BMI The Huddersfield Hospital

Quality Report

Birkby Hall Road
Birkby
Huddersfield
HD2 2BL
Tel: 01484 533131
Website: https://www.bmihealthcare.co.uk/hospitals/bmi-the-huddersfield-hospital

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

Overall summary

BMI The Huddersfield Hospital is operated by BMI Healthcare Limited. The hospital/service has 29 beds. Facilities include two operating theatres, X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, outpatients and diagnostic imaging for adults. We inspected surgery, outpatients and diagnostic services.

Summary of findings

We inspected this service using our comprehensive inspection methodology. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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.

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 report.

Services we rate

Our rating of this hospital/service stayed the same. We rated it as **Requires improvement** overall.

We found areas of practice that require improvement in the services for surgery:

- The requirements of the duty of candour regulation was not met in two cases we reviewed, actions taken did not comply with the requirements or with BMI policy. Patients did not consistently receive written information or were informed of the findings from the incident investigation. Leaders did not consistently ensure that duty of candour requirements were completed in line with regulatory requirements.
- The design, maintenance and use of facilities, premises and equipment did not keep people safe. The service did not always control infection risk well. While the environment and equipment were visibly clean, the premises were damaged, and wall and floor coverings were not always intact.
- Staff could not clearly articulate how and when to assess whether a patient had the capacity to make decisions about their care or deprivation of liberty safeguards. Records we reviewed did not provide assurance that patients were consented in line with best practice and professional standards.
- Leaders had the skills and abilities to run the service. However, there was some instability and change in terms of gaps in the senior leadership team at the time of inspection, once fully recruited, the team would need a further period to embed to be consistently effective.
- Leaders operated clear governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, due to the instability of the management team these required a further period to embed to be consistently effective.
- The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.
- Staff we spoke with said they felt respected, supported and valued. However, the hospitals own staff survey results did not correlate this view.
- Data we reviewed showed that the organisation was not consistently timely with the complaint investigation response.

We found areas of practice that require improvement in in relation to outpatient care:

- The design, maintenance and use of facilities, premises and equipment did not always help to keep people safe.
- The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience available to provide the right care and treatment.
- Staff kept records of patients' care and treatment. However, these were not always clear, up to date or stored securely.

However, we found the following areas of good practice in diagnostic imaging:

Summary of findings

- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff assessed risks for each patient and ensured they were removed or minimised.
- The service provided care and treatment based on national guidance and best practice.
- Leaders had the skills and abilities to run the service.

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 service improve. We also issued the provider with three requirement notice(s) that affected the core services of surgery and outpatients. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	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. We rated this service as requires improvement because it was not consistently safe, effective, responsive or well-led.
Outpatients	Good 	Outpatients services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good. We found the service was effective, caring, responsive and well led.
Diagnostic imaging	Good 	Diagnostic services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good. We found the service was safe, effective, caring, responsive and well led.

Summary of findings

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Requires improvement

BMI The Huddersfield Hospital

Services we looked at
Surgery; Outpatients; Diagnostic imaging;

Summary of this inspection

Background to BMI The Huddersfield Hospital

BMI The Huddersfield Hospital is operated by BMI Healthcare Limited. The hospital opened in 2008. It is a private hospital in Huddersfield, West Yorkshire. The hospital primarily serves the communities of Huddersfield and the surrounding areas of West Yorkshire.

At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in 2018.

Our inspection team

The team that inspected the service comprised of CQC advisors with expertise in theatre, outpatients and diagnostics, a lead inspector, four other CQC inspectors and an assistant inspector. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about BMI The Huddersfield Hospital

The hospital has two wards, only one ward is used for day cases and overnight inpatients. The hospital has 29 beds. Facilities also include two operating theatres, X-ray, outpatient and diagnostic facilities. Surgical services provide elective and day case surgery covering various surgical specialities including breast, colorectal, ear, nose and throat (ENT), general surgery, gynaecology, orthopaedics, ophthalmology, upper gastro-intestinal and urology.

There was a small on-site pathology service.

The hospital is registered to provide the following regulated activities:

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

The hospital also offers cosmetic procedures, such as breast and facial surgery, we inspected these services as part of our surgical inspection.

We last inspected services at this location in February 2016. At that time, we found that the location required improvement.

During this inspection, we inspected surgery, diagnostics and outpatients' services and for each, asked if services were safe, effective, caring, responsive and well led.

During the inspection, we visited the inpatients ward, outpatients, diagnostic areas and theatre area. We spoke with 27 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 24 patients. During our inspection, we reviewed 29 sets of patient records and we reviewed five patient complaints.

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 four times, and the most recent inspection took place in February 2016, which found that the hospital was rated as requires improvement.

Activity (January 2018 to December 2018)

- In the reporting period January 2018 to December 2018. There were 470 inpatients and 2854-day case episodes of care recorded at the hospital; of these 82% were NHS-funded and 18% non-NHS funded.

Summary of this inspection

- There were 11,098 outpatient total attendances in the reporting period; of these 27% were other funded and 73% were NHS-funded.

As of January 2019, 87 surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. The term "practising privileges" refers to medical practitioners not directly employed by the hospital, but who have been approved to practice there. Two regular resident medical officers (RMO) worked a one week on and one week off rota. The accountable officer for controlled drugs (CDs) was the registered manager.

There were 67 staff employed within the hospital, with 14.7 whole time equivalent (WTE) registered nurses, 12.7 WTE Operating department practitioner and health care assistants and 37.9 WTE other staff such as receptionist, maintenance and radiology staff. The hospital also had its own bank staff.

Track record on safety (Reporting period January 2018 to December 2018)

- There had been no never events reported in the period January 2018 to December 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- 324 clinical incidents had been reported across the hospital in this time frame. Of these, 271 had been classified as no harm, 52 as low harm, 4 as moderate harm, no severe harm, no deaths.
- Senior leaders reported two serious incidents requiring further investigation.
- There had been no cases of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (C. diff) or hospital acquired E-Coli bacteraemia, at the hospital in the reporting period.
- The hospital received 50 complaints, in the same reporting period.

Services accredited by a national body:

- None

Services provided at the hospital under service level agreement:

- Catering
- Pathology and Histology
- Microbiology advice
- Laundry
- Resident medical officers
- Medical records storage
- Ground maintenance
- Medical devices management
- Clinical and or non-clinical waste removal
- Agency staffing
- Medical gases

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:

We found the following issues that the service provider needs to improve:

- The requirements of the duty of candour regulation was not met in two cases we reviewed, actions taken did not comply with the requirements or with BMI policy. Patients did not consistently receive written information or were informed of the findings from the incident investigation.
- The design, maintenance and use of facilities, premises and equipment did not keep people safe. The service did not always control infection risk well. While the environment and equipment were visibly clean, the premises were damaged, and wall and floor coverings were not always intact.
- Within outpatients the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience available to provide the right care and treatment.
- Within outpatient's staff kept records of patients' care and treatment. However, these were not always clear, up to date or stored securely.
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- The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.

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

- The service provided mandatory training in key skills to all staff.
- 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.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Are services effective?

Requires improvement

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

We found the following issues that the service provider needs to improve:

Summary of this inspection

- Staff could not clearly articulate how and when to assess whether a patient had the capacity to make decisions about their care or deprivation of liberty safeguards.
- Records we reviewed showed that patients were not consistently consented in line with the organisations policy, best practice or professional standards.

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

- The service provided care and treatment based on national guidance and best practice.
- Staff offered patients enough food and drink to meet their needs.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Are services caring?

Good

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

We found the following areas of good practice:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Requires improvement

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

We found the found the following issues that the service provider needs to improve:

- The service was inclusive and took account of patients' individual needs and preferences. However, the environment was not always suitable for all patients living with dementia or with mobility issues.
- Data we reviewed showed that the organisation was not consistently timely with the investigation response.

However, we also the following areas of good practice:

- People could access the service when they needed it and received the right care promptly. Waiting times from referral to

Summary of this inspection

treatment and arrangements to admit, treat and discharge patients were in line with national standards. It was easy for people to give feedback and raise concerns about care received.

Are services well-led?

Requires improvement

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

We found the following issues that the service provider needs to improve:

- Staff we spoke with said they felt respected, supported and valued. However, the hospitals own staff survey results did not correlate this view.
- Leaders had the skills and abilities to run the service, however there was some instability and change in terms of gaps in the senior leadership team at the time of the inspection. The leadership team required a further period to be consistently effective.
- Leaders operated clear governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, due to instability and change in the senior leadership team, it required a further period to be consistently effective.
- Leaders did not consistently ensure that duty of candour requirements were completed in line with regulatory requirements.

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

- The service had a vision for what it wanted to achieve and plans to achieve it.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

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.

Our rating of safe stayed the same. We rated it as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- The hospital had a system to ensure staff received mandatory training, there were two different types of training, e-learning and face to face training. Mandatory training included, but not limited to; immediate life support, consent, infection prevention, safeguarding level 1 and level 2 and equality and diversity.
- All staff that we spoke to said they had completed their mandatory training or were booked onto outstanding courses.
- We reviewed nursing training data this showed that compliance was currently 100% at May 2019, against a hospital compliance rate of 100%.
- Training compliance rates for consultant medical and dental staff was not recorded. Staff we spoke with said that consultant staff attended mandatory training at the employing NHS trust, which was their main employer, and this was evidenced and monitored through the appraisal process. However, consultant files we reviewed showed that at the time of the inspection, there was not an effective system of monitoring this. During the inspection, the service contacted all consultants and asked them to share this information.
- Bank staff undertook the same mandatory training as permanent staff.
- All residential medical officers (RMOs) were employed through a national agency and completed mandatory training with the agency. The hospital received confirmation of the training and kept a record of attendance. We reviewed the staff file for the RMO which showed compliance with the key aspects of training required.

Safeguarding

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.

- The service had systems in place for the identification and management of adults and children at risk of abuse.
- Staff we spoke with said that they had completed adult and children's safeguarding as part of their mandatory training. Nursing staff received safeguarding vulnerable adults and children training to level two. Level three training had been completed by the clinical lead for safeguarding.
- Staff we spoke with also said that the hospitals safeguarding lead was accessible and supportive when staff needed advice about safeguarding concerns.

Requires improvement

Surgery

- The hospital had a safeguarding policy which was accessible on the intranet, which detailed the different types of abuse, and issues which staff should report. Staff we spoke with were aware of what could potentially be a safeguarding concern and knew how to raise them.
- We reviewed training data this showed that compliance was currently 100% at May 2019, against a hospital compliance rate of 100%.
- There had been two reported safeguarding alerts made in the reporting period, April 2018 to April 2019. Staff we spoke with could provide examples of safeguarding such as when a patient raised concerns about a care home and examples of domestic violence.
- The level of training completed by consultants working at the hospital was not formally recorded at the time of the inspection. Following the inspection, the service contacted all consultants and asked them to share this information.
- We spoke with staff in theatres and on the ward; all staff could describe their role in relation to identifying and reporting a safeguarding concern. If unsure, staff said they would escalate this to the unit manager or contact the safeguarding lead for advice.
- Safeguarding training included units on female genital mutilation (FGM), chaperoning and PREVENT (intended to identify and reduce radicalisation). Staff were aware of FGM and understood their responsibilities to report any cases.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. While the environment and equipment were visibly clean, the premises were damaged, and wall, floor and ceiling coverings were not always intact.

- At this inspection, we found the wards and departments we visited visibly clean and tidy. We reviewed patient led assessments of the care environment (PLACE) reports 2018, for the hospital and noted 99.3% compliance for cleanliness better than the 98.5% England average.
- During our inspection, we saw room cleaning audits completed between January 2019 to May 2019 the ward averaged 96% compliance.
- The hospital had an infection, prevention and control policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination and personal protective clothing.
- The hospital had access to a specialist infection prevention and control nurse (ICPN), they were based off site, however visited the site on a weekly basis. The IPCN was supported by an infection control doctor via a service level agreement (SLA) from the local NHS trust and a director of infection prevention and control (DIPC), employed within the hospital.
- All staff completed infection prevention and control training as part of their mandatory training programme. Training data provided by the hospital showed 100% compliance May 2019.
- The hospital reported zero cases of hospital acquired MRSA from April 2017 to March 2018. The hospital reported zero cases of hospital attributed Clostridium difficile (C. diff) in the same reporting period.
- The hospital had a policy to screen surgical patients for MRSA and some patients for methicillin-sensitive staphylococcus aureus as per best practice guidance.
- The hospital carried out surgical site infection surveillance. They participated in national orthopaedic surveillance for hip and knee replacement.
- The hospital participated in national surgical site infection surveillance, data we reviewed from the reporting period January 2018 to December 2018, showed no patients had reported an infection following primary hip replacement surgery, out of 126 operations performed. Primary knee replacement surgery showed no patients had reported an infection following surgery, out of 254 operations performed.
- Information supplied by the hospital we reviewed showed that the hospital reported:
  - Five surgical site infections following other orthopaedic surgery out of 1,032 operations.
  - One surgical site infection following Gynaecology surgery out of 332 operations.
  - Four surgical site infections following upper GI and colorectal surgery out of 391 operations.

- Three surgical site infections following urology surgery out of 407 operations.
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  No spinal, breast or vascular surgical surgery infections were reported

- During the inspection, we observed that ward and theatre staff were compliant with hand hygiene policies, including 'bare below the elbows' and personal protective clothing policies. Staff had access to at the point of use alcohol gel. The hospital audited hand hygiene compliance using observational hand hygiene audits, results from September 2018 to January 2019 showed that the ward scored 72% compliance and theatres were 100% compliant. The results of the audits were reported quarterly through the IPC committee.
- During the inspection, we identified a number of consultants who were non- compliant with bare below the elbows and hand hygiene, we reported this at the time and the senior leadership team, took immediate action to improve compliance.
- We inspected reusable equipment stored on the ward, and all items appeared to be visibly clean and ready for use. We reviewed five pieces of reusable clinical equipment and found these to be clean.
- Staff we spoke with said that they had access to appropriate personal protective clothing (PPE).
- We saw processes for segregation of waste including clinical waste. Staff were able to segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment. Sharps bins in the areas visited were secure and stored off the floor. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.
- Rooms were available for patients requiring isolation, during the inspection, no patients required isolation.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

- At the time of the inspection, six rooms did not have access to bath or shower facilities and the inpatient ward did not currently have a communal bathroom to enable patients to shower. Staff we spoke with said that they chose specific patients to go into these rooms who could not shower or would just be a day case. The patient satisfaction survey 2019, reported only 75.7% satisfaction with the bathroom facilities on the inpatient unit and 79% overall impression of the accommodation provided.
- The fixtures and fittings on the ward were damaged with peeling laminate, damaged paintwork, woodwork and wall surfaces. We reviewed 12 doors they were all damaged, some with bare wood showing. We saw damage with rust on radiator covers, peeling paintwork, damage to architraves and chips and holes in walls. Five bed tables and patient lockers we reviewed were damaged, with peeling laminate, exposing bare wood. Cupboards in two bathrooms were damaged, exposing bare wood. This made the environment difficult to keep clean and did not provide assurance of compliance with Department of Health and Social Care health building notes.
- The bedrooms and bathrooms that had been refurbished were small, but in good condition.
- Bathrooms were not accessible to all, for example they were not wheelchair friendly.
- At the time of the inspection, staff working within the hospital, acknowledged that the estate and facilities provided at the hospital required further refurbishment. Some refurbishment had occurred, and detailed plans were available for further refurbishment. However due to financial constraints no agreed dates or finances had been allocated to commence the work.
- < >suscitation equipment was regularly checked and tested consistently and in line with hospital policy. Equipment we reviewed was clean, tidy, ready for use and staff had checked the equipment on the majority of occasions. Trolleys we inspected were sealed, appropriately stocked and equipment was in date. We reviewed annual ventilation and verification report for the ventilation and theatre environment and saw that inspection had been carried out in March 2019, some maintenance work was identified as being required, this had been completed and further testing arranged. Staff we spoke with said that they had adequate stocks of equipment and we saw evidence of stock rotation.

Requires improvement

Surgery

- We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted 89.6% compliance for condition, appearance and maintenance were worse than the 94.3% England average.
- We found that cleaning chemicals were locked securely in the sluice room.
- We checked five pieces of equipment including blood pressure machines, and suction machines. All equipment had visible evidence of safety testing and when servicing was next due.
- Point of care testing equipment was regularly calibrated and checked.

Assessing and responding to patient risk

Staff completed and updates risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

- Although staff acknowledged recent deterioration in the compliance with the five steps to safer surgery, during the inspection we observed two occasions when the surgical checklist was in use, on both the occasions this was effective, and appropriate. We reviewed four sets of completed checklists in patient records and saw that these were completed appropriately at the time of the operation. We asked to review internal compliance data of the checks by the hospital, this showed 100% compliance, for July 2018 to April 2019.
- Patient safety briefings were carried out pre-operatively these included introductions from the clinical team, the order of the list, additional equipment anticipated and the addition of emergency patients.
- During this inspection, the hospital used the national early warning score (NEWS 2) tool. Nursing staff escalated any patient of concern to medical staff. Nursing staff we spoke with could articulate the deteriorating patient and were able to describe when they would escalate to medical staff. An internal audit scored 100% between January 2019 and March 2019. However, as part of this audit it was recognised that the pain and nausea pathways were not getting completed consistently, on average 82.5% were completed, this dropped to 60% in March 2019. The ward had completed an action plan to improve compliance.
- We reviewed four sets of medical records, no patients we reviewed required escalation. We asked to review internal compliance data of the checks by the hospital, this showed that the hospital achieved 100% compliance in the September to December 2018 audits.
- Staff had access to a sepsis response box, this contained key equipment and guidance for identifying and managing sepsis. Staff also had access to a sepsis screening and action tool. During the inspection, no patients were being treated for sepsis, so we were unable to review notes to see if the toolkit was used effectively.
- Staff we spoke with said that they had received sepsis training and staff we spoke with could articulate the signs of sepsis and were aware of actions required for escalation and treatment. At the time of the inspection, no patients were on a sepsis pathway, so we were not able to review any records of patients on sepsis pathways.
- We reviewed risk assessments including venous thromboembolism (VTE), pressure damage acquisition, malnutrition, falls, bed rails, moving and handling we found that on most of occasions these were completed.
- The hospital had a service level agreement with a local NHS trust to transfer patients in the event of an emergency or if a deteriorating patient required an increased level of care. Data we reviewed showed four patients had been transferred to NHS care between October 2017 to September 2018.
- Data we reviewed showed that five patients were re-admitted to the hospital between October 2017 to September 2018. We reviewed information provided by the service which showed that in all cases, patients had been re-admitted for further treatment and management.
- The hospital operated a 24-hour, on call service for unplanned returns to theatre. A team was available and would attend within 30 minutes. Data we reviewed showed no patients had an unplanned return to theatre from October 2017 to September 2018.
- An RMO was on duty 24 hours a day, seven days a week to respond to any concerns staff might have regarding a patient's clinical condition.

- Theatres were available seven days a week, with out of hours cover provided by an on-call team. Swab boards were used in theatre to record swab counts. Staff also used a paper record, which was attached to the patient's record.
- The hospital undertook regular simulated scenarios with clinical staff including cardiac arrest call, major haemorrhage and stabilisation in theatres. Two units of blood were available on site, should patients require emergency blood. Data we reviewed for the major haemorrhage policy showed this had been tested in November 2018.
- At discharge, patients were given contact details for both wards and advised to contact if they had concerns.

Nursing and support 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff an induction.

- Senior nursing staff used an organisational wide staffing skill mix tool based on the dependency of patients. Staffing rotas, we reviewed showed that the inpatient ward was staffed in line with the number of patients admitted.
- At this inspection, we reviewed duty rotas over the previous three months we examined 54 shifts. Data showed that the inpatient ward was staffed by two registered nurses (minimum) on all shifts, registered nurses were supported by healthcare assistants on the majority of day and evening shifts. Overnight, two registered nurses were on duty. The hospital had on average 10-day cases and two inpatients per day. Data ranged from zero to 17-day cases and zero to six inpatients March 2019 to May 2019.
- We also reviewed data which showed the number of cases being operated on in a month this ranged from 51 to 81 inpatients per month from January 2018 to December 2018.
- A weekly capacity meeting was held to review the following week's activity and plan staffing levels accordingly. Staff were flexed according to patient need and bank staff were utilised when required to ensure the appropriate number of staff were on duty.
- Staff held two site meetings every morning, Monday to Friday. The daily communication cell meeting included a representative from all areas. The meeting reviewed the number of inpatients, expected admissions and discharges, as well as key issues for the departments that day.
- The inpatient department had 10 whole time equivalent (WTE) registered nurses and 3.1 WTE health care assistants. The use of bank staff in the inpatient departments was low with an average use of 1.5% for registered nurses in the reporting period January 2018 to December 2019. The inpatient ward area did not use any agency staff in the same reporting period. Substantive ward staff worked additional hours as required. The theatre department had 3 WTE registered nursing posts and 8.1 WTE healthcare assistant and operating department practitioner posts (ODPs). The use of bank and agency staff ranged from 0% to 4% for registered nursing staff and 0% to 10% for ODPs and HCA's.On the majority of occasions staffing levels in theatres were in line with the national recommendations for safe peri-operative care (AfPP) 2016.
- The hospital had an annual vacancy rate of 23% for nursing and midwifery and 38.31% for ODPs and HCA's in theatres.
- Pre- the inspection, information supplied to us by the hospital showed that the hospital annual turnover rates of 40% for inpatients staff in surgery. We discussed this with the senior management team, who said that this was due to a number of staff leaving to take up posts within the NHS. Post the inspection, information supplied to us showed that the current turnover rate for nursing staff was 1.56% from August 2018 to September 2019.
- The inpatient annual sickness rate was 18.2% for registered nursing and midwifery in patient staff, 25%

HCA in patient staff, 23% ODP, 25.2% in theatres. At the time of the inspection, the hospital had two staff absent on long term sick and four absent with short term sickness.

- Staff we spoke with knew how to escalate staffing concerns. Staff we spoke with said that staffing issues were discussed at the morning huddle meetings.

Medical staffing

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff an induction.

- All patients were admitted under the care of a named consultant. There were 87 consultants with practising privileges, who provided a range of specialities for patients at BMI Huddersfield. The term "practising privileges" refers to medical practitioners not directly employed by the hospital, but who have been approved to practice there. Data showed 87 medical staff had their registration validated in the last 12 months.
- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care. The hospitals required them to review inpatients daily and be accessible out of hours. Consultants nominated a colleague to provide cover when they were not available.
- There was an RMO onsite 24 hours a day, seven days a week and a weekly rotation with a Monday handover. There was provision of an on-site residence for the RMO.
- The RMO attended a daily handover and a safety huddle with the nursing team, to anticipate any areas of concern.
- The RMO said that the hospital was very supportive and his relationship with the nursing, consultant and leadership team was positive.

Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

- Paper records were available for each patient that attended the wards and departments. Staff we spoke with said that they could access records out of hours with ease.
- We reviewed seventeen sets of records during the inspection and on the majority of occasions, they were legible, and documentation occurred at the time of review or administration of treatment. At the time of the inspection, patient's records were all stored securely.
- We saw that patient records held individualised plans of care; for example, pressure area prevention and falls care plans.
- All staff were required to complete information governance training every year. Training records showed 99% all of hospital wide staff had completed information governance training.
- Results from the medical records audit from September to December 2018 showed 93% compliance with record keeping.
- Appropriate risk assessments were completed for patients at pre-assessment. Staff completed fall assessments, Malnutrition Universal Screening Tool (MUST), pressure ulcer risk assessments.
- During the inspection, we reviewed 10 sets of cosmetic surgery notes and identified that documentation on consent, cooling off periods, information sharing with patients or patient expectations was not in accordance with the organisations policy, best practice or professional standards for cosmetic practice 2013. We identified that in all notes reviewed consent was taken on the day of surgery, in two sets of records there was no evidence of first consultation, and no evidence of cooling off period in one set of notes. Following the inspection, the hospital retrospectively reviewed the same ten sets of notes and their results echoed our findings, the hospital provided us with an action plan to improve compliance and patient outcomes.
- Patient records were multidisciplinary, and we saw the RMO, physiotherapist and nursing staff all documented in the same record.

Medicines

The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.

- Pharmacy services were available seven days a week, with an on-call service available out of hours. The RMO was also able to access emergency medicines out of hours.
- We checked that medicines were stored securely including controlled drugs on wards we visited. We saw controlled drugs were stored correctly with access restricted to authorised staff only, they were checked in line with the policy and there were no discrepancies in controlled drug registers.
- The drugs fridges we reviewed showed there was a process in place to record daily fridge temperatures. We saw minimum and maximum fridge temperatures were recorded daily and were within the correct range. Staff we spoke with could describe the process for reporting if the fridge temperature went out of a safe range.
- We looked at the medicine administration records for four patients on the ward. We saw no charts consistently recorded that medicines had been administered. All drug charts we reviewed had a number of blanks where administration times and signature boxes had not been recorded. We were unable to tell from the administration chart whether the medication had been administered correctly or had been withheld.
- There were 14 medicines incidents reported from April 2018 to April 2019. We reviewed these, themes included prescribing errors, we saw evidence of investigation and identification of learning to prevent the incident from happening again.
- The RMO spoke with us about the support and challenge to him from the pharmacy team. He felt this was a positive relationship which aided his learning.
- Staff within theatres had access to both paediatric and adult resuscitation medicines.
- The ward participated in an annual medication management audit and a controlled medication audit three times per year.

Incidents

Staff recognised incidents and near misses 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. However, patients did not consistently receive written information, or were informed of the findings from the incident investigation.

- Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain examples of when they would use this. We reviewed two cases which met the requirements of the duty of candour regulations. In both the cases staff had not taken the appropriate action to comply with the requirements or with BMI policy.
- The majority of staff we spoke with were aware of the duty of candour regulations, they said it was about providing apologies to patients and could provide us with examples of when they would use this such as patient falls. However, the evidence we reviewed did not provide assurance that all elements of the requirement was understood.
- 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 patient harm or death but neither need have happened for an incident to be a never event. The hospital had not had any never events in the reporting period January 2018 to December 2018.
- Serious incidents (SI) are incidents that require further investigation and reporting. In accordance with the Serious Incident Framework 2015, the hospital reported serious incidents (SIs) in surgery which met the reporting criteria set by NHS England; from April 2018 to April 2019 the hospital reported one serious incident.
- Staff we spoke with said that if a serious incident occurred, they would be involved in the root cause analysis process. We reviewed two serious incident reports; we found these to include contributing factors, identification of lessons learned and recommendations to prevent reoccurrence of the incident.

Requires improvement

Surgery

- The service had systems in place for reporting, monitoring and learning from incidents. The hospital had an incidents policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents. The hospital also had an electronic reporting system. in place and staff, we spoke with could describe how they would report incidents.
- We reviewed incident data provided by the hospital, between October 2017 and September 2018 the hospital reported 327 clinical incidents. Of these, 271(82%) caused no harm, 52 (15.9%) low harm, four moderate harm (1.2%) and no severe harm or death.
- Staff we spoke with said that the hospital shared learning from incidents by email, newsletters and by staff meetings. An example of a change in practice from a recent incident, was following a sharps injury, staff now ensured bags were labelled as to the location they were removed from.

Safety Thermometer (or equivalent)

Staff collected safety information, however we did not see evidence of it being shared with staff, patients and visitors, or using the information collected to improve safety.

- The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data collection took place one day each month – a suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of suggested data collection date.
- Data from the patient safety thermometer showed that the hospital reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter (CUTIs) from April to June 2019 for surgery. Although this data was collected, we did not see it being shared with staff, patients or visitors or displayed to improve safety.
- Venous thrombolysis (blood clot) assessments were carried out in the hospital and data we reviewed showed 100% compliance with VTE risk assessment documentation (January to March 2019).The hospital was currently meeting the VTE assessment indicator.

Are surgery services effective?

Requires improvement

Our rating of effective stayed the same.We rated it as **requires improvement.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

- Policies and guidelines in use within clinical areas were compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies.
- During this inspection, we reviewed some of the hospital clinical protocols and patient pathways used for patients on surgical wards; these included operation pathways.
- We saw that patients' treatment was based on national guidance, such as NICE, the Royal College of Anaesthetists and the Royal College of Surgeons.
- Policies were stored on the intranet and staff we spoke with could access them.
- Wards and departments, we visited participated in local audit programmes, results from the audits were benchmarked with other hospitals in the group.
- The hospital participated in national clinical audits including, patient reported outcome measures (PROMS), Commissioning for Quality and Innovation (CQUINS) and the National Joint Registry (NJR).
- A summary of any updates from NICE or Royal Colleges were provided in the monthly clinical bulletin cascaded from the corporate Quality and risk team, this was reviewed by the clinical services and risk managers for compliance with the hospitals own policies, if changes were required this was presented at the MAC and clinical governance meetings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

- We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted 97.7% compliance for food and hydration which was better than the 90.2% England average.
- The patient satisfaction report for April 2019, showed that there had been a deterioration in the satisfaction of patient catering, from 91.4% in April 2018, to 84.4% in April 2019.
- Staff, by using the malnutrition universal screening tool (MUST) documentation, identified patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes. Patient records we reviewed showed good levels of completion.
- Patients had access to a snack menu through the day. Dietary needs, including special diets, vegan and Halal were catered for.
- Pre-admission information for patients provided them with clear instructions on fasting times for food and fluid prior to surgery. Current guidance recommends fasting from food for six hours and fluid for two hours. Records we reviewed, showed that on the majority of occasions, patients fasted for appropriate periods.
- All patients we spoke with said that the food was good and that the water was replenished daily and as required. One patient said that they had "lots of choice", another patient said that "choices were excellent".

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

- During the inspection, we saw patients being offered pain relief. Patients we spoke with said that staff offered them pain relief regularly and that staff checked that pain relief administered had been effective.
- We observed staff using pain scoring tools to assess patients' levels of pain; staff recorded this information on the NEWS record.
- The patient satisfaction survey, April 2019, showed that 100% of patients reported that they felt staff had explained post-operative pain to them, however the survey found only 89.8% of patients reported that staff had done everything to control their pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

- The hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS. Data was submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- The hospital participated in corporate, topical and local hospital-initiated audit programmes, for example hand hygiene, five steps to safer surgery audits and pain.
- We reviewed the pre-operation theatre checklist audit which scored 90% compliance between January 2019 to May 2019 and included recommended actions to be taken to improve compliance.
- Within the theatre department, they had developed a system for reviewing audit information, within team meetings to share learning and improve patient outcomes.
- The hospital also participated in regional commissioning for quality and innovation (CQUIN) in conjunction with the local commissioning organisation to enable measurements of performance and quality outcomes. We reviewed the CQUIN dashboard 2018/2019 and saw that evidence was being collected and shared on pre-assessment, theatre cancellations and discharge planning.
- Enhanced recovery programmes for joint replacement surgery were in use and staff shared with us that they were achieving same day discharges for a number of knee replacement patients. Post the inspection, data supplied by the hospital showed in the previous 12 months, 61 patients had had day case knee replacement surgery, no readmission or complications had been recorded for any of these patients.

- The hospital participated in the national joint registry; the hospitals used this information to review individual consultant performance data to improve patient outcomes.
- Patients were contacted post- discharge to discuss experience after care and any follow up appointments required.
- The organisation produced monthly dashboards to measure performance within the hospital, this information was benchmarked against all hospitals on a regional and national basis to enable comparison and identify improvement.
- Data we reviewed showed that from October 2017 to September 2018, there were no unplanned visits to theatre. In the same reporting period, the hospital reported four unplanned transfers of inpatients to other hospitals, these patients all transferred appropriately for further treatment and management.
- In the same reporting period, there were unplanned readmissions within 28 days of discharge. All of these patients were re-admitted for further treatment and management.
- The hospital audited the number of unplanned returns to theatre using their clinical scorecards.

Patient Reported Outcome Measures

- In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations: knee and hip replacements.
- The hospital had commenced collecting data for EQ-5D index outcomes (a patient reported outcome measure, that captures five dimensions of health-related outcomes).

Competent staff

The service made sure staff were competent for their roles. Manager appraised staff's work performance and held supervision meetings with them to provide support and development.

- Since October 2018, 87% of staff within the inpatient department at the hospital had received an appraisal, within theatres this was 60%. The appraisal year ran till September 2019, so senior leaders were confident they would improve compliance in the remaining months.
- Staff described the appraisal process as a valuable experience and felt their learning needs were addressed. They were also given opportunities to attend courses to further their development.
- Staff we spoke with said that they had received a thorough induction to the hospital, with a period of being supernumerary.
- Staff working in the hospital had identified competences to complete, relevant to their area of work, including gaining consent, medicines, catheterisation and cannulation. Within the theatre department it had been acknowledged that these needed updating and a new process of recording competences had been developed. Staff working as surgical first assistants had further training and competencies to undertake this role. Within the inpatient ward, we reviewed a competence file that was overdue for review (April 2018), there were 18 complete competencies signed and dated by staff. One member of staff did not have a competence file available, we discussed this with staff, and they were unable to provide an explanation.
- Staff reported good development opportunities including additional training. Registered staff we spoke with that they had been supported through revalidation by the hospital.
- We reviewed 10 sets of consultant staff files and found that at the time of the inspection, there was not an effective process for recording mandatory training or health clearance. During the inspection, staff improved processes and ensured this information was now being recorded on all consultants. Evidence of mandatory training was only available in one set of records. Health clearance was not available in any records; however, disclosure and barring service checks were available in all records.
- We reviewed eight staff files of the leadership team, nursing and allied health professional and saw an effective system for recording key information about training, pre-employment checks and disclosure and barring service checks.

- The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practice there. Due to the non-recording of essential information, at the time of the inspection there was not a consistent effective process in place for granting practicing privileges to consultants. The new process needed a period of embedding to enable effective recording of relevant information.
- Resident medical officers had completed their advanced life support training and were included in resuscitation scenarios that took place in the hospital.
- There were systems in place to review and withdraw the practising privileges of consultants. Any concerns about a consultant's practice would be discussed with the hospital director and MAC chair. Practising privileges were withdrawn in line with the hospital's policy in circumstances where standards of practice or professional behaviour were in breach of contract.
- In the reporting period January 2018 to December 2018, 14 consultants had their practising privileges removed in the reporting period, Information provided by the hospital showed that consultants had their practising privileges removed due to no longer providing a service, not practiced at the hospital for 12 months and retiring from practice.
- The hospital director and MAC chair liaised appropriately with the General Medical Council and local NHS trusts about any concerns and restrictions on the practice for individual consultants. Any concerns about a consultant would be shared with their responsible officer within their NHS employment.
- The RMOs were employed through a national agency. The agency was responsible for their ongoing training and provided continuing professional education sessions throughout the year. The chair of the MAC when required provided clinical supervision, the RMO was allocated a mentor during their placement, to go to for support and guidance.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide care.

- We saw evidence of a multi-disciplinary team (MDT) approach to patient care and treatment. Staff described effective working relationships across all the areas we visited.
- Consultants accessed the NHS trust multidisciplinary team (MDT) meetings for discussion of patients on specific pathways or with complex needs, this included attendance from consultants, specialist nurses and radiologists.
- A multi-disciplinary on-call team was available 24 hours, seven days a week, this included access to a radiographer, theatre staff, engineers and senior managers.

Seven-day services

Key services were available seven days a week to support timely patient care.

- There was an RMO in the hospital 24 hours a day with immediate telephone access to on-call consultants.
- The service was available to be run seven days a week, however due to demand on the majority of occasions the service ran six days a week closing on Saturday evening.
- Staff had access to therapy support as required. The hospital had an on-site pharmacy, with access to NHS pharmacy services available 24 hours, seven days a week.
- Theatre services were available from 7.30am to 9pm, Monday to Friday and Saturdays from 7.30am to 4pm. There was an on-call rota for theatre staff and senior managers to support out-of-hours service.
- Clinical staff had access to diagnostic and radiology services, which was available 24 hours, seven days a week to support clinical decision-making.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

- Health promotion information was available within the hospital. This included display boards and information leaflets.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Requires improvement

Surgery

Records we reviewed did not provide assurance that patients were not consistently consented in line with best practice and professional standards. Staff could not clearly and consistently articulate how and when to assess whether a patient had the capacity to make decisions about their care or deprivation of liberty safeguards.

- Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. Records we reviewed showed that patients did not consistently consent to surgery in line with hospital policies and procedures and best practice and professional standards.
- Written consent is a legal requirement prior to any surgery taking place.From records we reviewed we did not receive assurance that patients always received the correct information about risks and benefits of surgery prior to signing consent forms. As the majority of patients signed consent forms on the day of surgery, we did not receive assurance that patients had sufficient time to consider the associated risks of surgery post consent discussions and prior to their surgery going ahead. This was acknowledged by the senior leadership team and we saw minutes of meetings were this had been discussed with consultants to increase compliance.
- During the inspection, we reviewed a consent audit, the department achieved 83% in April 2019 and May 2019. This was a deterioration from quarter three results that showed 100% compliance. An action plan was in place to improve performance.
- The Mental Capacity act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Were someone is judged not to have the capacity to make a specific decision, following a capacity assessment, that decision can be taken for them, but it must be in their best interests. Staff we spoke with showed limited understanding of the relevant consent and decision-making requirements.
- Records we reviewed showed that patients were not always assessed for surgery in accordance with effective pre-assessment pathways. We reviewed the eligibility criteria for admission into the hospital for surgery and saw that patients living with dementia were accepted for surgery. However; during the inspection, we had concerns about staff knowledge and implementation of mental capacity assessments, especially in relation to cognitive impairment. We reviewed a recent serious incident where a patient's cognitive impairment had not been identified on admission, despite the patient's family disclosing this information. Staff we spoke with provided a mixed view on how and when they would assess a patient's cognition and whether they did or did not accept patients living with dementia.
- The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are Deprivation of Liberty Safeguards (DoLS). DoLs can only be used if the person will be deprived of their liberty in a care home or a hospital. Staff we spoke with were not aware of the legislation around deprivation of liberty safeguards. We did not see any patients with DoLS authorisations. Staff we spoke with showed limited understanding of deprivation of liberty safeguards.
- Staff we spoke with were unable to articulate how patients accessed mental health referral pathways and how they would use these with any patients they had concerns about.
- We did not see any records where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place.
- Staff received consent training as part of their mandatory training requirements. Mental capacity and deprivation of liberty were covered within the organisation's safeguarding training, but we saw no evidence of any specific, extra or separate training on these topics.

Are surgery services caring?

Good

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

Compassionate care

Requires improvement

Surgery

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- We spoke with three patients on the surgical wards at this hospital. All patients we spoke with were happy with their care.
- In wards and departments, we visited, we observed staff caring for patients and found that they were compassionate and reassuring. We heard staff introducing themselves by name and explaining the care and treatment they were delivering.
- We heard staff providing encouragement and support to patients, we heard them comment in a positive manner to patients, providing clear instructions and answering questions with genuine warmth.
- Patients we spoke with said that staff were very caring and kind. Patients described their care as "absolutely excellent" and described the attitude of staff as "wonderful and caring" and "very professional". Patients also said that staff were motivational in relation to their rehabilitation post joint surgery.
- Patients we spoke with said that they were able to reach their buzzers and that staff answered buzzers quickly and during the inspection we did not hear buzzers ringing for long periods of time.
- The Friends and Family Test (FFT) scores at the hospital from July 2018 to December 2018 was 98%. The response rate was 19%.

  The hospital's patient satisfaction survey in April 2019, showed over 80% of patients were extremely likely to recommend the hospital and 96.7%, were likely to recommend the hospital. Again, response rates to this survey were low with less than 10% of patients returning the long version of the survey and less than 30% returning the short version of the form.
- In the same survey, over 93.8% of patients felt the care and attention they received from nursing staff was satisfactory, 100% felt they were given enough privacy when discussing their care and treatment.
- All patients we observed appeared comfortable, looked well cared for and had their privacy and dignity maintained.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- We saw that the ward/unit manager was visible on wards and departments we visited, and patients and relatives could speak with them.
- We heard a conversation between a patient and nursing staff and heard nursing staff providing comfort and support.
- Patients we spoke with said that staff were available to talk to them as required. Patients we spoke with said they had been "welcomed on to the wards and staff had been reassuring and kind".

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.

- Results from the hospital's patient satisfaction survey in April 2019, showed 100% of patients felt involved in decisions about their care and treatment.
- A range of information leaflets and advice posters were available on wards we visited. These included discharge information, specialist services and general advice about their care and treatment.
- The majority of patients we spoke with said that medical staff took time to explain their care and the risks and benefits of treatment, however records we reviewed did not demonstrate this discussion. The majority of patients we spoke with said that they were aware of their plans of care and they had been given the time for questions and felt listened too.
- Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions.
- The majority of patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.

Are surgery services responsive?

Requires improvement

Surgery

Requires improvement

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- The hospital had arrangements in place for planning and booking of surgical activities, ensuring patients were offered choice and flexibility.
- The hospital worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.
- Staff held a daily bed meeting to discuss staffing levels and clinical needs. Staff reviewed the number of admissions, discharges and patient dependency throughout the shift to assess on-going capacity.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. However, the environment was not always suitable for all patients.

- We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted 89.2% compliance for how well the needs of patients living with dementia were met. This was better than the 76.9% England average. Compliance was also better (89.9% compared to 84.2% England average) for how well the needs of patients living with disability were met. However, compliance for privacy, dignity and wellbeing provision was 76.9%. This was worse than the 84.2% England average.
- The pre-assessment teams identified patients' needs such as hearing, sight or language difficulties. Translation services were available for patients whose first language was not English. Staff we spoke with knew how to access these services.
- Patients living with dementia and patients with learning disabilities were assessed at pre-assessment and on admission. Staff said patients living with dementia and learning disabilities were not routinely treated at the hospital, however this was not detailed in the hospital's admission criteria.
- Patients were provided with information leaflets on topics, the leaflets were in English and staff informed us they would contact patient services for leaflets in other languages.
- Not all areas of wards and departments were accessible for patients with limited mobility and people who use a wheelchair.
- On discharge, patients were provided with information about their after-care and the ward contact number in case they had any concerns post-operatively.

Access and flow

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.

- There were 625 inpatient admissions, 3063-day case admissions and 2,744 visits to theatre in the reporting period January 2018 to December 2018. Of the inpatient and day case admissions, 82% were NHS funded and 18% were non-NHS funded.
- Monthly activity was shared at the clinical governance committee and information we reviewed showed that between January 2018 to December 2018 the hospital had on average 52 inpatients and 255-day case admissions per month. The hospital had on average ten-day cases and two inpatients per day. Data ranged from zero to 17-day cases and zero to six inpatients March 2019 to May 2019.
- We also reviewed data which showed the number of cases being operated on in a month. This ranged from 51 to 81 people per month January 2018 to December 2019.
- The most common procedures undertaken were knee operations, knee replacement and carpal tunnel release.

Requires improvement

Surgery

- From April 2018 to May 2019 the hospital's referral to treatment time (RTT) for incomplete pathways for surgery was 93.5%, which was better than the England average. Individual speciality performance for May 2019, ranged from 91.7% in gastroenterology to 95.5%, in urology, all other specialities fell between that range. The senior management team said that when the threshold had been breached this was discussed with the commissioning teams.
- The service held a service level agreement, with the local NHS trust to enable them to transfer critically ill patients back to the trust as required. In the reporting period from October 2017 to September 2018 there were four unplanned transfers of inpatients to other hospitals, five unplanned readmissions within 28 days of discharge and no unplanned returns to theatre.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. Data provided by the hospital pre-inspection showed that from January 2018 to December 2018, the hospital cancelled five procedures for non-clinical reasons. Only 60% of these cancelled patients received another appointment within the following 28 days.
- More recent data showed 52 cancellations between April 2018 and March 2019, approximately four patients a month were cancelled. Of these 37 cancellations were for clinical reasons and 15 for non-clinical reasons. Cancellations for clinical reasons, can indicate a problem with pre-assessment of patients. Following the inspection, the senior management team said that the patient pathway for surgical procedures was under review, this review included booking, decision making and assessment with the aim of reducing the number of cancellations. The cancellations for non-clinical reasons were due to surgery no longer being required or a lack of staff within the operating theatres.
- Approximately two percent of operations were cancelled and data on cancellations was collected and analysed, data was separated into avoidable and unavoidable cancellations. This data was then presented at the clinical governance meeting and was discussed by the committee and information and learning.
- As the theatre manager was new in post, they had not yet had the opportunity to review theatre usage, delays and overruns.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, data we reviewed showed that the organisation was not consistently timely with the investigation response.

- The hospital had a process that addressed both formal and informal complaints that were

  raised by patients or relatives. From January 2018 to December 2018 there were 50 complaints about the hospital of these five were about the care and treatment received on the ward.
- From data we reviewed, the hospital took an average of 76 working days to investigate and close ward complaints. The hospital had a target to close complaints within 20 working days.
- If the complaint was not resolved at local level, patients could have their complaint escalated to an internal review. If the patient remained unsatisfied, they could take their complaint to the Independent Sector Complaints Adjudication Service (ISCAS), for fee-paying patients, or the Parliamentary and Health Service Ombudsman for NHS patients for an independent review.
- The most common subjects complained about in surgery were: attitude of staff, communication and pain, one complaint each.
- We saw information displayed in ward areas about how to complain or raise a concern. Staff we spoke with could describe how they would respond to a complaint or if a concern was raised.
- Staff we spoke with said that themes and trends of complaints were shared with staff at daily meetings,

senior management meetings and heads of department meetings. The executive team said that themes and trends of complaints were discussed at the clinical governance committee and medical advisory committee, to identify leaning and changes to clinical practice required.

- Because of patient complaints, the service had developed a specific patient experience booklet for knee surgery to outline expectations around, the procedure, rehabilitation and pain.
- Response letters to complainants included an apology when things had not gone as planned. This was in accordance with the expectations of the service under duty of candour requirements.

Are surgery services well-led?

Requires improvement

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

Leadership

Leaders had the, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their key skills. However due to instability and change within the leadership team this had potential to impact on the effectiveness of this team.

- The leadership team consisted of an executive director, a director of clinical services, a quality and risk manager and an operations manager.
- Since the last inspection, the hospital senior management team had undergone changes and at the time of the inspection, a new registered manager was in post. A managerial re-structure had also occurred which had created a clinical lead for nursing, allied health and theatres, all roles had recently been recruited to. However, since the re-structure there had been medium-term staff sickness and resignations which had potential to impact on the effectiveness of this team. The team once fully recruited to required a further period to be consistently effective.
- During the inspection, all the senior management team spoke with us about dis-harmony and instability within the executive team and expressed concerns about relationships in the senior management team and the potential impact this had on staff working in the hospital. The registered manager acknowledged this and was committed to ensuring managerial stability within the team.
- Staff we spoke with said the senior management team was accessible and visible on the wards and departments. They said that some members of the executive team were supportive.
- In the 2018 staff engagement surveys the executive leadership team scored amber for communication and staff confidence in leadership of the organisation. When benchmarked against other BMI hospitals BMI Huddersfield did not score green for any of the metrics. We spoke with the theatre manager, who acknowledged challenges the department had, however had developed an improvement action plan.
- The executive leadership team had developed an action plan to address the issues identified on the survey, which included increased staff forums, attendance at staff meetings and planned improvements to sharing positives with the hospital teams, such as thankyou's, awards and acknowledgments.
- Resident medical officers said they felt supported by senior colleagues.

Vision and strategy

The service had a vision for what it wanted to achieve and plans to achieve it. The vision was focused on the sustainability of services.

- The hospital had a five-year vision 2015- 2020, this was based on the eight strategic corporate objectives, these were focused on patients, people, information, facilities, efficiency, governance, growth and communication.
- The hospital strategy was under development. Each department within the hospital had their own strategies to improve and develop services. The registered manager had recently reviewed this information to develop a specific hospital wide strategy and align the aims and objectives of the strategy to the corporate vision and strategy.

- Out of the two staff members we spoke with about the hospital's vision, only one was aware of it.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. However, the hospital's own staff survey results did not correlate this view.

- Staff we talked with said they said they felt valued by their patients, ward leaders and the hospital. They said that morale was variable, and this was echoed in the staff engagement survey results.
- The most recent staff survey showed a staff engagement score lower than both the previous year and the national BMI average. In the 2018, staff engagement survey, scores were least positive for morale (-22% difference from 2017, RAG rated red), communication (-15% from 2017 difference, RAG rated red) and change management (11% difference from 2017, RAG rated amber). Since this survey a new registered manager had been appointed and the senior management team had developed an action plan to improve engagement. We reviewed the action plan and it contained relevant actions to improve engagement.
- The senior management team were proud of the staff working in the hospital.
- The service had appointed a freedom to speak up guardian and staff we spoke with knew how to contact the guardian.

Governance

Leaders had clear governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, due to the changes and instability in the senior leadership team, there was a potential for these roles and responsibilities to be adversely affected.

- The hospital had clear governance structures. These were described in the hospital's quality and safety framework. The organisation had a series of corporate, regional and hospital boards and committees to provide assurance on the quality and safety of services provided.
- The hospital had a local committee structure with regular meetings. These had clear reporting structures, within the hospital and to the regional and corporate committees.
- The medical advisory committee (MAC) was held quarterly and chaired by a lead consultant. We reviewed three sets of minutes from the MAC and saw these included discussions about performance, business updates, learning from incidents, complaints, patient outcomes and new clinical services. The conditions of practising privileges were monitored for compliance and discussion was held about removing or granting practising privileges, 14 consultants had their practising privileges removed in the reporting period January 2018 to December 2018, these removals were all for non-clinical reasons, for example moving out of area, retirement and not wishing to undertake private practice.
- We reviewed three sets of minutes from the clinical governance committee. The clinical governance and the clinical effectiveness committee were combined. Again, all relevant information was discussed at these meetings. However; we did not see any issues documented requiring escalation to corporate clinical governance meetings, however staff we spoke with said that this did occur.
- Throughout all these minutes we saw evidence of discussion about a clinical incident that occurred, that required duty of candour requirements to be implemented. All the discussions we reviewed identified that duty of candour had not been carried out correctly, however the clinicians and senior management team did not act to ensure it was completed correctly.
- The hospital audited a range of indicators and presented the results to the relevant committee for discussion, for example VTE risk assessment compliance, effective discharge, surgical site infections in hip and knee arthroplasties and unplanned returns to theatre. They reported these on a clinical dashboard.
- A daily 'communication cell' meeting was held each morning at the hospital. This was attended by a representative from each team. We observed a cell meeting whilst on inspection and noted that key messages, staffing issues, patient risks, incidents and issues were discussed.

- The surgical services lead cascaded information from the head of department meeting to the team and escalated any issues back to the heads of department meeting. Information from the health and safety meeting was also shared.
- We reviewed three meetings from team and heads of service meetings, these included discussion about learning from incidents, complaints, audits, patient satisfaction and business updates.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- There was a clear risk escalation route from surgical services and other departments to the registered manager and the regional director of clinical services. We spoke with the regional operational manager who had a clear understanding of the risks in the service and the mitigation plans in place.
- The surgical department had a risk register which highlighted current risks and documented mitigating actions to reduce the risks. Data we reviewed showed that, at the time of our inspection, there were 10 risks identified with none rated as high risk, three rated as moderate risk and the remainder rated low or no risk following identification of mitigating actions. These risks had been reviewed regularly and had a date when the next review was planned.
- Senior staff identified their highest risks to be security, facilities and staffing. On review of the risk register, it was identified that these risks were rated as high risks but were not significantly broken down. For example, facilities were identified as a risk but specifically in relation to the building security and engineering aspects rather than the actual environmental fabric of the building (floors, walls and fixtures). The lack of shower facilities was not entered as a risk.
- Risk registers were reviewed regularly by the heads of department, quarterly these were reviewed at the regional quality assurance meeting and summary risk registers were presented to the organisations board twice a year. The senior management team of the hospital reviewed all risks on an annual basis.
- Risk were discussed daily at the communication cell meetings, monthly at department and heads of department meetings and then quarterly at clinical governance committee.
- Hospital performance was monitored using clinical dashboards and clinical governance reports. Data was presented on activity, incidents, complaints, cancellations and We reviewed these reports and they showed evidence of discussion and action for improvement. However, at the time of the inspection, the service did not collect and use all information required to enable them to manage performance effectively, for example they did not currently collect theatre utilisation or capacity data.
- Managers used information from a variety of sources to ensure they were delivering a quality service. This included patient satisfaction surveys, incident reports, complaints/compliments, training records, audit results and financial reports.
- Since being in post the theatre manager had reviewed and updated the risk register and the department risk registers now included current risks for the department.
- The department had business continuity plans in place to manage challenges such as IT system failure.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- The service had systems in place to collect information about performance and share it with staff, for example, information relating to waiting times and reporting times.
- Information provided by the hospital, showed that 97% of hospital staff had completed information governance training.

- During the inspection, patient records were stored securely, and computers were locked securely when not in use.
- Staff had access to a shared electronic folder, which provided access to policies and procedures.
- Patients had access to BMI live support which allowed support via an on-line chat.
- BMI consultants had access to an app which allowed them to remote login to book clinics and theatre lists. Medical staff we spoke with, spoke positively about this app.

Engagement

Leaders and staff actively and openly engaged with patients, staff to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, we did note that response rates for patients were low.

- At the inspection, we saw a formal feedback process in place to collect patient or relative feedback. However, we did note that response rates were low, which had the potential to not capture all aspects of the patient's feedback.
- All staff were invited to take part in an annual engagement survey. We reviewed the results for the most recent staff survey 2018. The hospital scored 59/100 for overall engagement. This was a decrease from the 2017 engagement score of 62/100. Overall engagement was 35% engaged, 59% passive and 7% disengaged. We heard the results of the patient satisfaction survey being shared with staff at the communications cell meeting. As a result of the survey, improvements had been made such as increased celebration of success, sharing of thanks and increased visibility of the senior management team.
- Staff working in surgical services said they had been consulted and included in discussions on the refurbishment of the hospital and included in the planning of the next phase of development for the hospital as part of the five-year plan.
- A patient satisfaction questionnaire was given to all patients to enable them to share their experiences. Results from the April 2019 survey showed over 80% of patients rated the overall quality of care as 'excellent' with the remainder rating the hospital as 'very good'. The hospital used various means to collect patient feedback including comment cards and social media.
- We saw posters in ward areas advising staff how to raise concerns or comments they had about the hospital.
- During April 2018 to April 2019, there were three whistleblowing enquiries reported to CQC. We investigated these concerns further prior to and during the inspection and will monitor the themes during our ongoing communications with the senior management team. Staff had access to a freedom to speak up guardian and had a whistleblowing policy in place
- The theatre manager had developed an employee of the month reward programme, where one employee got appreciation for an action within the previous month.
- Staff used the huddles, emails and meetings to share key messages and good practice.
- Staff were encouraged to nominate their peers, for thankyou- they had developed a "say cheers to your peers" board in the staff rest room and staff could add their thanks onto this.
- Thank you, cards, and compliments received were added to the IT system (for recording incidents, complaints and compliments) and were shared with all staff in the hospital via an email distribution list. Staff that were mentioned by name in the comments of the patient satisfaction report were provided with a hand written personalised thank you card and a box of chocolates.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

- Staff we spoke with were proud to be able to offer joint replacement as a day case service. This innovation was nominated for an award at the National Health Care Transformation Awards (London) held in June 2019 and came second.

Good

Outpatients

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

Are outpatients services safe?

Requires improvement

Previously, we rated outpatients and diagnostic imaging as a single core service. We have not yet rated outpatients as a single service. We rated safe as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- For our detailed findings on mandatory training, please see the safe section in the surgery report.
- Staff were up to date with their mandatory training and told us they were given time to complete this. Staff did not receive mandatory training to make them aware of the potential needs of people living with mental health conditions, a learning disability or autism.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not all have training at the correct level on how to recognise and report abuse.

- For our detailed findings on safeguarding please see the safe section in the surgery report.
- Staff we spoke to told us they understood the principles of safeguarding both vulnerable adults and children. Safeguarding training included units on female genital mutilation and PREVENT, intended to identify and reduce radicalisation.
- Safeguarding flowcharts for staff to use were clearly on display in both the outpatient clinic and preoperative assessment unit. These included named contacts with telephone numbers.
- Nursing staff received safeguarding vulnerable adults and children training to level two.
- We saw that where an incident had included a disclosure of historic significant harm to others by a patient, this had been appropriately raised with the local authority as a matter of urgency.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. While equipment was visibly clean, the premises were dated, and wall, floor and ceiling coverings were not always intact.

- Seats within waiting rooms were covered in fabric and therefore not compliant with infection control guidance. However, this was on the organisation's risk register and a steam cleaning timetable was in place to mitigate this as much as possible.
- Antibacterial hand gel was available on the entrance to the outpatient and preassessment units and we saw staff and patients using this, but not consistently.
- We observed three consultants in clinic wearing either long sleeves, wristwatches, jackets or cufflinks. This was not in line with the organisation's bare below the elbow policy.When we brought this to the attention of

leaders, this was addressed with those concerned. We saw evidence that this had been raised as a concern earlier in the year following the observational hand hygiene audit completed in January 2019.

- Nursing staff told us that if patients arrived and appeared to be or disclosed that they were infectious, they would be sent home once the risk to others had been fully explained.

- Nasendoscopes were decontaminated offsite and fully cleaned locally between patients. Clinical waste was managed by an external company and bags in clinical areas were removed daily.
  There was no accessible toilet suitable for wheelchair users. This had not changed since our last inspection despite our recommendation. There were no adult changing facilities.

- Equipment was clean and well maintained. We saw observational self-assessments showing that this had been the case over the previous six months.

- Waste management was outsourced to an external source. Onsite, we saw that waste was correctly stored, labelled and handled.

- The environment was not, on the whole, dementia friendly. While some areas had clear dementia friendly signage, other areas, such as the main stairs and corridors to the preassessment unit, did not have walls and floors of contrasting colours.

- The treatment room within the outpatient unit was not in a good state of repair. Wallpaper on the walls was torn and peeling in places, which posed an infection control risk. The floor had residual staining near the edges and in front of fridges where it was more difficult to clean effectively.

- Just outside the treatment room, at the rear of the main outpatients waiting area, was a floor to ceiling cupboard containing pipes, cables and computer equipment. This had been left open and posed a risk to visiting children, we closed this securely and informed a member of staff.

- The resuscitation trolley was stored in the corridor and was easily accessible to staff. We checked the trolley and found that it was tagged for security and had been checked daily and weekly. Staff signed to show weekly checks of the entire contents of the trolley had been completed and recorded the new security tag number. Staff clearly documented when the trolley was not checked to indicate that the department was closed.

- The physiotherapy department had a treatment area with cubicles and treatment room. There was also a large gym. All physiotherapy areas were tidy, well organised and appeared clean.

- The service's most recent PLACE assessment highlighted issues with wall, ceiling and floor coverings with scores significantly below the national average in privacy, dignity and wellbeing, and condition, appearance and maintenance.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

- Patients were triaged using a health questionnaire. Those deemed to need more in-depth review were seen by a nurse in clinic, who could then refer for an anaesthetic review if needed. Healthcare assistants did not see complex patients and could stop any appointment and rebook patients into a nurse-led clinic if they had any concerns. Those patients who were assessed as being low risk received telephone appointments.

- The outpatient unit was using the World Health Organisation surgical checklist and we saw that copies were all appropriately dated and signed. Use of and adherence to this checklist was audited regularly. There were no locally developed safety standard procedures.

Nurse staffing

- The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience available to provide the right care and treatment.

- Planned staffing was two members of staff in the outpatient clinic and two members of staff in preassessment clinic. For some shifts, one member of staff in each area was sufficient due to the number of clinics running.

- For two days of our inspection, there was only one registered nurse working in each clinic, with one

healthcare assistant working shifts. One morning, there were six consultant led clinics running with one nurse supporting. We were told that this was in part due to long term sickness in the team. Figures supplied by the organisation showed an 8% sickness rate for healthcare assistants and 19% for nursing staff.Staff told us there were no nurse vacancies.

- Weekly nurse staffing for the preassessment unit was determined in part by the complexity of patients. Nurses and healthcare assistants both saw patients in the pre-assessment clinic, with the nurse seeing the more complex patients. The team reviewed patients' completed health questionnaires to gauge a rough workload and number of clinics for the forthcoming week.
- The service had not used bank or agency nursing or healthcare assistant staff for the past two years. On the second day of our inspection there was only one member of nursing staff on their own in outpatients, supporting two clinics until 2pm. Consultants were seen waiting for the one nurse to become free to help them.
- All nursing and healthcare staff working in outpatients had received an annual appraisal.

Medical staffing

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.

- Consultants with practicing privileges from a number of different specialties saw patients in the outpatient department.
- A resident medical officer was available at any time to review a patient if required.
- For our detailed findings on medical staffing, please see the safe section in the surgery report.

Records

Staff kept records of patients' care and treatment. However, these were not always clear, up to date or stored securely.

- We looked at the records of six patients and saw that on the whole these were well completed. All records were paper based. Some consultant notes were not dated or signed and were illegible in places.
- Records were stored in paper folders. In the outpatient unit, consulting room six was being used as an office and medical notes for clinics that were waiting to be returned were stored there. However, we saw that despite being told by staff that the door was kept locked, it was always left open and it was unattended on at least five occasions. Additionally, the service used this room for weighing and measuring patients. This meant that patient records were not being stored securely and patients' personal information was not protected.
- Medical records were stored onsite and staff told us that these were available for consultations prior to clinic. Medical records staff showed us notes bundles for forthcoming clinics and every patient's notes were present.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

- The outpatient unit stored a small amount of medicines. We checked the expiry dates of five medicines and found all were in date. There was a log on the front of the fridges in which most medicines were stored detailing when the fridge contents expired. Fridges were locked, and fridge temperatures were monitored and recorded daily. Staff knew the procedure to follow if temperatures were abnormally high or low.
- Prescription books were locked away and a log kept accounting for every page of each book.

For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- Both outpatient and preassesment units told us that there was good learning from incidents. They met monthly to discuss any issues or difficult cases, and

staff teams told us that there were also daily conversations on an ad-hoc basis. However, we heard that in practice individuals did not record their own incidents on the system as this tended to be done by leaders. This meant that there was the potential for learning not to reach the person directly involved.

- We reviewed incidents reported between April 2018 and May 2019. We saw that these were reported promptly, and action had been taken where appropriate to limit the chances of recurrence.

Safety Thermometer (or equivalent)

For our detailed findings on safety thermometer measures, please see the Safe section in the surgery report.

Are outpatients services effective?

We do not rate the effective domain for the Outpatients core service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The preassessment unit was providing care and treatment in line with NICE guidelines and we saw evidence of how new systems and processes had been put in place since our last inspection to embed this.

- The hospital had introduced a telephone pre-assessment triage system whereby the lowest risk patients could complete their pre-assessment on the telephone. This saved time for both staff and patients, enhancing the delivery of effective care.
- Physiotherapy staff followed Chartered Society of Physiotherapy national guidelines.

Nutrition and hydration

Staff offered patients enough food and drink to meet their needs.

- Hot and cold drinks were available for patients and their families. Staff told us that in exceptional circumstances, for example when a patient had an unusually long wait, or were diabetic, they would provide a sandwich. There were no facilities for patients or visitors to buy food onsite.

Pain relief

- We observed a physiotherapy assessment. The patient's pain was assessed using a numeric pain intensity scale and treatment was explained clearly.
- The outpatient department kept a small stock of pain-relieving drugs in the department. We saw in patient notes that these were prescribed as and when they were needed. Pharmacy staff checked stocks regularly. Patients we spoke to told us they had not been in any pain during outpatient appointments but felt confident pain relief would be offered if they had been.

Patient outcomes

- For information about patient outcomes, please see the effective section of the surgery report.
- Patient outcomes were routinely collected and monitored. The hospital submitted information to the Private Healthcare Information Network (PHIN) and physiotherapists used quality of life tools to assess the benefits of care and treatment.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

- The hospital had systems in place to ensure that consultants working under practicing privileges were competent to carry out their role. This was regularly reviewed.
- One hundred percent of outpatient staff had received an appraisal within the previous 12 months.
- Staff could give examples of using their skills to sensitively manage difficult behaviours displayed by other staff members and patients.
- Nursing staff had received training in advanced life support and dementia awareness. Staff told us that the departmental aim was to become a dementia friendly area by the end of the year.
- Nurse leaders told us that while they were supposed to have protected management time each week, this was not always the case.

Good

Outpatients

- The physiotherapy department had a newly developed structured competencies framework and physiotherapy assistants were in the process of having these signed off.

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 saw positive interactions between staff working in different areas and with varying job titles. Communication between the pre-operative assessment unit and the outpatient unit was good and the two service leads spoke very positively about one another.
- Consultants spoke respectfully to staff supporting their clinics and nursing staff told us they felt supported by doctors.
- Representation was sent from all teams or an update was sent if there was no-one available.

Seven-day services

- The outpatient department ran clinics on weekdays between 8am and 8pm, and on alternate Saturdays between 8am and 12 noon. Occasionally, when consultants had busier periods, to avoid backlogs, additional clinics could be provided on Saturday afternoons. Physiotherapy services were provided on weekdays only.

Health promotion

- Staff discussed patient's health and wellbeing during their pre-operative assessment.
- We saw health promotion information on display in waiting areas including information about reducing alcohol intake.
- The hospital had smoke free grounds. Staff did not directly refer to stop smoking services but could ask the patient's GP to do this if needed.

Consent and Mental Capacity Act

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. The outpatient department did not have any specific documentation in place to support patients who may have fluctuating capacity.

- We were told by staff that they tended not to accept patients who may lack capacity. Senior leaders were not clear when asked to describe deprivation of liberty and we were told that the service had never applied for a deprivation of liberty safeguard.
- Mental capacity and deprivation of liberty were covered within the organisation's safeguarding training, but we saw no evidence of any specific, extra or separate training on these topics.
- Written consent is a legal requirement prior to any surgery taking place. The majority of patients signed consent forms on the day of surgery and we were not assured that patients always had enough time to consider the risks prior to their surgery proceeding. This was acknowledged by the senior leadership team and we saw minutes of meetings where this had been discussed with consultants to increase compliance.
- For further information about consent and mental capacity, please see the effective section of the surgery report.

Are outpatients services caring?

Good

Previously, we rated outpatients and diagnostic imaging as a single core service. We have not yet rated outpatients as a single service. We rated caring as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- We saw that notices offering chaperones for patients attending appointments were prominently displayed in the main waiting area, outpatients waiting area and pre-assessment unit. Staff told us they chaperoned

patients on request. There were no male staff working in the outpatient department, but nurses told us that if a male chaperone was required, it was possible to source one from the inpatient ward.

- Patients we spoke with told us staff had been friendly and helpful. None of the 17 patients or family members we spoke to had had cause to complain. However, one patient and their partner told us they had not found the service to be proactive and that they had had to chase up all of their appointments.
- We observed staff speaking to patients in a friendly and professional way. Patients told us they were happy with the way staff treated them. Staff answered questions posed by patients thoroughly and gave good instructions prior to surgery.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Patients we spoke to told us they had not needed any emotional support, but they felt this would be available if needed.

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.

- We observed a physiotherapist giving clear guidance to a patient about their treatment plan. The patient supplied further detail about what was limiting their progress and the physiotherapist was able to tailor the plan by providing additional aids that would help the patient overcome their current challenges. There was ample opportunity for the patient to ask questions and they told us they were very happy with their consultation.
- We saw in patient records that choices and options had been clearly explained to patients, and support to process these emotionally had been provided. Patients told us they felt well supported and were clear throughout their treatment pathway what their options and next steps were.

Are outpatients services responsive?

Good

Previously, we rated outpatients and diagnostic imaging as a single core service. We have not yet rated outpatients as a single service. We rated responsive as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way which met the needs of some local people and some communities served.

- The hospital was served by three local bus routes.
- Signage to both the outpatient and preassessment units were clear and in contrasting colours.
- Nursing staff told us they could assist patients living with a learning disability or autism to complete forms if needed. Staff explained that they could prioritise anyone who seemed upset in the waiting area and enable them to access the consultant more quickly. One of the treatment rooms could be used as a quiet room if needed and had been used for this purpose in the past.
- There was no hospital policy that specifically excluded patients with a diagnosis of dementia or confusion and NHS choose and book patients could not be excluded on this basis. Senior staff told us that the families of people living with dementia were encouraged to attend with the patient and accompany them to within the theatre suite and return to recovery once the patient's surgery is complete.

Meeting people's individual needs

The service was not always inclusive and could not meet the individual needs and preferences of all patients. Staff made some reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- There was a fully accessible lift between floors which was large enough to take a wheelchair or a patient in a bed.
- Processes were in place to support people who spoke English as a second language or required a British sign

language interpreter. Translators were available to attend appointments with patients, and staff knew the importance of making sure these services were offered and not relying on family members to act as translators. Appointment letters could be produced in a range of community languages on request.

Access and flow

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.

- The service was not commissioned to see patients requiring a two-week urgent wait appointment. In November and December 2018, the organisation did not achieve the NHS target of 92% of patients treated before 18 weeks of waiting, although this had improved in recent months. We saw evidence that this position was monitored regularly through meetings with local commissioners.
- < > NHS referrals are triaged for appropriateness by a member of the senior nursing team. Those that were accepted were then passed to the lists of individual consultants for booking by the administrators.
  We saw evidence that only three outpatient clinics had been cancelled in the previous six months, and these were all due to consultants not being available at short notice due to unforeseen and unavoidable circumstances.
- There was clear signage in both the outpatient and preassessment areas informing patients to let a member of staff know if they had been waiting for longer than 15 minutes. We did not see anyone doing this, and all patients and their families we spoke to told us their waiting time had not been excessive.
- At our previous inspection, we told the provider they must improve their pre-assessment processes, as breakdowns in communication were leading to high numbers of cancelled operations on the day of surgery. At this inspection, we found that these processes had been significantly improved and we no longer had concerns about this process. The service's 'did not attend' rates remained marginally above the 5% target for 11 of the previous 12 months, but we were assured this was due to individual patient choice and not hospital processes. Patients who did not attend were sent a letter to inform them about their non-attendance and asking them to book another appointment. If they failed to attend a second time they were referred to their consultant or GP.
- The new service manager for pre-assessment had put in place a tracker system for patients requiring anaesthetic review prior to surgery, meaning that it could be clearly seen in a patient's notes whether everything was in place prior to the day of the procedure.
- We asked to see the information provided to patients prior to their first appointment. Directions and signposting were clear. However, only one number was provided for patients to ring and some patients told us that it could be difficult to get to speak to the right person. Administration staff told us they always checked with the patient that an appointment was going to be suitable before booking, and patients could also choose to receive a text message to remind them of their appointment.
- Patients we spoke to said they were not waiting excessively to see a consultant.Two patients had been waiting for more than half an hour, but both told us they had arrived early and were very happy with their wait. Nursing staff revisited both patients several times to update them and let them know when they were the next person to be seen.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

- We discussed complaints with staff. They told us formal written complaints were uncommon. When patients had complaints, staff told us they would try to resolve them at the time and would involve someone more senior if necessary.
- Staff told us any complaints were discussed specifically with the individuals involved and more generally with the entire team as a way of learning lessons and preventing similar occurrences.

Good

Outpatients

- Friends and family test scores were high (above 90%) and the response rates were above the national average.
- Leaflets detailing how to make a complaint were prominent in all the waiting areas we visited, with accompanying posters on walls and in reception areas. Patients we spoke to said they knew how to make a complaint and would feel confident doing so. None of the patients we spoke to had felt they needed to make a formal complaint about their care.

Are outpatients services well-led?

Good

Previously, we rated outpatients and diagnostic imaging as a single core service. We have not yet rated outpatients as a single service. We rated well led as **good.**

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their key skills. However, due to instability and change within the leadership team, a further period of consolidation was required to be consistently effective.

- For further information about leadership, please refer to the well led section of the surgery report.
- Staff told us leaders were visible and approachable. All staff we spoke to told us they regularly saw the executive director and other members of the senior leadership team in their clinical areas and felt there was an open-door policy when it came to speaking directly to them.
- Managers were able to demonstrate to us that they had good oversight of their departments and provided good support to staff. They told us they had been offered the opportunity to access management qualifications to consolidate their skills.
- Staff told us they found the outpatient and preoperative assessment managers to be supportive and highly visible.

Vision and strategy

The service had a vision for what it wanted to achieve. Strategies were under development and was being designed to align with local plans within the wider health economy.

- For further information about vision and strategy, please refer to the well led section of the surgery report.
- The service had a vision and strategy and senior staff could articulate this. The outpatient department had a one page 'goals' table stating what they hoped to achieve and how. However, this did not contain any measurable targets and there was no clear link to the organisation's wider strategy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

- For further information about culture, please refer to the well led section of the surgery report.
- Staff told us they felt respected, supported and valued. They were focused on the needs of patients receiving care. There were some opportunities for career development. Staff working in the outpatient, pre-operative assessment and physiotherapy units told us they felt that the culture was positive, and they could raise concerns without fear.
- As part of daily morning meetings, there was a standard agenda item celebrating individual or team successes.
- Staff we spoke to described an improving culture.
- The service had appointed a freedom to speak up guardian following a number of whistleblowing concerns, and also provided staff with a telephone number if they wished to speak to someone within the organisation who didn't work at the hospital.

Good

Outpatients

- The most recent staff survey showed a staff engagement score lower than both the previous year and the national BMI group average. A draft action plan had been produced to address issues such as low morale identified in the survey.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- For further information about governance, please refer to the well led section of the surgery report.
- We observed a 'comm cell' meeting which took place each morning. All teams attended or sent information to this meeting. Staffing, leave, any incidents and issues were all discussed, providing the senior leadership team with a thorough overall picture of the service that day.
- Clinical governance reports were thorough and covered areas such as patient feedback, incidents, staffing and training comprehensively.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- For further information about managing risks, issues and performance, please see the well led section of the surgery report.
- Staff in both the outpatient and preoperative assessment units knew their local risks and had access to their risk registers, which were managed electronically.
- Risk registers were concise, revisited regularly and kept up to date.
- The department had business continuity plans in place to manage challenges such as IT system failure.
- The outpatient team did not have regular, documented team meetings. We were provided with minutes from October 2018 and April 2019, a gap of six months, and noted that the content of both was broadly identical. It was clear that the department knew its risks, for example, it was documented in both minutes that staff must challenge consultants who were not adhering to 'bare arms below the elbows' guidance., However at our visit we saw three consultants not complying without challenge. We therefore had concerns about the efficacy of these meetings.

Managing information

- For further information about managing information, please refer to the well led section of the surgery report.
- Staff were aware of their responsibilities in relation to data protection, and information governance formed part of their mandatory training.

Engagement

- The service engaged and collaborated with partner organisations such as the local NHS trust to plan services.
- Patient satisfaction scores were on display in the main waiting area in the hospital entrance.
- For further information about engagement, please refer to the well led section of the surgery report.

Learning, continuous improvement and innovation

- The service improved services by learning from when things went well or went wrong.
- For further information about learning, continuous improvement and innovation, please refer to the well led section of the surgery report.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings. We rated safe as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- For further information about mandatory training, please refer to the surgery section of the report.
- Staff were required to complete mandatory training in topic areas such as infection prevention, fire safety and information governance. All staff we spoke with told us they were up to date with all their mandatory training and demonstrated a good understanding of the topics covered.
- Staff were able to track which training they were required to complete for their role on an electronic system and could see the date they had last completed the training and when it was next due. There was a coloured coded RAG rating which showed green for completed, amber for due to complete within the next month and red if the training was overdue.
- Information provided by the hospital showed that radiography staff were 100% compliant with mandatory training. All training modules had either been completed or were in progress with none showing as past their expiry date.
- Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received automatic email reminders when they were due or overdue to complete a training session.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- Please refer to information about safeguarding vulnerable adults and children within the surgery report.
- Staff received training specific for their role on how to recognise and report abuse. Staff working in the diagnostic imaging unit had completed safeguarding vulnerable adults and safeguarding children training level one and level two. The manager of the unit was in the process of completing level three training. Safeguarding training included units on female genital mutilation, chaperoning and PREVENT (intended to identify and reduce radicalisation).
- Staff we spoke with were confident on how to identify adults and children at risk of, or suffering, significant harm and had a good knowledge of female genital mutilation.

Good

Diagnostic imaging

- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding flowcharts were displayed in the diagnostic imaging unit and included named contacts with telephone numbers.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- Cleaning records were up to date and demonstrated that all areas were cleaned regularly. A housekeeper checklist and weekly cleaning schedules were displayed in all areas and were adjusted according to the level of risk. We saw that all checklists were completed for the month of May 2019.
- Staff followed infection control principles including the use of personal protective equipment (PPE). We observed that all staff were bare below the elbows. We observed two x-ray guided procedures and we saw staff demonstrating good aseptic non-touch technique.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Ultrasound probes were cleaned appropriately between patients following an intimate examination.
- Patients waiting for diagnostic imaging shared the same waiting area as the outpatient's department. Some seats within the waiting room were covered in fabric and therefore not compliant with infection control guidance. However, this was on the organisation's risk register and a steam cleaning timetable was in place to mitigate this as much as possible.
- The changing cubicles had disposable curtains around to provide privacy. The curtains were labelled with the date they were last changed. Staff told us they were replaced every six months or earlier if they became soiled.

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.

- The diagnostic imaging unit was on the ground floor and there was clear signposting to the unit. A mobile MRI scanning unit visited the site once on a week on a Monday which was provided by an independent provider.
- The unit had newly refurbished x-ray room and ultrasound scanning room (refurbished in 2018) and two changing cubicles. There was a separate office for administration and a reporting room. All areas were well organised and clutter free. There was also a C-Arm mobile screening unit located in the theatre suite and a mobile x-ray machine.
- At the previous inspection we were concerned that the x-ray table was not height adjustable. At this inspection we found that the new x-ray table was height adjustable. On the day of our visit there was a technical issue with the x-ray table. Staff contacted the engineers to address this and it was resolved quickly with minimal impact on patients.
- We checked x-ray equipment and found it had been serviced and maintained in line with manufacturer and safety guidelines. The service had a radiology quality assurance test schedule and we saw that all equipment had been regularly calibrated and tested.
- The service had lead aprons and thyroid shields to protect staff. We saw that the aprons and shields were correctly stored and were checked every six months to ensure their efficacy. Dosimeters were worn by all radiographers to measure how much radiation they are exposed to.
- Clear signage was in place to indicate the x-ray room was a controlled area and there should be no unauthorised entry. Warning lights showed when the room was in use and entry was restricted.
- The diagnostic imaging unit shared a resuscitation trolley with the outpatient's department. The trolley was stored in the corridor and was easily accessible to staff. We checked the trolley and found that it was tagged for security and had been checked daily and weekly. Staff signed to show weekly checks of the

entire contents of the trolley had been completed and recorded the new security tag number. Staff clearly documented when the trolley was not checked to indicate that the department was closed.

- Waste was appropriately segregated into clinical and non-clinical with clear signage displayed. Sharps bins were correctly labelled, signed and dated.
- Risk assessments were completed for expected doses to staff and patients and these were updated yearly.

Assessing and responding to patient risk

Staff assessed risks for each patient and ensured they were removed or minimised. Staff identified and quickly acted upon patients at risk of deterioration.

- The service had local rules (IRR) and employers' procedures (IR(ME)R) which protected staff and patients from ionising radiation. We saw these were up to date, signed and displayed.
- There was a process in place for escalating unexpected or serious findings and staff could contact the reporting radiologist and the referring consultant to highlight the findings.
- During the inspection, we observed staff adhering to pause/check criteria to make sure they were examining the correct patient and carrying out the correct x-ray. Pause/check signs were displayed throughout the imaging areas to remind staff of this.
- Pregnant patients were not allowed to undergo any radiological interventional examinations at this hospital as they did not have obstetric back up. Staff questioned females of child bearing age to ensure there was no risk of pregnancy. The service displayed caution signs in waiting and changing areas which said, 'X-ray radiation - please let us know if you are pregnant'.
- The service used the surgical safety checklist for interventional radiology procedures. We saw this was correctly completed in two procedures we observed.
- There were processes in place to manage patients who may deteriorate whilst in the unit. There was an emergency pull cord in the x-ray room which staff could pull if a patient had a cardiac arrest to alert the crash team. Staff told us they had tested this in a scenario-based session. Staff had quick access to the resuscitation trolley and were trained in adult basic life support and care and communication of the deteriorating patient. We saw an advanced life support flow chart by the Resuscitation Council, displayed on the wall above the resuscitation trolley.
- The service had an appointed radiation protection supervisor (RPS) and a designated radiation protection advisor (RPA) who were available to provide radiation advice.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The unit was staffed by three qualified radiographers who worked part time (two whole time equivalent staff). Staff worked flexibly to meet the needs of the service.
- The service provided two ultrasound clinics per week which were staffed by two advanced practitioner sonographers and one regular bank health care assistant.
- There was a lead radiologist for the service and four other consultant radiologists who worked within the unit and reported on images. Radiologists also performed interventional radiology procedures such as ultrasonic guided injections to relieve pain.
- A buddy system was in place to ensure that radiologists' annual leave and other absences were covered and there was always a radiologist available for advice.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

- We checked six imaging request forms and two patient records and found they were completed correctly and thoroughly. Staff told us they always checked imaging

requests for quality and validity before processing them. If they had any concerns or there were any incomplete sections, they would be returned to the referrer.

- Paper records were stored securely in the unit office. All electronic images were stored on the picture archiving and communication system (PACS) with secure access.
- The service carried out regular audits of compliance with the completion of the surgical safety checklist for imaging guided procedures. The audit results showed good compliance with scores between 96% and 99% from January 2019 to May 2019. Actions were noted for any areas which did not meet 100% compliance.
- Staff carried out a six-monthly audit of 10 completed request forms which were randomly selected from the radiology information system (CRIS). The records were assessed using a quality of request information audit tool as part of corporate programme. The audit results for June 2018 and December 2018 were both at 100%.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

- For our detailed findings on medicines please see the safe section in the surgery report.
- The diagnostics unit held limited medicines such as contrast media. Contrast media were stored safely and appropriately in line with medicine storage guidelines. All medicines we checked were safely stored and within their expiry date including drugs for emergency use.
- There was a pharmacy on site. Please refer to the safe section of the surgery report for details about the hospital pharmacy.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

- 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 patient harm or death but neither need have happened for an incident to be a never event. The department reported no incidents classified as never events for diagnostics.
- Staff we spoke with knew how to report incidents on the electronic system. They understood the type of occurrences they must report, relating to radioactive materials, public and patient safety and staff safety.
- Between 30 April 2018 and 1 May 2019 there were seven incidents reported by staff in the diagnostic imaging unit. This included incidents where the wrong patient name had been selected on an x-ray, a duplicate x-ray referral and a fault with the MRI scanner. There were no serious incidents reported for this service.
- Staff told us that if they reported an incident, they received an acknowledgement and feedback. Incidents were discussed at staff meetings to share any learning and prevent a reoccurrence.
- Effective arrangements were in place to respond to relevant external safety alerts. We saw this was a standing agenda item at team meetings.
- Staff understood the principles of duty of candour, being open and honest and told us that if they made a mistake, they would inform the patient and then report it as an incident.

Are diagnostic imaging services effective?

We currently do not rate effective for diagnostic imaging.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

- Staff followed the unit's Employer's procedures and protocols for medical exposures which met with IR(ME)R 2000 and IR(ME)R 2017 regulations. We viewed the unit's procedures and protocols for x-ray, ultrasound and fluoroscopy injections and these were up to date and reviewed annually.

- Staff worked to the Royal College of Radiologists' Guidelines and to relevant guidance from the National Institute for Health and Care Excellence (NICE).
- The service set diagnostic reference levels (DRLs) for routine conditions and these were displayed in the x-ray room. The service compared them to national levels as an aid to optimisation in medical exposure.

Nutrition and hydration

Staff offered patients enough food and drink to meet their needs.

- Hot and cold drinks were available for patients and visitors in the shared waiting area.
- Food was not provided as patients only stayed in the unit for a short period of time. Staff told us that in exceptional circumstances, for example when a patient had an unusually long wait, or were diabetic, they would provide a sandwich. There were no facilities for patients or visitors to buy food onsite.

Pain relief

- For information about pain relief, please see the effective section of the surgery report.
- Staff asked patients about their pain levels and tried to ensure any procedures were carried out in the least painful way.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

- The unit had a regular clinical audit programme which included a request card audit, surgical safety (WHO) compliance audit, six-point identification check audit and consent form audit.
- The unit was audited annually by the radiation protection advisor (RPA). We reviewed the most recent RPA audit report for April 2019 which showed good compliance with radiation protection legislation. There were some minor areas which needed improvement and we saw an action had been formulated which included who was responsible for each action and a target completion date.
- The service did not participate in the Imaging Services Accreditation Scheme (ISAS).
- Radiologists told us that 10% of their reporting was peer reviewed every three months to ensure quality of reporting.

Competent staff

The service made sure staff were competent for their roles.

- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff in the unit had completed their annual appraisals.
- Staff had received equipment specific training from the manufacturer following the installation of the new equipment in the unit. This ensured they were competent to operate the equipment and understand all the controls, settings and programmes.Refresher training was also provided, and we saw that training records were kept up to date.
- All staff in the diagnostic imaging unit had received an annual appraisal in December 2018. This was followed up by a mid-year appraisal in June 2019. Staff told us appraisals were taken seriously and were completed every year. Staff kept up to date with current practice and this was recorded in their continuing professional development folder.
- The hospital had a standard induction programme for all new starters which covered the first 90 days of their new role. There had been no new starters in the diagnostic imaging team since 2014, however, managers told us that any new staff would receive a thorough local induction to the unit.
- The unit had a radiation protection supervisor (RPS) who had overall responsibility to ensure staff were working within their competencies. The RPS ensured that safety and quality checks of the unit were performed and that ionising radiation procedures were performed in line with national guidance and local procedures.
- Arrangements were in place to seek advice from an external radiation protection advisor (RPA) through a service level agreement.

Multidisciplinary working

Good

Diagnostic imaging

Professionals worked together as a team to benefit patients. They supported each other to provide care.

- Staff worked well with each other to provide patient care. Staff told us working relationships were good between the radiographers and radiologists working in the unit. Radiographers liaised with ward staff and outpatient staff to ensure patients received the diagnostic images they needed.
- As part of the justification process to carry out exposure to radiation, staff checked with patients if the same images had been taken elsewhere, for example, at another hospital. If they had, staff would not take another image they would request the images taken elsewhere. Images could be shared on the image exchange portal.

Seven-day services

The service worked flexibly to support timely patient care.

- The core opening hours for the unit were Monday to Friday from 8am to 8pm and Saturdays 8am to 12pm. Staff worked flexibly to cover the needs of the service.
- All staff participated in an on-call rota which meant they were on call one weekend out of three. Staff told us it was rare to be called in at weekends.

Health promotion

- Health promotion information was on display in the waiting area which included information on reducing alcohol intake.
- The hospital was a smoking free zone.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005. However, staff told us they rarely saw patients without capacity as there was a screening process in pre-assessment and patients living with dementia were not normally accepted by the hospital.
- Staff received consent training as part of their mandatory training requirements. Mental capacity and deprivation of liberty were covered within the organisation's safeguarding training, but we saw no evidence of any specific, extra or separate training on these topics.
- We saw that staff gained consent from patients for their care and treatment in line with legislation and guidance. Verbal consent was obtained from patients having an x-rays and ultrasound and written consent was gained from patients having an interventional procedure such as an x-ray guided injection. Staff informed patients of the risks of having an x-ray or other procedure prior to them giving consent.
- The service carried out regular audits of patient consent forms for interventional procedures.

Are diagnostic imaging services caring?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings. We rated caring as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- We found staff to be focused on the care and needs of patients.
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- Patients we spoke with said staff treated them well and with kindness.

Good

Diagnostic imaging

- Staff followed policy to keep patient care and treatment confidential.
- Chaperones were available for patients if required. We saw that notices offering chaperones for patients attending appointments were prominently displayed in all waiting areas. Staff in the diagnostic unit told us a chaperone was always present for intimate ultrasound examinations.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.
- The service participated in the Friends and Family Test. For the period July 2018 to December 2018 the overall results for the hospital showed scores of between 97.1% and 100% for patients who were likely or extremely likely to recommend the hospital to friends and family. The exception to this was November with a score of 90.9%, however, the response rate was very low for this month at 0.70%.
- The BMI patient satisfaction survey report (April 2019) showed positive results for the diagnostic imaging department, scoring a year average of between 90% and 100% for all questions. Questions included, overall impression, were you kept informed of what was happening, were staff friendly and caring and were you treated with dignity and respect.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Staff gave patients and those close to them help, emotional support and advice when they needed it.
- Staff talked with empathy about breaking bad news and having difficult conversations with patients.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

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.

- Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand.
- We observed staff communicating clearly with patients following an invasive procedure. This included aftercare and any physiotherapy follow up appointments they may need.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Are diagnostic imaging services responsive?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings. We rated responsive as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- The diagnostic imaging department was on the ground floor of the hospital and shared the same waiting areas as the outpatient's department. Entrance doors were wide to allow easy access for patients and relatives. It was clearly signposted and easy to find.
- There was sufficient car parking on site to meet the demands of the hospital.
- The unit had flexible opening hours which coincided with the clinics running in the outpatient department. The unit was open at the times when demand was at its highest.

- The service worked closely with local NHS hospitals and other BMI hospitals in the area.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

- Reading glasses were available for patients at the reception.
- We saw there was dementia signage on toilet doors and the hospital was promoting Dementia Awareness week by displaying posters in waiting areas.
- Translators were available to attend appointments with patients, and staff knew the importance of making sure these services were offered and not relying on family members to act as translators. Appointment letters could be produced in a range of community languages on request and information leaflets were available in large print for visually impaired patients.
- Staff told us they could request a British sign language interpreter for hearing impaired patients.
- Staff told us they were able to allow extra time for patient's individual needs.
- Processes were in place to ensure the right person received the right radiological scan at the right time. Staff used a three-point patient identification check and followed the Society and College of Radiographers "paused and checked" checklist prior to taking images.

Access and flow

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.

- Requests for x-rays were carried out on the same day if this suited the patient, otherwise they were booked in for a convenient date. Referrals for MRI or ultrasound scans were booked into the next available slot. Patients could contact the service and rebook their appointment time if the one offered was not convenient. Information provided by the service showed that between November 2018 and April 2019 the average waiting time for MRI or ultrasound scans ranged from 3.9 days to 13.7 days.
- Staff told us it was rare to receive an urgent referral. If an urgent referral was received for an ultrasound scan the patient would be booked onto the radiologists list which were held every other day. If they were unable to provide an appointment within two weeks, staff would liaise with the local NHS hospital or other BMI hospitals to arrange an appointment within this timescale.
- The service lead monitored referrals for the MRI unit and if necessary could book the MRI unit for an additional day.
- Under the NHS contract the service were required to meet a 6-week maximum wait target for MRI, x-ray and ultrasound. Staff told us it was rare not to meet this target and it was usually because a patient had failed to attend an appointment or were away on holiday. Information provided by the service showed that 100% of patients were seen within the six weeks wait period from April 2018 to May 2019 apart from one patient in June 2018.
- Once x-ray images were taken they were checked for quality by the radiographer and loaded onto the picture archiving and communication system (PACS). The images could then be sent direct to the referring consultant who had immediate access to them.
- There was a radiologist available every other day to report on images. Staff told us that images were normally reported on between two and five days. If an urgent report was needed and there was no radiologist available, staff could contact radiologists at other BMI sites.
- Between 30 April 2018 and 1 May 2019, the service reported a low number of cancellations. The MRI scanner had broken down on one occasion resulting in the cancellation of nine patient appointments. There were no cancellations reported for x-rays or ultrasound scans.
- Staff told us that it was rare for patients to have long waits in the department for imaging, however, if there were delays, they would inform patients of the delay

and the reason. We saw signs in the waiting area advising patients to check with the receptionists if they had waited longer than 15 minutes past their appointment time.

- The service managed did not attends (DNAs) effectively. Patients who did not attend were sent a letter to inform them about their non-attendance and asking them to book another appointment. If they failed to attend a second time they were referred to their consultant or GP.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

- We discussed complaints with staff. They told us formal written complaints were uncommon. When patients had complaints, staff told us they would try to resolve them at the time and would involve someone more senior if necessary.

- Staff told us any complaints were discussed specifically with the individuals involved and more generally with the entire team as a way of learning lessons and preventing similar occurrences. We saw that complaints were a standard item on the agenda for team meetings.
- Staff in the diagnostic imaging unit told us they had not received any complaints specific to the service between 1 January 2018 and 31 December 2018.

- Leaflets detailing how to make a complaint were prominent in all the waiting areas we visited, with accompanying posters on walls and in reception areas. Patients we spoke to said that they knew how to make a complaint and would feel confident doing so. None of the patients we spoke to had felt that they needed to make a formal complaint about their care.

Are diagnostic imaging services well-led?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings. We rated well led as **good.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- For further information about leadership, please refer to the well led section of the surgery report.
- The diagnostic imaging unit had stable leadership with clear roles and responsibility within the service. There was an imaging lead with overall managerial responsibility, a quality assurance lead and a clinical lead who was the nominated radiation protection supervisor (RPS).
- Staff in the unit were supported by a corporate lead for diagnostic imaging.
- Staff told us that leaders were visible and approachable, and they regularly saw the executive director and other members of the senior leadership team.
- Staff and managers were proud of their team and said they worked well together.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

- For further information about vision and strategy, please refer to the well led section of the surgery report.

- The BMI hospitals vision was displayed on notice boards around the hospital including patient waiting areas; 'Our vision is to offer the best patient experience in the most effective way, from our comprehensive UK networks of acute care hospitals'.
- The radiology department had its own philosophy and set of objectives. Their philosophy was;

- To provide the best possible care for all patients having radiological and imaging investigations.
- To provide a professional and caring service within a safe environment and of a standard that meets all our patient's expectations.
- To take into account differing needs of each individual.
- To be committed to continual professional development therefore improving and updating our skills as new technology and techniques are introduced.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

- We found a positive culture in diagnostic imaging services. The team had worked together for a long period of time and we observed good communication and relationships between staff. They were dedicated, professional and focused on meeting the needs of patients.
- Staff told us that overall, they felt respected, supported and valued by their colleagues, however, they sometimes felt overlooked by senior managers at the hospital.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- For further information about governance, please refer to the well led section of the surgery report.
- A daily 'communication cell' meeting was held each morning at the hospital. This was attended by a representative from each team. We observed a cell meeting whilst on inspection and noted that key messages, staffing issues, patient risks, incidents and issues were discussed.
- The service held regular team meetings to share and discuss information. The service lead cascaded information from the head of department meeting to the team and escalated any issues back to the heads of department meeting. Information from the health and safety meeting was also shared.
- Staff attended regular radiation protection committee meetings. We reviewed the minutes of the last meeting and saw that progress with the radiation protection advisor (RPA) audit action plan was reviewed, and this now formed part of the agenda for the clinical governance meeting.
- Clinical governance reports were thorough and covered areas such as patient feedback, incidents, staffing and staff training.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- For further information about managing risks, issues and performance, please see the well led section of the surgery report.
- Managers used information from a variety of sources to ensure they were delivering a quality service. This included patient satisfaction surveys, incident reports, complaints/compliments, training records, audit results, financial reports and continuing professional development files. We saw these were discussed in the minutes of the radiology department team meetings.
- Staff we spoke with were aware of their local risks and had plans in place to reduce or mitigate risks. We saw that risk assessments were in place including radiation risks. Staff told us that they did not have any current risks on the hospital risk register but could escalate them if necessary.
- Risk of power failure from national power supplier was clearly documented on the risk register. Controls were in place to ensure that services could continue if this occurred. The service had back up emergency generators which were regularly tested and maintained.
- Staff attended regular departmental meetings where risks and performance was discussed.

Managing information

Good

Diagnostic imaging

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

- The service had systems in place to collect information about performance and share it with staff, for example, information relating to waiting times and reporting times.
- The service used several IT systems to collect and share images and staff could access patient information such as previous x-rays and scans.
- Information governance policies and procedures were in place to ensure that information was stored securely, and patient and confidentiality was maintained.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services.

- The service used Friends and Family Test feedback to evaluate the service. In addition to this staff encouraged patients to complete a patient satisfaction survey during or after their visit. We saw surveys and collection boxes throughout the hospital and patients could also return them by pre-paid post. The surveys were analysed by an independent third party and the results were communicated back to the hospital monthly for learning and action.
- The service conducted an annual staff survey (BMI say) to monitor staff feedback and satisfaction. Following completion of the survey an action plan was drawn up to address areas of concern. We heard the results of the patient satisfaction survey being shared with staff at the communications cell meeting. As a result of the survey a picnic bench had been installed in the grounds for staff to use during break times. Team successes were also discussed at communication cell.
- Staff in the service told us they had been consulted and included in discussions on the refurbishment of the unit. They were also included in the planning of the next phase of development for the hospital as part of the five-year plan.
- Staff received awards for long service.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

- Staff took time out to work together to resolve problems and to review individual and team objectives. The unit had a set of departmental objectives with measures in place to ensure they delivered a quality service. The objectives were aligned with the hospital business plan.
- We found staff had a good appreciation of the importance of quality improvement and how this enhanced patient care and experience.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure patients are provided with a written notification of harm as soon as is practicable following a patient safety incident occurring. This written notification must include an apology, results of further enquires and other relevant information to the incident. Regulation 20 (1) (2) (3) (4) The provider must ensure the premises and equipment help to keep people safe, are properly maintained, and are suitable for their needs. (Regulation 15 (1) (a, c))

The provider must make reasonable adjustments to enable people with a disability to use the facilities on an equal basis and take due regard of any relevant protected characteristics of the Equality Act (2010). (Regulation 9 (1) (a, b))

Action the provider SHOULD take to improve

- The provider should ensure that all patients are consented for treatment in line with best practice and professional standards.
- The provider should ensure that all patients have access to shower facilities.
- The provider should ensure that safety information collected is displayed and shared by staff, patients and visitors to improve performance.
- The provider should ensure that all staff are trained in mental capacity assessments and Deprivation of liberty safeguards.
- The provider should continue to improve staff and patient engagement.
- The provider should ensure there are sufficient staff with the right skills working in outpatient and preassessment clinics.
- The provider should ensure that all consultants working in outpatient clinics comply with infection control best practice and 'bare below the elbows' policy.
- The hospital should replace the waiting room seat covers in the outpatient clinic to lessen the risk of infection.
- The hospital should ensure that patient records are stored securely at all times.
- The provider should ensure that evidence of use of a chaperone at outpatient appointments is clearly recorded in all notes every time.

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 20 HSCA (RA) Regulations 2014 Duty of candour The provider did not ensure that patients were provided with a written notification of harm as soon as is practicable following a patient safety incident occurring. This written notification must include an apology, results of further enquires and other relevant information to the incident. Regulation 20 (1)(2)(3)(4)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The fixtures and fittings on the ward were damaged with peeling laminate, damaged paintwork, woodwork and wall surfaces. We reviewed 12 doors they were all damaged, some with bare wood showing. We saw damage with rust on radiator covers, peeling paintwork, damage to architraves and chips and holes in walls. Five bed tables and patient lockers we reviewed were damaged, with peeling laminate, exposing bare wood. Cupboards in two bathrooms were damaged, exposing bare wood. Wallpaper in treatment room not IPC compliant. No wheelchair accessible toilet. Seats in waiting area were absorbent and not wipeable though were steam cleaned on a rota. Regulation 15(1)(c)(e)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Staff we spoke with gave mixed answers in relation to Patients being included or excluded patients living with dementia. The hospital policy was inclusive However staff we spoke with said that they were being excluded regularly. Senior staff said they would accommodate these pts. The hospital environment not dementia friendly. Staff we spoke with were not clear about deprivation of liberty safeguards. No wheelchair accessible bathrooms. Regulation 9(1)(b)