BMI The Duchy Hospital

Quality Report

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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?	Good
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Duchy Hospital is operated by BMI Healthcare. The hospital/service has 27 beds. Facilities include two operating theatres (both have laminar flow), X-ray, outpatient, diagnostic facilities and physiotherapy. The hospital provides surgery and outpatients with diagnostic imaging services.

We carried out this inspection using our focused inspection methodology. We inspected this hospital in October 2016 and we rated the safe and well led domains as inadequate. We issued the provider with four Requirement Notices as they were not meeting the legal requirements of the Health and Social Care Act (Regulated Activity) Regulations 2014. In order to follow up the progress that was being made we carried out a short notice announced inspection over two days on 31 July and 1 August 2017. During the inspection we looked at the safe and well led domains in the surgery and outpatient services. At this inspection we found the provider was now compliant with the four regulatory actions we had previously issued.

Services we rate

We rated this hospital as requires improvement overall but we rated the domain of safe as good overall and well led as requires improvement because:

- The hospital had improved the incident reporting process so they could track learning and outcomes of incidents. In addition to this, the new electronic system had made it easier for staff to report incidents.
- Staffing levels in the theatre recovery had improved and were in line with national recommendations.
- The five steps to safer surgery were now being consistently used and communication between staff at all of the stages of the operation had improved. There was now an opportunity for professional challenge between staff.
- The refurbishment of patient bedrooms had commenced with carpets being replaced in 20 out of 27 bedrooms. There was a plan to have all bedrooms refurbished by the end of August 2017 which was on track.
- The on-site decontamination of endoscopes had stopped and these were now being sent to a central decontamination hub. A system had been put in place to identify clean and dirty endoscopes which staff were following.
- The governance arrangements had been reviewed and a new structure had been put in place. The new structure was designed to give more assurance to the executive leadership team.
- Staff morale had improved since our last inspection and staff now told us they felt supported and could speak up without fear of retribution.
- Although there were many improvements in governance, leadership, staff and public engagement and staff morale/ culture, more time was needed to embed these improvements. Many of the new processes and initiatives were still in their infancy and the hospital leaders knew they had more to do to ensure they were embedded and improvement sustained.
- Improvements had been made in the hospitals approach to the Workforce Race Equality Standard (WRES) however; the hospital leaders acknowledged they were not yet fully compliant with the requirements.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Location	Good 	Start here...
Surgery	Requires improvement 	During this focused inspection we inspected the safe and well led domains of the surgery core service. We rated the surgery core service as requires improvement overall because: • Although there were many improvements in governance, leadership, staff and public engagement and staff morale/culture, more time was needed to embed these improvements. Many of the new processes and initiatives were still in their infancy and the hospital leaders knew they had more to do to ensure they were embedded and improvement sustained However; • The hospital had improved the incident reporting process so they could track learning and outcomes of incidents. In addition to this, the new electronic system had made it easier for staff to report incidents. • Staffing levels in the theatre recovery had improved and were in line with national recommendations. • The five steps to safer surgery were now being consistently used and communication between staff at all of the stages of the operation had improved. There was now an opportunity for professional challenge between staff. • The refurbishment of patient bedrooms had commenced with carpets being replaced in 20 out of 27 bedrooms. There was a plan to have all bedrooms refurbished by the end of August 2017 which was on track.

Summary of findings

- The on-site decontamination of endoscopes had stopped and these were now being sent to a central decontamination hub. A system had been put in place to identify clean and dirty endoscopes which staff were following.
- The governance arrangements had been reviewed and a new structure had been put in place. The new structure was designed to give more assurance to the executive leadership team.
- Staff morale had improved since our last inspection and staff now told us they felt supported and could speak up without fear of retribution.

Outpatients and diagnostic imaging

During this focused inspection we inspected the safe and well led domains of the outpatient and diagnostic imaging core service.
We rated the outpatient core service as requires improvement because:

- Although there were many improvements in governance, leadership, staff and public engagement and staff morale/culture, more time was needed to embed these improvements. Many of the new processes and initiatives were still in their infancy and the hospital leaders knew they had more to do to ensure they were embedded and improvement sustained.

Requires improvement

However;

- Improvements had been made in the use of the five steps to safer surgery, including the World Health Organisation (WHO) surgical safety checklist. During this inspection, nine out of the 10 cases we looked at were completed correctly. However, one WHO checklist was not completed correctly because we noted on a minor procedures column that not all of the boxes were initialled by the surgeon and the accompanying nurse. We escalated this to the person in charge who said they would address this.
- At our last inspection we raised concerns because we found not all patients attending the outpatient department for a minor procedure

Summary of findings

under local anaesthetic had their observations recorded before or after the procedure. We saw this had improved and all patients had their observations recorded pre and post procedure.

- The use of the minor procedure room had been reviewed and it was no longer being used for treatments requiring specialist ventilation. Patients requiring procedures who would need this were being scheduled into the operating theatres where there was the appropriate theatre environment.
- Risks in the outpatient department were now on the departmental risk register and mitigating actions were appropriate and up to date.

Summary of findings

Contents

Requires improvement

Services we looked at

Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to BMI The Duchy Hospital

The Duchy Hospital is operated by BMI Healthcare. The hospital opened in 2008. It is a private hospital in Harrogate, North Yorkshire. The Duchy hospital primarily serves the local communities, but also accepts patient referrals from outside this geographical area.

The hospital provides a range of surgical, outpatient and diagnostic imaging services to the NHS and other funded (insured and self-pay) patients and works predominately with consultants from local NHS hospitals.

Surgical services at the BMI Duchy Hospital provide day and overnight facilities for adults undergoing a variety of procedures. The hospital provided services for children, but on 31 August 2016 had stopped treatment for under sixteen year olds.

Our inspection team

The team that inspected the service comprised of three CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Why we carried out this inspection

The BMI Duchy Hospital offered a range of elective and outpatient treatments for different specialities such as cosmetics, dermatology, ENT, general surgery, gynaecology, oral and maxilla facial, ophthalmology, orthopaedic and spinal surgery, urology, plastics and vascular.

Facilities at the Duchy Hospital included one ward with 27 registered beds, two theatres both with laminar flow and, for patients recovering immediately post-surgery, a recovery area. Theatres were open 8.30am until 8pm, Monday to Friday. In exceptional circumstances, staff opened the department at 7.30am.

The outpatient department provided outpatient consultations and a range of diagnostic imaging services. The outpatient clinics covered approximately 16 different specialities, including orthopaedics, cardiology, dermatology, ophthalmology, urology and cardiology.

The outpatient department had 10 consulting rooms, a minor procedure room and a phlebotomy room. There was also an outpatient physiotherapy service which had three treatment rooms and a gymnasium.

Diagnostic imaging provided a range of services including X-ray, fluoroscopy and ultrasound. A mobile MRI scanner visited the hospital every week. We did not inspect this as part of our inspection as it is registered separately.

The Duchy Hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures (11 May 2011)
- Family Planning (3 April 2014)
- Surgical Procedures (11 May 2011)
- Treatment of disease disorder or injury (11 May 2011).

There were no special reviews or investigations of the hospital on going by the Care Quality Commission at any time during the 12 months before this inspection. The Duchy Hospital had been inspected four times; the most recent inspection took place in October 2016. This inspection found the hospital was not meeting all standards of quality and safety it was inspected against. There were four breaches of regulations identified during that inspection.

Summary of this inspection

Activity

- In the reporting period 01 July 2016 to 31 August 2017 there were 5,073 inpatient and day case episodes of care recorded at The Hospital; of these 14% were NHS-funded and 86% other funded.
- There were 12,016 outpatient total attendances in the reporting period; of these 80% were other funded and 20% were NHS-funded.

Track record on safety during the reporting period July 2016-July 2017

- One never event.
- Clinical incidents: No incidents causing no harm; one incident causing low harm; none causing moderate harm; none causing severe harm, and none causing death.
- Zero serious injuries
- Zero incidence of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA), healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA), healthcare acquired Clostridium difficile (c.diff) and healthcare acquired E-Coli.
- Three complaints.

Services accredited by a national body:

- The Duchy Hospital held no national accreditations.

Services provided at the hospital under service level agreement:

- Catering
- Decontamination
- MRI scanner
- RMO provision

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?

Good

Are services safe?

We rated safe as good because:

- The Duchy Hospital had improved the incident reporting process so they could track learning and outcomes of incidents. In addition to this, the new electronic system had made it easier for staff to report incidents.
- Staffing levels in the theatre recovery had improved and were in line with national recommendations.
- The five steps to safer surgery were now being consistently used and communication between staff at all of the stages of the operation had improved. There was now an opportunity for professional challenge between staff.
- The refurbishment of patient's bedrooms had commenced with carpets being replaced in 20 out of 27 bedrooms. There was a plan to have all bedrooms refurbished by the end of August 2017 which was on track.
- The on-site decontamination of endoscopes had stopped and these were now being sent to a central decontamination hub. A system had been put in place to identify clean and dirty endoscopes which staff were following.
- At our last inspection we raised concerns because we found not all patients attending the outpatient department for a minor procedure under local anaesthetic had their observations recorded before or after the procedure. We saw this had improved and all patients had their observations recorded pre and post procedure.
- The use of the minor procedure room had been reviewed and it was no longer being used for treatments requiring specialist ventilation. Patients requiring procedures who would need this were being scheduled into the operating theatres where there was the appropriate theatre environment.

Are services effective?

Start here...

Are services caring?

Start here...

Are services responsive?

Start here...

Summary of this inspection

Are services well-led?

Are services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- Although there were many improvements in governance, leadership, staff and public engagement and staff morale/ culture many of the new processes and initiatives were still in their infancy. The hospital leaders knew they had more to do to ensure they were embedded and improvement sustained.
- Improvements had been made in the hospitals approach to the Workforce Race Equality Standard (WRES) but the hospital leaders acknowledged they were not yet fully compliant with the requirements.

However, we also found the following areas of good practice:

- The governance arrangements had been reviewed and a new structure had been put in place. The new structure was designed to give more assurance to the executive leadership team.
- Staff morale had significantly improved since our last inspection and staff now told us they felt supported and could speak up without fear of retribution.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Requires improvement

Surgery

Safe	Good
Effective	
Caring	
Responsive	
Well-led	Requires improvement

Are surgery services safe?

Good

We rated safe as **good.**

The main service provided by The Duchy Hospital was surgery. Where our findings on surgery for example, management arrangements, also apply to other services we do not repeat the evidence but cross refer to the surgery services section.

We followed up on all of the areas that we had identified as being inadequate at the October 2016 inspection. In addition we rechecked the areas in this domain which we did not have concerns about to ensure the good practice had been sustained.

Incidents

- The Duchy Hospital had a policy for the reporting of incidents, near misses and adverse events. At the 2016 inspection we raised concerns that actions identified from incidents were not always implemented in a timely manner. We found improvements had been made with this. Since the last inspection, the provider had implemented a new reporting system for risks, incidents and complaints. Staff training on the new system was on going at the time of our inspection.
- The new incident management system had made it easier for the hospital to track trends in incidents and monitor actions to ensure any learning was implemented. We saw evidence that lessons learnt were discussed at the daily communication meeting so they could be cascaded throughout the hospital. The leaders in the hospital felt there had been improvements but had more work to do to ensure lessons learnt were consistently cascaded throughout the hospital. They had plans in place to introduce staff forums, more staff newsletters and listening posts.
- All of the staff we spoke with stated they were aware of the incident reporting process. We noted the numbers of incidents being reported had increased since the new system had been implemented. The leaders in the hospital stated this increase might have been attributable to the new system being easier for staff to use. The leaders in the hospital told us they had encouraged the reporting of incidents and near misses so that trends and actions were able to be tracked and lessons learnt. For example, data showed there were 233 incidents recorded between December 2016 and August 2017, compared with 147 incidents reported for the same period in the prior year before the new incident reporting system had been introduced.
- In August 2017 there had been one never event reported which was related to a retained guide wire. The hospital were in the process of reviewing this when we inspected. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need have happened for an incident to be a never event.
- In the same reporting period, the hospital reported no serious incidents. Serious incidents are incidents that require reporting and further investigation.
- At the last inspection we raised concerns that the hospital was not fulfilling the requirements of the duty of candour. 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. During this inspection we found improvements had been made. For example, the new incident reporting system included a section on the duty of candour. We looked at a recent incident and saw how the duty of candour had been acted upon and the patient had received an explanation, an apology and an offer to meet with the staff and hospital manager.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- To monitor performance, The Duchy Hospital had completed a range of BMI corporate dashboards. These were discussed at the relevant hospital governance meetings. For example, dashboards included quality, safety, health and environment, complaints and information security incidents.
- Venous thromboembolism assessments were carried out in the hospital. A venous thromboembolism (VTE) is a blood clot, which forms in a vein, often in a leg, which can lead to harm to patients. In the reporting period June 2016 to April 2017, data showed 98% compliance.
- In the same reporting period there were no incidents of hospital acquired VTE or pulmonary embolism (PE).
- In the reporting period July 2016 to July 2017 there had been no pressure ulcers and no catheter and urinary tract infections. The hospital used the safety thermometer tool for NHS patients to monitor performance against the harms identified above.

Cleanliness, infection control and hygiene

- At our last inspection in October 2016 we found the hospital was in breach of the requirements of the Health and Social Care Act (Regulated Activity) Regulations 2014 Regulation 12, Safe Care and Treatment. This was because of concerns relating to the decontamination of endoscopes and the furnishings in patient areas posing an infection control risk. We found action had been taken to address these concerns and the hospital was no longer in breach of this regulation.
- Since the last inspection, the decontamination of endoscopes has been moved off site to a central decontamination. The room which was previously used for decontaminating endoscopes was being refurbished at the time of this inspection and was going to be used for extra storage.
- There was a recognised system in place for identifying clean and dirty endoscopes. Clean endoscopes were stored in sealed trays in a clean theatre storage area. These endoscopes had a shelf life of six months. After this, if they had not been used, they would be sent back to the decontamination hub for reprocessing.
- When staff used an endoscope, they wiped the scopes clean before packaging them up for transportation to the decontamination hub.
- At our last inspection in October 2016 we raised concerns about some of the clinical areas as they were not compliant with some of the Department of Health Building Notes. We found evidence of action being taken to address these concerns. At the time of our inspection, the refurbishment of patient bedrooms was underway. The flooring in 20 out of the 27 bedrooms had been replaced with a flooring material which was compliant with Health Building Note (HBN) 00-09 infection control in the built environment. It was expected that all bedrooms would be complete by the end of August 2017.
- The lead nurse for IPC was involved with the refurbishment plans for the hospital and had advised on aspects of the project to ensure compliance with HBN 00-09 infection control in the built environment.
- Staff were able to inform us of what actions they would take in the event of a spillage of body fluids in the rooms which still had carpeted floors. One staff member was also able to give an example of when they had to close a room until the carpet had been removed due to a large spillage on the carpet which could not be removed.
- Since the inspection in October 2016, there had been zero cases of MRSA bacteraemia, Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia and Clostridium difficile (C. difficile). There were also no reported cases of Escherichia coli (E. coli) bacteraemia.
- Staff undertook screening for alert organisms (a specified microorganism or infection which if identified requires specialist advice) as part of preadmission checks. This included screening for MRSA, Carbapenamase producing organisms (CPO) and C. difficile if previously positive. CPOs are organisms which are highly resistant to a wide range of antibiotics including Carbapenems which are usually used to treat serious infections and can be easily spread between patients if careful infection control practices are not carried out. At the time of inspection, no audits for compliance with screening requirements had occurred. This was however on the audit programme to be completed.

- The ward was visibly clean and tidy despite the refurbishment work being conducted during our inspection. The lead nurse for infection prevention and control (IPC) told us they had suspended cleaning audits whilst the refurbishment work was being conducted, therefore no recent cleaning audit results were available.
- There were hand hygiene promotion posters around the ward area which were based on the World Health Organisation (WHO) five moments of hand hygiene. We also observed bare below the elbow posters, which reminded staff of their requirement to comply with this policy.
- We observed staff washing their hands appropriately during the inspection.
- The linen cupboard on the ward contained wooden shelving for items to be stored on but there was a hole in the ceiling above the clean linen. This meant there was a risk that clean linen could become contaminated due to the inability to clean the shelving appropriately because it was made of wood and dust and debris could come from the ceiling. A member of staff informed us the shelving was due to be removed at some point and replaced by linen trolleys. The hole in the roof had also been reported to the estates and facilities team.
- The IPC lead nurse had an audit programme for the hospital. The audits used were based on nationally recognised, evidence based infection prevention and control audits. All results were discussed at infection control committee meetings and action plans produced for areas where full compliance was not achieved.
- Theatre staff had reorganised the storage of sterilised equipment to ensure that equipment was stored in the right environment. The store rooms were visibly clean and items were not stored on the floor in these areas.
- We observed all staff complying with the bare below the elbow policy and the hospital uniform standards.
- Water safety and the management of water systems was a standing agenda item at the leads meeting. There was a dedicated member of staff who was responsible for collecting water samples for Legionella and Pseudomonas aeruginosa testing as part of the water safety plan. Regular tap flushing was also conducted and recorded by a member of ancillary staff.
- The lead nurse for IPC had been in place for almost a year and continued to implement the BMI hospital infection prevention and control strategy. The lead nurse for IPC had a good support system both within the BMI system and from the local acute trust. Staff told us she was visible and very helpful.
- IPC mandatory training continued to be provided for all staff on a monthly basis. Any staff required to update their training were identified by the lead nurse for IPC and notified of this requirement. The lead nurse for IPC also conducted additional interest training for staff on a regular basis to improve staff knowledge on current issues related to IPC.

Environment and equipment

- Staff regularly checked resuscitation equipment in the ward area and theatre area. We found the equipment was clean at the time of inspection.
- A difficult airway trolley was available in the theatre area and staff knew where to access this and understood the layout of the trolley. The layout was the same as in the local NHS trust to ensure staff were familiar and emergency procedures were consistent.
- We saw an area of flooring in a scrub room that had become damaged (underneath the sink). This could impact on the ability to appropriately decontaminate this area. A member of staff was informed of this and reported this to estates and facilities for immediate repair.
- Full clinical waste bags were stored in locked rooms within the ward and theatre areas. These were regularly moved on from these rooms to a central location where an external agency removed it from the hospital site for correct disposal.
- We reviewed the beds located in each theatre and a trolley which was found in the department. All items were found to be in a good state of repair, although a small amount of tape was found on a bed. This was removed immediately by a member of staff.
- There were two theatres in the Duchy Hospital both of which had laminar flow (specialist ventilation). This is considered best practice when carrying out orthopaedic surgery.
- We saw that the operating theatres were deep cleaned every 6 months and this was up to date.
- Staff told us that they had all the appropriate equipment required to complete surgical procedures and post-operative care. The hospital had service level agreements with the local NHS trust if any piece of equipment was required which was not usually used.

Requires improvement

Surgery

- At our previous inspection in October 2016, we saw that the anaesthetic and recovery areas were cluttered with equipment and personal staff items such as bags and newspapers. On this inspection, we saw that these had been cleared and that there were appropriate places for staff to put personal items. We saw on this inspection that equipment was stored safely and was easily accessible.
- We had previously seen that storage of equipment in anaesthetic areas meant that space was compromised, and that doors were opened into the theatre for space, which was a concern about cross infection and airflow. We saw on this inspection that this had been resolved with the removal of unnecessary equipment.
- We saw evidence of stock rotation and processes were in place to procure the appropriate amount of stock such as prosthesis.
- We did not re check any electrical patient equipment at this inspection because it was all satisfactorily checked when we inspected in October 2016.
- We did not re-check safety checks of anaesthetic machines at tis inspection as we were assured on our last inspection that the process for these checks was embedded into day to day practice.

Medicines

- On our previous inspection, we saw the hospital pharmacy provided a five day a week service. The resident medical officer was also able to access pharmacy and supply medications out of hours. This was still the case on our most recent inspection.
- Medicines were stored in a locked room, with access restricted to authorised staff.
- Medicines requiring refrigeration were stored in fridges. Systems were in place for the temperatures to be checked daily and staff were aware of the action to take if the temperature recorded was not within the appropriate range. We saw checks took place and were documented.
- Emergency medicines were readily available in a tamper evident box and they were found to be in date.
- Controlled drugs are medicines, which are stored in a designated cupboard, and their use recorded in a special register. There were systems in place to check these on a daily basis on the ward area and as used. In the theatre area, it was policy to check stock balance before and after working lists. We found at our previous inspection that a number of these had been missed. We saw when we followed a patient's surgical experience on this inspection that drug checks were included in the safety check list briefing.
- On this inspection, we saw that checks had been audited on a monthly basis, which had followed our last inspection. These showed an improvement in the checking of controlled drugs stock and appropriate signing of registers.
- The controlled drug audit highlighted individual missed checks, drug errors, omissions and abbreviations of signatures. Where there were deficits, an action plan was compiled with target dates assigned. We saw that where appropriate further teaching was offered and competencies revisited.
- Pharmacy staff visited the ward daily from Monday to Friday to check current stock levels, review pre-assessment medications and discharge medications.
- Following previous concerns about discharge medication left in patient lockers, there had been a change in the discharge procedure, which included locker checks prior to the patient leaving the hospital. Staff told us that there had been no recent issues.
- We observed the prescription sheet of the patient whose surgical experience we followed and saw that medications had been clearly prescribed, dated and signed for in line with professional guidance.
- Staff informed us that an antimicrobial stewardship audit took place twice a year. Antimicrobial stewardship is a co-ordinated programme that promotes the appropriate use of antimicrobials (including antibiotics) to improve patient outcomes, reduce microbial resistance and decrease the spread of infections caused by resistant organisms.

Records

- Paper records were available for each patient that attended the hospital; the Duchy Hospital used a computerised patient administration system to book appointments and hold non- clinical information, however records and patient assessments were still paper based.
- At our previous inspection there had been some difficulties voiced by staff that on some occasions paper records were not available for staff at the time of

admission. Seven members of medical and nursing staff told us on this inspection that this had greatly improved and that staff now had the relevant information available with which to treat patients safely.
- Patient records were stored in a cupboard at the nurses station in the ward that could be locked, or were stored in secure areas.
- Computer screens were not visible for the public to observe and locked when staff were not in the area.
- We reviewed two set of major elective medical and nursing care records on the ward and two sets of minor surgery notes whilst on site. We found staff used black ink, legible handwriting, and the documentation occurred at the time of the review or administration of medication as in accordance with BMI policy and professional standards. We saw clear postoperative instructions for the inpatient ward staff as regards the patient whose operative experience we followed.
- At our last inspection we found consultants were not always making daily entries in the patients' medical record as is the requirement of practising privileges. At this inspection we found this had improved and the two sets of major elective records had daily entries by the consultant. The hospital leaders told us they were monitoring this and had made it clear the expectations for consultants to adhere to this requirement.

Safeguarding

- There had been no safeguarding concerns reported to the CQC since our previous inspection, and no referrals to the local authority regarding the welfare of young people or adults.
- When we previously inspected the location we saw there was a corporate safeguarding and protecting vulnerable people policy and procedure, which included guidance on safeguarding adults and children. However, we had been concerned about the interpretation of the implementation of the training element of the safeguarding children's section.
- At the last inspection, we were concerned that only the executive management team had completed level 3 safeguarding children training and it was unclear how information was cascaded to other staff. There was a perception that young people over 16 -18 were legally adults and some staff had been unaware of the roles and responsibilities in safeguarding this age group under the Children Act 2004.
- At this inspection we saw all registered nurses were trained to level three in safeguarding and those staff we spoke to on inspection understood that the 16-18 year old age group were still legally minors. In addition, there was greater awareness about issues which may affect young people such as sexual exploitation and the recent concerns around abuse in sports culture. The hospital did not provide treatment for children under the age of 16.
- At our last inspection, we found that not all staff understood what female genital mutilation was, and the mandatory responsibility of health staff to report this. (Mandatory Reporting of Female Genital Mutilation –Serious Crimes Act 2015) We found at this inspection that whilst there had been no incidents, staff knew about this issue and the reporting responsibilities for health staff.
- Staff told us female genital mutilation was now included in level three safeguarding children training.
- At our last inspection we found staff had received training in vulnerable adults and safeguarding children level 2 and compliance with this was high. This had continued and at this inspection safeguarding mandatory training was over 90%.

Mandatory training

- On our last inspection, we saw that there were no effective systems to ensure that mandatory training records for consultants and Resident Medical Officer had been reviewed. Since then, we saw the provider had created a practising privileges file where all consultant-training records were kept and monitored for mandatory training requirements on a monthly basis. Documentation showed that out of 91 consultants, who had practising privileges at the hospital, 83 were up to date with their mandatory training requirements and the provider advising of their mandatory training requirements had written to the other eight.
- Nine nursing and support staff we spoke with in the surgical areas told us that that they had both face to face and e- leaning training. Staff told us that if they chose to complete mandatory training in their own time, then they would be paid for it.
- At our last inspection we found the mandatory training completion was good with an overall compliance rate of 87.5%. This had continued and we had no concerns

about mandatory training compliance. We saw training was being monitored and information was being presented to leaders in the hospital to ensure there was the appropriate level of oversight of this.

Assessing patient risk

- During our last inspection in October 2016 we found the hospital was in breach of the requirements of the Health and Social Care Act (Regulated Activity) Regulations 2014 Regulation 12, Safe Care and Treatment. This was because of concerns relating to the use of the five steps to safer surgery including the World Health Organisation checklist. We found action had been taken and there was no longer a breach of this regulation.
- At our last inspection, we were concerned that the WHO 'Five Steps to Safer Surgery' had not been embedded in practice. On this inspection we saw that there was a new BMI Safer Surgery Policy which came into force in January 2017. This document provided clear instructions on the implementation and evaluation of safer surgical checking procedures. Executive staff told us that they had 'gone back to basics' to refocus staff which included consultant colleagues on the WHO Five Steps to Safer Surgery.
- We observed a safety briefing at the beginning of a theatre list. We saw that there was clear ownership of the process and all staff were attentive and gave the process due concern. The briefing included ascertaining staff members and roles, satisfaction with equipment, medicines checks and ensuring all staff knew about the patients on the theatre list, which included diagnosis and planned procedure, site and side of procedure, allergies and infection risk.
- We observed that communication between staff during the briefing, during the operation, post operatively was good and gave opportunity for professional challenge.
- We followed a patient's experience through the preoperative, operating and recovery process and observed that each stage of the WHO guidance and other processes were implemented comprehensively. Checks were clearly verbalised and documentation of all stages were completed appropriately in all sections.
- All patients attended a nurse-led pre-operative clinic and the assessment included observations such as blood pressure, review of medication and discussion and understanding of admission and forthcoming procedure.
- This assessment complied with the National Institute for Health and Care Excellence (NICE), guidelines on preoperative care. The patient completed a comprehensive health questionnaire prior to leaving the clinic. This included social information in order to assess care arrangements following discharge.
- Staff told us that the hospital adhered to the BMI Policy for Management and Operating Session for Elective and Scheduled Surgery (June 2016). This policy helped ensure that theatre lists did not overrun and enhanced patient safety through effective use of resources. In addition it was clear that anaesthetists remain in theatre until the last patient on the list has been taken to the ward from recovery
- We saw that patient allergies were checked prior to admission and prior to surgery. These were clearly documented in the patient records.
- The Duchy Hospital used the modified national early warning score (NEWS) tool for identifying deteriorating patients. Nursing staff we spoke with were able to articulate the use of this tool in the recognition of a deteriorating patient. At our previous inspection, we were concerned that there had been a slow response to an incident where mortality had occurred post operatively. As part of the subsequent action plan, there had been minimal training. At the inspection we saw that there had been regular sessions for staff and that these were now mandatory.
- We observed appropriate completion of the NEWS on following the patient experience. Six staff we spoke with could articulate the process and actions to take if they were concerned a patient's condition had deteriorated.
- Staff we spoke with were knowledgeable about sepsis pathways. These were found on the corporate website and we observed information in staff areas.
- All patients attended a nurse-led pre-operative clinic and the assessment included observations such as blood pressure, review of medication and discussion and understanding of admission and forthcoming procedure. This assessment complied with the National Institute for Health and Care Excellence (NICE) guidelines on preoperative care. The patient completed a comprehensive health questionnaire prior to leaving the clinic. This included social information in order to assess care arrangements following discharge.
- We saw on this inspection that patient questions regarding falls in the pre-assessment stage was audited monthly, and where there had been concerns about

appropriate completion, an action plan compiled. There had been clarification of the questions asked of patients in July 2017 with regard to patients who had reported blackouts and fainting episodes. We saw that there would be further training on this for those staff members who completed the audits.

- On this inspection, we observed that adherence with the assessment of VTE risk was audited monthly and an action plan compiled if concerns arose. A venous thromboembolism (VTE) is a blood clot, which forms in a vein, often in a leg, which can lead to harm to patients. The assessments took place in the pre – assessment stage of care. We saw from January to July 2017 there were no concerns raised about the correct completion of VTE risk in the surgical areas, and therefore no action plan was reviewed.
- There was a clear hospital policy in place for the emergency management of cardiopulmonary resuscitation and haemorrhage. Staff we spoke with had attended regular simulated cardiac arrest and haemorrhage scenarios so staff were able to respond quickly and be rehearsed should a real life emergency occur. These sessions were undertaken in both the ward and theatre areas alternatively and there had been one the week before our inspection.
- Blood products were available in the hospital for use in an emergency. A supply of blood for all blood groups could be ordered from a local NHS trust and arrived on site within a minimum time scale. Patients undergoing major surgery were cross matched for patient specific blood type in a pre-admissions clinic, so blood was available on site at all times during their stay. We saw that blood products were stored safely at an appropriate temperature.
- At our previous inspection, we saw that there was confusion about patient fasting times and patients were sometimes fasted longer than was necessary. On this inspection, we saw that there had been an update to the letter sent to patients prior to admission, and this included clear fasting instructions that adhered to national guidance. Six staff we spoke with could articulate this and the patient had been asked at the pre-operative process when they last ate solids and had clear fluids.
- Fasting times were audited monthly against national guidance and now scored highly at 100% for compliance to process.
- We spoke with the patient whose surgical experience we followed and he told us that he had received clear guidance in the pre –admission letter that he had followed. We saw that staff checked his adherence to this at the appropriate stages of the safer surgery checks.
- We saw that there had been six monthly audits as regards resuscitation arrangements. The January 2017 showed no requirement for an action plan and the July audit showed that there was the development of a procedure to access toilet areas in an emergency with a date of completion to be August 2017.

Nursing and support staffing

- At our last inspection in October 2016 we found the hospital was in breach of the requirements of the Health and Social Care Act (Regulated Activity) Regulations 2014 Regulation 18, Staffing because there were not always sufficient numbers of suitably skilled, qualitied and experienced nursing staff to meet patients' needs. We found action had been taken to address staffing areas and there was no longer a breach of this regulation.
- During this inspection we did not have the same level of concern. We saw how the hospital leaders had introduced daily reviews of staffing levels at the daily communication meeting. They were using the acuity tool to ensure they had the required skill mix depending on the patient caseload. Unlike at our October 2016 inspection, none of the staff we spoke with during this latest inspection raised any concerns about staffing levels.
- The hospital used a corporate dependency tool which was also used across the BMI group. The tool assessed the nursing staff requirements for a ward, a department and for each shift.
- During our last inspection we found concerns about how much nursing time was being taken away from the inpatient ward because nurses needed to take and collect patients from theatre. This was also an area of concern that was highlighted in a previous incident at the hospital. At this inspection we found a healthcare assistant had been employed to escort patients to theatre which had made a positive impact on the ward.
- At the time of the inspection, the inpatient wards had 9.4 Whole Time Equivalent (WTE) registered nursing posts and 2.6 WTE unqualified nursing posts.

Requires improvement

Surgery

- The overall vacancy rate for the hospital was 4.2% which was 2.72 WTE.
- The operating theatre department had 9.2 WTE registered nursing posts and 2.6 WTE unqualified nursing posts and operating department assistants. The overall vacancy rate for theatre was 17% which equated to 2 WTE.

Medical staffing

- Patient care was consultant led but there was a Resident Medical Officer (RMO) on duty 24/7 when patients were in the hospital. When we inspected in October 2016 we did not have any concerns about the arrangements for the provision of a RMO. This position did not change during this latest inspection.
- It was a requirement that consultants were able to be contacted 24hours a day if they had patients in the hospital and were able to return to the hospital within 30 minutes. There were systems in place to mitigate risk if the consultant was working in theatre at the local NHS trust so couldn't adhere to the 30 minute timescale.
- There was a 24 hours a day, seven day a week anaesthetic on call rota and an emergency service level agreement (SLA) transfer arrangements with the local NHS trust.

Emergency awareness and training

- The Duchy Hospital had a corporate BMI Healthcare business continuity policy which set out the minimum standards for preparedness and response required by all BMI facilities.
- At our inspection in October 2016 we saw there was a major incident plan in place. We did not review this again.
- There were fire evacuation tests and evacuation plans in place and an immediate link to the local fire station in case a fire broke out.
- At our last inspection we found the hospitals fire risk assessment was completed every three years and was in date. However, the internal review was out of date at that time of the inspection. In addition there were a number of risks that had been identified which had not been addressed. At this inspection we found this had been updated and risks had been militated against.

Are surgery services effective?

Start here...

Are surgery services caring?

Start here...

Are surgery services responsive?

Start here...

Are surgery services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Vision and strategy for this core service

- BMI hospitals had a corporate operational plan which included strategic objectives. The new executive leadership team had developed a new strategy for the hospital.
- At our last inspection, staff could not always tell us about the vision and strategy of the Duchy Hospital. During this inspection we found staff felt more included in the management and leadership of the hospital. They did not have specific comments about the hospital's vision but there was a general sense that the new leadership team had taken control of some of the problems the hospital had faced and were making progress.
- The Duchy Hospital leaders told us they had started different types of initiatives to communicate with staff so they were much more informed and engaged with the strategy of the hospital. However, they knew they had more work to do with this and were not complacent that this work was completed.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- At our last inspection in October 2016 we found the Duchy Hospital was in breach of the requirements of the Health and Social Care Act (Regulated Activity) Regulations 2014 Regulation 17; Good Governance. This

was because the governance system was not operated effectively. We found action had been taken to address staffing areas and there was no longer a breach of this regulation.

- The executive leadership team told us although staff were really disappointed with the outcome of the last inspection they had used the findings to reflect, identify and change their ways for the benefit of patient's staff and stakeholders.
- When we inspected in October 2016 we raised concerns about the hospitals risk register. During this inspection we found there had been significant improvements to the risk register. There were now departmental risk registers in place as well as a hospital wide register. All risks had dates of entry and review dates in place. All risks had mitigating actions and progress against the actions was being monitored.
- The risk register reflected the issues the hospital faced and, unlike at the last inspection, we did not find any risks which were not on the risk register.
- Following the last inspection, the Duchy Hospital had a revised governance structure in place. This new structure had been reviewed in June 2017 and there was now one overarching governance committee which met bi monthly. The membership of that committee had been reviewed and strengthened and was chaired by the hospital's Executive Director and had consultant and clinical representation.
- There were a number of other groups/committees in place such as the water safety group and the medicines management committee which each reported to the Governance Committee.
- The hospital had introduced a new electronic incident reporting system. This had made a positive impact on the way incidents were being reported and managed in the hospital. Staff had received training on how to use the new system and there was a quality and risk manager in place who had oversight of the process. We noted this was only a temporary post, but an application had been made to head office to make turn this role into a substantive position.
- The Medical Advisory Committee (MAC) meetings had continued since the last inspection and were held bi monthly.
- When we inspected in October 2016 we did not have any concerns about the process for issuing practising privileges. We found no evidence on this inspection to suggest this position had changed.

Leadership / culture of service related to this core service

- At our last inspection in October 2016 we found the Duchy Hospital was in breach of the requirements of the Health and Social Care Act (Regulated Activity) Regulations 2014 Regulation 17; Good Governance. This was because the provider had not acted on the poor staff survey results or low staff morale. Staff were also concerned to speak out and there was no plan to address the cultural concerns.
- Following the last inspection the leadership of the Duchy Hospital had changed. In March 2017 a new interim executive director and registered manager took up post at the hospital along with a new interim director of operations. An interim director of clinical services took up post in April 2017. The team had a clear plan of what they needed to do to improve the culture of the Duchy Hospital.
- The executive leadership team appeared to work well together and were committed to seeing improvements for both the staff and for the patients. They had made many changes within a short space of time and we could see from our observations and discussions with staff that these had had a positive impact. However, the leadership team knew they had more work to do and needed to ensure changes were embedded into practice.
- All staff told us they felt supported by the interim leadership team. We also saw some written comments sent into the executive team about their leadership team which stated they felt supported and were also supportive of the changes they were making.
- We saw a significant improvement in staff morale at this inspection. Staff told us the culture was much better because there had been changes brought in by the new team. We found this very evident in the theatre and ward areas as their working relationships were much improved.
- Staff told us that they felt comfortable to report incidents without recriminations. They told us there had been an element of concern previously. Staff told us the new leaders had created a more open culture.
- The leadership team told us they wanted to create an open, honest, transparent working environment and tackle the obstacles to making changes for the better.

- We observed effective communication between staff throughout the inspection and staff talked to each other in a respectful manner.
- At the last inspection we raised concerns about the hospital's approach to workforce race equality standards (WRES). The WRES is a requirement for some independent hospitals where they are providing NHS services. There had been no audits, assessment or consultation with staff working at the hospital therefore the data on the WRES indicator could not be collected. At this inspection we found some improvements had been made. The hospital now had data regarding the age, ethnicity and gender of staff but did not collect staffs religion or belief and sexual orientation.
- Whilst they acknowledged their collection of WRES data was not in line with all of the expected requirements, BMI Healthcare had developed a national action plan to address this. The Executive Director had taken a lead role for WRES but there was no published WRES report for the hospital or for BMI healthcare nationally.
- During our conversations with staff we did not receive any concerns about discriminatory practice.

Public and staff engagement (local and service level if this is the main core service)

- The new leadership team had undertaken a range of staff engagement exercises in order to gain feedback from staff. They had talked with staff about expectations and behaviours and the visibility of leaders as role models.
- Staff forums, listening posts, one to ones and engagement meetings with the Royal College of Nursing had taken place. These were all methods that the leadership team were using to encourage staff to raise concerns and get involved in the running of the hospital.
- The new executive leadership team told us they were aware they needed to develop an outward looking approach and interact with key stakeholders and patients. They had spoken with the local Healthwatch and were embarking on ways to work more closely with them in the future. This was still work which required further development.
- We spoke with two consultants who both told us they felt the new leadership team had made positive improvements. Relationships with the executive team were described as good.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The new leadership team had implemented a quality improvement programme in June 2017 based on ten areas; standardise and improve the environment, ensure we are clean and safe, care and compassion, improve and standardise documentation, train and develop our staff, improve communication, have the right numbers of staff in the right place, focus on dementia, standardise operations and adhere to clinical standards.
- This programme was in the early stages of implementation and was being overseen by the executive leadership team.

Requires improvement

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	
Responsive	
Well-led	Requires improvement

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

The main service provided by this hospital was surgery services. Where our findings for outpatient services are the same as the surgery service we do not repeat the evidence but cross refer to the surgery services section.

Incidents

- Since the last inspection in October 2016, there were no never events reported in the outpatient service. Never events are serious patient safety that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need have happened for an incident to be a never event.
- In the same reporting period, the hospital reported no serious incidents. Serious incidents are incidents that require reporting and further investigation.
- In the same reporting period there were no non-clinical incidents reported within outpatients and diagnostic imaging service.
- All staff we spoke to in outpatients and diagnostic imaging were aware of the new system for reporting incidents and how to report incidents.
- We attended the daily communication meeting where we observed representatives from each hospital department discussing current risks, previous incidents, staffing levels, hospital information, staff and patient feedback and complaints.
- See Surgery section for main findings.

Cleanliness, infection control and hygiene

- At our last inspection in October 2016 we found the Duchy Hospital was in breach of the requirements of the Health and Social Care Act (Regulated Activity) Regulations 2014 Regulation 12, Safe Care and Treatment. This was because of concerns relating to the use of the minor procedure room. We found action had been taken and there was no longer a breach of this regulation.
- During the inspection in October 2016, we found staff were conducting procedures in the minor treatment room despite the room not complying with the requirements of Health Technical Memorandum (HTM) 03-01 specialised ventilation for healthcare premises. Since this inspection, the staff had reviewed the list of procedures that were conducted and had moved some of these procedures to the main theatres where the environment was more suitable. Procedures which had now been moved included cystoscopies and intravitreal injections as required under specialist ventilation.
- Staff told us the minor procedure room was still used for wound reviews, removal of clips and sutures, removal of small cysts and lesions and bladder instillations. The lead nurse for IPC had risk assessed the use of the room for these procedures and deemed it as a low risk. Staff from the department told us once the current refurbishment work had been completed, they planned to put a business case in to refurbish the minor procedure room so that it was compliant with HTM 03-01 and more procedures could be completed in this room. There was no time frame given for this work.
- The hand-washing sink in the minor procedure room was still non-compliant against Health Building Note (HBN) 00-09 infection control in the built environment. Staff told us there were no plans to refurbish this room

at present as any refurbishment would be included in the business case that would be written for complete refurbishment of this room. Staff continued to use the scrub sink located in this room for hand washing.

- The outpatient department was visibly clean and tidy despite refurbishment work being conducted during our inspection.
- There were hand hygiene promotion posters around the ward area and outpatient department, which were based on the World Health Organisation (WHO) five moments of hand hygiene. Alcohol gel was available within the department and at the point of care. During our inspection, the lead nurse for IPC was reviewing the department for placing new alcohol gel dispensers.
- We saw staff were washing their hands between patient contact.
- The consulting rooms were undergoing refurbishment at the time of our inspection to have the carpet replaced with flooring which was compliant with HBN 00-09 infection control in the built environment.
- Staff told us the department was cleaned once a day, however if additional cleaning was required, especially due to additional dust and dirt created by the refurbishment works going on, the cleaners were available onsite and would attend to provide further cleaning.
- We observed adequate amounts of wipes used for decontaminating items of equipment around the outpatient department, which were readily available for staff to use.
- The clinical hand-washing sink in the dirty utility did not comply with HBN 00-09 infection control in the built environment, as this was located within a worktop and not free standing as guidance suggests. Staff told us this sink was due to be replaced as part of the on-going refurbishment work.
- For our detailed findings on cleanliness, infection control and hygiene please see the Safe section in the surgery report.

Environment and equipment

- The resuscitation equipment was checked on a daily basis which involved the checking the cleanliness of the equipment. However, during our inspection, we found a layer of dust on the top of the trolley.
- We reviewed the examination couch in the minor procedures room; this was clean and in a good state of repair.
- All cystoscopies which were identified at the last inspection as being undertaken in the minor procedure room were now undertaken in theatre. This new practice had commenced since 02 February 2017.
- Staff had previously raised concerns about the lamp in the minor procedure room, which was used during some dermatology procedures. Staff said the lamp was difficult to move and became very hot. We reviewed the lamp at our previous inspection and found the safety checks were overdue and should have been completed in April 2016. We informed the outpatient manager who arranged to have the lamp reviewed. During this inspection, we observed the lamp had been serviced and was now easily moveable.

Medicines

- We checked the storage of medications in the departments we visited. We found medications were stored securely in appropriately locked rooms and fridges. No controlled drugs were stored in the department.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. We saw minimum and maximum fridge temperatures were recorded daily and were within the correct range.
- See surgery section for main findings

Records

- Paper records were used in the outpatient department and physiotherapy department. The radiology department used a mixture of electronic and paper records.
- During the last inspection, we observed the hospital had a medical records department that was responsible for filing, storing and maintaining patient records. We visited the medical records department, and found the room that stored patient records was open and could be accessed. There was a risk that confidential patient information could be accessed.
- At this inspection, we saw the medical records room was locked and there was a sign on the door reminding staff to keep the door locked.
- We had previously seen the physiotherapy department; patient records were stored in cabinets in a locked room behind the reception desk. When we visited the department on the unannounced inspection which we

conducted as part of our previous inspection, the door was open and the reception desk un-attended. Therefore, confidential patient information could be accessed.
- During this inspection, the door was closed and locked. The provider had also introduced a device to ensure the door closed automatically when staff left the room.

Safeguarding

- Since the last inspection, no safeguarding incidents had been raised
- During this inspection, we spoke with five members staff in outpatients, physiotherapy and the radiology department, all the staff we spoke to said that female genital mutilation (FGM) was part of their safeguarding training and were able to tell us what they would do should they witness a patient had undergone this illegal procedure.
- See surgery section for main findings

Mandatory training

- During the last inspection, it was found the provider did not have an effective process for ensuring mandatory training records for consultants and RMOs were reviewed. Since then, we saw the provider had created a practising privileges file where all consultant training records were kept and monitored for mandatory training requirements on a monthly basis. Documentation showed that out of 91 consultants, who had practising privileges at the hospital, 83 were up to date with their mandatory training requirements and the other eight had been written to by the provider advising of their mandatory training requirements.
- Data showed that training compliance in duty of candour for the outpatients department for 2017 was 35%, for the physiotherapy department it was 33% and for the imaging department was 0% against the provider target of 90% The executive management team advised us that the trainer who had delivered the duty of candour training sessions had moved onto a different role within the organisation and was no longer available to deliver this. However, documentation showed that arrangements had been made for the director of clinical services to deliver the training commencing September and October 2017 to all departments.
- During this inspection data showed training on the information technology application for reporting risks and incidents introduced in December 2016 stood at 100% compliance for the outpatients department for 2017, 100% compliance for the physiotherapy department and 50% for the imaging department against the provider target of 90%.

Assessing and responding to patient risk

- The five steps to safer surgery, including the World Health Organisation (WHO) surgical safety checklist, is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. The outpatient department used a modified version of this checklist for patients who were undergoing minor procedures. During the last inspection, we reviewed 12 sets of records in outpatients and found the WHO checklist was incomplete in nine sets of records.
- During this inspection, nine out of the 10 cases we looked at were completed correctly. However, one WHO checklist was not completed correctly because we noted on a minor procedures column that not all of the boxes were initialled by the surgeon and the accompanying nurse. We escalated this to the person in charge who said they would address this.
- At our last inspection we raised concerns because we found not all patients attending the outpatient department for a minor procedure under local anaesthetic had their observations recorded before or after the procedure. We saw this had improved and all patients had their observations recorded pre and post procedure.

Nursing and support staffing

- See surgery section for main findings
- The outpatient area had 3.16 Whole Time Equivalent (WTE) registered nursing posts and 2.45 WTE unqualified nursing posts. There were no vacancies at the time of the inspection.

Medical staffing

- See surgery section for main findings

Emergency awareness and training

- See surgery section for main findings

Are outpatients and diagnostic imaging services effective?

Start here...

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Start here...

Are outpatients and diagnostic imaging services responsive?

Start here...

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as **requires improvement.**

The main service provided by this hospital was surgery services. Where our findings for outpatient services are the same as the surgery service we do not repeat the evidence but cross refer to the surgery services section.

Vision and strategy for this core service

- See Surgery section for main findings

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- See Surgery section for main findings
- When we inspected in October 2016 we raised concerns about the hospital's risk register. During this inspection we found there had been significant improvements to the risk register. There was an outpatient risk register in place as well as a hospital wide register. All risks had dates of entry and review dates in place. All risks had mitigating actions and progress against the actions was being monitored.
- The risk register reflected the issues the hospital faced and, unlike at the last inspection, we did not find any risks which were not on the risk register.

Leadership / culture of service related to this core service

- See Surgery section for main findings.
- Staff working in outpatients told us there had been improvements in the leadership of the hospital.
- All staff told us they felt supported by the interim leadership team.

Public and staff engagement (local and service level if this is the main core service)

- See Surgery section for main findings.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- See Surgery section for main findings.

Action the provider SHOULD take to improve

- The provider should ensure they take action to be compliant with the requirements of the WRES.
- The provider should ensure the hand-washing sink in the minor procedure room is changed to make it compliant against Health Building Note (HBN) 00-09 infection control in the built environment.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure they take action to be compliant with the requirements of the WRES
- The provider should ensure the hand-washing sink in the minor procedure room is changed to make it compliant against Health Building Note (HBN) 00-09 infection control in the built environment.