Plymouth Hospitals NHS Trust

Mount Gould 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
Outpatients and diagnostic imaging	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Plymouth Hospitals NHS Trust as part of our programme of comprehensive inspections of all acute NHS trusts between 19 and 21 July 2016.

This inspection was a follow up to the comprehensive inspection covering the domains of safe, effective, responsive and well led.

During our inspection we inspected the following locations:

- Derriford Hospital
- Mount Gould Hospital

We rated Mount Gould Hospital as requires improvement overall, with improvements needed in the responsive and well led domain. Caring was not rated as part of this follow up inspection, but was rated as good on the previous inspection in April 2015 and has been included in the overall rating.

Our key findings were as follows:

- The systems and arrangements for reporting and responding to governance and performance management data had improved but still did not effectively monitor and record risks and incidents.
- The trust's target of 100% for compliance with mandatory training for safeguarding of children was met, and staff were able to confidently describe their responsibilities in respect of the Mental Capacity Act 2005.
- For some patients, access to new and follow-up appointments were delayed by an ongoing recognised backlog of appointments; however this had reduced since the last inspection. Also, a typing backlog of clinic letters was causing further delays for patients.
- There was no centralised monitoring of safety issues in remote clinics, although leaders visibility and engagement had improved on a local level.
- Patients were cared for in a clean and hygienic environment, and there were systems in place to reduce the risk and spread of hospital acquired infections, however, results of audits were not shared with all staff.
- There were improved practices in respect of the management of prescription forms and the trust's policy for the custody of the medicines keys which kept patients safe.
- The systems and data used to monitor reasons for the short notice cancellation of clinics were not accurate or robust.

We saw several areas of outstanding practice including:

- The results from programmes of audit in some specialities were being used to develop and improve services for patients.
- Strengthened working relationships in both clinical and administrative teams had led to further improvements in the delivery of outpatient services across the trust.

However, there were also areas of poor practice where the trust must;

- Reduce the number of clinics cancelled and capture the reasons why.
- Reduce the numbers of patients waiting past their to be seen date.

In addition, the trust should consider:

- Reviewing and sharing cleaning audits carried out by external companies.
- Reviewing its systems and process which give assurance that services delivered by external companies are carried out in a way that keeps people safe.

Summary of findings

- Reviewing secretarial staff numbers to help clear the typing backlog of Mount Gould clinic letters and ensure the digital dictation system is fully implemented.

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?
Outpatients and diagnostic imaging	Requires improvement 	• Some staff were still not receiving feedback from incidents. • Staff incident reporting was the only safety indicator used by some senior managers. • Cleaning audits carried out by Livewell were not shared with staff. • Some diagnostic imaging protocols were out of date and referred to out of date practice. • Staff were unsure how information about patients additional needs was gathered. • A backlog of typing in some specialties was having a knock on effect to other specialties. • The pain management service sometimes had more patients booked than it had capacity. • Some specialties still had DNA rates above the England average. However: • Senior staff provided guidance and support to junior staff to help them report safety incidents. • Regular hand hygiene audits in pain management fed results directly back to monthly governance meetings. • The number of temporary notes had reduced, and audits were being carried out. • A new system of monitoring FP10 had been introduced. • A pharmacy review of medicines had removed unused medicines from the pain management outpatients, and regular pharmacy visits had increased their visibility to staff and strengthened relationships. • Diagnostic reference levels had been implemented. • Patient outcome audit results had been presented nationally, and a senior nurse sat on the NICE board. • External organisations had been approached to help develop new policy documents. • Pain management planned some of its treatment to suit the needs of the patients.

Summary of findings

- Large notice boards displayed patient centered information.
- A new reporting structure in the bookings team had helped develop a live clinic booking system, and work was being done to maximise the clinic use through overbookings.
- Overall, the DNA rate in outpatients and pain management had improved, and less than 1% of diagnostic imaging patients DNA.
- Pain management and ENT collected friends and family test data to continually improve services for patients.
- There was strong leadership in the pain management service and good working relationships in the bookings team.
- Staff fed and understood how audits fed into the overall governance framework.
- One central equipment register in diagnostic imaging helped plan the future capital replacement program.

Mount Gould Hospital

Detailed findings

Services we looked at
Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Mount Gould Hospital

Plymouth Hospitals NHS Trust is the largest hospital trust in the South West Peninsula. It is a teaching trust in partnership with the Peninsula College of Medicine and Dentistry. The trust is not a Foundation Trust.

The trust provides comprehensive secondary and tertiary healthcare to people in Plymouth, North and East

Cornwall and South and West Devon. The catchment population for secondary care is 450,000 with a tertiary care role for 2 million people in the South West of England. The majority of these services are provided at the Derriford site.

The trust has 1,055 beds consisting of:

• 915 general and acute (inpatient and day case)

• 94 maternity (inpatient and day case)

• 46 critical care (of which 4 are paediatric beds)

There are 5,861.63 whole time equivalent staff employed

at the trust, consisting of:

• 877.2 medical staff

• 1,631.9 nursing staff

• 3,352.6 other staff.

Secondary care services include emergency and trauma services, maternity services, paediatrics and a full range of diagnostic, medical and surgical sub-specialties. Specialist services include kidney transplantation,neurosurgery, pancreatic cancer surgery, cardiothoracic surgery, bone marrow transplant, upper GI surgery, hepatobiliary surgery, plastic surgery, liver transplant evaluation, stereotactic radiosurgery and high risk obstetrics. The trust is a designated cancer centre, major trauma centre and level 3 neonatal care provider.

The City of Plymouth was ranked 67th of 326 local authorities in the English Indices of Deprivation 2010 (1st is 'most deprived'). The Public Health profile indicates that Plymouth is significantly worse than the England average for 17 of 31 indicators (55%), including violent crime and incidence of malignant melanoma. Four of five indicators in 'Children's and young people's health' were ranked significantly worse than the England average.

Plymouth Hospitals NHS Trust provides outpatient and diagnostic imaging services from Mount Gould Hospital, which is owned and operated by Plymouth Community Healthcare Community Interest Company (known as Livewell Southwest). It was one of six registered locations referred to as 'satellite sites' that offered an outpatient and diagnostic imaging service for adults, in addition to the service provided at Derriford Hospital.

Between April 2015 and March 2016, Plymouth Hospitals NHS Trust provided an outpatient service of 523,502 outpatient attendances.

The outpatient department at Mount Gould Hospital held 16342 appointments between July 2015 and April 2016 of which 11895 were attended (the remainder were either

cancelled or not attended), which is 20.4% overall. Did not attend rates (DNA) accounted for 6.7% of appointments made (out of all appointments made including cancelled appointments).

Our inspection team

Our inspection team was led by:

Chair: Jan Filochowski, retired NHS chief executive

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors, assistant inspectors and a variety of specialists: Consultants from medicine, anaesthetics, surgery, emergency medicine, paediatrics, obstetrics, and intensive care, a junior doctor, newly qualified nurse, a midwife and nurses from medicine, care of the elderly and critical care, and an outpatient Head of Nursing. The team also included analysts and an inspection planner.

How we carried out this inspection

The purpose of this follow-up inspection was to look at how the outpatient and diagnostic imaging teams had addressed our previous concerns in relation to safety, effectiveness, responsiveness, and well-led. During our last inspection we rated safety, responsiveness and well led at Mount Gould Hospital as requires improvement. Effective we did not rate due to insufficient data being available to rate effectiveness nationally. Caring was rated good so was not inspected during this inspection.

Prior to our inspection we reviewed a range of information we held about the organisation. We asked other organisations to share what they knew about the hospital. These included the local clinical commissioning group, the Trust Development Authority, the local council, Healthwatch Plymouth and Healthwatch Devon, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We held a listening event on 14 July 2016 in Plymouth, where people shared their views and experiences of care and treatment at Plymouth Hospitals NHS Trust. Six people attended this event. People who were unable to attend the event shared their experiences by email, telephone and our website.

We carried out our announced inspection on the 19, 20 and 21 July 2016 and 12 August 2016, and our unannounced inspections at Derriford Hospital on 29 July 2016. We did not carry out an unannounced inspection at Mount Gould Hospital. We spoke with 21 members of staff including managers, clinical (doctors, nurses, and health care assistants) and non-clinical staff, and spoke with six patients, relatives and carers."

We talked with patients and staff from across the trust. We observed how people were being cared for, talked with carers and family members and reviewed patients' records of their care and treatment.

Facts and data about Mount Gould Hospital

Plymouth Hospitals NHS Trust provides outpatient and diagnostic imaging services from Mount Gould Hospital, which is owned and operated by Livewell Southwest.

It is one of six registered locations referred to as 'satellite sites' that offer outpatient and diagnostic imaging services for adults, in addition to the service provided at Derriford Hospital. The service is delivered by staff who were employed by Plymouth Hospitals NHS Trust, from 08.00 – 17.00 hours Monday to Friday. There were no regular services provided at weekends or out of hours. The outpatients and imaging services was located on the ground floor and served by two reception desks.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Outpatients and diagnostic imaging

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

Information about the service

Mount Gould Hospital is a community hospital, which provides a limited range of outpatient facilities for Plymouth Hospitals NHS Trust. Outpatient clinics held at Mount Gould Hospital include audiology, dermatology, diabetic medicine, ear nose and throat (ENT), geriatric and general medicine, neurology, orthotic assessments, trauma and orthopaedics and rheumatology. Some minor hand and wrist procedures are also carried out as part of the trauma, orthopaedic and rheumatology clinics.

The day to day running of the clinics is staffed by Livewell Southwest with specialist nurses, healthcare assistants and doctors from Plymouth Hospitals NHS Trust coming down to run the clinics. The building at Mount Gould Hospital is owned and run by Livewell South west (formerly Plymouth Community Healthcare) who provide support staff and healthcare assistants to Work in the clinics.

The purpose of this follow-up inspection was to look at how the outpatient and diagnostic imaging teams had addressed our previous concerns in relation to safety, effectiveness, responsiveness, and well-led. During our last inspection we rated safety, responsiveness and well led at Mount Gould Hospital to be requires improvement. Effective we did not rate due to insufficient date being available to rate effectiveness nationally. Caring was rated good so was not inspected during this inspection.

A pain management service is also provided by Plymouth Hospital's staff, and is the largest of the outpatient services provided. The outpatient department and pain management services at Mount Gould Hospital held 16342 appointments between July 2015 and April 2016 of which 11895 were attended (the remainder were either cancelled or not attended). During the same time period, the pain management service held 5075 appointments.

The outpatient department and pain management department were separate. Pain management had five consulting rooms and one treatment room which was used for various clinics including group chronic pain management sessions. No paediatric clinics were held at Mount Gould Hospital.

Plymouth Hospitals NHS Trust also provided diagnostic imaging services at Mount Gould Hospital which included plain X-rays during daytime hours. Between April 2015 and March 2016, there were 6810 attendances and appointments (including some inpatient examinations for the Livewell Southwest run wards), which resulted in 13723 X-ray examinations.

During our inspection we visited the general outpatients department and visited, ENT, trauma and orthopaedics, audiology, rheumatology and pain management clinics. We also visited the diagnostic imaging department. We spoke with 21 members of staff including managers, clinical (doctors, nurses, and health care assistants) and non-clinical staff, and spoke with six patients, relatives and carers.

Outpatients and diagnostic imaging

Summary of findings

Mount Gould Hospital outpatient and diagnostic services were rated as requires improvement overall because:

- Some staff were not receiving feedback from incidents.
- Staff incident reporting was the only safety indicator used by some senior managers.
- Cleaning audits carried out by Livewell Southwest were not shared with Plymouth Hospital's staff.
- Some diagnostic imaging protocols were out of date and referred to out of date practice.
- Some staff were unsure how information about patient additional needs was gathered or if there was a flagging system.
- A backlog of typing in some specialties was having a knock on effect to other specialties.
- The pain management service sometimes had more patients booked than it had capacity.
- Some specialties still had DNA rates above the England average.
- The backlog and pending lists had increased over the past 12 months.
- Senior staff were accessible but not always very visible and there was no central oversight of safety assurances for clinics.
- We did not see any formal policies or risk assessments within services other than pharmacy that covered remote working.

However:

- Senior staff provided guidance and support to junior staff to help them report safety incidents.
- Regular hand hygiene audits in pain management fed results directly back to monthly governance meetings.
- The number of sets of temporary notes in use had reduced, and audits were being carried out.
- A new system of monitoring FP10 had been introduced.
- A pharmacy review of medicines had removed unused medicines from the pain management outpatients, and regular pharmacy visits had increased their visibility to staff and strengthened relationships.
- Diagnostic reference levels had been implemented.
- Patient outcome audit results had been presented nationally, and a senior nurse sat on the NICE board.
- External organisations had been approached to help develop new policy documents.
- Pain management planned some of its treatment to suit the needs of the patients.
- Large notice boards displayed patient centred information.
- A new reporting structure in the bookings team had helped develop a live clinic booking system, and work was being done to maximise clinic usage through overbookings.
- Overall, the DNA rate in outpatients and pain management had improved, and less than 1% of diagnostic imaging patients DNA.
- Pain management and ENT collected friends and family test data to continually improve services for patients.
- There was strong leadership in the pain management service and good working relationships in the bookings team.
- Staff understood how audits fed into the overall governance framework.
- One central equipment register in diagnostic imaging helped plan the future capital replacement programme.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated the safety of the outpatient and diagnostic imaging services at Mount Gould Hospital to be good because:

- Senior staff were providing guidance and support to junior staff to help them identify and correctly report safety incidents.
- The pain management service carried out regular hand hygiene audits and fed results directly back to monthly governance meetings.
- The number of sets of temporary notes in use had reduced, and regular audits of temporary note usage were being carried out.
- A new system of monitoring FP10 monitoring had been introduced across the pain management and Plymouth Hospital's outpatient clinics.
- Regular pharmacy visits had improved the systems and processes for ordering and storing medication and a review of medicines storage had led to the establishment of a secure electronic order and courier system.

However:

- Senior managers were reliant on staff reporting incidents as a way to tell if clinics were being delivered safely.
- Some protocols in diagnostic imaging were significantly out of date and referred to out of date practice.

Incidents

- Incident reporting at Mount Gould Hospital had improved since the previous inspection, and staff could clearly explain their responsibilities to raise concerns by reporting and recording safety incidents and near misses. Staff were reporting incidents, and senior staff told us how they were supporting staff to be confident in using the computerised system.
- Staff were clear about their roles, and understood what they were accountable for; however, senior staff told us they still had to remind some staff about the importance of reporting incidents and near misses.
- Some junior staff were still struggling with what sort of incidents should and shouldn't be reported, For example, when extra Saturday clinics were held, some patient's notes were unavailable, and staff in pain management told us they were still unsure if this had been reported as a safety issue.
- Between May 2015 and April 2016, 14 safety incidents were reported and identified at Mount Gould hospital. Of these incidents 12 were reported in pain management, and two in Audiology. 12 were classified as no harm, and two were classified as minor harm.
- When staff reported incidents, they received feedback via emails; however some non-clinical staff said they did not hear anything about the outcome of incidents.
- A senior manager based at Derriford Hospital told us they were reliant of staff reporting incidents correctly to enable them to identify safety issues and concerns at Mount Gould Hospital, and they used this as a way to gain their assurances that clinics delivered at Mount Gould were safe. However, this was dependent on staff identifying and reporting incidents consistently.
- The Radiation Protection Advisor (RPA) was easily accessible for providing radiation advice, and staff could describe how and why they would contact them, and understood their responsibilities to report certain radiology incidents to the Care Quality Commission under the Ionising Radiation (Medical Exposures) Regulations 2000. These regulations help protect patients from unnecessary harm caused by over exposure to ionising radiation. Staff told us they received a report from the RPA after they had reported an incident, but had not heard of any other outcomes from the investigation.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong when a certain threshold is met.
- On the previous inspection, staff had been unfamiliar with the term duty of candour, and could not describe what it meant. Staff in diagnostic imaging could explain

what they would do if something went wrong that affected a patient, and were familiar with, and referred to duty of candour as being open and honest, but also identified that in certain situations, patients should receive an apology.

Cleanliness, infection control and hygiene

- All of the waiting areas and clinical rooms we visited were visibly clean.
- Staff explained how standards of cleanliness and hygiene were maintained, and we saw evidence that cleanliness and hygiene checks were regularly carried out. We saw comprehensive checklists for each clinical area, including the diagnostic imaging department. Plymouth Hospital staff did not carry out these checklists, but they but showed good compliance with a thorough list of standards carried out on a weekly and monthly basis. However, the Plymouth Hospitals staff did not know where to find these checklists, and were unsure if the results were shared with Plymouth Hospitals staff. We found on our previous inspection that these results had not been available to the clinic staff also.
- Reliable systems were in place to prevent and protect people from a healthcare-associated infection. For example, the pain management service carried out regular hand hygiene audits, which were fed into the monthly governance meetings for discussion and monitoring. The most recent hand hygiene results showed 100% compliance. We saw clinical staff were bare below the elbow in line with hospital policy, and saw gel dispensers at the entrance to the pain management and outpatient clinic areas. Staff could also explain the importance of hand washing, which we saw being carried out.
- Precautions were taken in the outpatients and radiology settings when seeing people with suspected communicable diseases. We saw personal protective equipment, such as disposable aprons and gloves readily available in clinical areas and staff could tell us when they would use them.

Environment and equipment

- Facilities and premises were designed in a way that kept people safe. Waiting areas and treatment rooms were spacious and free from clutter, and there was plenty of seating in both the pain management and outpatient waiting areas.
- Equipment was regularly and adequately maintained to keep people safe. For example we saw evidence that equipment maintenance was monitored centrally, and we saw electrical testing being carried out on a piece of equipment whilst on site. Staff used equipment safely, and could explain how to report faulty equipment or equipment outside of its electrical safety testing dates.
- There were safe systems for managing waste and clinical specimens. For example there was a dedicated specimen toilet in the outpatient department with a hatch into the specimen storage room, which afforded patients privacy and dignity when providing samples.
- Resuscitation equipment was available on the nearby ward. This equipment belonged to Livewell Southwest and staff had assurances that it was regularly checked and in date, and we saw up to date records confirming this. However, the trolley was not sealed and did not have a tamper proof tag.
- The imaging service had one X-ray room, which had been installed in 2006. There were no concerns about the equipment, and regular monitoring and maintenance was planned for the year, and we saw evidence of monthly quality assurance checks being made. These checks ensured the X-ray equipment was working properly and safely.

Medicines

- There were reliable systems for obtaining, prescribing, recording, and storing of medicines, and these systems were reliably communicated to staff, and monitored when required. For example, on the previous inspection, we saw that FP10 prescriptions were not being stored or monitored in way that kept people safe. The pain management and outpatient clinics had introduced a system of monitoring and securing all FP10s issued to doctors working in the clinics. We saw signing in and out sheets which recorded the serial number of each prescription against a specific doctor at the start and end of a clinic. Staff told us copies of these records were also sent to the main pharmacy at Derriford Hospital for checking.

Outpatients and diagnostic imaging

- Only registered nurses held the keys to the FP10 and medicines cupboards in the pain management clinics. Since the previous inspection, the pain management service had brought in a secure signing system for obtaining and returning the keys from a locked cupboard on a nearby ward. We saw the signing sheet, which was filled in and up to date.
- Livewell Southwest staff had responsibility for medicines keys in the outpatient department, and band three healthcare assistants still held these keys. The matron in ear nose and throat (ENT) had visited Mount Gould to assure that a safe service was being provided to staff using Mount Gould Hospital to deliver clinics. As a result, the ENT matron had produced a competency framework and help sheet for all Plymouth Hospitals staff working remotely, which included escalation action if there was a problem.
- On the last inspection, we were told there was a pharmacy service employed to provide support, but staff could not recall any visits from a pharmacist. Since the last inspection, the pharmacy service had begun monthly monitoring visits to Mount Gould, and staff said they had seen them, and felt they had a better relationship with pharmacy as a result.
- Pharmacy had also conducted a review of medicines stored and of keys security at Mount Gould Hospital. As a result, all medicines except some pain relieving patches, had been removed from the pain clinic, and replaced with a secure courier service, so only medicines that were needed for a clinic were on site. We saw evidence of medicines audits in the pharmacy quarterly report.
- Since our last inspection a revised pharmacy policy now stated that in off-site clinics, where registered nurses were not always present, the keys may be held by a suitably trained healthcare assistant, in-line with the policy of the hosting organisation.

Records

- People's individual care records we looked at were accurate, complete, legible, up to date and stored securely either in locked rooms or behind manned reception desks. We looked at four sets of records during our visit, and we did not see any notes left unattended.
- There was a reliable system for ensuring medical records availability for clinics. This system was being audited, but had only begun in May 2016. Results showed five sets of temporary notes supplied in May and five sets in June, out of 602 appointments in May, and 627 appointments in June. We asked for data on the numbers of patient notes missing and found that during the time of the inspection there were only ten sets of temporary notes. Staff told us missing patient notes had prevented a number of patients from being seen in Saturday clinics, when medical records staff were not readily available to make up temporary folders. On our previous inspection, no evidence of any record management audit was available.
- Measures had been taken to increase compliance with notes availability. For example, staff told us the use of temporary notes had been decreasing for some time as a result of an existing action plan, which was being monitored and reported to the Plymouth Hospital's Governance meetings.
- Records were available electronically when paper records were unavailable. Staff were aware of the system to follow if records were not available. Staff told us all referral and clinic letters were scanned onto an electronic system, which meant that patients could still be seen even if their full medical notes were not available. However, staff told us this was not ideal when dealing with certain groups of patients, in particular patients who had spinal cord stimulators inserted under their skin. These patients attended Mount Gould clinics for follow up wound care, but their notes were frequently still in coding at Derriford Hospital, where the actual stimulator insertion procedure took place. Due to the risk of postoperative infections, staff said they felt they had to see the patients whether the notes were available or not, which staff said worried them, as they did not have all the up to date information about that patient. This had been escalated to senior staff, but staff were unsure if anything was being done about it.

Safeguarding

- There were systems, processes and practices in place to keep people safe and these were communicated to staff. The safeguarding steering group based at Derriford Hospital, had oversight of these processes and reported directly to the trust board.
- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements, and staff understood their responsibilities. Staff we spoke with could all tell us

when they had undertaken their adult and children safeguarding training, and describe the process for raising a safeguarding concern, including escalating any concerns to the safeguarding team.
- We saw posters displayed in the main waiting areas and corridors providing information for patients. We saw a flow diagram in the staff areas describing the safeguarding referral process.
- There were processes in place to ensure the right person received the right radiological scan at the right time. The trust had an electronic vetting process for accepting X-ray requests, which made sure the patient received the right X-ray based on the information provided by the referring clinician. However, staff told us they usually only accepted requests with the correct clinical information as there were not enough staff to follow up requests where more information was needed. This meant the imaging department at Derriford Hospital, picked up complex requests.
- Safeguarding has three levels of training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people. Plymouth Hospitals NHS Trust supplied four levels of safeguarding training to its staff which was delivered depending on the individual's roles and responsibilities. Training records provided by the trust showed that as of July 2016, all staff in the trust had received safeguarding level one and two training.

Mandatory training

- Mandatory training was monitored by each care group rather than at a trust wide level, so we were unable to determine the compliance of mandatory training specific to Mount Gould Hospital.
- The trust's target for compliance in mandatory training at any one time was 100%.
- Almost all staff received effective mandatory training in the systems, processes and practices to keep people safe. Data provided by the trust showed that in July 2016; 91% of outpatient and diagnostic imaging staff across all sites, had received resuscitation training, 93% had received manual handling training and 96% had received medicines management training.
- All staff were required to attend a 'trust update' on a yearly basis which included key skills and knowledge training (such as fire policy, manual handling and information governance) which 96% of staff had attended. Although the outpatients and diagnostic imaging departments performed below the trust target for some of the mandatory training requirements they were performing better than the rest of the trust.
- Managers and individuals were informed through email when mandatory training was due to expire and staff we spoke with were supported to book and attend planned sessions. Oversight of mandatory training was gained through an outpatients and diagnostic imaging audit tool called the Departmental Nursing Assessment and Assurance Framework.
- Staff we spoke with were all up to date with their mandatory training, and described how they received reminders three months before their training update, and were aware of their responsibilities for identifying and acting on their individual learning needs and development.
- Staff we spoke with were all up to date with their mandatory training in resuscitation, including non-clerical staff. On our previous inspection we found that non-clerical staff had not had any basic life support training, which is a standard recommended by the National Resuscitation Council.
- Staff told us there was a good mix of electronic distance learning and face to face sessions, which they felt were a good standard. During a quieter part of the clinic, we saw a member of staff undertaking some e-learning.

Assessing and responding to patient risk

- The Ionising Radiation (Medical Exposures) Regulations 2000(IR(ME)R) ensured the benefits for every examination involving ionising radiation outweighed the risks, and made sure patients received no more than the required exposure for that desired benefit.
- The imaging service ensured that the 'requesting' of an X-ray (the process of asking for and justifying why an x-ray is needed) was only made in accordance with IR(ME)R. We saw a list of non-medical referrers and protocols, however, some protocols were many years out of date and referred to old practices, for example the X-ray examination of patients with suspected Osgood-Schlatter disease.
- Senior staff from Plymouth Hospital ear nose and throat (ENT) department had written a safety guide for staff working at Mount Gould Hospital explaining where to find the nearest resuscitation equipment.

Outpatients and diagnostic imaging

- There were adequate signs displayed in the diagnostic imaging department waiting area informing people about where radiation exposure took place.
- The imaging service ensured women (including women using the services and female staff) who were or may be pregnant always informed a member of staff before they were exposed to any radiation, and obtained signed evidence of this.
- There were clear pathways and processes for the assessment of patients who became unwell and required hospital admission. Staff we spoke with could describe what to do if a patient became unwell, and could describe the procedure for summoning emergency help, and knew where their nearest resuscitation equipment was.

Nursing and allied health care professional staffing

- Since the last inspection, the trust had tried to recruit a head of outpatients matron with responsibility for the satellite sites, including Mount Gould. The trust had not been able to recruit to the post, so had delegated some of these responsibilities to existing senior staff.
- Senior nurses within each speciality managed the nursing and health care assistant staffing levels, and made arrangements for staff to work at both Derriford and Mount Gould Hospitals; we saw evidence that in ENT, this was based on a competency checklist.
- There is no standard guidance on the staffing mix in outpatient departments. However, the skill mix needs to be adequate to manage an emergency and meet the needs of individual patients. A registered nurse managed the day to day running of the pain management clinic, and also held the keys to the drugs and FP10 cupboards. This was done on a rotational basis, and we saw rotas showing this. Other staff including a consultant nurse, a band seven pain management specialist and band three HCAs also rotated through the department.
- Staff told us they felt they continued to provide safe care and that when there were unplanned staff absences, there was a procedure for requesting extra staff from Derriford Hospital which they said worked well. Most staff who worked at Mount Gould Hospital also worked at Derriford Hospital, so when short notice staff absences occurred, senior staff reallocated staff from Derriford to cover the clinics affected at Mount Gould.
- There were two vacancies for clinical psychologists, which staff told us was having an impact on the chronic pain management service, however attempts to recruit to the posts had been unsuccessful.

Medical staffing

- Doctors worked at both Derriford and Mount Gould Hospitals and individual specialities arranged medical cover for their clinics. Each service line oversaw the structure of the clinics and the patient numbers and ensured the staffing met the clinic requirements.
- Some future staffing vacancies had been identified in the pain management service, with a full time consultant retiring and coming back part time, and a recent resignation of a part time consultant. This was being monitored to assess what impact this would have on the waiting lists for pain management services, and had been recorded on the outpatient risk register. Plans were being made to try and recruit to the vacancies, but at the time of inspection, both doctors were still in post.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients and diagnostic imaging was not rated due to insufficient data being available to rate these departments' effectiveness nationally.

We found:

- Diagnostic reference levels were regularly audited and implemented in the imaging department.
- The pain management and diagnostic imaging departments undertook regular programmes of audit specific to Mount Gould Hospital.
- Senior staff had presented patient outcome audit results at national and European conferences.
- A senior nurse sat on the National Institute of Clinical Excellence (NICE) board and had developed a working group around pain management.
- A senior staff member had engaged external organisations to help develop new policies and procedures.
- An informal checklist was developed to guide staff working remotely at Mount Gould in ear, nose, and throat (ENT) clinics.

However:

- Some staff were aware of a trust wide flagging system for patients with additional needs, but were unsure how the information was gathered.
- An increased backlog of typing in some specialties was starting to delay typing in other specialties as typing resources were reallocated.

Evidence-based care and treatment

- The pain management outpatient service incorporated relevant and current evidence-based best practice guidance and standards, to develop how services, care and treatment were delivered. For example we saw that staff were continuing to following national guidance for pain management and acupuncture, which was also seen at the last inspection.
- A member of staff on secondment, had taken on the responsibility of reviewing and writing some new policies for the pain management service, and had approached other NHS trusts who had received 'Good' CQC ratings for advice.
- The imaging service used diagnostic reference levels (DRLs) as way to check the correct amount of radiation was being used to image a particular part of the body. Staff were able to locate and explain how they used these as a tool. A previous external audit carried out by the Imaging Standards Accreditation Scheme (ISAS) in March 2014, had found that DRLs had not been fully implemented in the department. We saw evidence that these levels were regularly audited and staff told us the radiation protection advisor (RPA) had overseen this work. We saw DRLs on display and staff could demonstrate how they referred to them in their daily work.
- We saw evidence of a programme of audits within the pain management service, which included hand hygiene, record keeping and consent, and the results of which were reported at monthly governance meetings, with any actions directly fed back to staff in the department.
- The diagnostic imaging service carried out regular request card audits to ensure the accuracy of the referrals received for diagnostic imaging, and fed any issues identified to the Plymouth Hospitals imaging directorate governance meetings.
- A senior nurse currently sat on the National Institute of Clinical Excellence (NICE) board as an expert panel member in lower back pain, and had been encouraged to develop a consultant group to meet and discuss individual areas of expertise and raise awareness of this throughout the trust. This group was preparing to present initial findings of these meetings to the trust board.

Nutrition and hydration

- We saw cold drinking water dispensers, and watched staff actively showing patients where to get drinking water. It was very hot at the time of the inspection, and we saw staff advising patients to keep hydrated whilst in the hospital. The water dispenser was clean and we saw records of regular maintenance.

Pain management

- Plymouth Hospitals NHS Trust had a large pain management service spilt across Derriford and Mount Gould Hospitals. Interventional pain management procedures took place at Derriford Hospital, whilst assessment, follow-up, psychological and some specialist clinics took place at Mount Gould Hospital.
- Staff working in the pain management service worked on both sites.
- Staff told us the patients who came to Mount Gould were often long term pain sufferers, and the service held many clinics and programmes designed to help patients cope with all aspects of their pain.
- Staff told us they used to deliver an Acceptance and Compassion Therapy (ACT) programme for patients living with long term chronic pain, but had to stop the service when the lead clinical psychologist on the project left the trust.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored and staff were involved in activities to monitor patient outcomes. For example, in the pain management service, an audit had taken place of the effectiveness of gel medicine patches as relief for neuropathic pain. The senior nurse in charge had taken a poster presentation on this work to several pain conferences in England and Europe. A peripheral neuropathic pain survey was currently underway for completion and presentation at the end of the summer.
- Information about people's outcomes in the pain management service was collected and used to assess

the effectiveness of some treatments, for example, staff were collecting patient outcome data about the use of 'Baclofen' as a treatment for spasms associated with multiple sclerosis when delivered into the spinal canal by a pump inserted under the skin.
- The Plymouth Hospitals diagnostic imaging service had achieved accreditation by the Imaging services accreditation scheme (ISAS). This meant the diagnostic imaging departments, including Mount Gould, had been inspected by an independent body of peer assessors and had met agreed standards in core areas covering the clinical aspects of the department, the facilities, resources and workforce, the patient's experience, and the safety of the services.

Competent staff

- All staff administering radiation were appropriately trained to do so. Those staff who were not formally trained in radiation administration were always adequately supervised in accordance with legislation set out under IR(ME)R 2000. First year student radiographers rotated through Mount Gould imaging department, and received one to one supervision from the lead radiographer. Students said they enjoyed placements as they had the opportunity to get hands on in a less pressured environment than some other placements.
- Staff in diagnostic imaging received a comprehensive induction, and had a competency checklist which was signed off by the lead radiographer before staff were allowed to work unaccompanied.
- Sub-speciality clinics such as the intrathecal pain management service, were entirely specialist nurse delivered and led by a consultant nurse. The service had previously been doctor run, but was taken over by the consultant nurse when a consultant retired.
- All staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, when they took on new responsibilities. The pain management and some outpatient specialty clinics had standard operating procedures which staff had to read before they could work within the clinics. For example, the ENT matron had written a competency checklist, and identified three healthcare assistants with appropriate knowledge and skills to work remotely in the ENT clinics delivered at Mount Gould, however, this was an informal document.
- The learning needs of staff were clearly identified, and staff told us they received appropriate training to meet their learning needs. For example, staff told us they could undertake a variety of e-learning training, which staff said was very good, and every staff member we spoke with had an appraisal. Staff told us they identified training needs during their annual appraisals, and developed a plan to meet these needs over the coming year. Plymouth hospitals NHS trust collected this data for all staff and reported it as an overall figure which covered all hospitals sites
- A member of staff told us they were encouraged and given opportunities to develop by joining the pain management team on secondment. In doing this, the staff member had brought unique skills to the pain management team, and would take their experience back to their original role and share it with their team.

Multidisciplinary working

- All staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. For example, the pain management service worked with a team of clinical psychologists to deliver a programme to help patients managing long term pain.
- As part of the justification process to carry out exposure to radiation, the imaging service always attempted to make use of the patients previous images, even if these had been taken elsewhere, and the lead radiographer told us that this was done as part of the electronic vetting process.
- All staff we spoke with said they felt communication between different teams was very good, and we saw evidence of this recorded in patients notes.

Access to information

- Despite the use of temporary notes in some clinics, staff told us they nearly always had access to the information needed to deliver effective care and treatment. For example, staff told us all referral letters were available electronically, and could be printed if necessary. However, when extra Saturday clinics were held, staff told us it was not possible to get hold of this information as readily, as staff told us there was no medical records staff cover for the clinic.
- When patients moved between teams and services, including at referral, discharge or transfer, the information needed for their ongoing care was not

always shared in a timely way. For example one consultant told us there had been an increase in the number of letters needing typing and signing in Neurology. As a result, the consultant's secretary had been reallocated to spend half of their time helping to reduce this backlog. This in turn had caused the consultant's own typing backlog to increase. The consultant had not been told when this arrangement would end.

- The systems that managed information about patients did not effectively support staff to deliver effective care and treatment. For example, some staff were unsure if there was a flagging system which allowed them to see if a patient had any additional needs such as learning difficulties. Some staff were unsure how information was gathered and fed into the system.
- The diagnostic imaging service provided electronic access to diagnostic results for all departments within the hospital who had access to the picture archiving and communication system (PACS), or who used the electronic requesting system. This system was being introduced to referrers in the community to further speed up access to diagnostic imaging results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff demonstrated understanding of consent and decision making requirements of legislation and guidance. The process for seeking consent was monitored by an ongoing programme of audit however; staff said they could not recall any specific instances where a Mental Capacity Act (MCA) assessment had been used.
- Since the last inspection, the pain management clinic had introduced an MCA reference folder for all staff to refer to which was readily available in the therapies room, alongside other policies and procedures. Staff also confirmed there was an e-learning package they had undertaken.
- Staff could describe how they would support patients to make decisions, and could describe where to find guidance. Staff told us they would ask senior staff for help if they suspected they had a patient who lacked capacity to consent, and said they would also contact the safeguarding team for advice.
- Doctors told us that patients' mental capacity to consent to care or treatment was assessed at the point of initial consultation and this assessment was recorded in their notes, however, they could not give any examples of where this had happened, and we did not see any assessments in the notes we looked at.

Are outpatient and diagnostic imaging services caring?

Good

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated the responsiveness of the outpatients and diagnostic imaging services at Mount Gould Hospital as requires improvement because:

- The pain management service cancelled 7.3% of all booked appointments between July 2015 and April 2016.
- The pain management service sometimes had more patients booked than it had capacity, which resulted in patient discussions taking place in the corridors.
- There was very little patient information on display within the outpatient department.
- There were large backlogs of typing in some specialties which meant the majority of specialities were not achieving the trust target of five days.
- Between July 2015 and June 2016, 5.8% of sessions cancelled had less than six weeks notice, and reasons were frequently not recorded.
- The backlog and pending lists for Mount Gould clinics had been increasing over the past 12 months.

However:

- The pain management service had planned some of its treatment programmes to best suit the needs of the patient group being treated.
- The pain management service had large notice boards with friends and family test results displayed, along with other patient centred information.

Outpatients and diagnostic imaging

- The manager of the outpatient management centre (OMC) reported directly to the Head of Performance and Management of Information, and had developed a live clinic booking system.
- Work was being done to maximise the clinic use by seeking permission from consultants to overbook clinics at Mount Gould Hospital.
- Overall, the DNA rate in outpatients had improved and was in line with the England average.
- Some specialties still had DNA rates above the England average, but had identified work to help reduce this amongst certain patient groups.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. For example, the pain management service provided psychological support programmes to some chronic pain patients. The programmes often required multiple appointments, so the clinical psychologists had taken over booking of these appointments. Patients were first sent in invitation to accept if they wished to take part in the programme, which was followed up by a telephone conversation to discuss the demands and requirements of the programme. This allowed patients to fully understand what was required of them before they committed to the whole course of treatment.
- There were specialist clinics for local population needs such as the nurse led intrathecal catheter service, which was one of only two such clinics in the South West of England.
- There were extra weekend clinics held in pain management, but other outpatient clinics only ran Monday to Friday 8.30am to 6pm. The clinics did not use technology such as telemedicine as an alternative to face to face appointments. However, nurse led telephone appointments were still being used.
- The pain management service had 5075 clinic attendances between July 2015 and April 2016. During the same time period, the hospital reported 11895 outpatient clinic attendances out of 16342 clinic appointments booked across all of the outpatient speciality clinics provided including pain management. The hospital also provided diagnostic imaging services which included plain X-rays. Between April 2015 and March 2016, the diagnostic imaging department had 6810 attendances and appointments (including some inpatient examinations for the Livewell Southwest run wards), which resulted in 13723 X-ray examinations.
- The facilities and premises were appropriate for the services that were planned and delivered. For example, the pain management service had five consultation rooms and a large three bay therapy room, which we were told was used for examinations and some of the group therapy sessions. However, it had been reported via the electronic incident system that at times, the clinics were too big for the facilities, and staff had held discussions with patients in the corridors.
- The environment of the pain management and diagnostic imaging clinics was appropriate and patient centred. For example, we saw two large whiteboards in the corridors where the pain management clinics were held, displaying up to date friends and family test results, along with examples of actions taken as a result of patient feedback. We also saw lots of information about self-help groups, which was relevant to the types of patient being seen in these clinics. In the outpatient department, we saw some general leaflets, but nothing specific to the clinics being held. However, staff did tell us that because the Mount Gould Hospital building did not belong to Plymouth Hospitals NHS Trust, it was difficult to get notice boards put up.
- Patients we spoke with told us they were offered a choice of appointments at Mount Gould Hospital or Derriford Hospital, depending on where clinics were being held. Patients told us there was plenty of car parking at Mount Gould Hospital, and it wasn't as daunting as going to Derriford Hospital.
- Patients were able to locate the outpatient, pain management and diagnostic imaging departments because they were clearly signposted and there were several non-clinical members of staff available to help.
- Since the last inspection there were improvements made in the booking process, with the manager for the outpatient management centre (OMC) now directly reporting to the Head of Performance and Management Information. Staff told us that having access to performance data had vastly improved the way the OMC was running, and now allowed the team to look at and breakdown data to clinic level to assess the usage of individual clinics as well as to look at clinic cancellations and did not attend (DNA) data.

Outpatients and diagnostic imaging

- As a result, staff told us they had developed a live clinic booking system to allow other specialties to see when extra capacity became available as a result of a cancelled clinic. Work was also beginning to look at overbooking some clinics at Mount Gould Hospital, however this was being done only with the consultant's permission. Overbooking of clinics would help utilise appointments where patients may have cancelled or not shown.
- Staff told us the OMC was now responsible for booking the vast majority of appointments, including new, follow-up and consultant led appointments, however, secretaries to individual consultants still retained responsibility for booking some procedures, which staff said remained confusing for patients, although the overall situation had improved.

Access and flow

- In June 2016, the backlog of patients across all specialities was 947 (patients overdue on their see by date), and 1629 patients on the pending list (patients who required a follow up at some point in the future). In July 2015, the backlog was 671, and pending list was 1402. Over the past 12 months the numbers of patients on these lists had been increasing.
- Patients told us they were offered a choice of appointments within the clinic hours of 8.30am to 6pm Monday to Friday, and patients told us that the appointments system was easy to use.
- Sometimes care and treatment was cancelled or delayed without an unavoidable reason, and the recording of the reasons for cancelling appointments was inconsistent. Frequently no reason was recorded at all.
- The trust had an annual leave policy which stated that booked sessions and clinics would only be cancelled in exceptional circumstances if less than six weeks notice was given.
- Between July 2015 and April 2016, the hospital cancelled 956 (5.8%) appointments. Of these cancelled appointments, 546 were in pain management which was 7.3% of all appointments made in pain management.
- On our previous inspection we found there were delays in the typing and signing of clinic letters for GPs. A digital dictation system had been introduced, but three consultants still used Dictaphones.
- In May 2016 there were backlogs (letters waiting more than two days to be typed) of typing in most specialties; the biggest backlogs were in rheumatology (214 letters), Trauma and orthopaedics (162 letters) and Neurology (360 letters, in combined consultant and junior doctor led clinics). The typing delay had also increased in general medicine form 49 letters to 73. A consultant told us this was because there had been a backlog of nearly 900 letters in neurology in March 2016, and secretaries from other specialties were being used to clear this backlog. However, this was causing the backlog in other specialties to rise.
- There were also some delays in the sign off of letters, and most specialties had a backlog (letters waiting over two days for sign off). In May 2016 the biggest backlogs were in neurology (278 letters), respiratory medicine (89 letters) and general medicine (80 letters).
- The Hospital target for letters to be typed and sent back to the GP was five days. Some specialties were achieving this; however it took an average of 14.13 days for junior led neurology clinic letters to be typed, and 9.5 days to be signed. This means that it took on average 23.63 days for a letter to be typed and signed in this speciality.
- We saw that pain management clinics usually ran on time, and patients were kept informed about any disruption. Patients told us that the waiting time for appointments was sometimes communicated. We saw that staff kept patients informed during pain clinic sessions using a white board in the main waiting area. The trust did not record the time that patients were kept waiting once they arrived in the department. We did not see any information displayed in the outpatient waiting area about who was running clinics, or if there was a delay.
- The trust did not record the time that patients were kept waiting if they required an additional appointment or X-ray.
- In diagnostic imaging, the lead radiographer explained that if patients had already attended the department and there was a breakdown of equipment, they would hold onto the appointment cards and ask the patients to call up later in the day, rather than return the cards to the central booking office at Derriford Hospital.
- Most patients who attended for X-rays at Mount Gould Hospital had an appointment within four weeks, which is within the NHS England target of six weeks.

Outpatients and diagnostic imaging

- The diagnostic imaging service had a did not attend rate of less than 1% of all appointments booked between April 2015 and March 2016.
- The outpatient and pain management service did not attend rates (DNA) for appointments were in line with the England average overall between July 2015 and April 2016, with 6.7% of appointments made not attended (out of all appointments made including cancelled appointments). This had improved since the last inspection. Previous data submitted to the Health and Social Care Information centre (formerly Hospital Episode Statistics) had shown a DNA rate slightly worse than the England average of 6.9% over the time period January 2015 to December 2015.
- The five specialties providing the greatest number of appointments were pain management, rheumatology, trauma and orthopaedics, ENT and neurology. All of which had DNA rates below the England average, except Pain management (7.9%) and trauma and orthopaedics (8.1%).
- Staff in pain management said they had identified a particular group of patients who seemed to be more likely to DNA than other patients. Staff felt the wording of the appointment letters to these patients was possibly the reason, and was being discussed within the governance and performance meetings to propose re-wording of the letters and monitoring of the outcomes from this.

Meeting people's individual needs

- Support with transport was available for patients with mobility issues, However, an incident was reported, where a wheelchair bound patient had attended for a specific appointment, to find they were not able to get access to the specialist clinic room because it was too small to accommodate the patients wheelchair. Staff told us they had updated the hospital flagging system to reflect the patient's needs, but said it was possible it could happen to other patients.
- The pain management service arranged appointments so that new patients were allowed time to ask questions at their first appointment.
- Staff could describe what they would do if they had a patient with learning difficulties who needed additional support. For example the receptionist said they would contact a clinical member of staff if they had concerns, and also mentioned the adult safeguarding team if they were really worried about a patient. However, there was some confusion amongst reception staff as to whether there was a flagging system to highlight patient's needs before they came to the hospital.
- Translation services were readily available if required, and staff told us of a patient who had attended pain clinic for a consultation, who did not speak English. The consultant used the telephone translation service and the patient received a very thorough and meaningful consultation as a result.
- Some non-clinical staff told us that before our last inspection, they had not known how to request telephone translation services, but since the inspection this had been better communicated to all staff.
- The pain management service attempted to engage with people who were in vulnerable circumstances such as those living with multiple sclerosis or fibro myalgia. Actions were taken to remove barriers when people found it hard to access or use services. For example, dedicated programmes and clinics had been set up to focus on pain relief treatments for these specific groups of patients, who staff told us can quickly become isolated because of their condition.

Learning from complaints and concerns

- Patients told us they knew how to make a complaint or raise concerns, and felt confident to speak up about concerns.
- Staff told us they encouraged patients to make complaints, but said they tried to sort out issues informally before directing patients to the Patient Advice and Liaison service (PALS).
- We saw patient advice leaflets on the PALS service displayed in the main waiting areas. This information was also available in other languages and formats, including easy read.
- Complaints were managed centrally in the outpatient department, and we did not see any complaints specific to Mount Gould Hospital. As we found on our previous inspection, complaints were managed by each service line and escalated to the care group managers and trust board if significant. Staff we spoke with were aware of this escalation process, but could not give any examples of where it had been used specific to Mount Gould Hospital.

Outpatients and diagnostic imaging

- Between April 2014 and April 2015 the outpatients departments across all Plymouth Hospitals NHS Trust sites received a total of 306 complaints with 193 of these being upheld. Of these complaints a total of 76 were concerning delays in appointments.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated the leadership in the outpatient and diagnostic imaging departments as requires improvement. This was because:

- The risk register did not record risk by site, which made identifying risks specific to Mount Gould Hospital difficult.
- The matron responsible for Mount Gould Hospital was based at Derriford Hospital, and staff could not recall seeing them.
- There was no central oversight of safety assurances about clinics run at Mount Gould Hospital.
- We did not see any formal policies or risk assessments covering staff who work remotely at Mount Gould Hospital.

However:

- The pain management service ran several specialty services, and collected data to continually improve those services for patients.
- There was strong leadership in the pain management service from the consultant nurse who was very visible and had taken over and developed a nurse led intrathecal pump management service.
- There was also a good working relationship between senior bookings staff and the Head of Performance and Management of Information.
- Staff fed and understood how audits undertaken in their department fed into the overall governance framework.
- One central equipment register in diagnostic imaging helped plan the future capital replacement programme.

Vision and strategy for this this core service

- The trust had adopted a set of values which had been developed and staff we spoke with were aware of these values. These values placed putting patients first, taking ownership, respecting others, being positive and listening and learning as its top priorities. On our last inspection, staff had not shown much awareness of these values.
- We saw notice boards in pain management which displayed these values, and staff were able to tell us how they would remind staff of these values if they displayed behaviours that were not consistent with the trusts values.
- Staff told us there was greater visibility of the trust values and vision on the Derriford Hospital site than on the Mount Gould site. This was also found on the last inspection.

Governance, risk management and quality measurement for this core service

- On our previous inspection, staff told us the governance processes at Mount Gould Hospital were not as embedded as at Derriford Hospital. We found there was now a governance framework to support the delivery of good quality care. For example, there was an improved culture around incident reporting, and the pain management service fed audit results directly into the monthly governance meetings. However, it was not clear who had overall responsibility for monitoring risks identified at Mount Gould Hospital, or how this was done.
- Staff were clear about their roles, and understood what they were accountable for; however, senior staff told us they still had to remind some staff about the importance of reporting incidents and near misses.
- The previous inspection had identified a lack of oversight and leadership, and the trust had decided to appoint a matron in charge of outpatients across all hospitals. The trust had attempted to recruit to this role, but had been unsuccessful, instead, some of the responsibilities had been delegated to an existing senior nurse.
- Senior staff told us they gained their assurances that services at Mount Gould Hospital were safe from the contract with Livewell Southwest, which stated that staff assigned to the services provided were adequately qualified and trained, and had the necessary skills, competence and expertise appropriate for the services they provided. We saw evidence that some service leads had sought their own assurances that this was the case. One said they had visited Mount Gould Hospital to

observe the staff as there were differences between the Plymouth medicines management policy and the Livewell Southwest medicines management policy in relation to the banding of staff allowed to hold the keys.

- Other service line managers and matrons told us they took assurances from the review of services pharmacy carried out, which had covered the holding of keys by of non-Plymouth staff. The pharmacy policy covering medicines management at satellite sites had been updated to reflect this.
- There was now an overall risk register for outpatients, and a separate risk register for diagnostic imaging, which covered Mount Gould as well. This provided a centralised way of identifying, recording and managing risks, issues and mitigating actions. However, the register was organised by care group and service line, so it was difficult to identify any risks specific to Mount Gould Hospital unless it had been entered in the description of the risk. We did not see any risks identified in relation to Mount Gould Hospital.
- The diagnostic imaging service had also centralised all of its equipment on one register so that managers had an oversight of the age of equipment and could predict when it may need replacement. This information was being used to plan future capital replacement projects. Diagnostic imaging managers had created this register since the last inspection, and said it was now much easier to present risks around individual pieces of equipment to the trust board. Each piece of equipment was given a rating depending on its age and when it was likely to be out of service contract and need replacing.
- There was no central system or policy that gave comprehensive assurances to managers and senior nurses that clinics were being delivered in a way that kept people safe. Senior nurses told us they were reliant on staff reporting incidents on the Plymouth Hospitals electronic system to be made aware of any safety issues at Mount Gould Hospital. However, the ear nose and throat department had developed an informal document which gave advice and guidance, and an escalation procedure which included a named person to contact at Derriford Hospital if needed.
- This information was held in each service line, and was not gathered centrally, and we did not see any formal policies in any service line covering remote working at Mount Gould Hospital outpatient department, except in pharmacy.
- There was a programme of clinical and internal audit in the outpatient and diagnostic imaging services. The data from these audits was used to monitor quality. For example in the pain management service the quality of records was being monitored, along with compliance with patient consent forms. The senior nurses were monitoring this and reporting back to the speciality governance meetings. Staff told us the quality of record keeping had improved as a result, and we saw evidence of this in the patient notes we looked at.

Leadership of the service

- Leaders of the pain management services told us they had all the skills, knowledge and experience that they needed to do their jobs. These leaders told us they had the capacity, capability, and experience to lead effectively. For example, staff in the pain management service told us the leadership provided to them by the consultant nurse in the delivery of the intrathecal pain management service was excellent, and this was reflected in the outcomes they collected and also in the friends and family test results.
- The lack of an overall matron or other onsite senior nursing staff in the outpatients department highlighted that no one person understood the challenges to providing good, safe care at Mount Gould Hospital, and the action needed to address these challenges was left to individual service leads to establish. For example, as part of Livewell Southwest policy, drugs keys were held by band 3 healthcare assistants. This is not in line with Plymouth hospitals policy, and individual service leads had to seek their own assurances that their clinics were being delivered safely, and that they were happy with the way Livewell Southwest staff were supporting Plymouth Hospitals staff. We did not see any policy documents to provide assurances that this was the case in all specialties.
- It was not clear if any senior nurses with responsibility for clinics at Mount Gould Hospital had sight of infection control cleaning audits, and it was unclear if they were shared with Plymouth Hospital's staff.
- The matron in pain management was not always visible, but was approachable and senior staff had weekly telephone conversations specifically about the pain service. Staff told us if any issues arose, the matron would come and visit. However, very senior nurses who ran specialist clinics were very visible and approachable.

Outpatients and diagnostic imaging

- Morning team briefings had recently been introduced, and staff explained how this helped all staff get together and discuss possible issues that may arise in the coming day, however, we did not have the opportunity to observe one of these briefings.
- Staff told us there was no senior nurse presence in the outpatient department, and a senior matron had oversight of the department from Derriford Hospital. However, we found that individual heads of service lines, such as the ear nose and throat matron, had visited Mount Gould outpatients to assess the clinics delivered by their speciality, and seek their own assurances that clinics were being delivered safely. After the inspection we saw a report which indicated that the Medical Care Group Director and Quality Manager had also visited the hospital.
- The Head of Performance and Management of Information had become the line manager for the outpatient management centre manager, and had given them oversight of performance data, which had helped them develop new ways of assessing and utilising outpatient clinics at Mount Gould Hospital and across all other Plymouth Hospitals outpatient locations.
- Poor or variable staff performance, which was not in line with the trust values was identified and managed appropriately using written feedback. For example, one senior nurse participated in a mentoring programme, and explained how verbal and written feedback were used to address substandard performance in staff.

Culture within the service

- Staff we spoke with told us about the open and honest culture which existed in the pain management and diagnostic imaging departments, and said they felt very well supported by their managers. However, the lead radiographer, said they did not visit Derriford Hospital very often, but had access to staff meeting minutes via the intranet, and had good access to their line manager by phone.
- Staff who worked in the outpatient department only visited to run or assist specific clinics, and did not really consider Mount Gould Hospital as being separate from Derriford Hospital.
- Clinics were run by individual specialities, and staff said the different service lines worked independently of each other, which staff said did not create a very supportive working environment. This was also found on the previous inspection.
- Staff in pain management and bookings services said there was two way dialogue between staff and mangers, which had resulted in several projects aimed at improving clinic utilisation, including the live booking system and discussions around wording of letters in pain management to help increase use of clinics and their attendance.

Public engagement

- The outpatient and diagnostic imaging services did not provide a forum for listening to the views and experiences of the patients in order to shape and improve the culture and the care in the outpatient's service.
- Healthwatch Devon continued to hold twice monthly engagement meetings in the main reception at Derriford Hospital, however we did not see any evidence that this or something similar had happened at Mount Gould Hospital since our last inspection.
- The pain management and diagnostic services actively engaged with patients, relatives and patient representatives to involve them in decision making about the planning and delivery of the service. For example, we saw reception staff giving out friends and family questionnaires. Data was available, specific to Mount Gould which was not available on the previous inspection.
- We saw posters and leaflets displayed, giving patients advice and information about how to give feedback on the care and treatment they received at Mount Gould Hospital, which had not been apparent on the previous inspection.
- Since the previous inspection, the pain management and ENT services now collected Friends and Family Test data for their clinics. This data showed 94.44% of patients recommended the service in ENT out of 108 respondents. In pain clinic, data was collected from both Derriford and Mount Gould Hospitals, and showed 93.9% of patients recommended the service out of 1146 respondents.

Engagement with other organisations

- A senior member of the pain management team had attended an external conference, and as a result had approached another NHS organisation for guidance around writing new policies and procedures for the pain management services.

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

- Staff told us that financial pressures did not compromise care, but staffing recruitment difficulties did, especially in clinical psychology. Staff told us they were concerned that some chronic pain services may be lost if they could not recruit to these roles, as had already happened with the accepting and compassion therapy course.
- There was evidence that leaders and staff strived for continuous learning, improvement and innovation. For example a nurse consultant took on a service which had previously been clinician lead, and developed a team of specialist nurses to support this service. The service focused on managing, monitoring and maintaining patients with intrathecal pumps and collected data about the effectiveness of different pain relieving medicines on chronic pain, when delivered into the spinal cord by a pump inserted under the skin, in particular the use of baclofen to reduce spasms in multiple sclerosis.
- Staff were focused on continually improving the quality of care. For example, staff told us about a pilot scheme around the use of the Hyland model in the long term management of fibro myalgia. The project aimed to assess the effectiveness of cognitive therapy and exercise in the long term self-management of patients with chronic pain.
- The diagnostic imaging department was taking part in an audit of the quality of referrals received by the department, with a view to improving this so that less time was to be spent chasing additional information, which slowed down the appointment process for patients.

Outstanding practice and areas for improvement

Outstanding practice

- The pain management service ran a consultant nurse led Intrathecal pain management service, which collected data about the effectiveness of different pain relieving medicines on chronic pain, when delivered into the spinal cord by a pump inserted under the skin. The specialist nursing team solely ran by the maintenance and monitoring of this service.
- The pain management service was auditing the effectiveness of quetenza 'chilly' (pain relief) patches in the treatment of longstanding neuropathic pain, and had presented the results nationally and in Europe.
- The pain management service had seconded an operating department practitioner to the service who had taken responsibility for writing new policies and procedures, and had engaged other external NHS organisations for guidance.
- A pain management consultant was leading a pilot study into the effectiveness of Hyland body reprogramming in the management of the long term condition fibro myalgia.
- The operation management centre manager was reporting to the Head of Performance and Management Information. Having oversight of performance data had helped the team analyse and come up with new ways to maximise clinic use, including developing a live booking system for clinics.

Areas for improvement

Action the hospital MUST take to improve

- Reduce the number of clinics cancelled and consistently capture the reasons why
- Take action to reduce the numbers of patients waiting past their to be seen date on follow-up and pending waiting lists.

Action the hospital SHOULD take to improve

- Consider reviewing cleaning audits carried out by external companies in relation to the environment in the outpatient, diagnostic imaging and pain management.
- Consider reviewing risk registers, to enable risks to be captured by site.
- Review its systems and process which give assurance that services delivered by external companies are carried out in a way that keeps people safe.
- Consider reviewing secretarial staff numbers to help clear the typing backlog of Mount Gould clinic letters.
- Ensure the digital dictation system is fully implemented to help reduce typing delays at Mount Gould Hospital.
- Ensure staff comply with annual leave policy when cancelling sessions with less than six weeks notice to patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance (2)(a) There must be systems and process in place to monitor and improve the quality of and safety of services; (2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The processes and systems to monitor the number of clinics cancelled was not effective, and the reasons for last minute cancellations were not recorded consistently or reviewed by senior staff. The processes and systems in place to identify and assess risks to the health and safety of people who use the service were not effective or timely. The numbers of patients at risk of harm due to the backlog of new and follow up appointments was continuing to increase. This placed patients at risk of harm due to delays in treatment and assessment.