both outpatients and Radiology 2014. The assessment showed that the department passed on cleanliness, condition and appearance, cleaning schedules and hand hygiene.

Environment and equipment

- The trust kept an inventory of all of the imaging equipment in use across all locations (updated May 2015). The inventory also included the manufacturing and installation dates.
- The department's risk register included replacing ageing imaging equipment and upgrading of treatment room areas. The manager showed us that the risk registers were reviewed regularly and we saw the register was up to date.
- We also saw from the radiology management team/ governance and strategy monthly meetings December 2014 to March 2015, and non-clinical quality committee monthly meetings January 2015 that risk registers were monitored and reviewed at these meetings.
- During the course of our inspection we observed staff wearing specialised personal protective aprons and these were available for use within all radiation areas and on mobile equipment.
- Staff were seen wearing personal radiation dose monitors and these were monitored in accordance with the relevant legislation.
- The manager told us that there were systems and processes in place to ensure the maintenance and servicing of imaging equipment.
- Patient waiting areas were spacious and colourful, clean, well maintained and uncluttered. Consultation rooms were also clean and uncluttered.
- At the time of our visit the manager explained that work to upgrade a number of treatment rooms had been approved by the trust. The upgrade will include replacing imaging equipment and create space to improve the There was easy access to emergency resuscitation equipment in all outpatient & radiology areas. These were checked every day to ensure they were in good working order.
- We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis.
- All OPDs had access to sufficient, appropriate equipment which was visibly clean and in good order.

Medicines

- Medicines including controlled drugs were stored and checked correctly. The senior nurses were responsible for medicines and medicine key controls. We looked at a random sample of the medicines stored, including controlled dugs and found all of the items looked at were in date.
- Medicines were stored at the appropriate temperature checks were recorded. There were suitable locked cupboards for the storage of medicines.
- Anaphylaxis boxes were available and easily accessible to staff. Boxes we observed were fully stocked and all medicines were in date.
- Paper prescription pads were in use in outpatients. Although these were not individually recorded they did need to be ordered by an authorised individual. Prescriptions were audited and tracked by the pharmacy department and pads were locked away at the end of every clinic. In the cardiology department we observed that prescription pads were locked in the controlled drug cupboard.

Records

- Records used in the outpatient department were a mixture of scanned and electronic information which included test results, reports and paper records.
- The department was moving towards a paperless system "Lorenzo" but at the time of inspection historical records were kept in paper format while newer attendances and results were accessible through the IT system. Both the current and new systems allowed for ready access to patient information such as letters and diagnostic results.
- Paper records were available in the outpatient department most of the time. It was reported that very occasionally paper notes may not be available for example if needed by another clinic or department but recent electronic records were always available and these provided enough information to carry out a clinical assessment safely. The Trust estimated that clinic records were unavailable between 0% and 5% of the time.
- In the main, clinic letters were typed within five working days. Administration staff told us that they were improving on this target and were working towards a two day target.

Outpatients and diagnostic imaging

- It was observed that the room used for preparing notes was sometimes used for patients which meant that computer screens had to be minimised to protect patient confidentiality to preserve confidentiality.
- Nursing staff in all outpatient areas we visited confirmed that they received patient records in a timely manner which allowed them to review information, access results and plan for the patient's visit.
- The trust had a central electronic patient records database, the Reporting Information System (RIS). This system was used to record comprehensive details of each patient's imaging history. The Trust also used the Picture Archiving and Communications System (PACS), a nationally recognised system to report and store patient images.
- MRI paper safety checklists were completed by the patient and checked and signed by the radiographer prior to the patient scan. The manager told us that the paper checklists were scanned onto the patient's individual electronic record on the RIS system and the paper copy was then safely destroyed.
- We reviewed four scanned electronic patient records and saw all four records included the safety checklists completed by the patient. One of the checklists had not been signed by the radiographer and the second checklist had not been signed by the patient. Whilst on site at CHH we looked at further three safety checklists and found all three to be completed correctly.
- The manager confirmed they would follow up on the recording issues observed with staff, and planned to audit records in the future. At the time of inspection records were not subject to regular audit.
- Ten sets of records were checked, all were filed correctly, with no loose documents and all had identity labels and contained the correct paperwork for the correct patient.
- A record of a patient visit was made in the notes and doctors dictated a record of the consultation. At the end of a clinic the list was checked against the outcomes sheets and records to enable entry of outcomes onto the IT system, accurate tracking of records and to ensure the correct information was sent to the secretaries for typing.
- We saw patient personal information and medical records were managed safely and securely. Paper records were held in a lockable trolley while in the departments.

Safeguarding

- Due to alignment of outpatient specialities within different business units and across both sites it was not possible to identify the entire outpatient and diagnostic services training data. However, where data was available there was a mixed picture regarding compliance with the 85% target for safeguarding training.
- Surgical outpatients showed that the qualified nursing staff group exceeded the 85% target for both adult and children's safeguarding training while health care assistants (HCAs) were at 75% compliance for both types of training. For general outpatients all staff groups were at over 90% compliance with children and adult safeguarding training.
- Within imaging medical, nursing and HCA staff groups were not compliant with safeguarding adult training with compliance at 74%, 81% and 67% respectively. Medical staff and HCA staff groups were also under target for children's safeguarding at 76% and 67% respectively.
- Other services such as pathology, dermatology and ophthalmology all showed good compliance. Staff we spoke with in the ENT, cardiology, oncology and main outpatient areas confirmed they had received adult and children's safeguarding training. Training was provided via e-learning and provision of a resource pack.
- Staff demonstrated they understood safeguarding processes such as how to raise an alert. They could access policies and procedures or support from senior staff if needed.
- We observed patients reporting to the main reception areas were identified by name, DOB and GP and radiography staff confirmed these checks prior to treatment.

Mandatory training

- Mandatory training for all staff at Hull and East Yorkshire Trust covered seven subjects including the two safeguarding elements mentioned above. The other mandatory training topics were; fire, information governance, major incident, moving and handling and safety. The trust target for all mandatory training was 85%. Again there was a mixed picture regarding compliance with the remaining five subjects.
- For general and surgical outpatients there was good compliance with mandatory training across all topics with very few exceptions. HCAs were non-compliant with information governance and moving and handling

and nursing staff were non-compliant with fire training. In general outpatients' scientific staff were non-compliant with fire and moving and handling training targets.
- Within imaging, medical, nursing and HCA staff groups were non-compliant with all training modules.
- Pathology, dermatology and ophthalmology all showed good compliance with the majority of mandatory training. In Ophthalmology the HCA and Medical staff groups had compliance between 80% and 82% missing the target of 85% while qualified nurses and scientific staff exceeded the target.
- Staff we spoke with reported they were up to date with mandatory training and that they were responsible for ensuring they kept up to date. Ward sisters received spread sheets from the training department to alert them when staff training was due.
- Mandatory training included e-learning modules and face to face events.

Assessing and responding to patient risk

- The trust had an up to date policy for staff to follow on the use of ionising radiation including x-rays and radioactive substances which had been endorsed by the health and safety committee and trust directors. This policy included the procedures for staff and patient safety. The trust also had in place the written procedures required under the IR(ME)R.
- We saw local rules were produced and available for staff to follow in all of the imaging areas we visited. These were available on one of the mobile imaging machines we looked at in accordance with IR(ME)R.
- The managers and staff we spoke with confirmed that the local rules were available within all of the diagnostic imaging areas and attached to all of the mobile x-ray machines.
- The manager told us there were formal governance arrangements in place for all specialities to seek advice from the Radiation Protection Advisors (RPA). There were also informal working arrangements in place for advice and support.
- The RPA produced annual reports in compliance with relevant legislation and attended a range of governance meetings. They reported on all matters relating to radiation legislation and these were covered in their annual report for 2014.
- The RPAs also chaired the quarterly radiology protection supervisors' (RPS) group meetings to ensure that clinical radiation procedures and supporting activities in the trust were undertaken in compliance with ionising and non-ionising radiation legislation.
- The manager confirmed that all specialities had an appointed and trained RPS, whose role was to ensure that departmental equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- There is a legal requirement to protect the public from unnecessary radiation exposure. This includes clear signage on all doors that enter into an 'x-ray controlled area'. These signs are warning signs and were in place throughout the department.
- The service used adapted versions of the world health organisation (WHO) surgical safety checklist when carrying out all interventional radiology procedures. They included the 'Safety Checklist for Radiological Interventional Procedures and the preoperative and operative safety checklists.'
- The nursing and radiography staff we spoke with confirmed that these checklists were used across the trust for all interventional radiological procedures. We saw a sample of these checklists and observed that they were completed correctly.
- Staff told us that an audit had been planned regarding use of the safety checklists but this had not been carried out by the time of our visit.
- The nurses told us that clinical observations such as temperature, pulse rate and blood pressures were monitored and recorded to detect any deterioration in the patient's condition prior to, during and following their interventional procedure.
- We saw signs displayed throughout the department alerting female patients to ensure that pregnancy information was brought to the attention of the staff. Staff also confirmed they completed checks to ensure women who may be pregnant informed them before exposure to radiation. This information was recorded in the patient's electronic records.
- In the outpatient departments we observed that consultation rooms did not have an emergency call system and staff shouted to raise an alarm if needed. Staff felt that this was an adequate process for raising an immediate alarm and worked well.

Outpatients and diagnostic imaging

Radiology/Pathology and Nursing staffing

- Nursing staff we spoke with in outpatients felt that staffing levels were adequate and that although there was not an acuity tool in use, workload measurement exercises had been undertaken to review numbers of staff required. We were told that staffing levels were determined by the numbers of clinics and attending patients and the type of clinics running on particular days of the weeks. In the main the same clinics ran at the same time and on the same day each week. Clinics were therefore largely predictable in terms of staffing requirements.
- Skill mix varied across departments with some clinics having a higher proportion of trained nurses than others. There was an on-going workforce analysis and reconfiguration within the OPDs to review the numbers and skill mix of staff available.
- There were enough staff in the oncology department to ensure patients received 1:1 treatments as appropriate.
- The trust provided details of the existing radiology staffing establishment and we saw from this information there were a number of vacancies in general radiography and MRI. These vacancies were being covered by locum radiographers at the time of our visit.
- Nurse vacancies to cover the busy interventional radiology services were of particular concern. There was an existing establishment of approximately 25 whole time equivalent (WTE) specialist nurses within medical imaging. At the time of our visit there were 7.40 WTE vacancies and along with leave and sickness the manager acknowledged this was placing the service under pressure.
- Both the radiology manager and matron explained that discussions were on-going to explore the options to address the shortfall in specialist radiology nurses. The manager showed us that the current vacancies in nurses had been risk assessed and escalated onto the departments risk register. We also saw from the radiology management team/ governance and strategy monthly meetings that nurse recruitment was reviewed regularly.
- Radiology workforce planning was a standing agenda item of the radiology management team/ governance and strategy monthly meetings, December 2014 to March 2015. The minutes provided details on the work the service was undertaking to address its recruitment and selection of all staff
- The majority of the staff we spoke with told us that staff shortages were of concern but they were aware of the service recruitment plans. The interviews for a new PACs manager had been completed just before our visit but the appointment had not yet occurred.
- There were 135 lab staff in blood sciences and there were two vacancies at each of the bands, two, five and six. There were no reported problems with sickness in blood sciences.
- In cell pathology there had been recent problems with sickness, but this had been better than the trust target for the last two months. There was one vacancy among the technical staff in cell pathology.
- The manager told us there had been problems recruiting healthcare scientists at band 5 and band 6 and it had been difficult to ensure enough qualified staff on the out-of-hours rotas.

Medical staffing

- There were 26.55 WTE Radiologists with two vacancies. Both posts had been advertised but recruitment had not proved successful at the time of our visit.
- It was reported that the radiology service was able to maintain support to all the multidisciplinary team (MDT) specialities for patient related meetings where Radiologist input was needed.
- The pathology clinical lead position was vacant but each discipline within pathology also had a clinical lead.
- There were five vacant histopathologist posts out of an establishment of 13. To mitigate medical staff shortages, the service was outsourcing some consultant work such as routine, non-cancerous histology, for example gall bladders, tonsils, and GP skin biopsies. The department manager was also in the process of developing new and extended roles for scientific staff to cover some of the workload. All cancerous samples were processed in the laboratories on site and examined by the departmental consultants.
- Two Cellular Pathology technical staff had been trained as advanced practitioners in histological dissection; this meant they could carry out some of the 'cut up' work which had previously only been carried out by histopathologist, saving on consultant time. Two more laboratory staff were about to undertake the training to become advanced practitioners in histological dissection.

Outpatients and diagnostic imaging

- There were two consultant vacancies in microbiology out of an establishment of five. The pathology manager told us these were being covered by medium to long term locum consultants.
- The recent move of plastics trauma from CHH to HRI to support the main trauma centre and split the elective and trauma patients was generally thought to be good idea. However, this had a negative effect on training and support as the medical team had been split between two sites. Staff reported that this was not a major concern but made it more difficult to provide and access the regular training sessions which had been in place prior to the move.
- Junior doctors reported that generally there was very good senior medical support, training and development.

Staffing (other)

- We visited the electrocardiography (ECG) department at Castle Hill Hospital following concerns raised regarding staffing levels. There were 12 whole time equivalent cardiac physiologists who supported 15 consultants and 10 registrars. Staff told us that 10 members of staff had left over the last five years and the trust was advertising to cover three of these vacancies.
- The pacemaker clinic had been run by one member of staff which was not in line with guidelines from Society for Cardiological Science and Technology recommendations that stated ideally the clinic should be staffed by two technicians.
- The British Society for Echocardiography recommended the average time required for performance and reporting of a fully comprehensive cardiac ultrasound time was considered to be 40-45 minute appointment slots however staff told us appointment slots were being booked for 20 minutes.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident.
- There were business continuity plans in place to make sure that specific departments were able to continue to provide the best possible safest service in the case of a major incident.
- The blood sciences laboratory manager told us the staff were always very responsive in the event of machine or IT system failure. They would revert to manual systems and phone results through to users. They said everyone had stayed late when this had last happened, in order to ensure that patients got their results.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Inspected but not rated

Outpatient and diagnostic services were inspected for effectiveness but not rated. Staff had access to evidence based protocols and pathways based on NICE and Royal College guidelines. The 2014 annual RPA's report showed that internal and external audits of radiation regulations demonstrated good compliance.

Systems and processes were in place to monitor report and address any issues with patient outcomes such as radiology reporting times,

There was generally good compliance with appraisals and training and evidence of good multidisciplinary team working. There were some seven day services and plans were in place to extend seven day working.

Access to information was generally good for staff but patients reported some issues regarding accessing and timeliness of results. Turnaround times for test results were acknowledged as an issue and there were some mitigating actions in place to improve this situation. There were some concerns regarding the provision of echocardiography regarding a lack of quality assurance.

Evidence-based care and treatment

- The 2014 annual RPA's report showed that internal audits of compliance with radiation regulations showed good compliance. The report also highlighted that an external audit undertaken in October 2014 was satisfactory.
- It was also reported that audits throughout 2014 across a number of areas, on patient radiation doses, showed good compliance with local and national diagnostic reference levels. Diagnostic reference levels (DRLs) are used as an aid to optimisation in medical exposures.
- The trust had systems and processes in place to monitor its performance for reporting times for all specialities.

Outpatients and diagnostic imaging

- The trust provided audit evidence on the quality of the sonographer scans and reports.
- Outpatient departments had clear protocols to follow for relevant treatments such as chemotherapy or for other interventional treatments or investigations.
- ENT had a clear pathway regarding rapid access and assessment of patients with a neck lump and were developing other patient pathways regarding appropriate discharge back to GPs.
- Staff in ENT also had access to protocols for dealing with ENT emergencies such as epistaxis.
- Clear pathways and protocols were in place for oncology treatments.
- Staff raised with us some concerns regarding the provision of echocardiography. Concerns raised were that the department did not meet British Society of Echocardiography recommendations; the 20 time slots allowed for the investigation were insufficient, it was felt to be inadequate for only one member of staff to be present when assessing pacemakers and supervision of trainees was inadequate. Although no errors had been reported in the department there was no quality assurance process in place.

Pain relief

- Pain relief (analgesia) and local anaesthetics were available for patients who needed this during procedures.
- Analgesia was offered on arrival and mostly prescribed to be administered “as required”.

Patient outcomes

- The ratio of new appointments to review appointments was approximately 1:3.4 in comparison to the England average of 1:2.4 and HRI which had an average of 1:2. As a whole the Trust new to follow up rate was the same as the England average.
- Radiology used a monthly scorecard to report and monitor patient outcomes against breaches of the six week wait target for diagnostics and percentage of reporting at two, seven, 10 and 14 days post investigation.
- Across the Trust there were 279 patients who had waited longer than 6 weeks for an investigation between April 2014 and February 2015. One hundred and sixty three patients had waited longer than 6 weeks for a CT scan and 116 patients had waited longer than 6 weeks for an MRI scan.
- There were no breaches in the other specialities in the other specialities, during this period. The scorecard for February 2015 showed that this was an improving trend.
- Average percentages, across all specialities of reporting at two, seven, 10 and 14 days post investigation were 75%, 88%, 91% and 93% respectively at February 2015. CT reporting was 81%, 94%, 97% and 98% for this month. The main pressure being seen in plain film reporting with averages of 65%, 79%, 81% and 83%.
- There were reporting radiographers who had dedicated reporting time.
- The trust was outsourcing some of its radiology reporting to support capacity demands and improve reporting times. There were systems and processes in place for monitoring the quality, tracking and timings of outsourced radiology reporting.
- We saw evidence that the trust also audited the quality of the sonographer scans and reports.
- Quality management was well-developed within pathology, for example audits, incident reporting and performance monitoring.

Competent staff

- The majority of the staff we spoke with told us they received appraisals and they were up to date with their mandatory training.
- Some radiography staff reported that they had experienced difficulties in keeping up to date with their continuing professional development (CPD). This was mainly due to staffing shortfalls.
- 27 staff were trained and qualified to undertake the role of RPS across the service. There was evidence of up to date in house training for RPS at the quarterly meetings.
- The trust provided up to date evidence of certificates of competence for its RPAs.
- The blood sciences laboratory manager told us the haematology service worked closely with the transfusion nurse practitioners. Nurses carried out competency assessments with staff on the wards, and trained staff to administer blood transfusions.
- The pathology managers had been on the ‘achieving breakthrough’ leadership programme.
- Staff we spoke with in outpatients had received an annual appraisal and felt this was a worthwhile process to identify and plan their development needs.
- Within all OPDs, staff told us that activities for learning and development were encouraged in line with individuals’ career plans.

Outpatients and diagnostic imaging

- The Trust target for appraisals was 85% of staff to have had an appraisal within the last 12 months. Many of the areas within Radiology had achieved or exceeded this but there were some areas not achieving this level of appraisals, nursing, admin and management staff had achieved rates of 44.4%, 48.6% and 57.1% compliance, respectively.
- Across the health groups that had outpatients as part of their portfolio, achievement of appraisal rate targets was generally good across nursing, scientific and medical staff groups. There was also evident improvement from the previous year's figures. There were however some areas where 85% of nursing staff and healthcare assistants had not received appraisals.
- There were processes in place for preceptorship of new staff and for mentoring student nurses.
- ENT staff had specialist training such as tracheostomy care and laryngectomy. Training was provided by the ENT nurse practitioner.

Multidisciplinary working

- There was good evidence of MDT working. Specialist radiologists were part of the multi-disciplinary teams such as the gastrointestinal and breast MDTs. The radiology clinical lead told us that the service was able to maintain support to all of the MDT specialities.
- Cell pathology had good working relationships with other trust departments and pathology consultants attended MDT meetings where appropriate.
- The pathology manager told us they worked closely with infectious diseases and the infection control nurses. They also told us that there was a good dialogue with the local clinical commissioning group, especially relating to demand for pathology services.
- Medical and nursing staff reported good multidisciplinary team working and good working relationships between speciality teams.
- Specialist nurses ran clinics alongside consultant led clinics. For example the laryngectomy voice clinic was led by a nurse practitioner.

Seven-day services

- In the main, outpatient departments were open 8.30am until 5pm weekdays. Some weekend and evening clinics were offered on an ad hoc basis mainly to help meet demand / waiting list initiatives. When additional clinics ran, they tended to be staffed by nursing and medical staff who had agreed to work additional hours over and above their contracted hours.
- Although the trust was working towards seven day services, plans were not yet fully developed as to how this would be taken forward. The department was currently looking at capacity and demand to identify areas which most needed this expansion.
- The oncology outpatient area was open from 8am until 6pm for day treatments and would stay open until 8pm if necessary to complete treatment. This most often occurred during bank holiday weeks and ensured all weekly treatments were given.
- The radiology and diagnostic services provided a range of services, some covering 24 hour, seven days a week and some within normal and or extended working hours Monday to Friday. On-call radiographers and radiologists provided cover for emergency X-ray and CT and MRI scanning outside of regular hours.
- The blood sciences laboratory services were open 24 hours a day, seven days a week and ran a shift system. There were two staff from haematology and two staff from biochemistry working in the blood sciences laboratory out of hours.
- The cell pathology laboratory was open from 8am to 5pm Monday to Friday; the laboratory manager told us they were looking into options for working extended days and weekends. The laboratory manager said this would help get rid of 'peaks and troughs' in the work flow.
- There was a staff and union consultation on-going regarding proposed changes to contracts for those staff only contracted to working Monday to Friday to incorporate weekend working.

Access to information

- Records and diagnostic information was readily available through the OPD electronic records system, paper records were almost always available for clinics and tracking systems were in place.
- Staff told us that blood and x-ray results, letters and notes were usually available and records were prepared for clinics the day before. This gave the opportunity to identify if there was any missing information prior to the clinic and therefore be able to chase information needed.

Outpatients and diagnostic imaging

- Staff had easy access to policies, procedures, news and training through the staff intranet.
- The trust had a system which allowed GPs to 'dial in' and listen to the patient's report. This system is due to be replaced in the near future to allow GP's access to see the reports electronically. The trust clinicians already accessed reports electronically.
- Discharge / consultation letters were dictated in the clinic and typed by the medical secretaries based at the HRI site. In the main clinic letters were typed within five working days. Administration staff told us that they were improving on this target and were working towards a two day target.
- The blood sciences laboratory manager told us all pathology results were available electronically and the laboratories did not generate many paper reports. They told us the laboratories generated paper reports for those users who wanted them, such as the outpatient department. The long term plan for the trust was to become paperless.
- The cardiology and main outpatients' teams had a daily "huddle" to ensure all staff were aware of what was happening for the day and of any alerts or issues relevant to their work. If patients with additional needs were known to be attending the department staff were made aware of this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies and procedures in place for staff to follow in obtaining consent from patients receiving diagnostic procedures.
- The majority of general x-ray procedures were carried out using implied consent from the patient. The trusts consent procedures were followed when performing more complex or invasive radiological procedures and patient consent was part of the interventional radiology safety checks.
- Staff we spoke with told us they were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards and they all told us they had received training.
- Compliance with MCA and DoLS training was around 80% across all business units who had outpatient areas as part of their portfolio. The 80% compliance level was also reflected across all relevant staff groups for outpatient and diagnostic areas however data was not disaggregated to outpatient specific areas.

Are outpatient and diagnostic imaging services caring?

Good

We rated this service as good for caring. Throughout our inspection we witnessed good care being given. Patients were given emotional support and involved in treatment decisions.

Patients were happy with the care they received and found the service to be caring and compassionate. Most patients spoke very highly of staff and told us that they, or their relatives, had been treated with dignity and respect. Patients did not always report good experiences with secretaries and admin staff when raising queries about appointments.

Compassionate care

- We spoke with 30 patients and carers in the radiology and outpatient departments at CHH. The vast majority spoke very highly of the care and treatment they received in the departments. There were no negative aspects about care highlighted to us.
- The majority of the patients and or their relatives we spoke with told us the staff were efficient and caring. One patient said the "Care has been brilliant every time". Patients also commented that staff did not always introduce themselves.
- Issues about privacy and dignity were raised with us around the wearing of gowns and waiting in mixed sex waiting areas. These issues were raised with the manager at the time of the visit.
- Staff were aware of and acknowledged that the waiting space for inpatients was an issue. Wherever possible the staff controlled and managed inpatient access and flow to reduce waiting times.
- During our inspection we saw patients being treated respectfully by all staff. Staff presented as skilled, caring and helpful and were seen responding to patients' individual needs in a timely manner.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas. Vacant / in-use signs were observed on treatment room doors in the cardiology area and there was a separate area for weighing patients which maintained privacy and dignity.

Outpatients and diagnostic imaging

- Patients reported that most of the time, staff made sure that patients were kept up to date with waiting times in clinic. Delays were verbally communicated to patients and there were expected waiting time boards in place.
- Friends and Family Test data for the month displayed in the outpatient departments indicated that out of 148 respondents, 93.2% would recommend the service and 14% were unlikely to recommend.
- Concerns were raised from some patients about staff who handled telephone enquiries about appointments; that sometimes staff were defensive and made excuses rather than just apologising and sorting the problem out.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Patients felt that they were given clear information and given time to think about any decisions they had to make about different treatment options available to them. They also told us that the treatment options had been explained to them clearly with enough information about side effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care however they respected the decision of patients when they chose not to involve their loved ones.
- We saw patients and people close to them being consulted prior to radiology procedures and staff were attentive to the needs of the patients.
- We saw no undue delays evident for treating walk in and out patients in the radiology department.

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that if they had any concerns, they were give the time to ask questions. Staff made sure that people understood any information given to them before they left the departments.
- Formal and informal networks had been created by staff to link patients with people with similar conditions who were further along their patient journey. There were posters on the walls advertising these groups
- There was formal counselling support available for patients who needed it.
- There was a bereavement service and dedicated bereavement officers who were available to support families needing to return to the hospital following the loss of a loved one.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated this service as requires improvement for responsiveness. The trust had performed worse than the England average for the three waiting time measures for "all cancers" since April 2013. There were four reported breaches of 52 weeks before completion of pathway in January 2015.

The Trust was actively managing its waiting lists for both new and follow up patients. The trust had implemented and was further developing initiatives to tackle backlogs and to meet the growing demand for their services. Improvements had been made to waiting times but there were still significant improvements needed, particularly with reviewing follow up patients. The trust had exceeded the target of 93% for; Cancer Waiting Times and Diagnostic waiting times for the trust were better than the England average

Work was ongoing to improve patient flow through work to reduce or reuse clinic cancellations and to reduce the number of patients not attending appointments.

Staff worked to meet individual patients' needs and prevent complaints through the promotion of patient comfort when in the departments.

Service planning and delivery to meet the needs of local people

- To meet the demands of the radiology and diagnostic services some services were provided over extended working hours Monday to Friday. To assist in managing demands for MRI, an extra eight to 12 days per month had been purchased and were being provided by an external mobile MRI service.
- To improve referral to treatment times and cancer waits and the performance team was rolling out training to all staff to facilitate a trust wide approach to improvement and sustainability.

Outpatients and diagnostic imaging

- Some of the services developed to meet local need included; the development of a one stop shop for patients suffering from trauma which required plastics intervention, phlebotomy was provided in in the outpatient areas and nurses and some HCAs were trained to take blood to save patients having to go to other areas of the hospital for these tests.
- Outsourcing to local independent hospitals was also being used as a means of tackling demand for orthopaedic work.
- Capacity for urgent referrals was built in to clinic lists.

Access and flow

- The trust had performed worse than the England average for the three waiting time measures for "all cancers" since April 2013. (18 weeks Referral to Treatment Admitted, 18 weeks Referral to Treatment Non Admitted and 18 weeks Referral to Treatment Incomplete)
- However the trust had exceeded the target of 93% for; Cancer Waiting Times: Two Week Wait Standard and Cancer Waiting Times: Breast Symptom Two Week Wait Standard.
- Generally the follow up to new rate was similar to the England average.
- Diagnostic waiting times for the trust were better than the England average between September 2013 and November 2014. People waiting over six weeks fluctuated between 0.1% and 1.2% during this time period.
- The trust reported four breaches of the 52 week wait target for completed patient pathway. Each breach was investigated and the trust was taking appropriate action.
- To reduce waiting lists, weekly performance meetings were held to monitor backlogs of appointments and progress against incremental monthly targets. Waiting list initiatives had demonstrated effectiveness against waiting times.
- There was recognition that there was still work to be done regarding validation and cleansing of data, a need to look at how rearranged appointments are monitored and recorded as well as a need to focus on reducing longest waits.
- Staff told us that there was capacity in clinics to see patients who were referred urgently. Patients arriving from outpatient clinics and walk in GP services for x-rays were accommodated into time slots within the department. Secretaries could also book extra appointments at the discretion of the consultant for urgent cases.
- Requests for diagnostic tests were sent to the laboratories electronically from wards and GP surgeries. Patient samples had a bar code which was scanned in on receipt. Results were also available electronically.
- Demand for diagnostic tests was increasing, for example pathology requests had increased by 9% in the previous year and vitamin D tests had gone up by 40%.
- Cell pathology had a backlog of unreported tests, which impacted on turnaround times for results. A patient told us they had waited up to six weeks for the results of biopsies. There were also a small number of complaints relating to delay in receiving results. Vacant consultant histopathologist posts were the main cause of the backlog. The histology service outsourced some work and was developing the roles of non-medical staff to help mitigate the effect of the vacancies on workflow. The service generally met the targets for the breast screening programme and bowel cancer screening programme and 90% of cell pathology samples were 'turned around' within one working week.
- Outpatient appointments usually originated from GP referrals (through a paper system or NHS Choose and Book, which is a national electronic web-based appointment system that offers patients a choice of where to receive health care), the central call centre or by consultant to consultant referral. Currently 70% of referrals were on paper and 30% choose and book. The managers were working with the clinical commissioning groups (CCGs) to try and improve GP uptake of the use of Choose and Book.
- Follow up appointments for patients were made as patients left the department if this was to be within 6 weeks. This system had been shown to reduce clinic cancellations as it meant that medical staff availability could be checked prior to making the appointment.
- There was work ongoing to reduce the number of clinic cancellations and improve alternative use of clinic availability when cancellations did occur. For example doctors' study leave and annual leave had to be requested at least six weeks in advance so clinics could be rescheduled or covered more effectively and reduce the number of cancellations. The OPD sisters checked each clinic and doctor availability one week in advance

to reduce the number of appointments being cancelled on the day of or day before appointment. During March 2015 there were 18 cancelled clinics trust-wide and 12 of these were able to be filled by other specialities.

- Cardiology offered a rapid access clinic for patients with chest pain. If doctors were unavailable for a cardiology clinic at short notice there was an escalation process to find cover and the service manager was readily available if needed.
- Cardiology staff told us clinics were busy three days a week and quieter on a Tuesday and Thursday due to consultants undertaking catheter lab work and being unavailable to run clinics.
- It was reported that clinics did overrun on occasion but there were no audits in place for auditing clinic start and finish times or regarding the length of time patients were in the departments, in most of the areas we visited. Cardiology staff told us clinics sometimes finished late to accommodate multiple tests for patients so they didn't have to return. Occasionally overbookings were made but clinics rarely ran more than 30-60 minutes over.
- Information boards displayed waiting times and staff informed patients of how long waits were likely to be and the reason for delays.
- ENT had a rapid access clinic for patients presenting with a neck lump. This included an ultrasound scan and consultation with an oncologist and same day results.
- CHH had a DNA rate of 7% in comparison to HRI 10% and the Trust and England average of 9%.
- The did not attend (DNA) rates varied across specialities and the trust has taken various actions to improve this. For example there was a texting reminder service in place to remind people of their appointments for patients who have chosen this option.

Meeting people's individual needs

- Staff told us they reviewed patients' records prior to appointment to screen for more vulnerable patients - for example, people with learning disabilities, dementia or more frail patients.
- Known dementia patients' records were marked with a blue butterfly to alert staff to the need for extra care needs such as time and space. New patients identified as having dementia had their records marked in the same way to alert the other services involved in the patients' pathway, such as radiology / diagnostics, pre-assessment or an admitting ward.
- There was a dementia link nurse available to staff for advice and support if needed.
- Patients with learning disabilities were encouraged to phone the department ahead of their appointment if possible and receptionists would make sure their appointments were fast tracked if necessary and ensure extra help was offered on arrival.
- Vulnerable patients could be offered first or last appointments if extra time was needed or could be provided with a room to wait in if waiting in the main area was likely to cause distress. Staff were aware of Learning Disability (LD) passports.
- Nurses were available and present throughout consultations where needed; to welcome, chaperone, ensure privacy and dignity and provide assistance where required.
- Staff were able to provide patients with hot drinks and biscuits if waiting times were going to be very long. There was access to drinking water.
- Interpreting services were available for patients on request and these services were available at the main receptions and through appointment bookings. Staff told us they were aware of the services available and knew what procedures to follow to book interpreters. There were also services for people who were deaf and used sign language. Leaflets and posters were seen to provide this information for patients.
- Radiology staff were able to describe how they cared for patients with memory impairments and learning disabilities and they would fast track patients through the departments to reduce waiting times for these patients whenever possible.
- Patients reported a lack of responsiveness in some areas. For example, that there was some inconsistency in the process to access results, sometimes patients received these at a follow up clinic and sometimes they had to go back to the GP. Patients told us that systems regarding appointments seemed inconsistent at times with appointments not received or sent with misinformation.
- Quiet rooms were available in outpatients for staff to use when delivering bad news and for patients who were distressed. These rooms were also used for prisoners receiving treatment to maintain privacy and dignity as much as possible.
- Self-check in computers were available for patient use and in the main these seemed to work well. There were occasions when patients preferred to go to the

receptionist desk to check in and this was accommodated politely. Car parking and drop off for the 3 wheelchair users we spoke to was reported as an issue and one wheelchair user said the receptionist spoke to his carer rather than him which was upsetting.

- In the oncology area patients undergoing chemotherapy were given a patient pack containing; emergency advice, contact information leaflets and thermometers, prior to commencing treatment.
- There was a cardiac support group for patients undergoing surgery and information leaflets were provided on what to expect. These leaflets had been designed in partnership with patients who had gone through the surgery themselves.
- Outpatient staff tried to prioritise patients using transport service to prevent unnecessary delays waiting for transport back to their home.
- Staff in the main outpatient area told us it was difficult to maintain confidentiality due to patients in waiting areas being able to overhear conversations in consulting rooms. We were told this had not been an issue when they had a licence for music to be played over the audio system, however the licence had expired and funding to renew had not been made available. Although there was a hospital radio, estates staff had not been able to get this to play through their system.
- The cardiology service provided a phlebotomy room / service to save patients making an extra appointment or having to visit a different part of the hospital.
- A range of information leaflets were available to patients and this information was also available on the trusts website.

Learning from complaints and concerns

- There were 193 complaints recorded by outpatients between April 2014 and March 2015 only 34 of these directly related to outpatients and diagnostic services. Themes from outpatient complaints included; consultant attitude and difficulties with appointments such as; long waits, cancellations or having to chase appointments. Complaints regarding x-ray or diagnostics were mainly to do with waiting for results and potentially missed or unreported fractures.
- The manager told us that the service had within the last 12 months provided staff with customer care training to assist staff with reducing and managing complaints and improve customer satisfaction.
- Complaints and compliments were discussed through the governance structures. Staff we spoke with confirmed that learning from complaints was discussed at team meetings.
- Staff in a number of departments told us that they tried to tackle concerns before they became a big issue and had learnt from historical complaints that waiting times, lack of food and drink and lack of explanation regarding delays were the most frequent causes of complaints.
- Information about how to access the PALS (patient advice and liaison service) or make a complaint was available within waiting areas.

Are outpatient and diagnostic imaging services well-led?

Good

We rated this service as good for well-led. Both staff and managers were clear about the vision and strategies for both the Trust and their own departments. Priorities, challenges and risks were well understood and good progress was being made against targets to improve services for patients and reduce waiting lists for both new and follow up patients.

There were clear governance structures and clearly defined reporting structures in compliance with ionising and non-ionising regulations. Risks were clearly identified and mitigating actions were put in place.

We found evidence of good local leadership and a positive culture of support, teamwork and innovation. Not all staff were aware of or felt involved with the work of the outpatient transformation board.

Vision and strategy for this service

- There had been a recent management reorganisation to align the speciality clinics with the four core health groups. For example the surgical clinics were managed from the surgical health group. This meant there was not a single management structure or identified individual responsible for the whole of outpatients.
- Despite this there was clear understanding among managers and staff that their service vision incorporated addressing capacity and demand issues, improving

referral to treatment times while maintaining follow up appointments and treatments, reducing DNA rates and using resources more effectively and efficiently to achieve cost efficiencies.

- There was recognition that there had been particular problems with following up patients with long term, chronic conditions and there were plans & processes in place to address backlogs and long waits.
- There was an OPD transformation group to bring together four different ways of working within the health groups. The core management team members we spoke with told us that it had been difficult getting people to the transformation board and that the group had not met for some time. It was generally felt it was difficult to maintain the momentum of the transformation work and an identified lead was needed to re-launch the process and engage the workforce in sustainable progress.
- There was little awareness of the work of the outpatient transformation group among staff and staff expressed a wish to be involved with this work but had not been invited to take part as yet. Staff in outpatients told us that there had been a lack of direction due to the number of changes of matron and the reconfiguration but information was starting to improve.
- The radiology staff we spoke with were aware of the trust vision and strategy and had an imaging and medical physics division forward plan – 2015/16 onwards which outlined the priority objectives and detailed the specific actions that the division is taking to address its current and anticipated quality priorities, performance issues and the outputs from its specialties' clinical service strategies. The was a clear vision for ENT regarding how he wanted to develop the service with regard to developing facilities, timetabling, staffing and providing paediatric and adult ENT services together in a dedicated unit.

Governance, risk management and quality measurement

- There were governance structures and clearly defined reporting structures in compliance with ionising and non-ionising regulations. The reporting structure included local and operational meetings, quarterly RPS group meetings, radiology management team/ governance and strategy monthly meetings, health group quality governance assurance committee and non-clinical quality committee. The non-clinical quality committee was a formal sub-committee of the Executive Management Board (EMB).
- Imaging departmental risk registers were up to date. The risk registers were regularly reviewed by the manager and at the radiology management team/ governance and strategy meetings and non-clinical quality committee.
- We saw from the minutes of the multi-disciplinary meetings radiology discrepancies were reviewed in accordance with the Royal College of Radiology (RCR) Standards. The purpose of these reviews was to facilitate collective learning from radiology discrepancies and errors with a view to improving patient safety.
- Following peer review at the radiology discrepancy meeting a process had been developed for staff to follow when a grade 2 or 3 error was identified. This involved reporting onto the datix system and following the duty of candour processes. The peer review process was an outstanding example of governance. The peer review meetings focussed on openness and learning and displayed a sensible application of legislation.
- We saw from the December 2014 radiology management team/governance and strategy meeting that the trust had identified inpatient plain film reporting had become an issue. 231 delayed reporting incidents were reported across the Trust from 01/01/ 2014 – 31/12/2014. The 231 cases had been reviewed and there were two delayed diagnosis incidents identified. Both cases had been medically reviewed and the trust took actions to address both incidents in accordance with their governance procedures.
- The trust also reported a further 91 incidents reported from 01/01/2015 – 21/05/15. The review of these incidents did not identify any further incidents of delayed diagnosis.
- The reporting capacity for plain x-rays was inadequate to cope with the demand hence a plain film strategy paper had been produced in January 2015. Outsourcing of some plain film reporting had been undertaken to alleviate the problems identified. There were mechanisms in place to monitor the quality of externally reported x-rays.
- The pathology directorate was part of the clinical support health group. There was a governance team within the health group.

Outpatients and diagnostic imaging

- We were told the biochemistry, haematology and microbiology laboratories had been inspected by Clinical Pathology Accreditation (CPA) in March 2015 and had achieved full compliance. CPA assesses and declares the competence of medical laboratories. This provided independent assurance that the accredited laboratory services were meeting current standards for quality and risk management.
- The cell pathology service was the "first histology laboratory in the country to get ISO 15189." This meant the laboratory was accredited under the new UKAS (United Kingdom Accreditation Service) standards. UKAS is currently managing the transition of all CPA accredited laboratories to UKAS accreditation to the internationally recognised standard ISO 15189:2012, Medical Laboratories – particular requirements for quality, competence. The immunology service was awaiting inspection by UKAS.
- The mortuary service and cell pathology service had recently been inspected and accredited by the Human Tissue Authority.
- The shortfall in histopathologist capacity was on the risk register. Turnaround times for cell pathology were also on the risk register as a moderate risk.
- Quality management was well-developed within pathology, for example audits, incident reporting and performance monitoring. Pathology was keen to share their quality management skills and knowledge with other areas of the trust.
- There were risk registers in place for each business unit and risk was discussed at team meetings. Staff understood how to highlight risks through governance structures and processes.
- Outpatient department teams collected data regarding activity and patient flow and analysis of patient activity and flow data was used to inform planning of clinics and use of staff resources.

Leadership of service

- Accessibility of matrons was reported as being good in some departments while other areas reported matrons and senior nurses as not visiting departments enough.
- All of the staff we spoke with were aware of the changes at trust level and could access the relevant information from the intranet.
- Staff were overall very positive about the recent and future management of medical imaging. It was felt that the present management structure was supportive and the direction in which it was going was clear.
- The core management team recognised that were many areas of good practice and innovation and passion for delivering good quality seven day services. They also recognised that some current seven day services had been operating on goodwill from staff working extra hours or voluntarily adjusting their shift patterns to accommodate the new services. The team understood they needed to share the good practice and instil the same vision and passion across all areas.
- Both staff and managers we talked to were highly motivated to provide good quality services.
- There were recent changes to the divisional structure for the OPD areas with new managers. Although it was recognised that change and uncertainty does affect staff morale we were told that there was some unhappiness with how the changes were being managed and a feeling that communication could be improved.
- Recent divisional restructure had resulted in the loss of the formal OPD sisters' monthly meeting but the surgical sister told us that informal meetings were still in place for sharing of governance information, good practice and peer support, whenever possible.
- The Chief Executive Officer (CEO) retained overall responsibility for ensuring that systems were in place to manage risks arising out of the use of ionising and non-ionising radiations. Radiology services across the trust were managed by a Radiology Manager, supported by a deputy and a number of speciality section leaders. Staffing for imaging services covered both hospitals and a number of small satellite units.
- Pathology services across the trust were managed by a Pathology Manager supported by a number of specialist laboratory managers. The clinical lead post for pathology was vacant at the time of the visit.
- Staff had been well prepared for the launch of Lorenzo and there would be a floor walker to assist with any issues when the system went live.

Culture within the service

- Staff we spoke with in pathology reported good teamwork and staff were extremely dedicated and responds well to adversity.

Outpatients and diagnostic imaging

- Radiology staff we spoke with had a positive, optimistic and confident view about the work within the department and direction of the service as a whole.
- There was a can do attitude from the staff we spoke with and they were loyal to the trust
- Within outpatients most areas had positive staff morale; staff felt they were encouraged to report incidents.
- Staff reported they were actively encouraged to undertake learning and development and were helped to develop their careers if they wished.
- All staff were aware of the pressures on their services particularly in relation to reducing waiting lists and ensuring patients received timely follow up appointments and they could contribute ideas to their local managers for improving services for their patients.
- Staff were aware that the trust had a bullying Tsar and that there was a helpline for any staff subject to bullying or harassment.

Public and staff engagement

- At the time of the inspection a formal consultation had started regarding staffing and sustainability of the outpatient services including seven day provision.
- Staff did not feel their opinions were valued and they were not as involved as they would like to be in the recent changes and generation of further proposals for service developments.
- The performance team were rolling out an awareness programme for all staff to understand the challenges the trust faced regarding referral to treatment times with the aim of engaging them in contributing to improving processes and achievement of targets.
- The trust was engaged with national patient surveys and friends and family test and had demonstrated improvements made towards addressing patient and public concerns through their waiting list initiative work and improvements made. The cardiology staff had worked with ex-patients to design information leaflets and provide a support group for patients waiting for and undergoing surgery and rehabilitation.
- We were told that staff meetings gave the opportunity for sharing of good ideas and making suggestions for changes/ improvements and that matrons were receptive to staff ideas.
- Admin staff attended monthly team talks to keep up to date with what was happening across the trust and what was needed in their own area of work.

Innovation, improvement and sustainability

- Six of the 86 GP surgeries who used the laboratories were trialling a new test requesting system (Cyber lab). The IT systems in local GP surgeries were not compatible with the hospital systems and this caused problems. The new system would provide the requester and the laboratory with improved clinical safety and more reliable and accurate test requesting and result reporting. There was a dedicated pathology IT team who were visiting GP practices and installing the new system.
- Pathology had recently appointed an 'innovation adoption manager' who worked with clinicians to improve the service offered. This had led to good engagement with clinical users.

Outstanding practice and areas for improvement

Outstanding practice

In relation to Radiology discrepancies we saw that the peer review process was an outstanding example of governance. The peer review meetings focussed on openness and learning and displayed a sensible application of legislation

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly the histopathologists, the echocardiography team and surgical staff.
- The trust must ensure there is a sustainable action plan to improve the reporting performance of histopathologist service.
- The trust must address the breaches to the national targets for referral-to-treatment times to protect patients from the risks of delayed treatment and care. It must also continue to take action to address excessive waiting times for new and follow up patients with particular regard those waiting the longest.
- The trust must ensure use of best practice guidance, such as national guidance to "ring-fence" orthopaedic patients to prevent cross infections, the safer steps to surgery checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections.
- The trust must ensure the sustainability of the work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014).
- The trust must ensure there is the development of a long term clinical strategy for the surgery health group in line with the Trust's overarching strategy which meets the clinical needs of patients.
- The trust must ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation.
- The trust must ensure compliance with theatre engineering performance measures and annual servicing of ventilation systems for all theatres.
- The trust must review the results of IPC audits across all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres.

Action the hospital SHOULD take to improve

Surgery

- The trust should review access to and security arrangements for theatres and recovery areas.
- The trust should review waiting areas within theatres and recovery areas to ensure privacy and dignity for patients.

Outpatients and Diagnostics

- The trust should review its programme of audit for outpatient and imaging departments to include; monitoring the quality and accuracy of patient waiting times, cancelled clinics and appointments and take action to improve cancellations by the hospital.
- The trust should ensure all areas but particularly the imaging department should continue to take action to improve compliance with mandatory training and appraisals.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. Care and treatment was not always provided in a safe way for patients. The provider must: 1. Ensure that planning and delivering care always reflects published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice specifically in relation to: breaches to the referral-to-treatment times with particular regard to eye services and longest waits. Regulation 12(1) 2. review all incidents in a timely manner and ensure shared learning Regulation 12(2)(b) 3. Review the results of IPC audits across all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres Regulation 12(2)(h)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

There were not sufficient numbers of suitably skilled, qualified and experienced persons employed for the purposes of carrying on the regulated activities. The provider must:

1. ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly on the:

- histopathologists,
- echocardiography teams and
- surgical wards.

Regulation 18(1)

2. ensure that appropriate support is in place to develop staff specifically sustaining the Trust's work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014)

Regulation 18(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and ensure compliance with the regulations. The provider must: 1. Ensure the use of best practice guidance, such as national guidance to "ring-fence" orthopaedic patients to prevent cross infections, the "Five steps to safer

This section is primarily information for the provider

Requirement notices

surgery" checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections.

Regulation 17 (2) (b)

2. Ensure there is a sustainable action plan to improve the reporting performance of histopathology service.

Regulation 17(2)(a)

3. Ensure incidents and duty of candour requirements are effectively acted upon and audited

Regulation 17(2)(a)

4. Ensure there is the development of a long term clinical strategy for the surgery health group which meets the clinical needs of patients and which is in line with the trust's overarching strategy.

Regulation 17(1) & (2)(a)

5. Ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation. Ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation.

Regulation 17(1) & (2)