BMI The Lancaster

Quality Report

Meadowside
Lancaster
LA1 3RH
Tel: 1524 62345
Website: www.bmihealthcare.co.uk

Date of inspection visit: 14 to 15 May 2019
Date of publication: 15/10/2019

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Overall summary

BMI The Lancaster Hospital is operated by BMI Healthcare Limited. The hospital has 25 beds and four chairs for day-case procedures. Facilities include one operating theatre and an endoscopy suite where injections for pain are carried out, outpatients and x-ray diagnostic facilities.

The hospital provides surgery, medical care (endoscopy only), outpatients and diagnostic imaging. We inspected surgery, outpatients, diagnostics, and medical care.

We inspected this hospital using our comprehensive inspection methodology. We carried out this unannounced inspection on 14 and 15 May 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Summary of findings

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service section.

We have provided guidance for services that we rate and do not rate.

Services we rate

Our rating of this hospital stayed the same, we rated it as **Requires improvement** overall. We found that diagnostic imaging services and outpatients required improvement, however we found good practice in surgery services.

- The static X-ray equipment was ageing, we were told by staff that the fluoroscopy function of the equipment was no longer in working order. There were no clear timescales for when it would be replaced.
- The documentation of cleaning schedules was not consistently completed in the outpatients and diagnostic imaging departments.
- The hospital was using an administration office for weighing outpatients. Patients were weighed in front of administration and healthcare staff which impeded on the patient's privacy and dignity
- During the previous inspection we told the provider it should consider improving the outpatient environment as it was not suitably adapted to respond to the needs of patients living with dementia. However, during our inspection we did not see an improvement in this.
- The static x-ray machine bed was not accessible to all patients. The bed had to be accessed using mobile steps as it was fixed at a high level and was not adjustable.
- Not all staff we spoke with were aware of the vision and strategy for the hospital.
- The diagnostic imaging service had Ionising Radiation (Medical Exposure) Regulations 2017 policies which were outside of their review date and some were not in line with up to date legislation.
- In diagnostic imaging we found standard operating procedures for specific diagnostic imaging procedures had been reviewed annually. However, there was no evidence of the involvement of other staff members in the review process since 2015 and staff confirmed this was the case.
- Staff told us that no meetings had taken place since March 2019 in the outpatient and diagnostic imaging services reported that they did not have regular team meetings.
- The diagnostic imaging service did not hold regular discrepancy meetings or peer review. This meant that they were not formally evaluating the quality of the service provided and working to improve it.

However,

- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training compliance rates were high.
- Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The hospital controlled infection risk well**.** They used control measures to prevent the spread of infection and infection rates were low.
- The hospital had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The hospital provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance. Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other hospitals to learn from them.

Summary of findings

- Staff gave patients enough food and drink to meet their needs and improve their health. Patients were assessed regularly to see if they were in pain.
- The hospital made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them. Appraisal compliance rates were high across the hospital.
- Staff cared for patients with compassion and provided emotional support to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Patients felt well informed about their care and treatment.
- People could access the hospital when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The hospital treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Complaints were low and there was evidence of shared learning.
- Managers in the hospital had skills and abilities to run a service providing high-quality care.
- Managers across the hospital promoted a positive culture that supported and valued staff. Staff reported good team working and a sense of pride in their work.
- The hospital engaged well with patients and staff to plan and manage appropriate services. The senior leadership team was passionate about engagement with staff and patients.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the hospital improve. We also issued the provider with two requirement notices that affected outpatient and diagnostic services. Details are at the end of the report.

Name of signatory

Anne Ford Deputy Chief Inspector of Hospitals (North West)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Not sufficient evidence to rate 	Medical care services were a small proportion of hospital activity. This included endoscopy. Due to the nature of the service provided and the limited activity at the time of our inspection we did not have evidence to rate medical care at the hospital.
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients	Requires improvement 	Outpatient services were available for consultants with practising privileges to refer patients. We rated this service as requires improvement because we identified it required improvement in responsive and well led. However, we rated safe and caring as good. We inspected but did not rate effective.
Diagnostic imaging	Requires improvement 	Diagnostic imaging services were available to consultants with practising privileges who were authorised as referrers. We rated the service as requires improvement overall, because we identified it required improvement in safe, responsive and well led. However, we rated caring as good, we inspected but did not rate effective.

Summary of findings

Contents

Requires improvement

BMI Lancaster

Services we looked at

Medical care (including older people's care); Surgery; Outpatients; Diagnostic imaging;

Summary of this inspection

Background to BMI The Lancaster

BMI The Lancaster Hospital is operated by BMI Healthcare Limited. The hospital opened in 1985 and was acquired by BMI Healthcare in 2008. It is a private hospital in Lancaster, Lancashire. The hospital primarily serves the communities of the Lancaster, Morecambe Bay and South Cumbria areas. It also accepts patient referrals from outside this area. The hospital did not treat anyone under the age of 18 years.

The hospital has had the current registered manager in post since 2017.

Our inspection team

The team that inspected the hospital comprised of four CQC inspectors, and three specialist advisors with expertise in outpatients, diagnostics and surgery. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about BMI The Lancaster

The hospital has one ward, with 25 beds, and is registered to provide the following regulated activities:

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

During the inspection, we visited the ward, theatre, endoscopy, outpatients and diagnostics areas. We spoke with 29 staff including registered nurses, student nurses, allied healthcare professionals, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. During our inspection, we spoke with 15 patients and reviewed 12 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected twice, and the most recent inspection took place in October 2016 which resulted in the hospital being given two requirement notices.

Activity (March 2018 – February 2019)

- In the reporting period March 2018 to February 2019, there were 1,2175 episodes of care and episodes of care recorded at the hospital.
- There were 461 inpatients, 2,096 day cases and 9,618 outpatient attendances.
- Between March 2018 and February 2019, there were 203 endoscopy procedures carried out.
- For inpatients, 68% were NHS-funded and 32% were non-NHS funded.
- For outpatients, 64% were NHS-funded and 36% were non-NHS funded.
- There were 3,445 diagnostic imaging patients seen in the last 12 months.

There were 77 doctors who worked at the hospital under practising privileges. Two resident medical officers (RMO) worked on a weekly rota. There were 11.8 (FTE) registered nurses of which 8.2 were employed in the in-patient area, 2.8 in theatres and 0.8 in outpatients. There were 7.2 (FTE) operating department practitioners and health care assistants of which 2.8 were employed for in-patients, 1.8

Summary of this inspection

for theatres and 2.6 for outpatients. There were 24.5 (FTE) other staff employed at the hospital. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (March 2018 – February 2019)

- No reported never events
- Clinical incidents 228 no harm, 24 low harm, 4 moderate harm, 0 severe harm, 0 death
- No serious injuries

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

There had been 47 complaints

Services provided at the hospital under service level agreement:

- Histopathology
- Pathology
- Microbiology
- Decontamination
- Occupational health
- Resident Medical Officer provision
- Catering services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- The static X-ray equipment was ageing, we were told by staff that the fluoroscopy function of the equipment was no longer in working order. There were no clear timescales for when it would be replaced.
- At the time of inspection there were surgical drills available in full working order, however theatre staff told us that the surgical drills were in need of replacement and were awaiting delivery of these items. This was included on the risk register.
- The design of the static x-ray equipment meant that the height of the bed was not adjustable and fixed at a high level. This resulted in patients needing to use a set of mobile steps to get up onto the bed. The patient group seen in the department were in the main those requiring hip and knee surgery and we observed that this was a challenge for these patients.
- In patients' rooms showers had bases, rather than wet rooms, meaning these may be difficult for patients following orthopaedic procedures, although there had been no falls as a result of access into the showers
- The documentation of cleaning schedules was not consistently completed in the outpatients and diagnostic imaging departments.
- The radiologist for the service worked under practising privileges one day per week this equated to one 0.2 whole time equivalent post. There was no onsite radiologist cover for sickness and annual leave.
- Staff in diagnostic imaging did not always report incidents particularly near miss incidents. Staff were not always clear about what incidents to report formally.
- Chairs within the outpatient area remained the same as on the previous inspection and were not wipeable and therefore not compliant with the Department of Health building note (HBN 00-09).
- There was no separate dirty utility room in the outpatient department which meant staff were disposing of waste in the consultation rooms.
- The clean utility room had one sink which had been decommissioned. The room was small and appeared untidy and cluttered.

Summary of this inspection

- The medicines cabinet in the ophthalmology treatment room was unlocked and we observed medicines outside of the manufacturers' recommended expiry dates.

However,

- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training compliance rates were high.
- Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The hospital controlled infection risk well**.** They used control measures to prevent the spread of infection and infection rates were low.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The hospital had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. They used an acuity tool to manage staffing on the wards and in theatre.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Are services effective?

Good

Our rating of effective improved. We rated it as **Good** because:

- The hospital provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance. Policies and procedures were accessible to staff on the organisations intranet. There were standardised policies for the provider and local procedures specific to the services.
- The surgical service had enhanced recovery pathways for certain orthopaedic procedures.
- Staff gave patients enough food and drink to meet their needs and improve their health. The hospital made adjustments for patients' religious, cultural and other preferences. Feedback from patients was that there was a good choice of food and special diets were accommodated.
- Staff assessed and monitored patients regularly to see if they were in pain. Patients told us that they were given pain medicines promptly if needed including prior to any physiotherapy.

Summary of this inspection

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other hospitals to learn from them. The surgery service had audit action plans displayed in theatre to show all actions completed.
- The hospital made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them. Appraisal compliance rates were high across the hospital.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the hospital policy and procedures when a patient could not give consent.

However,

- During our observations of the standard operating procedures for x-rays in the diagnostic imaging service, we saw that they had not been altered since 2015 when they were originally approved. There was no evidence of references to demonstrate that they had been updated in line with national guidance or best practice.
- The static x-ray equipment used film to develop and report images, this was no longer considered as best practice. Best practice would be for images to be produced and stored on an electronic system.
- The hospital had identified radiation dose reference levels for each diagnostic imaging procedure (this is the median dose of radiation a patient would receive for a diagnostic procedure); however, these were not displayed in the department and were not audited and monitored in line with best practice.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients we spoke with told us "staff were polite and caring" and "wonderful".
- The hospital demonstrated positive results in patients' feedback and friends and family test scores were high.
- Staff provided emotional support to patients to minimise their distress. We observed staff providing reassurance and comfort to patients.

Summary of this inspection

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Patients felt well informed about their care and treatment and stated that information was given to them in a way that they could understand.

Are services responsive?

Requires improvement

Our rating of responsive went down. We rated it as **Requires improvement** because:

- The hospital was using an administration office for weighing outpatients. Patients were weighed in front of administration and healthcare staff which not only impeded on the patient's privacy and dignity it allowed staff to hear confidential and personal details of the patients. In addition to this, patients could hear bookings being made for other patients and they could see documentation of other patients' personal details in the office.
- Patients told us that they struggled to find a parking space when attending the hospital. Expansion of car parking facilities was included on the site development plan; however, there were no clear timescales for completion.
- During the previous inspection we told the provider it should consider improving the outpatient environment as it was not suitably adapted to respond to the needs of patients living with dementia. However, during our inspection we did not see an improvement to this as signage was still not clear, toilet facilities or any adaptations to the area had not been implemented.
- The static x-ray machine bed was not accessible to all patients. The bed had to be accessed using mobile steps as it was fixed at a high level and was not adjustable.
- Image reporting times did not meet the organisations standard of seven days. A recent audit demonstrated that they took on average 15 days to be reported.

However,

- The hospital planned and provided services in a way that met the needs of local people. Adult patients were either referred from the local NHS trusts or were self-paying. The hospital did not treat anyone under the age of 18 years.
- People could access the hospital when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. Referral to treatment times were low across all services.

Summary of this inspection

- The hospital treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Complaints were low, and we saw evidence of learning as a result, being shared with staff in the monthly 'closing the loop' publications.

Are services well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as **Requires improvement** because:

- In the diagnostic service staff told us that they did not always feel supported by the senior leadership team within the hospital and the central team. Staff felt that the establishment for the team meant that the service lead did not always have the time to dedicate to management duties.
- Not all staff we spoke with were aware of the vision and strategy for the hospital. This had not improved since the last inspection.
- The hospital had governance processes in place, however identified improvement plans did not have dates for completion and funding had not been approved for changes identified on the hospital site development plan.
- There was not a robust system in place for the monitoring of policies and procedures within the hospital to make sure that they were reviewed in line with identified review dates. The diagnostic imaging service had Ionising Radiation (Medical Exposure) Regulation 2017 policies, which were outside of their review date, incomplete and some were not in line with up to date legislation.
- Staff in the outpatient and diagnostic imaging services reported that they did not have regular team meetings.
- The service had systems to identify risks, however they did not always plan to eliminate or reduce them. Some risks had remained on the register for a number of years and had not been eliminated these included actions identified from the last inspection in 2016.
- Staff in the diagnostic imaging department told us they did not have key performance indicators or set targets to work towards. This meant that they were unable to monitor their performance against a set criteria and identify underperformance or improvement.
- There were areas of infection prevention and control, plus audits and outcomes that we had told the provider to improve on in the last inspection, but these had still not been completed.

Summary of this inspection

- The diagnostic imaging service did not hold regular discrepancy meetings or peer review. This meant that they were not formally evaluating the quality of the service provided and working to improve it.

However,

- Managers in the hospital had skills and abilities to run a service providing high-quality care. Staff were positive about hospital leadership and felt managers were approachable.
- Managers across the hospital promoted a positive culture that supported and valued staff. Staff reported good team working and a sense of pride providing continuity of care using a team approach.
- The hospital engaged well with patients and staff to plan and manage appropriate services. The senior leadership team was passionate about engagement with staff and patients to continually improve services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	N/A	N/A	N/A	N/A	N/A	Not rated
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients	Good	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Not sufficient evidence to rate

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Medical care services were a small proportion of hospital activity. This included endoscopy.

The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Due to the nature of the service provided and the limited activity at the time of our inspection we did not have evidence to rate medical care at the hospital.

Are medical care (including older people's care) safe?

Mandatory training

- For our main findings please refer to the surgery report.

Safeguarding

- For our main findings please refer to the surgery report.

Cleanliness, infection control and hygiene

- For our main findings please refer to the surgery report.
- The endoscopy room was visibly clean, and we observed that equipment included 'I am clean stickers' to indicate when they were last cleaned.
- A clinical sink was available for hand washing with personal protective equipment of gloves and aprons available for use.
- Sharps bins were available and not over filled. Waste bins were available, colour-coded in order to segregate clinical and domestic waste.
- Clean, ready for use endoscopy trays were stored in a trolley in an open area outside the endoscopy room, accessed by a locked door.
- For each patient a clean tray was used. Following the procedure, dirty trays were placed in a trolley in the dedicated sluice room, accessed from the endoscopy room.
- At the end of the list, all the dirty trays were taken from the sluice and through the endoscopy room and sent for decontamination. There was no external route, avoiding the endoscopy room, to remove the dirty trays. Decontamination was carried out, as for surgery, at the organisation's central location.
- The waiting area and corridor included carpets, although there were plans to remove them for washable materials as part of a re-development of the area, however; there was no timescale confirmed for completion. Information received post-inspection showed that the ward corridor that was carpeted had been cleaned in September 2018 and March 2019.
- Patient chairs were a combination of washable materials and fabrics. This was highlighted on the risk register. Fabric chairs were deep cleaned and there was an ongoing chair replacement programme.

Environment and equipment

- For our main findings please refer to the surgery report.
- The endoscopy room was locked when not in use.
- There was signage to indicate it was a controlled area.
- We observed that equipment included stickers to indicate a process for maintenance and electrical testing within the 12 months prior to inspection.
- We checked a sample of sundries and found these were all within the manufacturers' expiry dates.

Not sufficient evidence to rate

Medical care (including older people's care)

- There were plans to upgrade the endoscopy and ambulatory area. At the time of inspection, patients waited on chairs in rooms formally used as inpatient rooms.

Assessing and responding to patient risk

- For our main findings please refer to the surgery report.
- The endoscopy room was also used for minor procedures such as pain injections. A board was available if needed for theatre checks.
- There were organisational pathways for endoscopy and pain management that could be individualised for patients.
- There was a process for patients identified with Creutzfeldt–Jakob disease. This is a serious condition where if diagnosed there is a possibility of transfer between patients via surgical instruments if not cleaned effectively.
- The serial numbers of each endoscope were recorded in a register, maintained in the endoscopy room and also in the patient's records in case there was a need to trace the scope.

Nurse staffing

- For our main findings please refer to the surgery report.
- The endoscopy room was staffed by three theatre staff who had received appropriate training. Endoscopy clinics were arranged outside of theatre working hours.

Medical staffing

- For our main findings please refer to the surgery report.

Records

- For our main findings please refer to the surgery report.
- We reviewed one record, for a patient, following a pain injection and found they had been completed appropriately.

Medicines

- For our main findings please refer to the surgery report
- We reviewed a random sample of controlled medicines and found they were all correct and within the manufacturers' recommended expiry dates.

Incidents

- For our main findings please refer to the surgery report
- There were no serious incidents reported in respect of endoscopy in the 12 months prior to inspection.

Are medical care (including older people's care) effective?

Evidence-based care and treatment

- For our main findings please refer to the surgery report.
- The service was not externally accredited by the Joint Advisory Group (JAG). There was a standard operational policy that was aligned to JAG domains. There were plans to apply for accreditation, at a future date, however; the environment changes were the priority.

Nutrition and hydration

- For our main findings please refer to the surgery report.

Pain relief

- For our main findings please refer to the surgery report.

Patient outcomes

- For our main findings please refer to the surgery report.
- The service was not externally accredited by the Joint Advisory Group.

Competent staff

- For our main findings please refer to the surgery report.
- Theatre staff, with competencies in endoscopy skills supported the medical staff, which were consultants with this service.

Multidisciplinary working

- For our main findings please refer to the surgery report.

Seven-day services

- For our main findings please refer to the surgery report.

Health promotion

- For our main findings please refer to the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Not sufficient evidence to rate

Medical care (including older people's care)

- For our main findings please refer to the surgery report.

Are medical care (including older people's care) caring?

Compassionate care

- For our main findings please refer to the surgery report.

Emotional support

- For our main findings please refer to the surgery report.
- In the event of the endoscopy procedure finding a concern, the patient was referred back to the NHS trust or referring consultant to continue care and treatment.

Understanding and involvement of patients and those close to them

- For our main findings please refer to the surgery report.

Are medical care (including older people's care) responsive?

Service delivery to meet the needs of local people

- For our main findings please refer to the surgery report.

Meeting people's individual needs

- For our main findings please refer to the surgery report.

Access and flow

- For our main findings please refer to the surgery report.
- Between March 2018 and February 2019, there were 203 endoscopy procedures carried out.

Learning from complaints and concerns

- For our main findings please refer to the surgery report.

Are medical care (including older people's care) well-led?

Leadership

- For our main findings please refer to the surgery report.

Vision and strategy

- For our main findings please refer to the surgery report.
- Staff were aware of the values that each patient has an individual right to a high standard, safe clinical and nursing care in the endoscopy service.
- There were plans to redevelop the endoscopy and ambulatory area, although there was no confirmation of when this would take place.

Culture

- For our main findings please refer to the surgery report.

Governance

- For our main findings please refer to the surgery report.
- We were told that an endoscopy user group had been established, however; there had not been any meetings at the time of inspection.

Managing risks, issues and performance

- For our main findings please refer to the surgery report.

Managing information

- For our main findings please refer to the surgery report.

Engagement

- For our main findings please refer to the surgery report.

Learning, continuous improvement and innovation

- For our main findings please refer to the surgery report.

Good

Surgery

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

Information about the service

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

See information under this sub-heading in the surgery section.

Are surgery services safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Mandatory training was delivered using a mixture of face-to-face training and e-learning, which were completed annually, bi-annually or every three years.
- Individual figures and any outstanding modules were displayed in the theatre area.
- Compliance targets for training were 90%, with staff reminded electronically before their renewal date to book an update course. At the time of inspection all eligible staff were up-to-date with mandatory training requirements for both the ward and theatre.
- Mandatory training covered a range of topics including information governance, anti-bribery and corruption, equality and diversity, deteriorating patients, health and safety, basic life support and moving and handling. Staff had individual electronic learning hub records which outlined the mandatory training required for their role and identified their compliance.
- Staff maintained portfolios of all training completed that were monitored by managers.

Safeguarding

- Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Organisational policies included a chaperone policy, safeguarding adults and safeguarding children policies. The legislation "working together to safeguard children" was referenced, as well as female genital mutilation, child sexual exploitation and prevent. Prevent training is awareness of individuals that may be vulnerable people of being exploited and drawn into terrorism. A flow chart of how to escalate a concern was included in the policies. Safeguarding contact information was clearly displayed for staff. We noted that the safeguarding policy was past its review date. We raised this with management and was told it was currently awaiting ratification. Following our inspection, we were told that the policy had been updated.
- Staff we spoke with were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately.
- There were no safeguarding incidents reported to the Care Quality Commission between March 2018 and February 2019.

- There was a safeguarding lead who was available at the hospital for support for adults and children.
- Staff received safeguarding training as part of mandatory training requirements with a compliance of 100%. They completed safeguarding level three for children and level two for adults. The hospital only treated adults over the age of 18. Following changes in the Intercollegiate Guidance (August 2018) there were plans for staff to attend 'train the trainer' sessions to deliver the course to other staff at the hospital.

Cleanliness, infection control and hygiene

- The service controlled infection risk well**.** Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- Screening was carried out routinely for meticillin-resistant staphylococcus aureus including patients planned for joint surgery, any patient with a previous positive result and those working in healthcare.
- There were no incidences of methicillin-resistant staphylococcus aureus, methicillin-sensitive staphylococcus aureus, clostridium difficile or escherichia coli reported by the service between March 2018 and February 2019.
- All ward and theatre areas visited were visibly clean and corridors were clear of any clutter.
- Personal protective equipment was readily available and included gloves and aprons. Soap dispensers included hand sanitising techniques and posters to support the policy of arms 'bare below the elbows' were displayed throughout the ward and theatre.
- Wall-mounted hand gel sanitizers were readily available in all areas, including patient rooms. We observed staff using sanitising hand gels before providing patient care. All staff we observed adhered to the arms 'bare below the elbows' policy in clinical areas
- I am clean stickers were applied to equipment that was not currently in use.
- Sinks were in each of the en-suite patient rooms. Since the last inspection, carpets in patient rooms and corridors had been removed and replaced with washable flooring, with the exception of the ambulatory area where carpets remained but plans were in place to remove them. There were clinical sinks available on the corridors for staff to use for hand washing.
- The service had daily cleaning schedules which were clearly displayed. Housekeepers maintained checklists of rooms that required cleaning as well as water testing records for Legionella in patient rooms and clinical areas.
- Privacy curtains, in theatre, included dates when last changed and had been changed recently.
- The hospital had an infection prevention and control lead nurse who provided a service through a service level agreement with a neighbouring NHS trust. The lead nurse provided on site cover one and a half days per week.We were told the lead nurse was available seven days a week for phone for advice if needed. There was a consultant microbiologist who sat on the infection prevention committee.
- We observed that a nurse, in theatre was wearing earrings, which was not in line with the organisation's uniform policy that states that staff are not permitted to wear earrings. This policy was past the date of review recorded as June 2016.
- Staff, including ward staff, changed into uniforms, at the hospital. We observed staff throughout the hospital, in theatre attire, rather than changing when outside of the theatre. The organisation's uniform policy stated that "If scrub suits are worn outside the theatre environment they must be changed when returning to the department." We did not see evidence of staff changing attire.
- There were two sluices at each end of ward although one had been out of commission. It was included on the risk register, and it was located in an area awaiting redevelopment.
- The service had sharps bins in clinical areas. These were dated when collected. All were secure and not over filled.
- We observed patient chairs, in waiting areas covered in a cloth material. Staff told us that these were deep cleaned, and that these chairs were in the process of being replaced to wipeable fabrics. This was on the risk register.

Good

Surgery

- The service monitored the number of post-operative infections. Between July 2018 and April 2019, the service reported nine infections of which six were wound infections and three were urinary.
- Surgical instrument trays were decontaminated and sterilised externally at the organisation's central site. Due to the distant location of the decontamination facility, instrument trays could also be decontaminated by the local NHS trust, if they were needed quickly.
- An infection prevention and control management audit, March 2019, scored 90% compliance and identified areas for improvement including compliance with policies such as staff not always following arms bare below the elbows guidance.
- A ward assessment of infection prevention and control, in March 2019, scored 100% compliance.
- There was an annual infection prevention audit as well as quarterly observational audits.
- A Patient-Led Assessment of the Care Environment of cleanliness for 2018 achieved a score of 100%.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- Staff, patients and those close to them entered the building via a choice of a ramp or stairs and automatic door
- There was a ward with 25 individual patient rooms, an endoscopy area, with four ambulatory chairs. The main theatre was on the ground floor and the endoscopy area was on the first floor. There were two lifts in case of a mechanical failure and aids were available in case of an emergency evacuation. A back-up generator and an uninterrupted power supply was available and checked monthly at a time when there was no surgery planned.
- Each patient room was en-suite with a toilet, sink and shower, however; the showers had bases, rather than wet rooms, meaning these may be difficult for patients following orthopaedic procedures.However, there had been no falls as a result of access into the showers.
- We saw improvement since the last inspection with regards to the, entry to theatre, we found it was secured with keypad entry and a door bell to gain access otherwise.
- On the ward, there was keypad entry for clinical and store rooms, however, these were not all locked. Medicines and intravenous fluids were secure, however; we observed during the inspection that the equipment store, and kitchen doors were not locked. Signage, on the doors, indicated that these doors should be locked if children were visiting the ward.
- Theatre staff told us that there were items, for example surgical drills that were in need of replacement and were awaiting delivery of items. This was included on the risk register.
- The organisation maintained an asset register that indicated that electrical equipment was monitored and maintained appropriately.
- Equipment on the ward and in theatre had stickers to identify maintenance checks had been carried out; all were recorded within the 12 months prior to inspection. We saw improvements since the last inspection in the checking of the anaesthetic machine in theatre and saw evidence of twice daily checks.
- Emergency resuscitation trolleys on the ward and in theatre included evidence of daily checks of items on the top of the trolley, including the defibrillator, and full weekly checks of the whole trolley. The trolleys were secured with tamper proof tags that could easily be removed in the event of an emergency.
- We reviewed random samples of sundries and found these were all within the manufacturers' expiry date with the exception of one tubing in the clean utility that was removed immediately when raised with staff at the time of the inspection.
- There was piped oxygen available in all patient rooms but not suction. Portable suction was available and accessible in the event of an emergency.
- The theatre had laminar air flow and was used for all types of surgery including orthopaedics, general surgery, gynaecology, urology, ear, nose and throat, cosmetics, plastic surgery and ophthalmology. A laminar flow helps to help prevent infection and bacteria in wounds and on instruments. We received a

copy of the annual ventilation inspection, carried out in May 2019. This included compliant systems and highlighted areas that required monitoring and reviewing.

- The endoscopy room was also used for pain management injections. There were plans to update this area, that included dedicated waiting areas and removing the remaining carpeted area. All procedures carried out in that area were performed under local anaesthetic or sedation.
- A Patient-Led Assessment of the Care Environment for condition appearance and maintenance achieved a score of 87.59% in 2018.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- There were care pathways that were individualised for each patient. There were clear sections that highlighted any variances to be aware of. Any allergies were clearly highlighted.
- Any patient that was planned to have a general anaesthetic attended a preoperative assessment clinic where investigations were carried out and history taken to ensure they were safe for surgery at the hospital. Any concerns were discussed with the anaesthetist or referred to the weekly multi-disciplinary meeting. The hospital accepted patients using the American Society of Anaesthesiologists (ASA) physical status classification system. Patients were accepted if assessed as ASA1 or ASA2. (ASA1 – A normal healthy patient: healthy, non-smoking, no or minimal alcohol use. ASA2 – A patient with severe systemic disease: Mild disease only without substantive functional limitations such as social alcohol drinker, pregnancy, mild lung disease.)
- The hospital did not operate on bariatric patients; those assessed with a body mass index of 40 or more.
- Each patient room included a nurse call bell system with emergency buzzers. The room number was displayed on a central system and on the corridors to help prevent a delay in responding.
- Registered nurses and health care assistants completed immediate life support training as part of mandatory training requirements. A resuscitation champion was available to cascade any changes in policy.
- The hospital had a resident medical officer on site 24 hours a day seven days a week who was trained in advanced life support. The resident medical officer could call the patients consultant if needed.
- A team of staff, including the anaesthetist, operating department practitioner, ward nurses, resident medical officer and porter, carried the cardiac bleeps in the event of an emergency. Scenarios were practised that included the multidisciplinary team.
- In theatres, the organisation's severe haemorrhage policy and flow chart were displayed as well as those for a cardiac arrest (Resuscitation Council UK), malignant hypothermia and the Association of Anaesthetists of Great Britain and Ireland safety guidelines for management of severe local anaesthetic toxicity. A difficult airway trolley was accessible in the event of an emergency as well as anaphylaxis kits.
- Blood was stored in theatre that was obtained from the local NHS trust. The expiry dates were monitored by the trust and replaced as needed.
- Other emergency equipment included sepsis kits, first aid boxes, eye wash kits and spill kits that were accessible when needed.
- Glucometers (for measuring sugar in the blood) were available and checked in theatre. On the ward there were two glucometers that were used for patients requiring this test. At the time of our inspection the policy required that glucometers were calibrated on a weekly basis. We found an omission in the weekly checks this was due to the lack of availability of testing fluid.
- Staff in theatre attended a daily huddle. We observed the huddle that included nurses, operating department assistants, surgeon and anaesthetist. Patients planned for that day were discussed.
- A 'golden patient' was highlighted. This was the name given to the first patient of the day on the theatre list who had been identified the previous day, were medically fit and had a clear plan in place. This assisted with the efficiency of the theatre list.

- Staff we spoke with told us that patients identified with diabetes would be planned to be first on the surgical list.
- We observed appropriate handover of patients from theatre to recovery and between theatre and ward staff.
- The service used the World Health Organisation's Five Steps to Safer Surgery surgical safety checklist. We found that it was completed appropriately.
- An observational World Health Organisation five steps to safer surgery audit, carried out in February 2019, showed good practice followed, except that silent focus was not always observed with staff moving in and out of theatre during time out checks. Plans were in place to update training in July 2019. These audits took place every six months.
- The organisation shared their safer surgery policy. This included information such about National Safety Standards for Invasive Procedures that were introduced in 2015. However, we found that this policy was due for review in January 2019 and staff we spoke with were not familiar with these standards. Following our inspection, we were informed that the policy review date had been extended until January 2020.
- As there was only one theatre, if a patient needed to return to theatre during the day, the elective list was halted to give priority to the emergency. There was an on-call team available if there was a need to return to theatre overnight.
- The anaesthetist remained in theatre until the last patient left the recovery area.
- The hospital had implemented the NHS England national early warning score two (NEWS 2) to monitor patients. If a patient deteriorated, they called for an NHS emergency ambulance to transfer to the local NHS trust. The hospital was part of the North West Critical Care Network; although there was no official service level agreement with the local NHS trust. This was highlighted on the risk register, where it was indicated the trust had advised transfer to accident and emergency.
- The hospital had a sepsis lead who staff could contact for advice.
- Between March 2018 and February 2019, there were four patients transferred from the hospital to the local NHS trust. The hospital managed the patients and recorded the outcome for these patients.
- The hospital joined the breast implant register in 2016. The registry recorded patients details and used them to trace patients in the event of an implant recall or other safety concern relating to a specific type of implant.

Nursing and support staffing

- The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- There were organisational acuity tools available for the ward and theatre. The hospital used an electronic roster tool across all departments in line with the providers rostering policy. At the time of inspection, there were no vacancies. Shortfalls in specialised skills, had been filled with regular bank and agency staff.
- Weekly planning meetings took place to discuss staffing needs according to the demands of the service. Senior staff met with managers to check the previous days staffing, look at present days staffing and look forward to the rest of the week to ensure adequate staffing to provide safe care.
- Following the last inspection, we observed that the Association for Perioperative Practice standards for staffing numbers in theatres was adequate.
- Student nurses attended placements, although were supernumerary to the planned staffing numbers.
- There was a nurse led discharge system for routine recovery of patients with medical staff available if needed.
- There was a requirement for a minimum of two registered staff to be present on the ward at all times, in line with minimum staffing level requirements.
- Between March 2018 and February 2019, the ward used an average of 20% per month of registered bank or agency nurses. There were no health care assistant bank or agency staff used between March 2018 and September 2018 with an average usage of 22% between October 2018 and February 2019.

- In theatres, between March 2018 and February 2019, there was an average of 50% per month of registered bank or agency nurses. For operating department assistants or healthcare assistants, there was 22% who were bank or agency in July 2018 and an average of 31% between November 2018 and January 2019. The staff used were regular bank and agency due to the fluctuating demand of the service.
- Between March 2018 and February 2019, there was an average sickness rate for registered nurses on the ward of 1% per month. There was 3% sickness, per month between March 2018 and April 2019 and 6.5% in October 2019 for health care assistants on the ward.
- In theatres, between March 2018 and June 2018, the average monthly sickness rate for trained nurses was 3% per month. There was an average of 8% per month sickness for operating department assistants and health care assistants between March 2018 and February 2019.
- Between March 2018 and February 2019, on the ward, the turnover of registered nurses was 1.2% and 2.8% for health care assistants. In theatre, for the same period, the turnover was 4% for theatre operating department assistants or health care assistants.

Medical staffing

- The service accessed medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The hospital employed 77 consultant doctors under practising privileges. The granting of practising privileges is a process within independent healthcare whereby a medical practitioner is granted permission to work by the healthcare organisation.
- There was a resident medical officer who remained at the hospital 24 hours a day, seven days a week. These were supplied by an external agency on a rotational basis. Routine work was completed up to 10 pm at night; following this time the resident medical officer was available on-site for emergencies. Consultants could also be contacted if needed for individual patients.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- All records were kept securely in areas restricted to access by staff only.
- Records of observations, pain assessment and fluid charts were located in patient bedrooms; all other records were stored in one file. Following the last inspection, we found that all health professionals contributed to the patient pathway records.
- We reviewed four patient records and found that they were completed appropriately.

Medicines

- Staff we observed followed guidance when prescribing, giving, recording and storing medicines, such as administration of anaesthetic medicines.
- Part of the pre-operative process included advice on medicines to take when fasting, which was confirmed in the admission letter.
- There was a pharmacy located next to the ward. Pharmacy staff monitored stock levels and provided prescribed medicines for inpatients and take home medicines. Each bedroom included a locked medicines cabinet where their prescribed medicines were reconciled and stored.
- We reviewed four paper prescription records and found that they had been completed appropriately.
- Allergy status was clearly recorded on prescription sheets.
- We reviewed a sample of controlled drugs on the ward and in theatre and found that these were recorded and stored in line with national guidance. A controlled drugs audit was carried out in March 2019, with a score of 100%.
- Fridge temperatures and environmental temperatures of the clean utility room were monitored, and record sheets completed including the ranges.
- Portable oxygen cylinders were available on corridors and with emergency equipment and were stored securely in all areas.

- In the recovery area of theatre, we observed a tray of medicines used in case of an emergency with ampoules of medicines including propofol. This is a medicine that is used in anaesthetic procedures. This was addressed on site and it was immediately removed into appropriate locked cupboards in the anaesthetic room next to the recovery area. At the last inspection, this medicine was found, not locked away securely, in the anaesthetic room. Staff told us that the policy was for the medicine to be locked until needed.

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff reported incidents via the organisation's electronic system. Staff were encouraged to report incidents and could give examples of incidents reported.
- Between March 2018 and February 2019, there were no never events reported. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic barriers are available as at a national level and should have been implemented by all healthcare providers.
- For the same time period, there were two serious incidents reported to CQC. The hospital investigated incidents using a root cause analysis approach. We reviewed the incidents investigation reports and found they included lessons learned and changes to practise as a result of the incidents.
- Learning from incidents was shared in team meetings and via the organisation's 'closing the loop' monthly report, this included outcomes of incidents and shared learning. The senior managers spoke directly to any individual involved followed by a written 'sharing of information' bulletin where any learning could be highlighted.
- Staff we spoke with understood the principles of duty of candour to be open and transparent. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person).

Safety Thermometer (or equivalent)

- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The hospital submitted data to the organisation about safety performance, however; we did not see this information displayed in public areas for patients and visitors to see, at the time of inspection.
- For 2018, the hospital reported a score of 99.92% in an audit to check compliance with completing risk assessments for venous Thrombo-embolism (VTE).

Are surgery services effective?

Good

Our rating of effective improved. We rated it as **good.**

Evidence-based care and treatment

- The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance.
- Policies and procedures were accessible to staff on the organisations intranet. There were standardised policies for the provider and local procedures specific to the service.
- Policies we reviewed were in line with best practice. Prior to the inspection we noted that some policies provided to CQC, such as the safeguarding policy, were past their review date, however; during the inspection we were shown that these were currently in the process of review and ratification.
- The copies of the organisation's safer surgery policy and uniform policy, that we reviewed were both past their dates for review.
- The service had clinical dashboards to monitor performance.

- The service had enhanced recovery pathways for certain orthopaedic procedures.
- An audit schedule was in place that included medicines management, the World Health Organisation observation, national early warning scores and documentation. Pharmacy audits included controlled drugs, reconciliation and gases.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health. The service made dietary adjustments for patients' religious, cultural and other preferences.
- Feedback from patients was that there was a good choice of food and special diets were accommodated.
- There was a fasting policy for the service. If patients were listed for surgery in the afternoon, fasting was adjusted to keep the time that they were nil by mouth to a minimum.
- Fluid balance charts were completed for patients requiring intravenous fluids or if there were concerns about hydration of patients
- Following surgery, food and drink was available as necessary.
- A ward kitchen was available for drinks and snacks with main meals being prepared in the hospital's main kitchen.
- A Patient-Led Assessment of the Care Environment for ward food achieved a score of 98.68% in 2018.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain.
- Pain charts were completed as part of patient care and monitoring.
- Patients told us that they were given pain medicines promptly if needed including prior to any physiotherapy.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service had audit action plans displayed in theatre to show all actions completed.
- One consultant carried out an audit following six patients who had developed similar complications of bleeding following surgery. As a result of the findings, the surgeon had reviewed the processes and other historical patients at other health locations, both NHS and independent provider. Following our inspection, we were provided with an update which demonstrated that the surgeon had made changes in practice and as a result there had since been no returns to theatre. Monitoring was ongoing.
- PHINN indicated that the hospital regularly submits completed health outcomes information for the majority of eligible procedures, including pre and post treatment questionnaires. There were 96% of patients who would recommend the hospital (based on 343 responses) and 96% of patients reported a positive experience about their care needs (based on 141 responses).
- We received information about patient reported outcome measures (PROMs) for surgery. PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. Data was available for knee replacements and hip replacements. Between April 2018 and March 2019, there was an average of 18% per month participation for hip replacements and 32% for knee replacements. We were told PROMS were discussed at monthly quality meetings with commissioners where any concerns could be discussed PROMS were discussed with patients undergoing hip and knee procedures at pre-assessment appointments as well as being given leaflets about the importance of PROMS.
- Following a meeting with Quality Health (who pull information on PROMS and PHINN together), new posters and leaflets were planned to encourage patients to complete as well as information on a revised simpler cataract process.
- We were also told that there was a need for analysis of the data at the clinical governance committee.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them.
- Staff completed competency records specific to their roles that were checked by managers to monitor completed appropriately.
- Bank and agency staff were required to complete the competencies in line with permanent staff.
- Staff completed appraisals; at the time of the inspection there was a 100% compliance rate for the ward and theatre areas. Objectives were set at the start of the year with a mid-year review and final review at the end.
- Staff received clinical supervision bi monthly as part of ongoing monitoring and support.
- Medical staff working under practising privileges had their competencies, appraisal and revalidation checked annually by the executive director of the hospital as part of the practicing privileges review process.
- Staff were allocated champion roles, if an interest was expressed, in areas such as sepsis, dementia acute kidney infection and resuscitation, with an expectation to cascade information to other staff. The champion roles were still in their infancy and had not been standardised across the whole hospital.
- Staff were encouraged to extend their roles and participate in relevant training such as in theatre. At the time of inspection, there were no surgical first assistants employed at the hospital. The role was being filled by regular agency staff, although, a member of permanent staff was undertaking the training in order to take on the role following completion.

Multidisciplinary working

- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals such as pharmacy staff and physiotherapists supported each other to provide good care.
- There was effective internal multidisciplinary working with weekly meetings to discuss listed patients that included attendees from each area.
- There was effective external team working. The service was supported by staff from the neighbouring trust for tasks such as decontamination.
- Discharge summaries were forwarded to patient GPs to assist with planning of ongoing care and treatment.

Seven-day services

- The service was open 24 hours a day, seven days a week. Surgery was planned Monday to Saturday. Theatre sessions were Monday to Friday from 8.30am until 6.00pm and Saturdays from 8.30am until 5.00pm. Morning theatre sessions were planned from 8.30am until 12.30pm and afternoons from 1.30pm until 5.30pm. Extra evening sessions were scheduled if needed to cope with demand.
- The pharmacy was routinely open during the day Monday to Friday between 8.00am and 4.00pm. If medicines were required out of opening hours, there was a process for staff to access the pharmacy safely which included a two person check.
- The resident medical officer was available every day and could be contacted overnight if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- We observed staff obtaining verbal consent from patients before providing care.
- Written consent was obtained before surgery and recorded in the patient's paper records. There was a policy which included a two week cooling off period for cosmetic surgery.
- There was an interpreter service available to help with consent for patients whose first language was not English.
- Staff understood what to do if a patient lacked capacity, although the service did not routinely accept patients who lacked capacity. If patients lacked capacity to make their own decisions staff made decisions about care in the best interests of patients and involved their representatives and other healthcare professionals appropriately. This may include referring back to the NHS for care and treatment.

Good

Surgery

Are surgery services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- We observed staff interacting positively with patients and those close to them. These included medical staff, allied health professionals and support staff as well as nurses. Staff spoke to patients sensitively and appropriately depending on individual need.
- Staff introduced themselves and communicated well to ensure patients fully understood. Patients were encouraged to ask questions and were given time to ensure they understood what was being said to them.
- Patients were cared for in individual rooms. Names were displayed on the doors following written consent to display. Rooms that overlooked the residential street had opaque glass to maintain privacy.
- Patients were escorted to theatre by either theatre staff or ward staff with porters located in the ward area for support.
- Curtains were used appropriately to maintain privacy for a patient in the recovery area of theatre.
- Leaflets were available for patients to provide feedback. These were collected, and information submitted to the NHS friends and family test, for NHS patients or to the provider's patient satisfaction system for private patients.
- The scores for the hospital were displayed for patients, staff and visitors to view. They showed that for 2018, 96.7% of patients were either likely or extremely likely to recommend the hospital, 98.1% of patients considered the quality of care to either be very good or excellent and 97.4% of patients reported that their expectations had either been met or exceeded. These results did not indicate response numbers of patients.
- Between March 2018 to February 2019 there were 13 compliments recorded on the hospitals electronic system from thank you cards and emails.
- Comments from patient feedback included that staff were caring, kind, courteous, efficient, friendly, helpful, wonderful, professional, excellent and approachable.
- A Patient-Led Assessment of the Care Environment for privacy, dignity and well-being scored 87.1% in 2018.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- We observed staff providing reassurance and comfort to patients. Staff provided support as required.
- Comments from patients included that they felt they had been put at their ease with the care and explanations of the treatment by nursing and medical staff.
- We observed a patient pre-operative assessment consultation and noted that full explanations were given to the patient about the process including the pre and post-operative period.
- For patients booked for cosmetic surgery, extra psychological support was provided including a cooling off period to consider any final decision and counselling for breast surgery.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff respected patient choices and delivered their care with an individualised person centred approach.
- Patients and those close to them told us that they received information in a manner that they understood.

Are surgery services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Good

Surgery

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people.
- Adult patients were either referred from Lancashire and Cumbria NHS services or were self-paying. The service did not treat anyone under the age of 18 years.
- There was one NHS trust who commissioned services at the hospital for day case or inpatient surgical services.
- There was a dedicated pay and display car park, although we observed space was restricted at busier times. The hospital was situated in an urban residential area with restricted parking.
- The hospital was located close to the local NHS trust and was accessible by public transport.
- The hospital had a number of service level agreements with external services such as decontamination of instruments and waste disposal services.
- The hospital was open 24 hours a day, seven days a week, with surgery operating Monday to Saturday.
- Patients who were attending preoperative assessment clinic, ahead of joint surgery, were seen by a physiotherapist on the same day.
- Patient rooms were decorated in neutral colours and some had views of mature planted areas, helping to create calm surroundings.
- Following the inspection, we were told that patients were phoned 24 hours post operatively to ensure that there were no concerns following their discharge.

Meeting people's individual needs

- The service took account of patients' individual needs.
- There were dedicated accessible parking spaces directly in front of the hospital main entrance, for patients with reduced mobility, although there was a steep incline to the main car park. The hospital could be accessed via a ramp and the main doors were automatic.
- A portable hearing loop was located at the reception desk for patients, or those close to them, with a hearing impairment.
- For patients whose first language was not English, an interpreter service was available. Leaflets we observed were all in English, although; the staff could access leaflets on an individual bespoke basis in a range of languages on the hospital intranet.
- Staff completed a pre-operative evaluation, at the pre-operative assessment clinic, prior to surgery. This included recording the patients first language and if an interpreter was required. It also included if a patient could understand writing and reading and if the patient communicated through lip reading or sign language.
- Patients with complex needs such as a mental health concern were seen in the pre-operative period to access if their needs could be met at the hospital.
- Staff we spoke with explained that patients with a learning disability may be assessed as suitable; they were usually accompanied by someone close to them. There were no hospital passports available to view during the inspection as there were no patients who required them. A hospital passport is a document that includes individualised information about patients with a learning disability such as personal details, prescribed medicines, and any health conditions. There was no information available that was easy read.
- There was no information available in large font format or Braille for patients with a visual impairment.
- There was no bariatric equipment available and patients assessed with a body mass index of over 40 were referred back to the NHS trust.
- There was a dementia strategy and a dementia champion. The ward was awaiting a dementia clock and dementia-friendly signage. There were plans to decorate a dedicated room, so it was dementia friendly. Staff we spoke with told us that patients identified with dementia were often admitted for day-case procedures.
- Drinks and snacks were available throughout the day to accommodate individuals following procedures.
- Patient-Led Assessments of the Care Environment achieved a score of 92.22% for dementia and 84.35% for disability in 2018.

Access and flow

- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Between March 2018 and February 2019 there was a total of 461 in patients, of which 225 were NHS funded and 236 were self-paying either or insured. There was a total of 2,096 day case patients, of which 1,501 were NHS funded and 595 were self-paying.
- Between May 2018 and April 2019, there were no unplanned admissions or readmissions following surgery.
- Between January 2018 and December 2018, there were 39 procedures cancelled with 85% of patients offered another appointment within 28 days. All cancellations were recorded as non-clinical reasons including unforeseen events such as staff sickness, adverse weather conditions or surgical lists taking longer than expected.
- Achievement of referral to treatment time standards for non-admitted patient pathways were 100% for all services which was above the hospital 90% target. However, general surgery had been consistently under target for the months October 2018 to March 2019; despite this the percentages were gradually increasing in a positive trend and March 2019 demonstrated a percentage of 92.31%.
- Referral to treatment rates for incomplete pathways demonstrated percentages above the hospital target of 92%. Most services were 100%, however, for the month of March 2019, trauma and orthopaedics and gynaecology demonstrated percentages of 91.08% and 86.36% respectively.
- In the event of patients needing to be re- assessed following discharge, a dedicated treatment room was allocated on the ward where the resident medical officer could review in a timely manner.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Complaints raised in the hospital were investigated and managed by the senior leadership team. Complaints were reviewed as part of the heads of department and clinical governance committee meetings. Complaint outcomes and learning from complaints was shared with all staff across the hospital through the daily huddle and the monthly closing the loop publications.
- There were leaflets displayed in the surgical ward if patients wished to complain. These included signposting to adjudication services, other than the provider, if not satisfied with responses from the service.
- Between March 2018 to February 2019 there were five complaints received for the surgical core service; four for the ward and one for theatre. One complaint was upheld that related to the attitude of one staff member. The hospital target for managing complaints was a written acknowledgement response within two working days and a completed response in 20 days.
- Following their completion, the hospital included any learning in the 'closing the loop' publication which was shared with staff across the hospital. The senior managers spoke directly to any individual involved followed by a written sharing of information where any learning, could be highlighted. In our review of the closing the loop publication for March 2019 we saw evidence of a complaint with regards to the communication of costs to patients for pre-operative assessments and surgical procedures. We saw that a change had been made as a result and shared with staff, this included the check and sign off, of theatre equipment charges by the theatre team prior to the communication of costs with the patient.
- The hospital monitored and recorded adherence to the complaint response times, which included delayed acknowledgements of complaints and delayed final responses. Performance data demonstrated that between March 2018 and March 2019 the hospital demonstrated an improvement in late acknowledgements and responses. Within this time period there were four occasions where there had been a late acknowledgement of a complaint and there had been no occasions since December 2018 where a complaint had had a late acknowledgement. There had been 11 occasions where a complaint had not been responded to within the 20 day standard, however there had not been a late response since August 2018. The provider told us that a holding letter was sent if a response was delayed.

Good

Surgery

- Between March 2018 and March 2019, the hospital had received 50 complaints in total. Data provided by the hospital demonstrated that 17 of the complaints received had been upheld which equated to 30%. All of the complaints received had been resolved at stage one and there were no complaints which had been escalated to stages two or three.
- Complaints were logged on the risk management system and monitored for themes and trends. It had been identified that the main theme from the complaints was communication.
- We were told that the hospital had received a number of complaints which related to the telephone system and the difficulty patients found using the automated system to speak to the relevant department. As a result, the hospital had increased administrative support and changed the way the telephone system worked. We were told there had been positive feedback from patients as a result. We saw that this was displayed on "you said we did" information around the hospital. Senior staff stated that this had encouraged a national review of the telephone system.
- In addition, the senior leadership team undertook weekly walk arounds on the ward where they spoke with patients to gain their feedback. We were told that from these sessions it had been identified that there was a theme of patients being dissatisfied with the size of the televisions in the bedrooms. As a result, the hospital had replaced the televisions in all bedrooms to a larger size.

Are surgery services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as **requires improvement.**

Leadership

- Managers in the service had skills and abilities to run a service providing high-quality care.
- The hospital was led by an executive director who was the registered manager and the accountable officer. The executive director was supported by a senior management team, consisting of a commercial finance manager, sales and marketing manager, director of clinical services, operations manager and quality and risk manager. At the time of our inspection the hospital had just recruited to the quality and risk manager post.
- The senior leadership team were experienced and had worked in healthcare for a number of years. At the time of our inspection the executive director had been in post at the hospital since 2017 and had a number of years' experience in hospital management. The clinical services director had worked at the hospital for two and a half years and had a background in nursing leadership in NHS trusts. The senior leadership team described good links with the regional leadership for the organisation.
- Managers told us that they felt supported by senior managers and they were visible, approachable and contactable. In addition to this, staff told us that senior management were very focused on staff development and there was no hierarchical leadership.
- There was clearly defined and visible leadership for the service.
- Staff understood the organisation's reporting structures and told us they were well supported by their managers both on the ward and in theatre.
- The senior leadership team understood the challenges to the hospital and the local healthcare economy. The leadership team articulated that the main challenges for the hospital were the aging estate and access to financial support to obtain updated equipment and develop the hospital and the services provided. The hospital had recently obtained funding from the organisation and a site development plan had been created.
- There were links with local commissioning groups to support waiting lists in nearby NHS hospitals and they were developing plans to expand this.
- The senior leadership team attended regional and national peer meetings within the provider organisation to share best practice and learning.
- The leadership team were keen to promote inclusive and compassionate leadership and enable staff to take responsibility and the lead on projects and developments to the service. Staff in outpatients and the surgical departments had been involved in

improvement sessions which had followed principles of externally recognised quality improvement processes. The senior management team facilitated the sessions to develop and improve the services. We were told that the sessions were led by the staff and they had identified areas for improvement and implemented new processes.

- There was a recognition for the need for succession planning. Staff were encouraged to develop and there were leadership programmes provided by the organisation which staff could attend, in addition to funding for external courses. We spoke with a member of the leadership team who was undertaking an external leadership qualification funded by the hospital. They spoke highly of the support they had received from the senior leadership team.

Vision and strategy

- The service had a vision for what it wanted to achieve and workable plans to turn it into action. However, there were no clear timescales for completion and not all staff we spoke with were aware of the vision and strategy for the hospital.
- The hospital's five year vision was displayed in theatre for staff to view. We were provided with the organisational strategy that included their five-year vision and site development plans. This included enhancing both patients and staff connectivity with digital technology and improving patient management by moving to an electronic patient record.
- The senior leadership team described the main focus for the strategy; which was to increase theatre usage from 50% to 75%. To do this the hospital required an expansion of theatres and an improvement to clinical pathways to enable more day case procedures. The strategy for the service was outlined in the 'site development plan 2019'. The strategy identified operational and clinical objectives. The main objectives were growth (financially and clinically), increase patient satisfaction, achieve CQC outstanding rating, be the hospital of choice for Cumbria and Morecambe Bay, become a trusted partner of local commissioning groups, employer of staff that recruits and retains staff and an increased net contributor to the profit of BMI healthcare.
- The site development plans were extensive and included the introduction of an ambulatory care and day case centre, refurbished bedrooms, revised nurses station and office, creation of a discharge lounge, reconfiguration of the restaurant and outpatient waiting area, ward store and clean utility, outpatient clean and dirty utilities and disabled toilets, additional parking and the introduction of electronic imaging and image reporting systems to include a re-design of the imaging area.
- Whilst there were clear plans of action for the strategy there were no identified timescales to turn them into action and we were told that funding had been approved for some of development plans. At the time of our inspection there were no clear timescales for the completion or the initiation of some of the plans and we were told that the update to the imaging department had not yet been approved.
- The hospital shared briefings with staff to provide updates on progress with the vision and strategy. However, not all staff we spoke with across each department were aware of the vision and strategy for the hospital.
- Whilst not all departments had an individual strategy or plans for what they wanted to achieve each department was included in the hospital strategy and business plan.

Culture

- Managers across the service promoted a positive culture that supported and valued staff.
- There was an open and clear culture that encouraged the reporting of incidents to learn from them and improve quality for patients accessing the service.
- There was a positive attitude and culture where staff valued each other. Staff reported good team working and a sense of pride providing continuity of care using a team approach.
- All staff, we spoke with, were passionate about the service they provided.
- Staff we spoke with had been employed for varying lengths of time with recently appointed staff reporting feeling supported by their managers to discuss ways of improving services to provide quality care for patients.

- Staff were awarded for exemplary performance through an 'above and beyond' staff reward programme. Anyone could nominate another member of staff for any reason.
- We observed certificates of achievement displayed in the hospital canteen. For example, an award for excellent communication and professional discussion with ophthalmic surgeons in responses to a safety alert and a staff member who had gone above and beyond their role in ensuring that a patient was reassured prior to treatment.
- Proud boards were displayed in the all departments as well as outstanding work achievements. These ranged from staff going out of their way to follow the patient journey through, to consultants waving allergy test fees so that patients didn't have to wait for treatment on the NHS.
- The 2018 staff survey results identified areas for improvement and the hospital put in place improvement plans as a result. An example of this was the introduction of a 'Lancaster say committee' which consisted of staff members from different departments within the hospital. The committee met monthly and worked to identify and implement changes to improve staff satisfaction. There had been a focus on staff engagement and as a result they had introduced 'ask senior management' cards so staff could direct questions and suggestions directly to the senior management team. At the time of our inspection the hospital had just received the results of the 2019 survey and staff feedback sessions were being planned to identify areas for improvement. However, we were told that the results for staff engagement had increased by 10% from the previous year.
- Wellbeing was an important part of the hospital strategy. The 'Lancaster Say Committee' was also involved in arranging social occasions for staff. They had arranged summer barbecues, Christmas parties and looked at ways in which to spend the staff fund which was received from patient donations. In addition to this, the hospital ensured that every member of staff received a free birthday meal, discounted food in the hospital canteen, discounted treatments at the hospital and free parking for all.
- Staff told us that recognition awards were given, for example long service awards or certificates of appreciation. In addition to this, staff could receive spa days, massages and discounts for other treatments.

Governance

- The service had governance processes in place, however funding had not been approved for all changes identified on the hospital site development plan 2019.
- There was a system in place to monitor procedures against their review dates which were recorded on a spreadsheet, so that they could be tracked. However, we saw that this did not cover polices and despite this we found policies and procedures which were outside of their review date This included information such as National Safety Standards for Invasive Procedures that were introduced in 2015. We found that this policy was due for review in January 2019 and staff we spoke with were not familiar with these standards.
- We reviewed organisational policies and procedures. The copies of the organisation's safer surgery policy and uniform policy, that we reviewed were both past their dates for review. Following our inspection, we were provided with evidence which showed that the review dates for these policies had been extended.
- A clinical governance process was in place within the service that allowed risks to be escalated to divisional and board level in the organisation.
- The senior management team was supported by the medical advisory committee, where clinical quality and governance matters were reviewed. The committee met quarterly, and reviewed the minutes and actions arising from the hospitals sub committees which included health and safety, clinical governance and infection prevention and control. The medical advisory committee was led by a chair who was a senior clinician with experience in a clinical director role at an NHS hospital, at the time of our inspection they were relatively new to the role and had chaired two meetings. We were told that there was a close working relationship between the hospital management team and the medical advisory committee and that there was regular communication between the chair and the executive director for the hospital.

- We reviewed the medical advisory committee meeting minutes for September 2018 and January 2019. We saw that there were standard agenda items which looked at key governance areas these included a review of practising privileges, accreditation and credentialing, feedback from clinical governance committee, feedback from the operations manager, feedback from the quality and risk, CQC updates and feedback from the orthopaedic governance group. In addition to the standard agenda items we saw that concerns raised by the medical team were discussed, patient outcomes and incident investigations reviewed. There was an action tracker in place which identified actions to be completed and a review of actions from the previous meeting with ownership detailed.
- Clinical governance meetings were held monthly with members invited from each department. We reviewed governance meeting minutes for the three months prior to our inspection. We noted a structured agenda and timeframes and ownership of actions to be completed
- There was a daily communication cell meeting each morning at 9.30 am in which a representative from each team in the hospital attended. The update worked through a standard agenda and looked at a range of service aspects such as an update from each service to include staffing, patient numbers and issues, general hospital wide updates such as health and safety, incidents and shared learning, a 'hot topic' and the clinician and manager on call for the day. The meetings were recorded, and we saw that they were displayed in staff areas within departments.
- We attended the monthly operations committee meeting which had a structured agenda. Items of discussion were finance, recruitment, policies, risks and audit. We noted that all items had an owner and a timeframe documented to ensure monitoring and progress could be measured.
- Weekly updates and news bulletins were shared with staff from other BMI providers. In addition, the executive director produced a monthly 'closing the loop' publication. Throughout our inspection we saw that these were displayed in staff areas of each department. We saw that they covered hospital wide incidents complaints and compliments with evidence of shared learning to improve care in the future. Staff spoke positively about the publications and the hospital wide communication.
- There were service level agreements in place with the external providers for services such as decontamination, resident medical officer provision and pathology.
- There were 77 doctors employed under practising privileges at the hospital. Between March 2018 and February 2019, the hospital reported that three medical staff had had their practising privileges removed. The reasons identified were retirement and the limited availability of work at the hospital.
- The practicing privilege review process was thorough. The organisation policy for the review of practicing privileges was for the review and to be undertaken every two years. However, the executive director for the hospital had implemented an annual review at the hospital to mitigate potential risk. The review process reviewed work undertaken by the medical staff in NHS and other private hospitals, comments and learning, complaints, incidents, professional registration, review of indemnity insurance, appraisal and training certificates. The hospital director met with consultants to discuss their practicing privileges, applications and the approval process was overseen by the medical advisory committee. We reviewed practicing privileges documentation for four medical practitioners and saw that appropriate documentation had been completed and was held in relation to this.
- The policy identified the responsibility of the hospital and the practitioner for the sharing of concerns and incidents in relation to medical staff working under practising privileges.
- The employers' certificate of liability and insurance was on display and in date, up to September 2019.

Managing risks, issues and performance

- The service had systems to identify risks, however they did not always plan to eliminate or reduce them. Some risks had remained on the register for a number of years and had not been eliminated these included actions identified from the last inspection in 2016.
- The senior leadership team clearly articulated the main risks to the hospital, which in the main related to capital

investment within the hospital for equipment and the development of the site. We saw that the main risks had been on the risk register for a number of years, with limited progress. We were told that there had been limited investment in the hospital from the organisation in the last few years. However, we were told they had recently secured some funding, but we did not see documented evidence to support this. Risks which had remained on the register included the coverings of the chairs which were not in line with department of health guidance for infection prevention and control, carpeted flooring in some ward areas and the lack of a service level agreement for the transfer of deteriorating patients to the local NHS trust. These had not been actioned since the last inspection in 2016. Whilst the leadership team had plans in place to undertake improvement works which would include updating these areas, there were no clear timescales for the completion of the plans.

- The hospital used an electronic risk register which identified hospital and departmental risks. Risks were discussed quarterly at the clinical governance committee and reviewed annually. We reviewed the risk register that indicated dates of review and control measures in place. Risks were visible to all staff across the hospital via the electronic system. This was an improvement since the last inspection.
- The top three hospital risks were displayed in the hospital at the time of our inspection the risks displayed were dated March 2019. We saw that the top risks for the hospital were ligature points throughout the hospital, failure to meet the CQC requirements and a lack of investment in the fabric of the building, electrical biomedical engineering equipment and fixtures and fittings.
- For the ward area, one of the top risks was one of the sluices not being fit for purpose. Although initial actions had taken place the risk remained on the register as it was situated in the area that was awaiting redevelopment. The top risks in theatre were displayed including the mitigating actions, for staff to view.
- The hospital had service level agreements in place with external services, for example the decontamination of instruments and waste disposal services.
- There was no service level agreement in place for emergency transfers to the local NHS trust. However, we were told by management that there was a verbal agreement in place for transfers if required. In an emergency, 999 would be called and patients would go directly to the accident and emergency department at the local NHS trust.
- There was a BMI audit plan in place for the hospital which monitored compliance with care and performance was monitored using dashboards. Results from audits were discussed as part of senior management meetings and the medical advisory committee. The hospital submitted performance data centrally to BMI and benchmarked their performance against other hospitals within the organisation. Performance was also discussed regularly with local commissioners.

Managing information

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The service had clinical dashboards to monitor performance.
- The risk management system was electronic and enabled the leadership team run reports relating to incidents or complaints so that themes and trends could be identified.
- Information governance was included in staff mandatory training.
- There was a business continuity plan including back-up systems in case of electrical failure, which we were told is tested regularly.
- Mandatory training and appraisal data was held on an electronic learning system. The executive director monitored compliance across the hospital and was able to produce reports in order to identify areas of non-compliance or areas for improvement.
- The hospital had systems in place for the submission of information to external bodies. This included the submission of audit data to the Private Healthcare Information Network (PHIN) and Patient Reported Outcome Measures (PROMs). The hospital had an identified contact for the CQC and there were no concerns with the submission of statutory notifications.

Good

Surgery

Engagement

- The service engaged well with patients and staff to plan and manage appropriate services.
- We saw leaflets in the waiting areas encouraging patients and family members to provide feedback about the care they received.
- There was public engagement through the feedback from the patient satisfaction survey. The senior leadership team held interviews with patients on a weekly basis to obtain feedback from their stay in hospital and identify areas for improvement where necessary.
- We reviewed the friends and family test scores for September 2018 to February 2019 and saw that the average score was 97.83% and there were four months where the hospital had achieved a score of 100%. The average response rate was 32.2%.
- The senior leadership team worked closely with commissioning groups and local NHS trusts to plan and develop services to support NHS waiting lists. We were told the hospital performed well in comparison to other similar hospitals within the organisation.
- For staff a daily 'com cell' meeting took place with representatives from all departments with discussions and messages that could be passed on to all staff. Staff received weekly updates from the organisation sharing news from other locations.
- Team meetings were held monthly on the ward and in theatres. Minutes of meetings were available for staff unable to attend. We reviewed meeting minutes that included set agenda items such as staffing, incidents, training, risks and medicines.
- New starters, to the hospital were sent a welcome card and staff birthdays were celebrated with a gift and a meal in the hospital canteen. The 'Lancaster say' committee organised social events for staff, these included barbeques, Christmas parties and at the time of our inspection were looking into arranging a social trip
- There were 'star awards' for staff who had gone above and beyond, award winners had their certificates displayed in public areas. We saw an example was for 'excellent communication and professional discussion with surgeons in response to a patient safety alert'. There were also proud boards displayed in public areas where staff could demonstrate why they were proud.
- At the time of inspection, the hospital was celebrating nurse's day with managers supplying cakes for staff.
- Student nurses, we spoke with, felt supported by the staff with mentors and targets to achieve during placements.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or wrong and promoting training.
- The senior management team was working with staff to improve services using externally recognised quality improvement methodology. At the time of our inspection we were told that there were four improvement projects ongoing within the hospital that were 'staff led'. Examples of these projects were electronic tracking of medical records, scheduling of theatres and 'keeping Saturdays safe'.
- We were told by senior management that research projects were undertaken following rigorous discussion within the medical advisory committee.

Requires improvement

Outpatients

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

Information about the service

The main service provided by this hospital was surgery. Where our findings on outpatients – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

Are outpatients services safe?

Good

The service has not previously been rated. We rated safe as **good.**

Mandatory training

- See information under this sub-heading in the surgery section.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Mandatory training for all outpatient staff was 100% compliant. We saw an electronic management spreadsheet and staff certificates to confirm training had been undertaken.
- We spoke with staff regarding time given to complete training and were told that they were given time to undertake e-learning and face to face learning.

Safeguarding

- See information under this sub-heading in the surgery section.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- We looked at four staff competency files and observed documented evidence that safeguarding training had been completed following NHS England guidance (Safeguarding Adults 2019). Staff had completed safeguarding level three for children and level two for adults. We were told by management that following changes in the intercollegiate guidance (2018) and advice from the local safeguarding provider board, staff were in the process of completing safeguarding adults training level three. Staff were to be trained at this level by October 2019.
- Safeguarding contact information was displayed in the outpatient area for staff. We spoke with staff in the department who told us they knew who to contact if they had any concerns and how to raise matters of concern to their manager. There was a safeguarding lead available at the hospital for staff to access if required.
- We saw details of a five-minute safeguarding briefing bulletin that had been emailed to the hospital from the local council. This was discussed within the daily communication meeting so that the information could be shared verbally within each department.

Cleanliness, infection control and hygiene

- The service told us they had an infection prevention and control lead that shared their time between the local NHS trust and the hospital.

Requires improvement

Outpatients

- We looked at four staff competency files and there was documented evidence that all had attended training in infection prevention and control.
- The outpatient department treatment room and consultation rooms were visibly clean and tidy. These were cleaned first thing in the morning by the housekeeping staff and then cleaned again at the end of clinic by the healthcare staff. We had told the provider on the previous inspection that it should ensure that cleaning checklists were fully completed to ensure that cleaning had taken place. However, at the May 2019 inspection we saw cleaning schedules that had lots of dates that were missing signatures; this did not give us assurance that areas had been cleaned. We raised this at the time of inspection and were told that due to a new cleaning schedule being developed the old schedules had been removed from the file and therefore staff had been unable to sign the sheets to document that the areas had been cleaned. Management told us that the new schedules were awaiting approval from the hospital board. There was no timeframe evident for the approval process.
- Equipment throughout the department appeared to be clean and tidy. 'I am clean' stickers were used to show what equipment had been cleaned.
- Uniforms appeared clean and tidy and arms were bare below the elbow on all healthcare staff within the department.
- There were hand sanitiser gel dispensers outside the entrance to outpatients and next to the reception desk. We observed both patients and staff using the gel upon entry to the department.
- Hand hygiene audits were completed monthly. We reviewed a hand hygiene audit that was carried out in March 2019 which demonstrated 100% compliance in all areas.
- On the previous inspection in November 2016 we told the provider that it should consider identifying and allocating a separate area as a dirty utility room. However, on our inspection there was still no separate dirty and clean utility room and staff were disposing of urine samples in the consultation rooms or treatment room by using silica gel crystals to solidify the urine. These were then emptied into the clinical waste bins. We raised this with management at the time of inspection and were told that the dirty utility room was part of the hospital redevelopment plan. There was no defined date for this and it was on the hospital risk register.
- Clinical areas had flooring which was washable and compliant with the Department of Health building note (HBN 00-10).
- On the previous inspection we had told the provider to replace their seating arrangements to assist in maintaining good standards of infection control. However, chairs within the outpatient area remained the same as on the previous inspection and were not wipeable and therefore not compliant with the Department of Health building note (HBN 00-09). We raised this with management at the time of inspection and were told that they had received a quote for the chairs, but they could not confirm when they would be ordered. This was on the hospital risk register.
- Staff informed us that for patients with suspected methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. diff) or carbapenemase producing enterobacteriaceae (CPE) a deep clean would be carried out. There were no incidents of either of these bacteria reported at the time of inspection.
- The hospital had a MRSA screening and management policy, this was version controlled and in date. Patients were screened in accordance with this policy.
- For patients with communicable diseases such as tuberculosis (TB), staff told us that the areas would be cleaned as per the organisation's infection prevention and control policy.
- Infection, prevention and control audits were carried out on a quarterly basis. We reviewed an audit that had been carried out in March 2019. Out of the 11 questions asked, all were positive which demonstrated staff were 100% compliant.
- There were a good selection of nitrile gloves in all areas. Nitrile gloves are made out of synthetic rubber and are an ideal alternative when latex allergies are of concern. However, within the consultation rooms there were no disposable aprons. We raised this with management and were told that when the consultation rooms were carpeted there was no need

for personal protective aprons as no examinations were carried out in these areas. However, following our inspection and now that the rooms had flooring compliant to the Department of Health (HBN 00-10) they would now put aprons in all areas. Post inspection the provider confirmed that the disposable apron dispensers had been installed.

- There were sharps bins available in the outpatient department. However, we observed in the treatment room that the safety hatch was not closed.
- The hospital had a risk assessment and a policy for the decontamination of nasal endoscopes. The policy stated that the equipment was to be cleaned between each patient use in a separate space to where the procedure had been carried out. We spoke with staff and were told that the equipment would be cleaned in the treatment room once the patient had left the room as the utility area was too cluttered to use. A tristal system was used and a log kept of when the cleaning took place. The decontamination of the scopes at the end of clinic were sent to the organisations central site, however if they were needed quickly they could be sent to the sterile servicing department at the local NHS trust. This adhered to the Department of Health Technical Memorandum on the management and decontamination of flexible endoscopies (HTM 01-06). A service level agreement was in place for this process.
- A Patient-Led Assessment of the Care Environment of cleanliness achieved a score of 100% for cleanliness in 2018.

Environment and equipment

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- All the consultation rooms had new sinks in place. These adhered to the Department of Health building note (HBN: 00-09).
- Fire exits were clearly signposted. Fire break glass points were observed at each exit which complied with the Fire Industry Association BS EN 54-11:2001. A review of all fire extinguishers within the outpatient department were in date with their annual service.
- Emergency call bells and alarms were evident in all clinical rooms. We were told by staff that they were checked on a weekly basis by the maintenance department. We did not see evidence of this during our inspection.
- A resuscitation trolley was in the main reception area outside the outpatient department. Checks were completed by the inspector of diagnostics and imaging as the resuscitation trolley was shared between the two departments. The automated external defibrillator, suction and oxygen were within the manufacturers' recommended expiry dates; however, three pieces of equipment were outside of their expiry date and this was brought to the attention of staff who replaced the items immediately.
- We observed the use of safety needle devices which were fully compliant with the directive 2010/32/EU, the prevention from sharp injuries in the hospital and healthcare sector.
- Staff told us that equipment was always available to meet patient's needs. If equipment was faulty it would be repaired or replaced promptly by the environmental biophysics and molecular ecology (EBME) department.
- The hospital maintained an asset register that demonstrated that equipment was monitored and maintained appropriately. All equipment was in service and had reminders in place to indicate to staff when the next service was due.
- Fridge and treatment room temperatures were checked daily. We reviewed the daily signing sheets and noted that in March 2019 the ambient room temperature in the ophthalmic treatment room was reading too high. Pharmacy staff had been advised and the maintenance department had rectified the situation.
- The toilet facilities were unisex in the outpatient area. We were told by management that these would be changed to single sex toilets when the re-development plan was implemented.
- We were told by management that the physiotherapy department was to be reconfigured, however there was no timeframe evident for this project.

Assessing and responding to patient risk

Requires improvement

Outpatients

- See information under this sub-heading in the surgery section.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- Staff we spoke with were aware of the deteriorating patient and sepsis guidelines. The hospital had a sepsis lead who staff could contact for advice. Staff compliancy for the deteriorating patient training was 100%.
- There was a procedure in place for patients' to be transferred to the local acute NHS hospital if their condition deteriorated whilst in the outpatient department. Staff we spoke with were aware of the procedure and told us that they would either contact the trust directly to explain they were transferring a patient, or they would dial 999 if it was an emergency.
- There was an anaphylaxis kit on the resuscitation trolley based in the main reception area.
- For patients who were referred for surgery, a health questionnaire was completed prior to the pre-assessment clinic appointment. This identified any key risk areas, for example allergies and past medical history. We reviewed five patient medical notes and observed that health questionnaires that had been completed.
- No bariatric patients were seen in outpatients. We were told that patients with a body mass index (BMI) above 40 would be referred to their GP or the body that referred them to the hospital.
- We reviewed a variety of patient care pathways that were individualised for each patient. For example, we saw the pain management local anaesthetic procedures pathway which demonstrated clear sections for patient details, check lists and evaluations. Any allergies were clearly highlighted.
- We were told by staff in the physiotherapy department that risk assessments were carried out before the use of any equipment to maintain patient safety and meet their individual needs.

Nurse staffing

- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- We were told by management that bank staff were used and not agency staff. There had been no agency staff used within the outpatient department for the 12 months prior to our inspection.
- There were two registered general nurses that were regular bank staff and used within the department, two healthcare assistants and one trainee assistant practitioner. On review of the nursing duty rota, no shifts had gone below agreed staffing numbers.
- There were no vacancies at the time of inspection. The use of bank nursing staff as an average percentage in the period March 2018 to February 2019 was 53% and the average percentage for healthcare assistants for the same period was 12%. Although figures demonstrated a high use of bank staff, we were told by management that this was due to clinic demand and there were no job vacancies as occasionally clinics were low on capacity. Bank staff were used as regular flexible workers to meet the demands of the service.
- We were told by management that there was no registered general nurse for evening clinics. These were run by a healthcare assistant and a consultant. Clinics were reviewed in advance, so the right staff were provided for the appropriate clinic. However, if a nurse or another doctor was required, then a registered general nurse from the surgical ward or the resident medical officer would attend.
- Management told us that the orthopaedic clinics occasionally required patient injections. These clinics would be triaged in advance so that they could ensure that a registered general nurse was in attendance on these dates.

Medical staffing

- See information under this sub-heading in the surgery section.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Staff in the outpatient and physiotherapy departments were able to request the resident medical officer to attend any patient that became ill in the department.

Records

- Staff kept detailed records of patients' care and treatment. We reviewed five sets of patient medical records, all were clear, up-to-date, stored securely and easily available to all staff providing care.
- Patient records were securely stored in locked cabinets in the outpatient's department administration office the night before clinics and during clinic hours. However, we observed patient records and clinic lists open on desks within the nursing and administration shared office where patients or visitors could see them. In addition to this we observed that a patient was being looked after in the room with other patients details visible. We raised this with management at the time of inspection and were told that they would speak with staff regarding patient confidentiality.
- We found patient records in a cardboard box in a locked consultation room. We raised this with management at the time of inspection and were told that they would speak to the staff to remind them about the medical records policy. The notes were removed and stored securely in a locked cabinet in the administration office.
- We were told by management that the medical records team collated the patients' medical record for all follow-up appointments.
- If a patient's medical record was not available on the day of clinic a temporary medical record was created. The last patient letter for the consultation and any relevant documentation was printed off and placed within the record.
- An external provider was used to electronically archive medical records. A BMI corporate contract was in place for this service.
- The consultation document comprised of three carbonated copies. The top copy was kept by the consultant and this would be taken back to their personal administration secretaries. We reviewed the service policy 'Management of Health Records and Clinical Documentation, version 2, bullet point 9.3' which stated that records must be recorded when taken off site; however, we did not see evidence of these top copies being documented as leaving the building.
- We reviewed quarterly audits undertaken in March and May 2019 on consultant record keeping and both were 100% compliant in all areas.
- We told the provider on the previous inspection that it should consider that physiotherapy documentation was held in the patient medical record. We reviewed three patient records and observed that this was now being carried out.

Medicines

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- There was a pharmacy department in the hospital. Pharmacy staff monitored and ordered stock levels within the outpatient department. A medicines management audit in the outpatient department was carried out annually. We reviewed the audit from November 2018 and no concerns were noted.
- There were no medicine incidents within the outpatient department for the 12 months prior to our inspection.
- Medicines were stored in lockable cabinets. We reviewed a sample of the medicines in each cupboard. The cupboard in the clean utility room was locked and all medicines were within the manufacturers' recommended expiry dates and kept in chronological order. However, the medicines cabinet in the ophthalmology treatment room was unlocked and we observed medicines outside of the manufacturers'' recommended expiry dates. We raised this with management at the time of inspection and the medicines were disposed of and the cabinet locked. We were told that this would be discussed and emailed to staff to ensure that all adhered to the hospital medicines policy.
- Private prescriptions that could be given to patients. Safe processes were in place, for example, one copy to the patient, one copy inserted into the patients' medical record. The prescription pads were stored in a locked cupboard and records demonstrated that each prescription pad was logged with its number, what

patient it had gone to and which consultant had requested it. We were told by management that they did not carry out any prescription audits to see if the process remained safe.

- We were told by staff that antimicrobial medicines were prescribed by consultants for either internal or external prescriptions. No microbiological samples were taken; however, the patient's treatment was reviewed on follow-up appointments. A local NHS trusts antimicrobial prescribing policy was being followed by the service. We reviewed this policy which was version controlled and in date.
- There was oxygen available in the treatment room in required.
- We reviewed five patient medical records and noted that the allergy status was clearly recorded on all assessment and prescription documentation.
- There was a signatory sheet to be completed if consultants wanted to use the medicine 'Gabapentin' off license. This medicine was now a controlled drug for the hospital and most consultants were not using it.

Incidents

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- We reviewed a monthly information security dashboard with all hospital information security incidents. This was reviewed monthly by the clinical governance committee and the health and safety committee for any trends or lessons to be learned.
- All staff we spoke with were aware of the incident reporting system and understood their responsibility to report incidents. Incidents were reported through an electronic system. There was an incident reporting policy for the hospital and a dedicated information security co-ordinator.
- In the 12 months prior to our inspection there had been no reported never events in the outpatient department. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between the period January to December 2018 there had been 54 clinical incidents in the outpatients and diagnostic imaging departments and no non-clinical incidents. In addition to this between March 2018 and February 2019, there was one patient transferred from the outpatient's department to the local NHS trust. The hospital followed up the condition of the patient and highlighted good practice as well as learning from the events.
- We were given examples of lessons learnt and changes made from recent incidents. For example, following one incident that involved blood sampling documentation, the administration staff would now ensure that patient labels had their NHS number and not just their hospital number clearly documented on them. In addition to this, all staff on induction to the hospital had to complete competencies for blood sampling. The service told us this new way of working had reduced incidents from this.
- Information from incidents was shared in emails, team briefings, newsletters and discussed in daily safety huddles. We reviewed copies of the clinical governance and quality risk bulletins which outlined key learning points from incidents. In addition to this we were told that incidents were discussed within the medical advisory committee meetings.
- All staff we spoke with were aware of the duty of candour and the principles of being open, honest and transparent.

Safety Thermometer (or equivalent)

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Are outpatients services effective?

We do not provide a rating for effective when we inspect outpatient departments.

Requires improvement

Outpatients

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence-based practice.
- There were a range of clinical patient care pathways and protocols for the management and care of various outpatient procedures which had been developed in conjunction with healthcare professionals from a range of specialities.
- Staff told us that they were able to access local and corporate guidelines through information folders held in the administration office and via the hospital intranet.
- The service benchmarked itself to other providers within the BMI group. Governance reports were shared nationally.
- Clinical governance and quality bulletins were shared with all staff in the department. These included any safety alerts or NICE guidance updates.
- We were told by management that the local clinical commissioning group communicated any alerts or changes to practice if required.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health.
- Hot and cold refreshments were available within the outpatient department waiting area and a menu displayed of what was available on that day in the hospital canteen.
- We were told by staff that if patients were waiting on transport and it was delayed they would be able to get food from the hospital canteen.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain.
- Pain relief was managed on an individual basis. Patients we spoke with told us they were always asked about their pain during appointments and were supported by staff on how to manage it.
- All recommendations from the consultants to the patients regarding medicines for pain relief were included in the patient's letter and sent to their GP.
- If a patient was to experience any pain during their physiotherapy clinic appointments, the resident medical officer would be contacted to examine the patient and prescribe pain relief if required.

Patient outcomes

- Staff monitored the effectiveness of care and treatment.
- Patient outcome forms were completed by the consultants following patient appointments and these were collated by the administration staff.
- We requested information regarding patient outcomes post inspection, however we were not provided with any evidence to corroborate that they were using the findings to make improvements.

Competent staff

- The service made sure staff were competent for their roles.
- Appraisals and personal development plans were 100% compliant for all staff in the outpatient and physiotherapy department.
- We looked at three staff personnel files and all had disclosure and barring service checks in date. Nursing staff had nursing and midwifery council registrations in date.
- All staff had received induction training. For example, we saw that fire safety, basic life support, information governance and equality and diversity were completed.
- The service told us that staff received clinical supervision, but this was not recorded.
- We looked at three staff competency files which demonstrated competencies achieved to carry out their roles, for example, aseptic non-touch technique assessment, tristel three wipe system competencies, the deteriorating patient, blood transfusions and venous blood sampling. These were annual competencies and staff told us that if they felt they needed extra training the support was given to achieve this.
- We were told that the two bank registered general nurses provided support to the dermatology consultant for minor operations that were carried out

in the treatment room, but we did not see any evidence of competencies for these procedures. We raised this with management and were told that a healthcare assistant was booked onto the next course for competencies in minor surgery in August 2019. The two bank registered general nurses had not yet got places for this. There had been 34 dermatology minor operation procedures in the period May 2018 to April 2019.

- We spoke with the acting outpatient manager who told us they were currently completing a foundation degree which had been funded by the hospital. Following completion of the degree there was potential funding from the hospital to complete a nursing apprenticeship.
- There were link nurses within the department, for example the healthcare assistant was the infection, prevention and control link nurse. They attended regular meetings with the infection, prevention and control lead nurse and then cascaded the information learnt to staff within the department, either by discussion, email or team meetings.

Multidisciplinary working

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- We were told by staff that all departments supported each other and worked well together.
- We attended a daily morning 'communication cell' meeting. We saw that this was attended by all departments within the hospital and included both junior and senior members of staff.
- The hospital was supported by staff from the local NHS trust in infection, prevention and control and staff told us they felt comfortable in contacting other departments within the trust for support and advice if required.
- Consultants and staff worked closely with the patients' GPs to ensure that good collaborative working, and continuity of care was maintained.

Seven-day services

- Key services were available seven days a week to support timely patient care.
- The outpatient department service was offered five days per week, Monday to Friday, 9am to 5pm. It did not offer a seven-day service.
- Evening clinics were available in outpatients for patients who could not attend during daytime hours.
- Outpatient physiotherapy was provided on weekdays only.
- A resident medical officer was available 24 hours a day, seven days per week.
- Pharmacy staff were available for the outpatient's department Monday to Friday, 8am to 4pm with out of hours support covered by an on-call pharmacist and support from the resident medical officer.

Consent and Mental Capacity Act

- See information under the sub-heading in the surgery section.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients consent.
- Staff we spoke with were aware of the Mental Capacity Act (2005). Staff told us that if a patient lacked capacity the consultation would stop in agreement with the patient and their family if present. The patient would have a capacity assessment undertaken by the consultant to identify any additional support required or if needed they would be referred to their GP for assessment.
- Verbal consent was gained from patients undergoing physiotherapy. If staff had concerns about a patient's capacity to consent, then the treatment was rescheduled, and a mental capacity act assessment was requested of the patient.

Are outpatients services caring?

Good

The service has not previously been rated. We rated caring as **good.**

Compassionate care

Requires improvement

Outpatients

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- We spoke with three patients and all stated that their respect and dignity and confidentiality was always maintained.
- Patients told us that they were asked if they wanted a chaperone present if they had no family members with them at their appointments.
- We observed two consultations; introductions were made at the outset of the appointment from both doctors and nurses. We noted during the consultations that there was good rapport between the staff and the patients.
- Staff took time to interact with patients who were waiting on their appointments. Interactions were respectful and considerate.

Emotional support

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- All consultation rooms in the department were private. This ensured that privacy and dignity was maintained throughout the consultation process. Staff told us that if patients were upset during their appointment they would be in a private room which helped to maintain their privacy.
- Patients told us that they did not feel rushed during their appointments and felt that their privacy and dignity was always maintained.
- We observed two consultations and noted that explanations were given to the patients in a sensitive and kind manner.

Understanding and involvement of patients and those close to them

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Patients who had to pay for their treatment were informed of the costs prior to consultation. The hospital website also displayed the costs of treatment for patients to be informed prior to attending the hospital.
- Patients we spoke with told us that they felt reassured that if they had any concerns or worries about their treatment they could contact staff on the telephone numbers they had been given.
- During the consultations we observed discussions on treatment options and noted that patients and their families were encouraged to be part of the decision-making process.
- Following clinic appointments, patients told us that they felt very well informed of upcoming treatments, test results, next appointment dates and that all correspondence was copied to themselves and their GPs.

Are outpatients services responsive?

Requires improvement

The service has not previously been rated. We rated responsive as **requires improvement.**

Service delivery to meet the needs of local people

- See information under this sub-heading in the surgery section.
- The service was planned but did not always provide care in a way that met the needs of local people and the communities served.
- The service was using a nursing and administration office for weighing patients. Patients were weighed in front of administration and healthcare staff which not only impeded on the patient's privacy and dignity it allowed staff to hear confidential and personal details of the patients. In addition to this, patients could hear bookings being made for other patients and they could see documentation of other patients' personal details in the office. We raised this with management at the time of inspection.

Requires improvement

Outpatients

- Patients told us that they struggled to find a parking space when attending the hospital. We raised this with management who told us that they were aware of the problem but could not change this as they had limited space available.
- There was enough comfortable seating in the waiting area for the number of patients waiting for appointments.
- Patient information leaflets were available in the outpatient and physiotherapy department on the services available and what to expect.
- We were informed by the outpatient manager that patients referred by their GP could use the choose and book system. Choose and book is a national electronic referral service that gives patients a choice of treatment centre and at a time that is convenient for them.
- Out of hours evening clinics were held within the outpatient department. Staff told us that patients had said this was an invaluable resource if they could not attend during day time hours.
- Consultants provided telephone appointments to patients to discuss test results.
- Patients could contact the physiotherapy department in between appointments if required.

Meeting people's individual needs

- The service was inclusive and took account of patients' individual needs and preferences.
- During the previous inspection we told the provider it should consider a loop system to help patients who have a hearing impairment. We observed that a hearing loop system was now in place within the main reception area for those with sensory impairment.
- We were informed that patients who did not speak English were flagged on referral so that plans could be put in place ahead of their consultation. An interpretation service was available at point of contact for patients who did not speak English as their first language.
- Staff told us that patients with mental ill health or learning disabilities were identified via their GP and referred directly to the consultant. If patients were not identified in this way, they would be prioritised to ensure that they were seen quickly. In addition, once identified patients were flagged on the booking forms.
- We were told by management that if a patient had learning disabilities or a patient was anxious then an empty consultation room would be used for them to wait in for their appointment.
- During the previous inspection we told the provider it should consider improving the environment as it was not suitably adapted to respond to the needs of patients living with dementia. However, during our inspection we did not see an improvement to this as signage was still not clear, toilet seating or any adaptations to the area had not been implemented. Site development plans were shared post-inspection which demonstrated changes to be made to the environment, however no timescales were evident in this document.
- The entrance to the hospital was accessible for wheelchair users. In addition, there were toilet facilities located in the reception area for people with a physical disability. All outpatient clinics were available on the ground floor of the building.
- Transport was booked via the patient's GP. However, if patients were waiting for a long time following their appointments, the hospital would pay for taxis.
- Patients undergoing physiotherapy were asked if they wanted their treatment provided by someone of the same gender. If this was requested then staff would, if possible, ensure that the correct arrangements were made.

Access and flow

- See information under this sub-heading in the surgery section.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Requires improvement

Outpatients

- Staff told us that appointment times varied depending on patient need from the triage process. New patients would have a longer appointment so that they had time to ask questions.
- The service monitored the number of patients that did not attend (DNA) appointments. We reviewed the electronic tracking system for each outpatient service provided and the DNA percentages. We noted that there were for example, 212 trauma and orthopaedic appointments in March 2019 and a percentage rate of 14.2% DNA appointments and 43 general surgery cases with a percentage rate of 9.3% DNA's.
- Patients were contacted the day before their appointment by the national enquiry centre to remind them of their appointment.
- We were told that clinics very rarely ran late; however, if they did patients would be kept informed at regular intervals. In addition to this, if a consultant was going to be late arriving at the hospital, patients were telephoned at home to make them aware, so they had the option to re-arrange their appointment if required. Patients we spoke with told us that the reception staff and all the healthcare staff were wonderful and always polite and helpful.
- NHS referrals into the department were from GPs, consultants or through the NHS choose and book appointment system. Patients could also contact the national enquiry centre to book an appointment.
- All clinics were scheduled appointments with set specialities on a weekly basis. There was a total of 12,740 outpatient attendances in the period May 2018 to April 2019.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section.
- Information on how to raise a complaint was displayed in the main reception area.
- There were no complaints recorded in outpatients at the time of inspection. We spoke with staff and were told that any complaints would be dealt with by the outpatient manager to try and resolve the issue as it occurred. However, if this could not be resolved then the complaint would be escalated to senior management.

Are outpatients services well-led?

Requires improvement

The service has not previously been rated. We rated well-led as **requires improvement.**

Leadership

- See information under this sub-heading in the surgery section.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. However, following the last inspection we identified actions that the service must or should complete, but we found that not all actions had been completed. This included the lack of sluice area and the chairs in the waiting area which were not compliant with the department of health standards for infection prevention and control.
- The outpatient clinical lead was off on long term sickness at the time of inspection. A senior healthcare assistant was acting as outpatient manager with support from the clinical governance lead. We spoke with the acting outpatient manager and were told that they felt very supported by senior management and by their peers.
- Link nurses were evident for various specialities. This ensured that information was shared between specialist teams and the staff and patients in the clinical areas that they worked. Staff told us that all the departments throughout the hospital worked together and shared good practice.

Vision and strategy

- See information under this sub-heading in the surgery section.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

Requires improvement

Outpatients

- Staff we spoke with were not aware of the hospital strategy and vision. However, one member of staff knew about the new development plans for the outpatient area.

Culture

- See information under this sub-heading in the surgery section.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff we spoke with told us that management were very approachable and supportive. Staff were positive about working at the hospital and all agreed that it was a great place to work.
- Management informed us that they had an open culture where all staff could discuss ideas and concerns. We spoke with staff in the department who all confirmed that the culture of the organisation was very positive and open.
- The overall staff sickness rate in the outpatient department for the period January 2018 to December 2018 was 0%. However, there had been long-term sickness in the department prior to our inspection.

Governance

- See information under this sub-heading in the surgery section.
- The service safeguarded high standards of care by creating an environment for excellent clinical care to flourish. However, there were areas of infection prevention and control, plus audits and outcomes that we had told the provider to improve on in the last inspection, but these had still not been completed. For example, the fabric on the chairs in the waiting area, the inconsistency of the cleaning schedules and the lack of patient outcome data.
- Daily communication meetings were held each morning. All managers from each department attended.
- During the inspection we did not see any evidence of team meetings within the department. We were told by management that the meetings had not taken place since the outpatient manager had gone off on long-term sick. We were provided minutes post-inspection of team meetings that took place in February and March 2019. Both had structured agendas and owners of items listed. However, no timeframes were documented of actions that were required. For example, the cleaning schedules were discussed in both meetings, but this was still an ongoing item during our inspection with no timeframe for completion.

Managing risks, issues and performance

- See information under this sub-heading in the surgery section.
- The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. Whilst there were controls and actions in place to mitigate the risks, there was minimal progress to resolve them.
- There was a standard operating procedure for surgical procedures in the outpatient treatment room. This stated that staff were to be trained in scrub technique. On talking to staff in the department they told us that they were not yet competent and were awaiting training to commence in August 2019.

Managing information

- See information under this sub-heading in the surgery section.
- Although patient outcome data was collected following consultations, we did not see evidence that it was used to measure performance.
- Information governance was included in staff mandatory training. All staff in the department were compliant with their training.
- A variety of leaflets were available in the main reception area. For example, infection, prevention and control on how to clean your hands, understanding individual pain management and physiotherapy, a guide for patients.

Engagement

- See information under this sub-heading in the surgery section.

Requires improvement

Outpatients

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- Regular weekly updates on other hospital locations were shared with staff in every department.
- Public engagement was carried out about care and treatment at the hospital, through social media and feedback from the patient satisfaction survey.
- Friends and family test questionnaires, outpatient questionnaires were collated by an external quality and health company. We reviewed the results for the period January to March 2019 and all answers were positive demonstrating that patients would be extremely likely to recommend the service to their friends and family.
- We reviewed a patient satisfaction dashboard for March 2019 with comparisons taken from the patient questionnaires in March 2018. The dashboard demonstrated which areas had improved and which areas had deteriorated. These results were benchmarked with other regions and discussed at local and corporate governance meetings to see how they could improve on the findings.
- The outpatient friends and family postcard results for the months January to March 2019 demonstrated that over 95% of patients would recommend the hospital to their friends and family if they required similar care or treatment. We were not provided with the response rate.
- Comments from patients for the physiotherapy department were all positive and all patients would recommend the physiotherapy to their friends and family for treatment within the department.
- We were provided post-inspection, patient feedback on the physiotherapy department. All respondents on the overall impression of the service were either very good or excellent.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

Requires improvement

Diagnostic imaging

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

Information about the service

The main service provided by this hospital was surgery. Where our findings on diagnostic imaging – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

Are diagnostic imaging services safe?

Requires improvement

The service has not previously been rated. We rated safe as **requires improvement.**

Mandatory training

- See information under this sub-heading in the surgery section.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff received emails to inform them when their mandatory training was due for renewal. Staff we spoke with explained they continued to receive email reminders until they completed the required training. The service lead had oversight of staff mandatory training compliance for the service and reported to the senior leadership team.
- Staff had twelve months to complete mandatory training which ran from April to April. At the time of our inspection the service reported an overall compliance of 85.7% against the hospital target of 90%.The compliance rate included new starters, who we were told had three months to complete mandatory training modules as part of their induction.
- Radiologist staff completed mandatory training at their NHS trust and submitted evidence of their compliance to the executive director for the hospital annually. The hospital confirmed that the radiologist was compliant with mandatory training requirements.

Safeguarding

- See information under this sub-heading in the surgery section.
- Staff understood how to protect patients from abuse and had training on how to recognise and report abuse.
- The hospital provided an adult only service and treated patients who were 18 and above. There was a safeguarding lead for the hospital who was the clinical service director. All staff in the service received safeguarding training level one and two for children and adults, two members of the team were identified to complete safeguarding level three for adults. Overall the average safeguarding compliance rate for the service was 83.33%. The compliance rate included new starters, who we were told had three months to complete safeguarding modules as part of their induction.
- Staff we spoke with had not had a need to raise a safeguarding concern. However, they could articulate the policy and were aware of how to identify a potential safeguarding concern which included information in relation to female genital mutilation.

Diagnostic imaging

- The service used a 'pause and check' process which met with Ionising Radiation (Medical Equipment) Regulations 2017 and the Society of Radiographer guidelines. This is where staff check three points of the patient's identification and the intended procedure against the referral with the patient. We observed three patients undergoing diagnostic imaging procedures and observed that this was undertaken appropriately each time and we saw posters in place to remind staff.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection. However, the documentation of cleaning schedules was not consistently completed.
- All areas we visited within the department were clean and tidy. There were hand washing facilities within the main x-ray room and there was hand sanitizer available on the entrance to the department. We observed staff adhering to arms bare below the elbow guidelines and we saw that they washed their hands between and cleaned the x-ray bed between patients.
- The hospital had an infection prevention and control lead nurse who provided a service through a service level agreement with a neighbouring NHS trust. The lead nurse provided on site cover one and a half days per week.
- There was an infection prevention and control link staff member for the department their role was to disseminate information to staff in the team from the infection prevention and control lead nurse.
- There were cleaning schedules in place for the department which were split into housekeeping and clinical staff responsibilities, these detailed the areas to be cleaned and the frequency of cleaning should be undertaken. We saw that these were displayed in the main office for the department.
- We reviewed the weekly schedule for imaging staff completion and housekeeping staff for 1 January to 14 May 2019. We found that there were six weeks where it had not been documented that the cleaning had been undertaken by imaging staff and we found that there were ten weeks where the schedule had not been documented that the cleaning had been completed for the housekeeping staff.
- The lead for the service oversaw the imaging staff cleaning schedule completion and the housekeeping lead for the hospital oversaw the housekeeping schedule. Cleaning schedules were audited by the infection prevention and control lead nurse, we requested evidence of this and were provided with an audit which took place following the inspection. We were told that environmental cleaning had not been raised as a concern through recent audits.
- Hand hygiene and management Infection control audits were undertaken on a quarterly basis. We observed the March 2019 audits and we saw that the service had demonstrated 100% compliance for hand hygiene.

Environment and equipment

- The service had suitable premises, however the static X-ray equipment was ageing, we were told by staff that the fluoroscopy function of the equipment was no longer in working order and there were no clear timescales for when it would be replaced.
- We were told the static x-ray machine for the department had been identified as end of life in 2015. This meant that if the machine were to break down or parts failed on the machine they could not be replaced. The main x-ray machine was initially a fluoroscopy (use of x-ray to provide moving images of the interior of an object) machine and was used for the administration of pain injections. We were informed that the fluoroscopy function on the machine had failed and was no longer in use. The machine was only used for static x-ray images.
- The design of the static x-ray equipment meant that the height of the bed was not adjustable and fixed at a high level. This resulted in patients needing to use a set of mobile steps to get up onto the bed. The patient group seen in the department were in the main those requiring hip and knee surgery and we observed that this was a challenge for these patients. We saw that it had been identified as a risk and there was a risk assessment in place for this, however it was not

included on the department risk register. There was a risk that patients could fall when getting onto the bed, however at the time of our inspection we had no evidence that patients had fallen.

- We were informed by senior management within the hospital that the replacement of the main x-ray machine had been on the risk register and the equipment replacement plan for a number of years. Funding for the rolling equipment replacement plan for the hospital and department had not been granted and there were no clear timescales in place for when equipment would be replaced. There was a risk the equipment could fail and that the imaging department would not be able to provide a service. We were told that contingency plans were in place if this happened, which involved patients receiving a service from a neighbouring NHS trust or for patients to be transferred to one of the other BMI hospitals in the Lancashire area.
- The service did not use a computerised imaging system. Images were developed and reported on film. There was no picture archiving and communication or radiological information system in use. This meant that images could not be immediately shared with GPs or other healthcare providers. The hospital had submitted a business case to obtain the electronic system, however there were no agreed timescales for when it would be implemented. Following our inspection, we were told images from other hospitals were requested in advance of patient's appointments so that there was access to them. An image exchange portal (IEP) was in place and clinics were planned in advance to enable this.
- Equipment quality assurance was provided by an external company through a service level agreement. Quality assurance testing was undertaken annually, and the results were discussed as part of the radiation protection committee for the hospital.
- Local quality assurance testing of equipment was undertaken three times a year by a designated radiation protection supervisor for the department. Results were inputted on an online system and sent to the medical physics expert team who monitored the results. Results of local quality assurance testing were discussed at the annual radiation protection committee and medical physics expert would raise concerns beforehand if needed. This was in line with the quality assurance policy for the service.
- There was an equipment maintenance agreement in place for the x-ray equipment held within the department. We saw evidence that equipment had received an annual service and all servicing records were up to date. Staff had access to contact details for the manufacturers to report faults with the equipment.
- Risk assessments were in place for the use of the diagnostic equipment within the department. We saw evidence that risk assessments were up to date, regularly reviewed and contained control measures to protect service users and staff.
- The waiting area for the department was a designated area off the main corridor, which provided a calm and comfortable environment. There was a sofa for patients and relatives to use whilst they waited. The walls contained information for those attending to read and we saw that this included radiation protection information, radiation percentages for different types of X-rays, explanations about the radiographer and radiologists' roles, pregnancy information, and the chaperone policy. There was a coffee table which contained a selection of magazines, patient information leaflets and feedback cards.
- All department doors were secured by keypad access. There was illuminated signage outside of the x-ray room to indicate it was a controlled area with limited access. There were also the contact details for the radiation protection supervisors for the hospital displayed. This met with the Ionising Radiation (Medical Exposure) Regulations 2017. We observed the x-ray room contained panic buttons for use in case or a medical or security emergency.
- Personal protective equipment was available for staff to use this included lead aprons, protective screens and personal radiation dosimeters (these measure the amount of radiation staff working in the department receive).We saw evidence that the monitoring of personal protective equipment was up to date and in line with standards and the service had recently had new lead aprons.

Diagnostic imaging

- Stock of sundries were kept in cupboards within the department. We checked a range of stock which was held in the department and found that these within the manufacturers' recommended expiry dates.
- Waste was appropriately segregated into clinical, domestic and sharps waste. There were appropriately labelled waste containers.
- The service had access to a resuscitation trolley which was shared with the outpatient department. The trolley was located in the main entrance which was off the corridor outside of the department.

Assessing and responding to patient risk

- Staff used appropriate methods and documentation to identify potential risks to patients and responded appropriately to the changing risks to patients.
- The service had two permanent radiographer staff members who provided a radiation protection supervisor role. This meant that they had received additional training in the Ionising Radiation (Medical Exposure) Regulations 2017 and were responsible for ensuring compliance with the regulations and the local rules. The service had access to a medical physics expert which was provided through a service level agreement with an external organisation. Staff could access them if there were radiation concerns relating to the equipment. Within the organisation based centrally there was a lead for radiology who provided the radiation protection advisor role and was contacted for concerns in relation to compliance with the regulations or incidents involving radiation exposure. The contact details of the teams were available to staff in the department.
- The service had illuminated signage in place which identified radiation risks and indicated when x-rays were in progress. We were told that each week there was a check of the signage to ensure it was in working order.
- The service had identified approved refers for x-rays or diagnostic imaging, these had to be qualified doctors. Referrals were accepted from consultants and general practitioners which were included on a signature register. Referrals were checked as part of the procedure prior to undertaking the diagnostic imaging and we observed that this took place. The service had a local Ionising Radiation (Medical Exposure) Regulation policy which supported this, however at the time of our inspection the policy was in draft form to bring it up to date with the Ionising Radiation (Medical Exposure) Regulations 2017 and had not been completed or approved. Following our inspection, the hospital provided a corporate ionising radiation safety policy which had been implemented in April 2019 and referenced the up to date regulations.
- Staff asked female patients between the ages of 12 and 55 the date of their last menstrual period which was documented on referral forms. This was in line with the Ionising Radiation (Medical Exposure) Regulations 2017. We observed posters in waiting areas which provided patients with information about pregnancy and diagnostic imaging. At the time of our inspection the service was in the process of updating the policy for this to reflect the updated regulations in 2017.
- If radiographers identified something of concern on a patient's image and the radiologist was not in work, we were told they would escalate their concern to the referring consultant who was on site. If this was the case images could be sent by taxi to another BMI hospital in the Lancashire area for urgent reporting, we were told there was a policy in place to support this. We reviewed the policy, however we found that it had not been updated or reviewed since 2009. Following our inspection, the hospital provided a copy of the policy which demonstrated that it had since been reviewed in July 2019.
- Staff had received training in how to perform basic life support if a patient needed it. Staff described the process for how to raise an alert if a patient had gone into cardiac arrest which involved the use of an emergency buzzer and an internal standardised emergency resuscitation team call number. The hospital had a designated resuscitation team who had intermediate and advanced life support skills and knowledge. Staff were made aware of who the team was during the daily huddle.

Nurse staffing

Requires improvement

Diagnostic imaging

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Radiographer staffing establishment was 1.4 whole time equivalent contracted staff members. There was one full time radiographer who was also the service lead and one part time radiographer who worked 15 hours per week. The service also used three regular bank radiographer staff to cover remaining shifts.
- Radiographer staff provided a twenty-four hour on call service seven days a week for urgent imaging requests. The rota was covered by a mixture of substantive and bank radiographer staff. The rota was designed so that they covered one week in four. Staff stated they were rarely called out.
- The service had a radiology assistant who provided administration duties and supported the radiographer and the surgeon in theatre during pain injections. The assistant was undergoing a training qualification to extend their scope of practice to use the mobile x-ray machines in theatre. This would free up the radiographer role and utilise the skill mix of the team more efficiently.
- Staff sickness was covered by bank staff, this included cover for the service lead. We were told that if there were no radiographers available to work the service would be stopped and patients would be sent to one of the other BMI hospitals in Lancashire area for their imaging appointments.
- We were told that there were no concerns with staff retention and staff turnover was low. The staff who worked in the department had been in post for a number of years. At the time of our inspection we were told there were no current vacancies for radiographer staff. However, staff felt that they did not have an adequate establishment to meet the needs of the service and felt this had a knock-on effect for the service lead and management duties.
- Staff often worked on their own in the department. There was a hospital policy in place for staff who were lone working. We did not see evidence of a risk assessment associated with staff lone working in the department and staff confirmed that there was not one in place.However, following our inspection we were provided with a departmental risk assessment and policy for staff lone working which were dated March 2019.

Medical staffing

- The service did not always have enough radiologist staff. However, staff had the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The radiologist for the service worked under practising privileges one day per week this equated to one 0.2 whole time equivalent post. The radiologist also worked at an NHS hospital , and submitted evidence to support their practicing privileges on an annual basis. The radiologist did not have a speciality field and reported all images taken at the hospital. There was no radiologist cover for sickness and annual leave.
- The radiologist for the service had worked at the hospital for a number of years. We were told that attracting radiologist staff was difficult due to the out-dated method of viewing and reporting images and as a result the establishment for the service had been reduced.
- Images were reported on film and not electronically. There was a policy and process in place for patients' images to be transferred to another BMI hospital in the North West region for the reporting of images if the radiologist was not in work. However, staff told us that this rarely happened and that images would usually wait at the hospital until the radiologist returned. There was a risk that patients' treatment could be delayed due to the time spent waiting for reporting. Staff confirmed this caused a delay in image reporting and a recent audit demonstrated an average reporting time of fifteen days. We were told images were reviewed by the consultant prior to the radiologist review to prevent delays to patient treatment.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date.
- Records were primarily paper based. Imaging referrals were completed on paper and diagnostic imaging information was added to the referral form during the

procedure. All X-rays were printed onto film, and, alongside the referral forms, were held within the main patients notes. There were no patients notes stored within the department.

- We reviewed three patients records and saw that they had been completed appropriately. We requested the record audits; however, we were not provided this and it was not clear if there was a monitoring process in place for the quality of records.

Medicines

- See information under this sub-heading in the surgery section.
- The service followed best practice when storing medicines.
- Medicines were stored in a secure room within a locked cupboard in the department. The keys for the medicine cupboard were stored securely in a keypad entry cupboard which only authorised staff had access to.
- Medicine stock top ups were undertaken on a weekly basis by the pharmacy team on site and staff could request medicines in between if necessary. The service did not keep any controlled drugs within the department and all medicines were to be stored at an ambient temperature.
- The monitoring of the temperature of stored medicines was undertaken daily and there was a thermometer kept inside the cupboard with the medicines. Daily monitoring sheets were sent to the pharmacy department on a monthly basis for auditing. We reviewed the daily medicine temperature checks for 1 March to 14 May 2019. We found that the majority of temperature checks had been completed, and we identified three days where this had not been done. There was no evidence of temperature deviations between this time period and staff were aware of how to escalate concerns if necessary.
- We checked a range of medicines that were held within the department and we found that they were clean, intact and within the manufacturer's recommended expiry dates. The service held one emergency anaphylaxis medication kit, we observed that the kit was tamper proof and within the recommended expiry date.
- We did not observe staff administering medicines during our inspection.

Incidents

- See information under this sub-heading in the surgery section.
- Staff recognised incidents and managers investigated incidents and shared lessons learned with the whole team and the wider service. However, staff did not always report incidents particularly near miss incidents.
- Incidents were reported using an electronic report form and were investigated internally by the service lead. Radiation incidents were reported centrally to the radiation protection advisor. Staff were aware of how to raise an incident.
- Staff we spoke with were not always clear about what incidents to report formally. We were given examples of near miss incidents that had happened, and improvements identified as a result. However, staff confirmed that these had not been reported as an incident via the incident reporting system and our review of incidents confirmed this. There was a risk that themes and trends from incidents in the department may not be identified to improve practice and there was no audit trail to support action staff had taken in response to incidents that had not been reported.
- There had been six incidents reported for service in the last 12 months. We were given details of one of the incidents which took place in the x-ray department in which the wrong area of a patient was x-rayed. We were told this was a 'no harm' incident. We reviewed the incident investigation and saw that appropriate action had been taken. However, we saw that there had been a delay in the reporting of the incident of seven days and that the investigation had taken 52 workings days to complete, this did not meet with the incident management policy for the hospital. We were told that there was a delay in the investigation of this incident due to the absence of the service lead.

Requires improvement

Diagnostic imaging

- The hospital provided a monthly report which was called 'closing the loop', this included outcomes of incidents and shared learning. We saw that this was on display in the imaging office for staff to read and staff were positive about the communication.
- We were told that incidents requiring duty of candour (the process of being open and honest when things go wrong) were escalated to the hospital's clinical lead who would contact the patient. Whilst we were told that staff received training in duty of candour as part of their annual mandatory training. Not all staff could describe duty of candour and were not always clear about their roles and responsibilities under the duty of candour regulation.

Are diagnostic imaging services effective?

We do not provide a rating for effective when we inspect diagnostic services.

Evidence-based care and treatment

- The service did not always provide care and treatment based on national guidance and evidence of its effectiveness.
- There were standard operating procedures in place which detailed how staff should undertake specified imaging procedures. Standard operating procedures were reviewed annually, and we saw evidence of this. However, the review process was undertaken by one member of staff and did not include the radiologist for the service. During our observations of the standard operating procedures we saw that they had not been altered since 2015 when they were originally approved. There was no evidence of references to demonstrate that they had been updated in line with national guidance or best practice.
- The static x-ray equipment used film to develop and report images, this was no longer considered as best practice. Best practice images would be produced and stored on an electronic system.
- Patients who required post-operative x-rays following knee or hip surgery could not always access the static x-ray machine bed. We were told that practice was adapted for those patients and x-rays were undertaken on the hospital bed. There was a risk that the image quality was not as good and that repeat x-rays may be needed, with the risk of additional exposure to radiation. The service did not audit repeat images and so there was no evidence of the impact of this.
- The service had identified dose reference levels for each procedure (this is the median dose of radiation a patient would receive for a diagnostic procedure); however, these were not displayed in the department in line with best practice.
- The medical physics expert team for the department had identified a need for a review of the dose reference levels in the assessment undertaken in January 2019. At the time of our inspection we observed that the documentation for dose reference levels had not been updated and reviewed with other staff since 2015.
- We saw evidence that dose reference levels were recorded for each patient which was in line with best practice and Ionising Radiation (Medical Exposure) Regulations 2017. However, we were told that there had been no audit of dose reference levels administered to patients. The service could not be assured that they consistently met or that they were using the optimum levels. Following our inspection, we were provided with a dose audit which had submitted to the radiation protection advisor data and we were told this information had been sent at the time of our inspection. However, the data did not provide details of the monitoring period or demonstrate how the service performed in-line with recommendations.

Nutrition and hydration

- The service did not provide food or drinks to patients. However, outpatients had access to hot and cold drinks in the main outpatient waiting area and they had access to the hospitals restaurant facilities to meet their needs.

Pain relief

Diagnostic imaging

- The service did not provide pain relief to patients.Patients pain was monitored during imaging procedures and pain relief was provided by the outpatient consultants or on-site resident medical officer, if it was required.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service contributed to some annual internal audits including imaging general, radiation safety, medicines management, imaging in theatres and clinical practice and documentation. In addition to these there was the annual equipment quality assurance audit and the department had recently undertaken an audit of reporting times.
- We reviewed the audit results detailed on the imaging audit programme 2019 and saw that the service had achieved 100% in the majority of the audits except imaging general which they received 95%.
- Radiologists and radiographers for the service explained that there was no process in place for peer review of images or reporting. We were told that the radiologist would flag to the imaging lead if there was a concern with the quality of images and this would be addressed informally. However, there was no formal quality assurance process for this in place and there was a risk that concerns in relation to quality were not addressed.

Competent staff

- The service did not have effective systems in place to make sure staff were competent for their roles. Staff did not feel confident in their knowledge of the Ionising Radiation (Medical Exposure) Regulations 2017.
- Staff told us that they did not feel confident in their knowledge of the updated regulations, which had been amended in 2017. Staff could not always articulate the updated regulations, this included staff who were involved in updating the service policies and procedures to reflect the updated legislation. We were advised there was little support from the central team for staff with this. Staff had last received updated training in November 2017 which was prior to the regulation changes.Following our inspection, we were told staff had been allocated training which was due in September 2019.
- The radiologist confirmed there were no opportunities for peer review of reporting of images within the hospital. There was no formal process in place for the peer review of radiographer staff for image quality. We were told that concerns with regards to image quality were managed informally in response to concerns raised by the radiologist.
- The appraisal process was made up of two sections there was an initial appraisal in which objectives were set for the year and a final appraisal to review progress against these. Staff we spoke with had received an appraisal in the last twelve months. The service provided data that demonstrated that the service was 100% compliant with appraisal completion.
- The radiologist for the service received an appraisal through the NHS trust that they worked for and provided evidence of this annually to the executive director for the hospital.
- The was an equipment training and assessment competency framework that all radiographer staff had to complete. All staff completed initial training and were re-assessed annually. We saw that the training covered the imaging equipment used within the department and looked at a variety of aspects such as use of the controls, image acquisition, patient care, radiation protection, administration and post image processing. Assessments and sign off was undertaken by the lead service lead. The service lead was assessed by a member of the radiographer team who had been signed off as competent.
- Staff equipment training records were held in the department office, we reviewed the training records for substantive and bank staff who worked in the department, this was six staff in total. We saw that two members of staff had not received the annual competency assessment in 2018. We brought this to the attention of the service lead at the time of our inspection.
- Bank staff received the same induction and competency training framework assessments as substantive staff members.

Requires improvement

Diagnostic imaging

- The radiology assistant was undergoing a training package which was delivered through the organisation in conjunction with a university to become a qualified radiology assistant. This meant that they could undertake diagnostic imaging of patients using the mobile X-ray units during pain injections. One of the permanent radiographer staff members had qualified as a mentor for this course in order to assess and support the staff member in attaining their qualification.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service worked closely with theatre staff and the pain consultants to plan pain injection clinics.
- The service lead attended the daily communication cell with staff from across the hospital.

Seven-day services

- The service operated Monday to Friday 8.30 am to 5.00 pm. There was a service provided to support the pain list on a Saturday morning on an as needed basis and these sessions were planned in advance.
- Outside of working hours there was an on-call service provided by radiographer staff for urgent diagnostic imaging.

Consent and Mental Capacity Act Deprivation of Liberty Safeguards

- Staff understood the consent process and they followed the service policy and procedures when a patient could not give consent. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Consent was gained for all patients undergoing an x-ray. We observed the process for three patients who were having an x-ray. We observed that staff made patients aware of the risks and patients were able to make an informed decision. Documentation audits for 2018 demonstrated 100% compliance

Are diagnostic imaging services caring?

Good

The service has not previously been rated. We rated caring as **good.**

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- We spoke with three patients about their care. Feedback from patients was continually positive. Examples of patient feedback was 'wonderful', 'it is an excellent service', that they 'had no problems at all' and "staff were polite and caring".
- We observed three patients who were undergoing diagnostic imaging. We observed that staff were caring in their approach to patients and treated them with compassion.
- Discussions with patients were held inside the diagnostic imaging room in private to maintain the patient's privacy and dignity. There were changing rooms available to patients who needed to get changed and the hospital provided gowns to maintain their modesty.
- There was a chaperone policy in place and all patients could request a chaperone. We observed posters in patient areas which informed patients of their right to request a chaperone.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Staff we spoke with told us that the use of the steps in the main x-ray room was not ideal, particularly for the group of patients they treated. They made sure that they re-assured and supported the patients as much as they could.
- We observed a patient was apprehensive about using the steps to access the bed, the staff member allowed the patient time, was encouraging and put them at ease.

Requires improvement

Diagnostic imaging

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- Patients who had to pay for their treatment were informed of the costs prior to their appointment. The hospital website also displayed the costs of treatment.
- Patients felt that staff provided them with adequate information about their procedure and the process afterwards.
- The service had a carers and comforters policy which was in development so that patients who needed a career or loved one to accompany them during their imaging procedure could do safely.

Are diagnostic imaging services responsive?

Requires improvement

The service has not previously been rated. We rated responsive as **requires improvement.**

Service delivery to meet the needs of local people

- See information under this sub-heading in the surgery section.
- The service provided services in a way that met the needs of people.
- The service operated Monday to Friday 8.30 am to 5.00 pm. They provided a service for a pain injection list on a Saturday morning on an as needed basis to meet the needs of patients, these sessions were planned in advance in conjunction with the pain consultants.
- Outside of working hours radiographers provided an on-call service for urgent imaging needs.
- The department was situated on the ground floor next to the main entrance and was clearly signposted. The environment was accessible, appropriate and met patients' needs. The waiting area provided comfortable seating and a calm environment for patients and relatives. There were magazines and hospital information leaflets for patients to read.
- The walls displayed information for those attending to read and we saw that this included radiation protection information, radiation percentages for different types of X-rays, explanations about the radiographer and radiologists' roles, pregnancy information, and the chaperone policy.

Meeting people's individual needs

- The service did not always take account of patients' individual needs.
- The static x-ray machine bed was not accessible to all patients. Staff told us for inpatients who were physically unable to use the steps to access the X-ray bed, were often x-rayed on the hospital bed. Staff stated this was not ideal and did not produce the best image quality.
- Due to the strict criteria for patients to be treated in the hospital we were told that there were small numbers of patients who were treated who had complex or additional needs. However, we were told that staff from the referring area would communicate the patients' needs prior to them arriving, so that the service could make appropriate arrangements.
- The service was in the process of developing a carers and comforters policy. This meant that those who needed a carer or loved one to accompany them during their imaging procedure could do safely.
- The service had access to over the phone interpreters to assist with communication for patients who were unable to speak or understand English. Contact details were available to staff via the intranet.

Access and flow

- People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice. However, image reporting times did not meet the organisations standard.
- Patients who were attending the outpatient clinics could be referred for an x-ray and receive one the same day. Images were sent to the consultant for review following the x-ray but were not formally reported on the same day, this was due to the radiologist establishment for reporting of one day a week. Images requiring an urgent review in the

absence of the radiologist, were highlighted to the appropriate consultant and could be transferred to another BMI hospital in the north west for reporting via a taxi. There was a policy in place for this.

- Images were not held electronically using a picture archiving and communication system and so could not always be shared easily across the hospitals or with outside organisations. However, following our inspection, we were told an image exchange portal (IEP) was in place and images from other hospitals were requested in advance of patient's appointments so that there was access to them, clinics were planned in advance to enable this.
- Staff we spoke with told us the service had no identified key performance indicators to work towards or that they measured performance against for image reporting times. However, we were told that the organisation standard was that urgent reporting should be completed within 24 to 48 hours, and non-urgent cases within seven days.
- The service had recently undertaken an audit of image reporting times. The audit results demonstrated that image reporting times for the x-ray service were an average of fifteen days which was outside of the organisation standard. We were told that this had been raised with the clinical governance committee. There was a risk that this could delay a patient's treatment. At the time of our inspection there were no improvement plans in place to improve this.
- Staff felt that the process for reporting images was slow and not efficient. Radiologists dictated their reports into Dictaphones and these were sent to the administration team to be typed. Reports were then checked by the radiographer team for spelling mistakes and accuracy which sometimes involved listening back to the recordings prior to sending the final report to the referrer.
- The service did not receive referrals for patients who were acutely unwell. Referrals came from GPs, the outpatient department and the wards within the hospital. All referrals to the service were on paper and they had to be signed by a verified clinician. Appointment bookings were handled and overseen by the radiology assistant.
- Requests for scans such as computed tomography (CT) and magnetic resonance imaging (MRI) were handled by the service and sent to the appropriate BMI hospital in the area. Once reports were received the department held copies of the report in the patient records and forwarded these to the appropriate referring consultants.Following our inspection, we were told that that these images were also on a digital based imaging service, which all consultants had access to.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service reported no complaints in the last twelve months.
- The service reported no compliments received in the last 12 months. We saw that feedback forms were available in the waiting area for patients to complete.

Are diagnostic imaging services well-led?

Requires improvement

The service has not previously been rated. We rated well-led as **requires improvement.**

Leadership

- Managers at all levels in the service had the right skills to run a service providing high-quality sustainable care.
- There was a clear leadership structure in place. The service lead reported directly to the clinical services director for the hospital and any concerns which required escalation were reported to the executive director of the hospital as necessary. The was a central lead for radiology services who the service lead reported to for issues relating to radiation.
- The service lead was a radiographer with many years' experience. They provided direct leadership and line

management to staff within the service. Staff described the immediate leadership for the service as supportive and explained that they felt comfortable to raise concerns if they needed to do so.

- The radiology assistant had been supported to develop and obtain a recognised qualification and extend their scope of practice. As a result of this one of the substantive radiographers had received additional training to be an official mentor and assessor for the staff member on the course.
- However, staff did not always feel supported by the senior leadership team within the hospital and the central team. Staff felt that the establishment for the team meant that the service lead did not always have the time to dedicate to management duties.

Vision and strategy

- See information under this sub-heading in the surgery section.
- The service had a vision for what it wanted to achieve. We were told the vision for the department was 'to continue to provide excellent patient care to patients and develop the skills of the workforce.'
- The hospital had a site development plan which was dated March 2019. The site development identified the imaging department as an area of improvement. The plans identified for the department were the introduction of an electronic picture archiving and communication system and radiology information system, decommissioning of the fluoroscopy and a re-design of the imaging area. We were told that the introduction of the electronic systems would involve the introduction of a new static x-ray machine. At the time of our inspection the development plans were awaiting approval and there were no clear timescales for when they would be completed.
- Staff within the department were not all aware of the vision and strategy for the hospital.
- There was no strategy specific to the diagnostic imaging department. Plans to update the department were included in the site development plan for the hospital.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service was a small team and the staff that worked in it had worked there for a number of years. Staff felt that they worked well together as a department and with the wider team. They described a culture where they supported each other and could be open and honest.
- All staff we spoke with were proud of the service, and all felt that they provided excellent patient care.

Governance

- The service did not always systematically monitor service quality to improve and safeguard high standards of care.
- The service had IRMER policies which were outside of their review date, incomplete and some were not in line with up to date legislation. We reviewed 12 of the local radiation policies and saw that 10 were either incomplete or out of date. There were two which had been completed in May 2019 and were awaiting approval. We were told that there were no company-wide standardised policies for ionising radiation policies. We were told that this had contributed to the delay in updating the policies and there was limited support from the central imaging team for policy requirements. There was a risk staff were not completing duties in line with updated legislation. Following our inspection, we were provided with a copy of the organisation wide imaging ionising radiation safety policy which had been issued in April 2019 and was in line with the updated regulations.
- The service did not have regular team meetings which included all staff, we were told this was due to the working patterns of staff members. There was a risk that important information and learning from other meetings was not shared across the team. This also meant that there was no opportunity for peer review and discussion to improve practice or develop the service.
- We saw that standard operating procedures for specific diagnostic imaging procedures had been reviewed annually. However, there was no evidence of

the involvement of other staff members in the review process since 2015 and staff confirmed this was the case. The standard operating procedures had also not been updated since 2015 and did not reference guidance or best practice. There was a risk that they did not reflect updated practice or evidence based care.

- There was a national radiation protection framework for the organisation which the local radiation protection committee for the hospital fed into. We were told that information from the national and regional committees were distributed to the service lead from the central team.
- The local annual meetings were attended by the radiation protection supervisors, the clinical services director, the medical physics expert and the radiation protection advisor. The meeting followed a set agenda which covered equipment, personal protective equipment, quality assurance, audit and risk assessments. We saw that the last meeting was held in February 2019 and there was an action log in place from the meeting we saw that all of these had been signed off as complete except the update of the Ionising Radiation (Medical Exposure) Regulations 2017 policies which had an expected completion date of March 2019. At the time of our inspection this action had not been completed.
- The service did not have robust audit systems in place which monitored how the service performed so that improvements could be identified and implemented.
- The service lead attended the clinical governance committee meetings which were held monthly. We were told that the meeting had a standardised agenda which was organisation wide. The meeting covered departmental updates, infection prevention and control, ratification of standard operating procedures, risk, incidents and good practice. The lead for the service found it was a positive forum for managing risks and sharing information.
- Equipment maintenance and the Medical Physics Expert role were provided through service level agreements with external providers. Agreements were up to date and managed by the hospital leadership team.

Managing risks, issues and performance

- See information under this sub-heading in the surgery section.
- The service had systems to identify risks. However, they did not always monitor performance and have improvement plans in place for areas of concern.
- Service leads were aware of the risks to the service. The identified risks for the service on the risk register was the lack of electronic imaging systems and the potential delay in image reporting times. Staff reported this was a concern and we were told this had been on the risk register for a number of years.
- The service used a static X-ray machine which was originally a fluoroscopy machine this resulted in the bed being at a fixed height. Patients needed to use mobile temporary steps to get up onto the bed for their x-rays. We saw that there was a risk assessment in place for this however it was not recorded on the hospital risk register as a departmental risk. The patient group for the service were primarily those with hip and knee complaints. We observed patients were unsteady in using the steps and we were told that they felt 'uncomfortable' using them. The machine was end of life in 2015 and had not been updated. Although there was no evidence of patients falling when using the steps, the risk had not been eliminated in a timely manner.
- Staff we spoke with told us that the service did not have key performance indicators or set targets to work towards. This meant that they were unable to monitor their performance against a set criteria and identify underperformance or improvement. Staff told us that the recent reporting audit demonstrated that reporting times were on average 15 days which was above the seven-day standard for non urgent reporting. We were told it had been discussed at the clinical governance committee, however there were no improvements plans in pace as a result. The service hoped to obtain funding to introduce an electronic system which they felt would help this but at the time of our inspection the business case was awaiting approval. However, following our inspection we were told that the service was part of the reporting suite for the NHS six week diagnostic pathway and had reported no breaches of this.

Managing information

Requires improvement

Diagnostic imaging

- The service collected data, however they did not always analyse and use the information, to support all its activities.
- The service did not have clear and robust service measures in place that they worked towards. This meant that they were not able to use the information collected to monitor performance and identify areas for improvement.
- Some information was recorded that could be used to monitor performance. Examples of this were referral times, reporting times, dose reference levels, last menstrual period date, consent and reporting times. However, we were told that the service currently only monitored image reporting times which had been identified as a concern. At the time of our inspection there were no improvement plans in place for this in addition to the introduction of the electronic imaging system which was in the business case development stages and was awaiting funding approval.
- The service practiced in accordance with General Data Protection Regulations and patient confidentiality and staff received training on this annually.
- The service carried out local equipment quality assurance on a four-monthly basis. The data was submitted into an electronic system which could be accessed by the medical physics expert for monitoring to ensure that radiation safety was maintained.

Engagement

- See the surgery section under this heading for more information.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- Staff from the service attended the daily huddle which included at departments in the hospital. Information was shared with regards to staffing, incidents, complaints and risk. There was a monthly 'closing the loop' newsletter sent to all staff across the hospital where information was shared about all departments. We observed the most recent published 'closing the loop' report was on display and accessible to staff in the department. Staff were positive about hospital wide engagement.
- The service did not have regular team meetings or take part in discrepancy meetings or peer review. Staff identified working patterns as a barrier to this.
- Patient feedback was encouraged, and we saw that the department had feedback forms available in the waiting area for patients to complete. Patient feedback was monitored and reported on a monthly basis. We saw that the overall results for the service from December to January 2019 were broken down into four sections these were, overall impression, were you kept informed of what was happening, were staff caring and friendly and were you treated with dignity and respect. The results demonstrated an overall average satisfaction score of 89.7%, with the highest score of 92% for were staff friendly and caring and were you treated with dignity and respect. The lowest score was 86.8% and that was for the overall impression for which 2.6% of patients stated they were dissatisfied.
- Patient survey results were discussed as part of the clinical governance committee meetings where action plans for improvement were identified and monitored.

Learning, continuous improvement and innovation

- The service was not always formally committed to improving services by holding structured sessions for learning from when things went well or wrong and promoting training.
- The service did not hold regular team meetings, discrepancy meetings or peer review. This meant that they were not formally evaluating the quality of the service provided and working to improve it. We were provided examples of when concerns in relation to the quality of imaging had been raised and how the leadership had addressed this to make improvements. However, this was done informally and there was no documented evidence of this.
- The service was looking at different ways to use the skill mix within the team. The imaging assistant for the department was being supported to undertake a university accredited course in order to become a qualified assistant and undertake some of the imaging duties. One of the permanent radiographer staff members had been supported to undertake the mentor training attached to the course in order to support the assistant to attain the qualification.

Requires improvement

Diagnostic imaging

- At the time of our inspection the service was not contributing to any research projects, research projects were approved by the hospital medical advisory committee.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that service users are weighed in a private area to maintain their dignity and respect. (Regulation 10 (1) (2) (a)).
- The provider must ensure that there are processes in place to review and update policies within the identified time scales and in line with updated legislation and national guidance. (Regulation 17 (1) (2) (a))
- The provider must ensure that there is a robust review process in place for policies and procedures that include the relevant qualified staff members. (Regulation 17 (1) (2) (a))
- The provider must ensure that there is a process in place to monitor the quality of the service so that improvements can be identified and demonstrated. (Regulation 17 (1) (2) (a))
- The provider must ensure that staff who are responsible for updating policies and procedures in line with current legislation receive the appropriate training and support to do so. (Regulation 17 (1) (2) (a))

Action the provider SHOULD take to improve

- The provider should ensure that staff receive safeguarding level three training for adults in line with Intercollegiate Guidance (2018).
- The provider should ensure that policies are reviewed to reflect National guidance.
- The provider should ensure that they can assure themselves staff are compliant with organisational policies, including infection, prevention and control, uniform and medicines management policies.
- The provider should ensure that ensure that the monitoring of outcome measures are improved.
- The provider should ensure staff have an understanding of all theatre safety measures in line with best practice.
- The provider should ensure that all staff securely store medicines in line with best practice.
- The provider should ensure that there are sufficient supplies of testing fluids to check glucometers.
- The provider should ensure that all rooms are secure where keypads are fitted.
- The provider should consider implementing the new cleaning schedules to ensure that all premises and equipment used by the service provider are clean.
- The provider should consider changing the seating to ensure that hygiene standards are appropriately maintained for the purposes for which they are being used.
- The provider should consider providing personal protective equipment, including aprons in all consultation rooms.
- The provider should ensure that equipment is in full working order so that it is used for its intended purpose, and provides image quality that meets with best practice.
- The provider should ensure that staff are aware of their roles and responsibilities in reporting and recording incidents to include near miss incidents.
- The provider should consider a review of the strategy for what it wants to achieve and include workable plans with agreed timescales, to turn it into action.

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 10 HSCA (RA) Regulations 2014 Dignity and respect The provider must treat service users with dignity and respect, ensuring the privacy of the service user. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must have systems and processes in place to assess, monitor, and improve the quality and safety of the services provided in the carrying on the regulated activity. Regulation 17 (1)(2)(a)