

# BMI The Huddersfield Hospital

## Quality Report

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

### Ratings

#### Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

The BMI Huddersfield hospital was owned by BMI Healthcare, a company which has a nationwide network of private hospitals. It provided surgery and inpatient treatment for NHS funded and private patients across a range of outpatient, diagnostic, and surgical services including cosmetic surgery, endoscopy, general surgery, cataract surgery and orthopaedic care. The building was built in the 1970's and was originally used as a nursing home. It was acquired by BMI Healthcare in 2008. The hospital is registered with the CQC for 29 beds.

Facilities at the hospital included;

- An outpatients department and consulting rooms. There was a pre-assessment clinic located on Hanson wing. Diagnostic imaging facilities provided on site included an ultrasound scanner, and X-ray. There were two operating theatres where surgery, endoscopy and fluoroscopy were carried out. In-patient facilities were provided on Simpson ward.

The hospital had made the decision not to see any children in the outpatient department from January 2016 due to low numbers who had attended.

We inspected the hospital as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. It was a routine planned inspection. We inspected the following two core services at the hospital; surgery and, outpatients and diagnostic imaging. We carried out the announced part of the inspection on 9 and 10 February 2016. We also carried out an unannounced visit on 18 February 2016.

Staff sent pathology tests twice a day via courier to an external off-site laboratory. Some pathology tests were performed on site at BMI Huddersfield using point of care testing equipment.

Referrals for outpatient consultations in orthopaedics, urology and ear, nose and throat (ENT) were seen at Oaklands health centre. We did not visit this location during the inspection. An MRI (magnetic resonance imaging) scanner unit was brought to the site once a week on a Saturday; we did not inspect that aspect of diagnostic services.

We rated the hospital as 'requires improvement' overall. Outpatients and diagnostic imaging services were rated as 'requires improvement', as were surgical services. For the hospital overall we rated the safe, effective, responsive and well led key questions as 'requires improvement'. The caring key question was rated as 'good'.

### **Are services safe at this hospital**

We rated safety at the hospital as 'requires improvement' overall. We found;

There had been one 'never event' and one serious incident at the hospital during the reporting period. There had also been 246 clinical incidents during the same time reporting period from October 2014 to September 2015. We saw 56% of the incidents had an adverse outcome.

Most staff were aware of duty of candour and the need to be open and honest when things went wrong, although some outpatients staff had limited or no knowledge. The nominated person for the safeguarding of children and vulnerable adults was the director of clinical services. The interim executive director was also trained to the same level and staff could contact them for advice. Staff received mandatory training in safeguarding of vulnerable adults as part of their inductions and had two yearly safeguarding updates. Compliance for both adult and children safeguarding training was 100% across the hospital. Information provided to us by the hospital showed the safeguarding training module was out of date. Clinical areas were visibly clean; however a comprehensive infection prevention and control audit in March 2015 showed 38 areas of non-compliance were found. Some actions had been completed and some were still outstanding. There had been two deep joint surgical site infections reported in 2015.

# Summary of findings

Water safety was potentially unsafe due to action plans not being followed in a timely way. There were 47 risks on the risk register in relation to estates and facilities. Some risks had been on the register for almost three years without remedial action being taken. There were safety issues with external and internal aspects of the building which had not been acted upon at corporate level. The hospital did not directly employ any doctors. The two Resident Medical Officers (RMOs) were contracted to an external company. They worked a 24 hour - 7 day a week service on a rotational basis. During this time they were on site and available 24 hours a day. The consultant surgeons and anaesthetists had practising privileges. In October 2015 there were 76 doctors who had been approved to practice; all of these had more than 12 months service at the hospital. The RMO told us patient handovers took place to the other RMO at the end of the seven day period. RMOs also handed over patient care to consultants as needed. Medicines were stored safely. There had been previous incidents reported in relation to routine medicines and controlled drugs (CDs) covered by the misuse of drugs act. Arrangements were in place to transfer seriously ill patients to a local NHS hospital.

## **Are services effective at this hospital**

We rated effectiveness as 'requires improvement' overall.

Effectiveness in outpatients and diagnostic imaging was inspected but not rated. We found;

The hospital took part in national and local audits; results were compared at a corporate level through the production of a monthly quality dashboard against other BMI hospitals and the NHS as a way of determining effectiveness in patient outcomes. Long term monitoring of patient outcomes was measured using Patient Reported Outcome Measures (PROMs), the National Joint Register programme and the Private Healthcare Information Network (PHIN). An enhanced recovery programme meant length of stay was shorter than average. Pain relief was effective and met patients' needs in a timely way. There was positive multi-disciplinary working in the interest of patients and 24 hour medical cover from the resident medical officer. A corporate audit calendar enabled results to be aligned to improvement plans. Policies were mostly developed nationally but a number of the corporate policies were out of date. Staff did not always have the most up to date guidance to follow. There had been four unplanned readmissions within 29 days of discharge for the reporting period. This is low compared with other independent acute hospitals. 76 consultants had practising privileges to work at the hospital. All of these had more than 12 months service at the hospital. Practising privileges are when authority is granted to a doctor or dentist to provide patient care in the hospital by a hospital's governing board. There was good practice in the use of association for peri-operative practice guidelines. Staff were allocated to theatre lists based on their skills and competencies. Consent forms had just 69% compliance in September 2015. Action plans to improve recording patient consent had begun to have improved results. Compliance figures for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training in the hospital was 95% in December 2015. All of the microwaveable meals in the ward fridge for patients were out of date by one day and no checks had been carried out on the ward freezer temperatures. The temperature gauge was broken and a new one had been ordered. However we did not see alternative arrangements in place to monitor the temperature or ensure the contents were kept at a safe temperature, while the gauge was broken. We found ice cream sorbet in the freezer which had been expired for three months.

## **Are services caring at this hospital**

We rated caring at the hospital as 'good' overall. We found;

All patients we spoke with said they had been looked after with compassion and their dignity had been respected. An internal survey showed over 97% of patients were satisfied with the care they had received. The hospital scores in the friends and family test (FFT) averaged 85% for the reporting period. People understood the care and treatment choices available to them and were given appropriate information and support. Patients were supported to return to

# Summary of findings

independence as soon as possible. We observed positive interaction between staff and patients. Staff gave patients information in a way they could understand and allowed time for questions. Patients and their families were able to be partners in their care. Phone calls were routinely made 48 hours after discharge to check patients were recovering and managing at home. During our inspection we heard only positive comments from patients.

## **Are services responsive at this hospital**

We rated responsiveness at the hospital as 'requires improvement' overall. We found;

A high number of surgical procedures were cancelled due to lack of equipment or broken equipment, or a breakdown in pre assessment procedures. Some of the patient rooms and clinical areas were quite dated. Referral to treatment times (RTT) data for the reporting period had exceeded the target of 90% of admitted patients beginning treatment within 18 weeks. Reasonable adjustments had not been made to allow wheelchair users or patients with significant visual loss to use the inpatient facilities on an equal basis. There were no rooms on the ward which had been adapted for a physically disabled patient to use. The hospital reported that wheelchairs users would be accommodated on an individual basis with an assessment of their needs undertaken prior to admission. Toilets for wheelchair users were available in the outpatient department. Patient information leaflets were not available in other languages however translation services were available and staff knew how to access these. Sign language services were provided for those patients that needed them. The two theatres were used six days a week in order to support patient flow and reduce waiting times. Access and flow in the OPD and radiology departments was well managed. Dementia training was part of the corporate training programme for staff, but patients with advanced dementia were not treated at the hospital. If someone had advanced dementia or did not have capacity, they would be triaged against exclusion criteria on receipt of referral as the service was not designed to meet their needs. There had not been any complaints for the six months before our inspection and the number of complaints made about the hospital had decreased from 2014.

## **Are services well led at this hospital**

We rated the well led key question as 'requires improvement' overall. We found;

The vision, values and clinical strategy were not well developed. They did not contain elements of compassion, dignity or equality. Staff were not aware of the overall vision or strategy for the hospital. The strategy action plan had not been updated since January 2015 and lacked having safety as a priority. The clinical governance committee fed into the Medical Advisory Committee (MAC). The hospital fed into the corporate governance arrangements via the hospital's executive group. However, the governance framework and risk management approach did not always support the delivery of safe, good quality care. The governance, risk management and quality monitoring in outpatients required improvement. There was no audit programme in outpatients and audits carried out were unstructured with no action plans or follow up. A service level agreement (SLA) with an external company used to transfer patient notes to other sites, should have been reviewed every two years. It had not been updated since 2011. Governance in radiology was well established and there was an annual audit programme. We reviewed records during the inspection; over 80% of the World Health Organisation (WHO) safer surgery checklists had omissions. If preventable measures had been in place, the never event would not have occurred. There were repeated failures in equipment or a lack of equipment in theatre which resulted in procedures being cancelled after patients were anaesthetised. Incidents related to pre assessment were repeated over the course of a year and lessons apparently not learned. A recent change in leadership of pre assessment had been made. We reviewed the hospital risk register. Maintenance of the building and water safety did not appear to be a corporate priority. Some risks had been on the register for two to three years without full remedial action being taken despite being reported at a corporate level; for example, falling masonry, potholes in the drive, and the lack of fire doors in theatre. Water safety plans had not been acted upon in the required time. The senior managers had recently been in post and were aware of many of the issues. They had local improvement plans but were constrained by the corporate team. There was positive local leadership, the executive director, the ward manager and the director of clinical services were visible, approachable and accessible to staff. However, not all leaders had the necessary experience, or knowledge for aspects of their role. We found some staff had not been properly prepared or trained to

# Summary of findings

take on certain roles such as carrying out root cause analysis (RCA) investigations. For example, managers carrying out root cause analysis (RCA) investigations had not received training in carrying these out. Staff told us they were happy and felt well supported in all of the services we visited. There was evidence of good team working, both within and between teams, and a positive open culture. The chartered society of physiotherapy (CSP) recognised the hospital's physiotherapy team in their 2014 awards. This was related to the enhanced recovery programme for joint replacements. We saw evidence of good communication in the form of daily 'comm cells'. These were meetings held between the hospital's senior management team and the heads of department where patient admissions, staffing, risk and incidents were discussed. We also saw good practice in the form of safety 'huddles' taking place in theatres where surgeons discussed allergies and patient safety with all staff.

We saw several areas of outstanding practice including:

- We saw evidence of good communication in the form of daily 'comm cells'. These were meetings held between the hospital's senior management team and the heads of department where patient admissions, staffing, risk and incidents were discussed.
- We also saw good practice in the form of safety 'huddles' taking place in theatres where surgeons discussed allergies and patient safety with all staff.
- The chartered society of physiotherapy (CSP) recognised the hospital's physiotherapy team in their 2014 awards. This was because of their involvement in the enhanced recovery programme for joint replacements. The average length of stay for both hip and knee replacements at the hospital was now below three days.
- We found the physiotherapy department had introduced the use of a quality of life questionnaire for all patients to monitor the effectiveness of treatment they gave to patients.
- The ward manager told us one of their objectives was to set up an ambulatory care centre which could be managed by skilled health care assistants. They said uncomplicated conditions could be treated without the need for an overnight stay in hospital.

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

Importantly, the provider must:

- The hospital must ensure compliance with the WHO 'five steps to safer surgery' procedures.
- The hospital must ensure theatre equipment is safe, available and fit for purpose.
- The hospital must put processes in place to ensure there is a robust assessment in pre-assessment phase and a process must also be established so that action can be taken on investigation results from pre-assessment.
- The hospital must ensure infection control policies and procedures are followed and actions from the infection control and water safety plan are implemented.
- The hospital must ensure staff receive up to date safeguarding training relevant to their roles.
- The hospital must ensure the building management system has an alarm fitted so any unsafe changes in water temperature can be immediately detected.
- The hospital must ensure checks are in place and food served is within date; review delivery dates of food from external supplier.
- The hospital must ensure premises are safe and properly maintained. In particular, review lack of fire doors in theatre, fire doors in OPD, safe storage of waste in order to comply with legislation (HTM 07-01), security of the medical gas storage area, and ward freezer checks for temperature.
- The hospital must ensure sufficient numbers of suitable competent staff in theatres and OPD, including allied health professionals.
- The hospital must ensure policies and procedures are reviewed and are in date.
- The hospital must ensure staff are suitably trained before carrying out root cause analysis investigations to optimise learning from adverse incidents.

In addition the provider should:

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- The hospital should ensure there are clear systems in place with identified responsibilities for carrying out external quality assurance checks on point of care testing equipment.
- The hospital should review the position of the endoscope washer and review the route of trollies brought into theatres from the outside and through theatres.
- The hospital should consider using leaflets in other languages as well as in English.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

### Rating

### Summary of each main service

#### Surgery

**Requires improvement**



Overall we rated this service as 'requires improvement'.

We had limited assurance about safety in several areas including theatre equipment and procedures. We also had limited assurance around the safety of the premises and facilities, including the lack of fire doors in theatres and the lack of action taken to ensure water safety. The overall clinical strategy action plan had not been updated since January 2015 and lacked having safety as a priority. The hospital reported they followed the BMI corporate clinical strategy which had an associated action plan.

Over 83% of the WHO safer surgery checklists we looked at had omissions and no evidence certain checks had taken place.

We found services did not always meet people's needs; patients could not always have their surgery or procedure as planned due to a lack of theatre equipment or broken equipment, or a breakdown in pre assessment procedures.

Reasonable adjustments had not been made to allow wheelchair users or patients with significant visual loss to use the facilities on an equal basis.

The hospital reported that wheelchairs users would be accommodated on an individual basis with an assessment of their needs undertaken prior to admission.

The leadership, governance and risk management approach did not always support the delivery of high quality person centred care. The vision, values and clinical strategy were not well developed. They did not contain elements of compassion, dignity or equality.

Patients had good outcomes because they received care and treatment which met their needs. Information about their care was routinely collected and used to improve care. Patients were supported and treated with kindness, dignity and respect. They were and encouraged to be partners in their own care. There was positive feedback from people who had used the service

# Summary of findings

## Outpatients and diagnostic imaging

### Requires improvement



Senior managers had come into post recently. They were already aware of many issues; local plans were made for improvement, but were constrained by capital expenditure being limited. There was positive leadership at ward level, staff were happy and a supportive open culture was evident throughout surgical services.

We rated this service as 'requires improvement' overall.

The safety of the care and treatment delivered by the services required improvement. This was because there was limited assurance about safety in several areas involving the premises and environment. There was no evidence that the recommendations from a legionella water hygiene risk assessment in May 2014 had been effectively implemented.

We found staff knowledge about the new duty of candour requirements was limited and some staff did not know about it.

Systems for ensuring relevant staff were aware of abnormal patient test results were not robust. This meant there was a risk that abnormal results were not acted on.

Managers carrying out root cause analysis (RCA) investigations had not received training in carrying out RCAs. This meant they did not necessarily have the right skills in this area.

The induction process for bank and agency staff working at the hospital did not assure us that patients would be kept safe at all times.

The leadership and governance at the hospital required improvement and did not always support the delivery of high quality person-centred care. The sustainable delivery of quality care was being put at risk by financial limitations.

Some staff and managers were unable to tell us about the vision and strategy for the future and were not always aware of their risks and challenges. However, staff were happy and felt supported. There was an open and supportive culture where incidents and complaints were reported, and lessons learned.

Incidents were reported and investigated and we saw evidence of lessons learnt. Cleanliness and hygiene was good and there was sufficient



# Summary of findings

well-maintained equipment to ensure patients received the treatment they needed in a safe way. There were sufficient well-trained and competent nursing and medical staff to ensure patients were treated safely.

Care and treatment in the services inspected was effective and evidence-based. Patient outcomes were measured, staff were competent and there was evidence of multidisciplinary working.

Staff caring for patients and their families treated them with compassion, kindness, dignity and respect and maintained their privacy. All of the patients we spoke with gave positive feedback about the service: patient satisfaction scores from surveys were high.

Outpatient and diagnostic imaging services were responsive to patients' needs. Access and flow in the OPD and radiology departments was well managed.

Translation services were available and staff knew how to access these. Sign language services were also provided for those patients that needed them.

# Summary of findings

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**Requires improvement** 

BMI The Huddersfield Hospital

**Services we looked at**

Surgery; Outpatients and diagnostic imaging.

# Summary of this inspection

## Background to BMI The Huddersfield Hospital

The BMI Huddersfield hospital was an independent (non NHS) hospital owned by BMI Healthcare, a company which has a nationwide network of private hospitals. It provided surgery and inpatient treatment for NHS funded and private patients across a range of outpatient, diagnostic, and surgical services including cosmetic surgery, endoscopy, general surgery, cataract surgery and orthopaedic care. It is situated in Birkby, located to the north of Huddersfield, and primarily serves the communities of West Yorkshire. The building was built in the 1970's and was originally used as a nursing home. It was acquired by BMI Healthcare in 2008. The hospital is registered with the CQC for 29 beds.

Facilities at the hospital included outpatient and diagnostic areas, a surgical pre assessment area, an in-patient ward and two operating theatres. The in-patient area, Simpson ward had 21 single rooms in use with ensuite facilities, the other beds were located on Hanson wing. Four bedrooms had been converted to pre-assessment rooms and a pre-assessment waiting room. Two rooms were used as male and female ambulatory care rooms, and could be converted back to patient bedrooms if required. Two rooms were maintained as patient rooms and utilised as required; one was currently not in use whilst awaiting renovation.

Simpson ward had all single rooms with ensuite facilities. The outpatient department had seven consulting rooms, a treatment room, a physiotherapy area and an X-ray room. Mobile MRI scanning facilities were available on a Saturday from an external company which brought the scanner to the hospital. Referrals for outpatient

consultations in orthopaedics, urology and ear, nose and throat (ENT) were seen at Oaklands health centre in Holmfirth. This site is registered separately with the CQC and was not visited as part of this inspection. In January 2016, the hospital made the decision not to treat children due to low patient numbers.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during 2015-2016. The hospital had been inspected previously; the most recent inspection before this one took place in December 2013 and the hospital was found to be meeting all the standards of quality and safety it was inspected against. We inspected this hospital as part of our independent hospital inspection programme. The inspection was conducted using the Care Quality Commission's new comprehensive inspection methodology. It was a routine planned inspection. For this inspection, the team inspected the following two core services at this hospital;

- Surgery
- Outpatient and diagnostic imaging.

The registered manager had applied to the CQC in December 2015 to be deregistered as the named person; however they were still the registered manager at the time of our inspection in February 2016. A new registered manager subsequently registered with the CQC. (A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law).

## Our inspection team

Our inspection team was led by:

Inspection Lead: Sarah Dronsfield, Inspection Manager, Care Quality Commission.

The team included CQC inspectors and a combination of specialists including a consultant surgeon, theatre nurses and an estates specialist professional advisor.

# Summary of this inspection

## How we carried out this inspection

We carried out the announced part of the inspection on 9 and 10 February 2016. We also carried out an unannounced visit on 18 February.

We spoke with patients and members of staff, including managers, nursing staff (registered and unregistered), medical staff, pharmacy staff, allied healthcare professionals, support staff and managers. We observed how patients were being cared for and reviewed patients' clinical records.

Prior to the inspection we reviewed a range of information we had received from the hospital. We also distributed comment cards for patients to complete and return to us. We also asked the local clinical commissioning group to share what they knew about the hospital.

## Information about BMI The Huddersfield Hospital

### Activity (October 2014 to September 2015)

Inpatients: 3440

- NHS funded overnight inpatients (550)
- NHS funded day case patients (2043)
- Other funded overnight in patients (150)
- Other funded day case patients (697)

Visits to the theatre: 3375

The five most common procedures performed were;

- Multiple arthroscopic operation on knee (including meniscectomy) (584)
- Carpal tunnel release, including endoscopic (265)
- Total prosthesis replacement knee joint, with/without cement (211)
- Phacoemulsification of lens with implant - unilateral (207)
- Laparoscopic repair of inguinal hernia - unilateral (165).

### Outpatient appointments (including follow up):

13,625

- NHS funded (7928)
- Other funded (5697)

### Staff

Doctors and dentists with practising privileges: 76

Nurses: 14.8

- Inpatient departments 10.3
- Theatre departments 3.7
- Outpatient departments 0.8

Operating department practitioners (theatre) 4.0

Care assistants: 8.5

- Inpatient departments 2.3
- Theatre departments 3.6
- Outpatient departments 2.7

Other hospital wide staff: 31.3

- Allied health professional 5.5
- Administrative and clerical staff 20.9
- Other support staff 4.9

Surgical site infections: 11

- Limb surgery (8)
- Abdominal surgery (2)
- Thoracic surgery (1)

Unplanned transfers of inpatients to other hospitals: 8

Unplanned readmissions within 29 days of discharge: 4

At the time of the inspection the controlled drugs accountable officer was the registered manager.

# Summary of this inspection

At the time of inspection none of the services were accredited by a national body.

## **Outsourced services**

Catering

Histology

Medical records archiving

MRI Scanner

Pathology

Radiology

Resident Medical Officer

Sterile Services.

# Detailed findings from this inspection

## Overview of ratings






Our ratings for this location are:

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

## Notes

1. We will rate effectiveness where we have sufficient, robust information which answer the KLOEs and reflect the prompts.

# Surgery

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

## Information about the service

The BMI Huddersfield hospital was owned by BMI Healthcare, a company which has a nationwide network of private hospitals. It provided surgery and inpatient treatment for NHS funded and private patients across a range of surgical services, including cosmetic surgery, endoscopy, general surgery, cataract surgery and orthopaedic care. The building was built in the 1970's and was originally used as a nursing home. It was acquired by BMI Healthcare in 2008.

The hospital did not employ any consultant surgeons. Consultants who applied for and were granted practising privileges used the facilities of the hospital to provide services to their patients. The resident medical officer was contracted through an external agency. Nursing staff were employed by the hospital.

BMI Huddersfield hospital had a pre assessment area (Hanson wing) and treatment rooms. There was one in-patients' ward, (Simpson ward) which had 21 single rooms with en-suite facilities. There was a theatre area which comprised of two preoperative rooms, two theatres and a recovery area. All operations were planned in advance; the hospital did not have provision for treating high dependency patients and in an emergency, patients were transferred to the nearby NHS hospital. Surgeons carried out the majority of operations on weekdays.

Between October 2014 and September 2015, there had been 3375 theatre procedures carried out. The five most common surgical procedures were 'keyhole' arthroscopy of the knee, carpal tunnel release, total knee replacements, cataract surgery and keyhole hernia repairs.

We carried out this inspection as part of our comprehensive inspections of independent healthcare providers. The hospital had reported a never event and a serious incident in September 2015 and had reported issues with the endoscope decontamination procedures to the CQC in July 2015.

We visited the Huddersfield hospital on an announced inspection during 9 and 10 February 2016. We carried out an unannounced inspection on 18 February. As part of the inspections, we visited the pre assessment area, the ward, pre-operative areas, theatres, the theatre recovery area, pharmacy and consulting rooms. We also visited estates and facilities areas including medical gas storage areas.

During our inspection we spoke with a range of ward staff and theatre staff, consultants, the resident medical officer, catering staff, housekeepers, the ward manager, the theatre manager, pharmacy staff, estates and maintenance staff, the infection prevention and control lead and senior managers. We spoke with 26 staff in total.

We spoke with five patients, and one relative; we observed care and treatment and looked at 18 care records. We reviewed comments from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about the hospital.



# Surgery

## Summary of findings

We rated BMI Huddersfield hospital as 'requires improvement' overall. We rated safe, effectiveness, responsiveness and well led as 'requires improvement', and we rated caring as 'good'.

We had limited assurance about safety in several areas including theatre equipment and procedures. We also had limited assurance around the safety of the premises and facilities, including the lack of fire doors in theatres and the lack of action taken to ensure water safety. The overall clinical strategy action plan had not been updated since January 2015 and lacked having safety as a priority. The hospital reported they followed the BMI corporate clinical strategy which had an associated action plan. Over 83% of the World Health Organisation (WHO) safer surgery checklists we looked at had omissions and no evidence certain checks had taken place.

We found services did not always meet people's needs; patients could not always have their surgery or procedure as planned due to a lack of theatre equipment or broken equipment, or a breakdown in pre assessment procedures.

Reasonable adjustments had not been made to allow wheelchair users or patients with significant visual loss to use the facilities on an equal basis. The hospital reported that wheelchairs users would be accommodated on an individual basis with an assessment of their needs undertaken prior to admission.

The leadership, governance and risk management approach did not always support the delivery of high quality person centred care. This appeared to be at risk by the financial challenge upon the hospital. The vision, values and clinical strategy were not well developed. They did not contain elements of compassion, dignity or equality.

However, we also found;

Patients had good outcomes because they received care and treatment which met their needs. Information about their care was routinely collected and used to

improve care. Patients were supported and treated with kindness, dignity and respect. They were and encouraged to be partners in their own care. There was positive feedback from people who had used the service

Senior managers had come into post recently. They were already aware of many issues, local plans were made for improvement, but they were constrained by capital expenditure being limited. There was positive leadership at ward level, staff were happy and a supportive open culture was evident throughout surgical services.

# Surgery

## Are surgery services safe?

Requires improvement 

We found safety in surgery to require improvement. We found;

- There had been one never event, one serious incident and 246 other incidents from October 2014 to September 2015; 56% of the incidents had an adverse outcome. There had been 21 incidents where theatre equipment was faulty, broken or not available. This resulted in procedures being cancelled or abandoned after patients had been anaesthetised.
- Surgical equipment such as blades, screws and forceps had gone missing during surgical procedures (they had not been found inside patients).
- There had been 32 incidents where surgery or procedures had to be cancelled as a result of pre assessment clinic staff not taking action on test results.
- Over 83% of the WHO safer surgery checklists we looked at had omissions and no evidence certain checks had taken place.
- Decontamination of an endoscope had been ineffective in 2015 and services were suspended until investigations took place.
- The positioning of the endoscopy washer room was unsuitable; after use, wet endoscopes were unloaded next to sterile theatre packs. Senior staff told us there was nowhere else for the washer room to be situated.
- There had been 38 areas of non-compliance with an infection prevention and control audit from March 2015 on Simpson ward; some issues were yet to be acted upon.
- Water safety was potentially unsafe due to action plans not being followed in a timely way. There were safety issues with external and internal aspects of the building which had not been acted upon at corporate level.

However we also found;

- Hospital acquired infection rates were very low. There had been no cases of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium difficile (C.Diff) infections at the hospital from October 2014 to September 2015.

- Evidence of good communication in the form of daily 'comm cells'.
- Good practice in the form of safety 'huddles' taking place in theatres where surgeons discussed allergies and patient safety with all staff.
- Newly appointed senior staff and managers were aware of safety issues and were addressing them at that level.

## Incidents

- During the time period October 2014 to September 2015 there was one never event and one serious incident. (Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event). The never event and the serious incident both occurred in September 2015, and were in different clinical areas.
- The never event was wrong site femoral nerve block carried out during a theatre procedure. We reviewed the root cause analysis (RCA) and saw the incident had been fully investigated. An action plan had been implemented and lessons learned. 'Stop before you block' signs had been put up in theatres. The serious incident was a failure to recognise deterioration of a patient following a surgical procedure. We reviewed this RCA and saw a full investigation had taken place. An action plan had been implemented and lessons learned. A new ward manager had undertaken actions and also carried out regular spot checks for assurance the changes were embedded.
- There had been 246 other incidents reported from October 2014 to September 2015. Of these, 139 had an adverse outcome (56%). Out of those with an adverse outcome, 59% were recorded as no harm; they included examples such as procedures cancelled due to risk of infection, and equipment failure which resulted in operations being cancelled. Around 27% were recorded as low harm; they included examples such as extended length of stay or readmission with infection. Moderate incidents accounted for 19% of those with an adverse outcome; they included examples such as wrong site nerve block and complications of surgery. Severe

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outcomes accounted for 1.7% of those reported and included examples such as serious complications after surgery and failure to respond to deterioration of a patient.

- On five occasions the wrong patient was taken to theatre (this was noticed before any procedures commenced). It was not possible to see from the incident register what had been done to prevent this re-occurring.
- There were 32 incidents arising from errors or omissions in pre assessment clinic which resulted in operations being cancelled on the day patients were admitted. The reasons included failures to act on test results, not advising patients to stop taking certain medications before admission and not obtaining sign language interpreters when they were needed.
- On four occasions, incident forms were completed after staff found surgical equipment such as blades, screws and forceps were missing upon final counts in theatres. No items were found to be retained in patients following extra x rays, and none were found in refuse or linen bags.
- In early 2015, staff at the hospital discovered decontamination of the endoscope had not been effective. Senior staff reported this to Public Health England (PHE an executive body of the Department of Health) and the Clinical Commissioning Group (CCG). PHE were satisfied with actions taken by the hospital and no patients needed to be recalled.
- Staff told us they felt supported to record and report incidents. We saw that lessons had been learned on the ward and in pre assessment areas following the appointment of a new ward manager; however we were concerned some incidents continued to be repeated in theatres such as equipment failures. Senior managers had recognised a need to strengthen assurance in this area and were in the process of forming a group to look into making lasting improvements.
- Staff told us communication in the form of 'comm cells' were held on a daily basis as a way to pass information about incidents. We also saw evidence that senior staff discussed clinical and non-clinical incidents at the hospital's Clinical Governance Committee (CGC) and Medical Advisory Committee (MAC) meetings.
- We observed a safety 'huddle' taking place in theatres where a surgeon discussed allergies and patient safety

with all staff. We saw the order of patients had been changed and good practice was followed as the list was reprinted in a different colour to make staff aware of changes.

## Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff told us of the need to be open and honest when things went wrong and we saw documented evidence from governance meetings where duty of candour had been applied. We also saw it had been applied in response to formal complaints.

## Safety thermometer or equivalent (how does the service monitor safety and use results)

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm-free care. It was used at the Huddersfield hospital for patients whose care was funded by the NHS. The use of the tool allows the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTEs), pressure ulcers, falls and urine infections to be measured on a monthly basis.
- We reviewed data from August 2015 to January 2016 for Simpson ward; the care was 100% 'harm free' during that time. In December 2015 there was one patient who had a previous deep vein thrombosis, and another with a previous pulmonary embolism.

## Cleanliness, infection control and hygiene

- There had been no cases of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium difficile (C.Diff) infections at the hospital from October 2014 to September 2015.
- Patients were routinely screened for infections during their pre assessment appointment. If they were found to be positive for MRSA, information was faxed to their GP and the GP prescribed a five day course of treatment.

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We saw two incidents (April and October 2015) where this communication had not been passed to the GP; the patients were admitted but their operations were cancelled and rescheduled.

- Clinical areas were visibly clean and personal protective equipment (PPE) in the form of aprons and gloves was available in wall mounted units on the ward. We observed staff using PPE during our inspection. Ward staff wore alcohol hand gel clipped to their uniforms so they could use this in between patient contacts. Theatre staff wore theatre 'scrub' wear in the theatre department and there were 'one-way' walking areas in and out of staff changing rooms to maximise cleanliness.
- Theatre staff cleaned the theatres in between patients and housekeepers cleaned at the end of the day. There was a deep clean of theatres twice a year by an external company.
- We saw systems were in place for the preoperative phase for patients to minimise the risk of infection, for example, patient gowns for theatre wear and the removal of jewellery and artificial nails.
- Systems were also in place for the intraoperative phase, including staff hand decontamination, and the use of sterile drapes, gowns and gloves.
- Two deep joint surgical site infections were reported in 2015. We saw these were discussed at the infection prevention and control (IPC) committee meetings in September and December 2015. An RCA was carried out to look at how the infections occurred and to learn lessons. There had been 11 surgical suite infections in total during the period from October 2014 to September 2015.
- Hand hygiene audits were carried out, a sample of 10 staff were randomly selected and observed. The World Health Organisation (WHO) 'Five moments for hand hygiene' was used. In August 2015, theatre staff achieved 100% compliance. Simpson ward staff achieved 95% as one person was found to be not following the correct procedure and was retrained. In September 2015, Simpson ward achieved 100%.
- The Director of IPC annual report (2014-2015) was the most recent one available to us. It contained a self-assessment against a code of practice. Three out of ten compliance areas achieved 100%. Action plans were

developed for areas of non-compliance for example; in relation to people who had or developed an infection being identified promptly and receiving the appropriate treatment and care.

- A comprehensive IPC audit was carried out in March 2015; 38 areas of non-compliance were found. Some actions had been completed and some were still outstanding. These included;
- All clinical hand wash basins were non-compliant with regulations (this was put on the risk register and was still ongoing in February 2016; it was due for review in April 2016).
- The outside waste compound was not secure as per Department of Health regulations (this was placed on risk register in June 2013, and reviewed in December 2015, there was no further date for action or review at the time of our visit).
- Fabric, non-wipeable chairs in patient rooms (these were to be replaced, this was ongoing in December 2015)
- No evidence of mattress checks (monthly checks were commenced).
- Carpets in patient rooms which were stained and difficult to clean (this was placed on the risk register and became part of a refurbishment programme).
- Re useable plastic wash bowls for patients with residual water in them (all were replaced with disposable bowls).
- We were concerned as trolley cabinets with used theatre packs were wheeled through 'clean' theatre areas. We saw unwrapped used surgical instruments in the trollies. Clean / sterile equipment was delivered and loaded onto 'clean' trollies and wheeled from the outside area back in through theatre areas. The wheels of the trolley had been in contact with the ground outside in the loading/ refuse area. We raised this with staff at the time of inspection who told us there was no other way to get the trollies in or out.

## Endoscopy decontamination

- The endoscopy unit was not JAG (Joint Advisory Group) accredited area. JAG is an independent quality improvement and service accreditation programme. Senior staff told us the company were working towards accreditation. New guidance from NHS England meant if they did not achieve this by September 2016, they would not be able to carry out endoscopy services. Senior staff told us there were plans to move endoscopy decontamination off site by the end of the year

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- In May 2015 an audit was carried out using the Infection Prevention Society Quality Improvement Tool. Issues were found relating to the environment, decontamination processes and a lack of an independent monitoring device on the reconditioned endoscope washer.
  - There were concerns around its effectiveness and the hospital consulted with Public Health England (PHE). Endoscopy services were suspended and the issues were escalated to PHE and the CCG. A 'look back' exercise was carried out to ascertain any risks to patients. An action plan was put in place and carried out at the time. We were informed in July 2015.
  - An incident review carried out by the hospital and PHE showed the risk to patients was low and no patients needed to be recalled. Duty of candour was discussed with the consultant in Communicable Diseases from PHE and it was felt it did not need to be applied to patients who had been treated.
  - We saw there was shared use of the theatre dirty utility room and endoscopy decontamination area. There was a risk of cross contamination after the endoscope was manually cleaned. There had been a risk assessment of this in June 2015 and a plan to clarify the use of the room. When we visited in February 2016, the room still has shared use. We raised this with senior staff; they told us there was no other space for either of these functions to take place.
  - The rear of the endoscopy washer opened into the theatre sterile storeroom. This meant that once the washing cycle was complete, staff unloaded the washer next to sterile ready to use theatre packs. There was a risk of water transfer from handling of wet endoscopes. We saw on the risk assessment form there were no controls in place to reduce this risk. As there was nowhere else to site the sterile theatre packs, staff had positioned shelving with laminated backs to form a small square area around the clean side of the endoscopy washer. This made the space very small and meant staff had to squeeze in and out of shelving with sterile theatre packs on.
- guidelines such as World Health Organisation (WHO) Guidelines for drinking water quality (GDWQ 2008) and legislation by the Health and Safety Executive and Health and Safety Act.
- Faults within buildings and hazardous conditions raise the risk of outbreaks of illness such as Legionnaire's disease. There were faults and conditions in the water system at the hospital such as poor design and stagnation from 'dead legs' (redundant pipework). The presence of dead legs had been on the risk register since October 2013 and estates staff told us annual water inspections had taken place since then.
  - An annual inspection was carried out by an external company on 4 December 2015 and published in January 2016. We saw the report 'Legionella Risk Assessment Domestic Hot and Cold Services' and noted several points of non-compliance. The risks were RAG rated (red, amber green), this indicated a timescale of urgency for remedial work to be carried out.
  - The report stated it was essential that the recommendations were applied as required, and that high priority (red) risk tasks should have been carried out within three months of the date of the risk assessment. These included:
    - Deep cleaning and disinfection of water tanks, sealing them to prevent contamination from dirt and insects
    - Drain and clean hot water cylinders
    - Removal of 'dead legs' (redundant pipework)
  - The hospital put in place an action plan and updated it in March 2016; it indicated there was no evidence the recommendations from the water risk assessment had been effectively implemented across the hospital site. We raised this with senior managers during our inspection. We were told this had been escalated to the corporate team however authorisation had not been given for work to be carried out.
  - We saw from safety plan some of the moderate (amber) risk tasks had begun to be carried out, such as the descaling of taps to help prevent bacterial spread.
  - There was a building management system (BMS), which was computer-based control system to control and monitor the building's mechanical and electrical equipment such as heating, ventilation, lighting, power systems, fire systems, and security systems.

## Environment and equipment

### Water safety

- Water safety is a vital part of reducing the risk of infections from water borne bacteria and organisms. We were concerned the hospital did not adhere to



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- We saw the BMS did not have an alarm and no automatic print outs if something went wrong. Staff told us they carried out manual checks every Monday. This meant if there was a fault in the hot water systems between Tuesday and Sunday it would not be detected.
- We met with the IPC lead and discussed the main challenges of infection prevention and control; they told us it was the failure in the building, the lack of hand wash basins and having carpets in patient rooms.

## Equipment

- There had been 21 incidents where theatre equipment was faulty, broken or not available. This resulted in procedures being cancelled or abandoned after patients had been anaesthetised.
- One incident occurred when a screw broke following a cosmetic surgery procedure and part of the metal screw was left in the patient's skull. A follow up examination by the consultant found no harm had been caused and a decision was made to leave the screw in place. Senior managers told us this incident had been notified to the Medicines and Healthcare Products Regulatory Agency (MHRA), who escalated it to the manufacturers..
- The freezer in the ward kitchen had a door which was rusty and scratched at the bottom. We raised this with staff; they told us a new freezer had been ordered the day before after a four week wait for approval. They did not know when it was due to be delivered.
- We spoke with the executive director and director of clinical services about theatre equipment. They had already identified work needed to be done and were in the early stages of addressing these issues, for example, new endoscopy equipment had been received on site at the time of inspection but was not yet in use.

## Environment

- There were 47 risks on the risk register in relation to estates and facilities. Some risks had been on the register for almost three years without remedial action being taken. Some examples included:
- Potholes in the car park and uneven paving outside the hospital entrance
- The capacity and condition of the clinical waste compound.
- The potholes had been reviewed in December 2015 and it was felt this was optimally controlled. According to the risk register, work would be carried out if the potholes became dangerous.

- During our visit, a member of the CQC inspection team tripped on uneven paving outside the hospital entrance when it was dark. The lights in the car park were out and the change in levels could not be seen. We reported this to senior managers and one week later new lights had arrived and were due to be fitted. Senior managers told us they were also obtaining quotations for repair work to be carried out on the potholes.
- The risk register noted legal requirements may not be met for the waste compound as the waste did not fit into the number of containers on site and the wooden compound was not high enough for security purposes. Increasing the number of waste collections had been proposed but this would have incurred extra costs so had not been carried out. This had been escalated to the corporate team but further action had not followed.
- The Department of Health 'Health Technical Memorandum 07-01: Safe management of healthcare waste (2013) provides practical advice for all healthcare providers involved in the management of healthcare waste. We were concerned these were not being followed.
- An enclosure around the roof water tank which was 'rotting'; it had an asbestos roof. The risk register indicated it was preferable to replace the enclosure due to asbestos risks. An inspection had taken place by an external company. Some remedial work was taking place during our inspection.
- In the soiled equipment room at the back of theatres (where endoscopes were washed by staff before being placed in the machine for decontamination), there were ceramic wall tiles missing; the laminated windowsills were broken at the edges due to water ingress from the sink. Plastic tubing for additives to the washing water in the sinks were stuck on with plastic suckers. The plastic suckers were provided by the manufacturer to secure the tubing to the wall. Staff reported that the suckers were removed by the staff on a regular basis to ensure the area was thoroughly cleaned. We saw walls on the way into and out of theatres had holes which had been roughly filled and not sanded down.
- There was unused equipment (suction machines) stored in the plant room next to theatres. Staff told us these were for disposal; there were no signs on them to indicate this.
- The recovery room was intended for the recovery of up to three patients at a time. We found this was a small area and only suitable for safe recovery of two patients

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at a time. An unused endoscopy decontamination machine was stored in the recovery room. This space could have been opened up to make better use. There was no sluice to dispose of bedpans or urinals if patient had needed to use them. Staff used absorbent crystals and then could dispose of this in clinical waste bags. Falling masonry and concrete gutters had been on the register since February 2014. Barriers had been erected to prevent pedestrians walking under the crumbling masonry).

- We carried out an unannounced inspection on 18 February and spoke with estates and maintenance staff. We saw records of a simulated power failure every month to check a back-up generator started. The generator covered all of the power for the hospital in the event of mains failure. The fuel in the generator was at a 40% level, staff told us this would last approximately two days if necessary. Staff told us theatres had an uninterrupted power supply (UPS) and a new UPS system was due to be fitted later in 2016.
- We looked at the medical gas storage area. There were signs outside to indicate medical gases were stored. There were louvered doors to vent any escaped gases. A padlock was in the unlocked position and the door was opened with a Yale key. We did not see any CCTV cameras. We were not assured the security in this area was up to NHS Business Service Protect standards (Guidance on the security and storage of medical gas cylinders).
- We also visited the main hospital kitchen; food preparation areas and the ceiling mounted filters looked clean, however the overall condition of the kitchen area was poor. The entry and exit area to the kitchen was messy.
- The 'pantry' food storage area could not be cleaned properly. For example, shelving had porous wooden edges which could not be effectively cleaned.

## Medicines

- The hospital had one pharmacist and a pharmacy technician; there were three bank pharmacists to provide cover. The pharmacy was open Monday to Friday 8.30 am to 4.30 pm. The hospital had an arrangement with a local pharmacy for out of hours and weekends so patients could collect prescriptions if necessary. Taxis were also used at weekends to collect any out of stock medication which had been prescribed for in patients.

- If emergency medication was needed on a weekend, the RMO had a set of keys and the senior nurse on duty had the other, both were needed to access the area. Only the on call pharmacist had keys to the out of hour's controlled drugs cupboard. If controlled drugs were needed in an emergency for theatres the on call pharmacist was asked to respond.
- There were drug fridges in the pharmacy department with calibrated thermometers. If the temperature dropped out of hours, an alarm sounded, the resident medical officer or senior nurse on duty could respond.
- Pharmacy staff dispensed medicines for in patients and to theatres. They carried out a top up service for the ward to ensure they had safe levels of medication. Pharmacy staff also did medicines reconciliation rounds every week day to ensure patients were only taking medicines which was necessary and did not interact with each other. They also checked medicine allergy status of patients.
- All medicines were prescribed by the patient's consultant or anaesthetist. The resident medical officer (RMO) was also available to prescribe medication.
- Guidelines and resources were available for medication including online guidance and the British National Formulary.
- We saw patients were prescribed antibiotics in line with national guidance. Pharmacy staff kept a log of patients returning to the ward with a post operative infection and monitored the results of wound swabs.
- We checked four medication records and saw all were legible and completed in line with the hospital policy and national guidance.
- Possible theft of medical gases from the medical gas storage area had been on the risk register since August 2014 and reviewed in December 2015. Actions to improve this were still waiting to be completed.
- There had been previous incidents reported in relation to medicines management on both Simpson ward and theatres, for example; discrepancies in the stock levels of liquid controlled drugs (CDs) on the ward. An action plan indicated monthly audits were commenced to monitor this.
- There had also been signature omissions in the CD register on the ward in September 2015. Pharmacy audits in September and October 2015 found liquid medicines did not have an open or expiry date written on them as the hospital policy stated they should.

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- The audit showed gaps in the checklist for the ward drug fridge temperature checks, staff were reminded to document when they checked the fridge.
- A missed dose audit carried out on Simpson ward in June 2015 found only one medicine had not been given without a reason being documented.
- A CD audit carried out by pharmacy in the theatre recovery room in October 2015 found some expired liquid CDs were being stored and had not been destroyed. There were entries in the CD register where only one person had signed for controlled drugs. An action had been put in place to address this.
- In January 2015 the first three patients on a theatre list had their joints flushed with an amino acid solution rather than saline. The patients had all been prescribed antibiotics afterwards.

## Records

- The hospital used paper based patient records in all departments. Radiology used a picture archiving and communications system (PACS) for electronic storage and transfer of patients' imaging records. We saw patient records were stored safely and tidily in the ward office. The hospital had its own set of BMI records; NHS records were not routinely requested. If a surgeon wanted to see NHS records and asked for them in a pre-operative consultation, they were requested. Staff told us it took approximately five days to obtain them. On two occasions between October 2014 and September 2015, they had been requested by a surgeon but not obtained and the operations were cancelled.
- We reviewed 18 sets of care records. We were concerned about the implementation of safety systems such as the World Health Organisation (WHO) Safer Surgery Checklist. This was adapted for England by the NHS National Patient Safety Agency. By following a few critical steps, health care professionals can minimize the most common and avoidable risks endangering the lives and well-being of surgical patients.
- The checklist identifies three phases of an operation, each corresponding to a specific period in the normal flow of work: Before the induction of anaesthesia, before the incision of the skin, and before the patient leaves the operating room. In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation.
- Day case patients had an adapted checklist 'pre-operative verification form' at the hospital.
- We looked at 18 care records of day case and longer stay patients. Just three of the checklists (16.6%) were complete. In over 83% there were omissions and no evidence certain checks had taken place.

## Safeguarding

- The nominated person for the safeguarding of children and vulnerable adults was the director of clinical services. They had received level 3 training for vulnerable adults and children. The interim executive director was also trained to this level and staff could contact them for advice.
- There was an up to date policy for safeguarding adults and staff told us they could access this easily. Staff we spoke with were able to describe examples where they would escalate safeguarding concerns between Monday to Friday. Two staff were not able to tell us what they would do out of hours.
- Staff received mandatory training in safeguarding of vulnerable adults as part of their inductions and had two yearly safeguarding updates. All staff were required to undertake safeguarding children and vulnerable adults training by completing a mandatory e-learning module. Front line staff were required to complete level 1 only. Senior staff in a management role were expected to comply with level 2 training.
- Information provided to us by the hospital (the mandatory training matrix) showed the safeguarding training module was out of date. The training referred to out of date guidance ('No secrets,' from the year 2000) and did not refer to current guidance, for example the Care Act 2014 and the Mental Capacity Act 2005. Since the Care Act was implemented, the 'no secrets' guidance has not been used nationally.
- We reviewed mandatory training figures for safeguarding up to December 2015. Compliance for both adult and children training was 100%. The hospital did not record where staff worked, the training figures were for all departments and not specific to this core service.
- We asked staff if they had received training in relation to domestic abuse. One person remembered seeing a video two years previously. One person said they had managed to avoid watching the video and had not had any training. We asked staff in pre assessment clinic if they asked routinely patients about domestic abuse.



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They said this did not happen and there were no prompts on any documentation to remind them to do this. They told us they would not know what to do if someone disclosed abuse to them.

- No staff we spoke with had received any training about female genital mutilation (FGM). FGM is illegal in the UK; since October 2015 registered health professionals have had statutory duties around identifying and reporting cases of FGM. We were not assured staff would know what to do if they identified a woman had had FGM as staff had not received any training.

## Mandatory training

- Staff told us they received mandatory training according to their role. Up to December 2015 there was 100% compliance with several topics including information security, data protection, equality, diversity & Human Rights; fire safety; and PREVENT (protecting people at risk of radicalisation).
- However only 8.9% of staff required to undertake conflict resolution training had done so and none of the 38 staff required to complete patient moving handling been compliant with training for this.

## Assessing and responding to patient risk

- The practicing privileges agreement meant the designated consultant surgeon should be contactable at all times when they had inpatients within the hospital. They needed to be available to attend up to 24 hours post operatively if there was an emergency or significant deterioration in their patient's condition. There were arrangements in place to provide additional cover if the consultant was unavailable.
- There were two occasions when patients deteriorated within 24 hours post operatively and staff could not contact the consultant. In May 2015 a patient deteriorated and was reviewed by the RMO, the consultant was not contactable; the patient was transferred to the nearby NHS hospital. In September 2015, a patient deteriorated and became seriously ill, staff were unable to contact the surgeon and the patient was transferred to the NHS hospital by emergency ambulance.
- We saw learning had taken place after a serious incident in which staff had not recognised the deterioration of a patient and had incorrectly calculated NEWS scores. The

NEWS (National Early Warning System) tool is a way to identify deteriorating patients by recording certain observations such as blood pressure, respirations and conscious level.

- After the serious incident, ward staff had received local training in recognition of sepsis. Patient observation charts were then kept on a clipboard at the end of the bed instead of in a folder. Senior staff told us compliance with accurate recording rose from 48% to 100% within one month.
- Senior ward staff told us there was no corporate policy or pathway for the management of suspected sepsis. Sepsis is a potentially life threatening complication from an infection. There are national guidelines and care bundles on early recognition and management of sepsis.
- There were omissions of ward checks before the patient left the ward, theatre checks (for correct site being marked), a lack of checks in recovery, and illegible writing and signatures. One set of records had one handwritten entry of a patient name on a four page pathway; there were no other patient identifications such as date of birth or hospital number. We spoke with the director of clinical services; they had already identified these gaps and had started work to ensure improvement.
- We reviewed three post-operative care records on Simpson ward. All had up to date risk assessments such as moving and handling and skin assessments. The NEWS (national early warning scores) records of observations were all up to date and had been calculated correctly.
- Patients completed part of the admission documentation in pre assessment clinic; the rest was completed by nursing staff. We saw there had previously been a lack of a robust system in pre assessment clinic. Registered nursing staff told us Health Care Assistants in pre assessment clinic had completed assessments and decided patients were appropriate for surgery when there had been a shortage of registered nurses. The shortage of registered nurses meant countersigning of assessments had not always taken place. We spoke with senior staff about this; they had started to address this. It was being reviewed as part of the Simpson ward manager role taking over management of pre assessment clinic.

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- Staff told us patients were not automatically approved for surgery if their body mass index (BMI) was over 40-45, they were then referred to see an anaesthetist to determine if it was safe for them to receive an anaesthetic.
- From Monday to Friday during 8.30am to 5pm the cardiac arrest 'crash' team consisted of the RMO, the ward manager or their deputy, the director of clinical services and an operating department practitioner. At night time and on weekends the crash team consisted of the RMO and the two registered nurses on duty. There was an on call anaesthetist and an on call consultant who could be phoned and asked to respond.
- We spoke with senior staff about our concerns and were told the ward nurses were immediate life support (ILS) trained as first responders to treat the patient until the cardiac arrest team arrived. We asked about the care of other patients in the ward if two nurses were involved in resuscitation and were told a health care assistant might be on duty if there were enough patients staying overnight to warrant this; and if not, the other inpatients did not have serious co-morbidities (several disease disorders) which required rigorous observation.
- We saw good practice was followed after short stay surgery; patients were given written and verbal instructions and advice and told to ring the hospital if they had any concerns. The hospital sometimes closed at a weekend if there were no inpatients and an answerphone message was given to patients advising them what to do in this situation.
- Patients were asked to come back to the ward one week after surgery for post-operative wound checks.
- One set of information (from the standard operating procedure January 2016) told us in October 2015 there were 10.3 whole time equivalent (WTE) registered nurses and 2.3 WTE health care assistants who worked on the ward (total 12.6 WTE). The other information sent to us by the hospital told us there was a total of either 29.9 or 31.5 WTE staff including 5.3 WTE theatre nurses which would mean a total of 24.6 WTE or 26.2 WTE nursing staff worked on the ward.
- There had been high usage of agency registered nurses in 2015 on both Simpson ward and in theatres. For the 12 months between October 2014 and September 2015 the average use was 17.5 % on Simpson ward. There were six months when agency nurse usage was over 20% each month. In September 2015 there had been 60% reliance on agency nurses. Senior staff told us agency staff had been used in the past to help keep patients safe.
- In theatres, for the same time period, usage of registered agency nurses ranged from 4% to 144% per month. The average was 38.7% usage per month.
- We spoke with senior staff about our concerns; they told us the first time agency staff worked on the ward they received an induction to the area. We were shown a form containing comprehensive information relevant to the area. We were told there was always one member of permanent staff, and two agency nurses were never on duty together. We were told two registered nurses would always be on duty at night and at weekends.
- No incidents had been reported related to clinical areas being short staffed.
- During the same time period sickness levels on the ward were not high; they ranged between 1% and 8%. There were no vacancies during this timeframe.
- The disparity between sickness levels and usage of agency staff meant the establishment or baseline number of permanent staff may not have been sufficient to meet the needs of the ward.
- Senior staff told us this issue had been addressed and there had been no usage of agency nurses on the ward in 2016 up to the time of our visit. It was not clear why this had been an issue in the past and was no longer a problem.

## Nursing staffing

- Nurse staffing levels were planned and reviewed using a corporate 'labour tool' according to the acuity and number of patients expected to be admitted in two weeks' time.
- The ward manager used the patient booking information to arrange the skill mix and numbers of registered and unregistered nurses.
- We saw staff were flexible and would often work at short notice; they told us this worked in their favour as the ward and hospital closed if there were no overnight patients, and this also sometimes happened at short notice.
- We received conflicting information from the hospital about the number of nurses employed there.

## Surgical staffing

- The hospital did not directly employ any doctors. The Resident Medical Officers (RMOs) were contracted to an

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external company. They worked a 24 hour - 7 day a week service on a rotational basis. During this time they were on site and available 24 hours a day. There were two RMOs who worked at the hospital.

- The consultant surgeons and anaesthetists had practising privileges.
- In October 2015 there were 76 doctors who had been approved to practice; all of these had more than 12 months service at the hospital.
- The RMO told us patient handovers took place to the other RMO at the end of the seven day period. RMOs also handed over patient care to consultants as needed.

## Other staffing

- There had been high usage of agency operating department practitioners (ODPs) in theatres. This ranged from 10% to 231% between October 2014 and September 2015. This was an average of 74% a month. Information provided by the hospital indicated there was no sickness or vacancies amongst ODPs. This meant the establishment or baseline of ODPs may not have been sufficient to meet the needs of the service.
- There had been high reliance on agency allied health professionals such as physiotherapists. Average use had been over 34%, and it ranged from 40% to 154%.
- Permanent catering staff told us there were problems in recruitment and retention. They said when staff were employed they left soon after. The chef on duty on the day of our unannounced inspection was employed by an agency. We saw there was a 50% vacancy rate, and staff told us they thought this could be the reason we found food past its expiry date.
- Pharmacy staff told us there were times they worked alone during usual hours and were at risk from being a lone worker. They had escalated this and it was recorded on the risk register in December 2015. We saw there were actions in place for staff to remain safe and inform senior managers when they were working alone. There was a corporate lone worker policy which could be followed.

## Major incident awareness and training

- Senior staff told us potential risks were taken into account when planning their services. They said staff were very flexible and most lived locally so could be

called upon in cases of adverse weather or other disruptions. There was a business continuity plan which identified keys risks that could affect the provision of care and treatment.

- Senior staff told us they had a close working relationship with local NHS trusts and would support them in the event of a major incident.

## Are surgery services effective?

Requires improvement 

We found the effectiveness of surgical services to require improvement. We found;

- There had been no process in place to check the competency of theatre first assistants (or scrub practitioner) when they were brought in by surgeons. Senior managers had revised this and were developing a process together with the MAC to prevent this reoccurring
- A number of the corporate policies were out of date; this meant staff did not always have the most up to date guidance to follow.
- There were 12 occasions between October 2014 and September 2015 when staff did not have the information they needed to deliver effective care.
- On our unannounced inspection we found all of the microwaveable meals for patients in the ward fridge were out of date by one day.
- No checks had been carried out on the freezer temperatures in the ward kitchen, and we found ice cream sorbet in the freezer which had expired in November 2015, and was three months out of date.

However we also found;

- An enhanced recovery programme meant length of stay was shorter than average.
- The hospital took part in national and local audits and benchmarked itself against other BMI hospitals and the NHS as a way of determining effectiveness in patient outcomes.
- Good practice in the use of association for peri-operative practice (AFPP) guidelines. Staff were allocated to theatre lists based on their skills and competencies.
- There was a comprehensive audit calendar which enabled results to be aligned to improvement plans.

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- Pain relief was effective and met patients' needs in a timely way.
- The medical advisory committee had oversight of the consultants with practicing privileges and took action where necessary.
- There was positive multi-disciplinary working in the interest of patients and 24 hour medical cover from the resident medical officer to provide clinical support to surgeons, staff and patients.
- The hospital had seven day on-call arrangements for theatres, radiology and physiotherapy services.
- Action plans to improve recording patient consent had begun to have improved results.
- The Huddersfield hospital had CQUINs for safety thermometer, 48 hour post discharge telephone calls to patients and for giving alcohol advice.
- There was a comprehensive audit 'calendar' which was set at corporate level. Results were fed back to the corporate management team and objectives set against the results.
- The audits were carried out to measure if patient care was planned and delivered in line with evidence based practice.
- The clinical governance report of November 2015 indicated some audit results which required action. These included;

## Evidence-based care and treatment

- Policies were accessible on the hospital intranet and paper copies were kept in files in the sister's office. Policies were based on professional guidance such as National Institute of Health and Care Excellence (NICE), Department of Health infection prevention and control standards and Royal College guidelines.
- Senior staff told us they had started a guidelines tracker in the last few months so they could monitor for updated guidance and standard being published.
- There was an enhanced recovery programme adapted from the NHS Institute for Innovation and Improvement (2008)
- Not all policies and guidelines were up to date. For example the resuscitation policy contained guidance from the Resuscitation Council UK which was out of date by several years; the Risk Management of safety alerts policy had been due for review in March 2014. (The policies and guidelines were written and reviewed at corporate level, not by the senior managers at the hospital)
- Senior managers told us they were aware of this and these policies and guidance were under review at a corporate level.
- The hospital took part in national and local audits and measured itself against standards such as patient related outcome measures (PROMS), the BMI clinical dashboard and CQUIN initiatives (Commissioning for Quality and Innovation). CQUINs are set to make a proportion of healthcare providers' income conditional if they can show improvements in quality in specified areas of patient care).
- Documentation compliance of 52% in September 2015 and 72 % in October 2015. The consultant documentation and daily summary required attention. Patient details were not recorded on every page.
- Blood transfusion training had not been completed by all necessary staff.
- The WHO checklists had 60% compliance in September 2015.
- Consent forms were incomplete, and had 69% compliance in September 2015.
- Senior staff were new in post; we saw they had developed action plans to improve effectiveness of services. For example the new ward manager had implemented documentation audits and was monitoring how staff responded if a patient's condition deteriorated.
- New audits added to the calendar for 2015- 2016 included medicines reconciliation by pharmacy staff and dispensing times from pharmacy.

## Pain relief

- Surgeons and anaesthetists prescribed post-operative patient relief for patients and could be contacted if effective pain control was not achieved.
- The RMO could also be contacted to prescribe additional or alternative pain relief. There was no additional specialised pain team at the hospital.
- A range of pain relief methods were available, these included patient controlled analgesia pumps.
- Ward staff told us the Abbey pain scale was in use. This is a basic movement based pain score which can be used for patients who cannot verbalise their pain. There was some reference to pain scores in documentation,

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but we did not see consistent use or detailed assessment of pain. Pre assessment clinic staff told us a more basic pain tool was in use, it had pictures of a range of facial expressions to determine how much pain someone had. It did not consider site or type of pain.

- Senior staff told us lessons could be learned to combat some of the less positive results regarding assessment of pain which had been a trend on the Quality Health Patient Satisfaction scores.
- We asked three patients about pain relief, they all told us they had been asked about their pain and had received pain relief in a timely way.

## Nutrition and hydration

- Patients were asked about their nutrition and hydration needs as part of the pre assessment process.
- In the records we reviewed all patients had a completed MUST assessment (malnutrition universal screening tool)
- Patients were offered a choice of meals and additional snacks. Specific dietary requirements could be catered for.
- Intravenous fluids were prescribed as appropriate and recorded according to hospital policy. We observed that fluid balance charts were used to monitor patients' hydration status.
- Staff told us their biggest challenge for patients eating and drinking was set fasting times. Patients are asked to fast before planned surgery in order to reduce the risk of stomach contents causing airway problems during anaesthetic.
- Royal College of Anaesthetic guidance 2012 indicates traditional fasting from food for six hours before anaesthetic and that all healthy elective adult patients should be allowed to drink water or other clear fluids until 2 hours before the induction of anaesthesia. We found this had not been in place previously, but had now been picked up through the MAC.
- Staff told us fasted patients were admitted on the day of surgery at either 7am or at midday for the convenience of the surgeons and anaesthetists. They said when the order of the theatre list changed, patients might not go to theatre until 5 pm, having been without fluids for up to 12 hours.

- In the last few weeks prior to our inspection, staff said they had begun to use staggered admission times and informed patients they could still drink if the list was delayed. They said this had made a difference to patient anxiety pre operatively.

## Kitchens and patient food

- Following our announced inspection, we carried out an unannounced inspection on 18 February 2016. We saw all the patient meals in the ward fridge were out of date by one day. Staff told us the microwaveable meals were delivered by an external company on Mondays, Wednesdays and Fridays; we inspected on a Thursday, and no other meals were due to be delivered until the next day. We raised this with senior staff; they told us they would buy food in for the patients that day and ensure they had enough supplies going forward.
- We saw daily fridge checks took place to ensure the temperature was within a safe range for food storage; however no checks were recorded for the freezer on the ward.
- The freezer did not have a temperature display or alarm to indicate if the temperature fell below safe levels. The Food Safety (Temperature Control) Regulations 1995 require that certain foods are kept at or below certain temperatures. There were no defined temperatures for freezers although standards recommend they operate at -18°C or below. There was no way to tell if this was the case at the hospital.
- We found ice cream sorbet in the freezer which had expired in November 2015.
- We saw one out of date patient meal in the industrial sized fridge in main kitchen.

## Patient outcomes

- Information about the outcome of peoples care was routinely collected and monitored using a variety of methods.
- The BMI quality dashboard was used to monitor a number of indicators and to compare them to other BMI hospitals in the region. These indicators included;
  - urgent transfers to NHS hospitals
  - unplanned returns to theatres
  - surgical site infection rates
  - average length of patient stay
  - Day case conversion to overnight patient rates and readmission rates.



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- We could not compare the numbers of patients who needed to transfer to NHS care with numbers from other BMI hospitals as we did not have full data for this.
- Two patients had unplanned returns to theatre in April 2015, (none any other month in 2015) compared to an average of 13 patients for the other BMI hospitals in the same 12 month time period.
- Two deep joint surgical infections were reported; there were also nine other surgical site infections in 2015. We did not have the data to compare this with other BMI hospitals.
- A shorter average length of stay post operatively is usually better for patients as it reduces the risk of hospital acquired infection. The average length of stay for patients who had a total hip replacement in 2015 was 2.5 days for NHS patients and 3 days for private patients at the Huddersfield hospital. This compared to 3.1 days for NHS patients and 3.6 days for private patients at other BMI hospitals.
- The average length of stay for patients who had a total knee replacement in 2015 was 2.6 days for NHS patients and 2.8 days for private patients. This compared to 3.1 days for NHS patients and 3.7 days for private patients in other BMI hospitals.
- There were eight unplanned readmissions at the Huddersfield hospital from October 2014 to September 2015; this compared to an average of 12 at other BMI hospitals.
- The hospital reported they monitored daycase conversion to overnight patient rates on the BMI Quality Dashboard. Information about patient outcomes was used at a corporate level. Negative trends were fed back to individual consultants and the medical advisory committee (MAC). Senior staff told us positive findings were analysed corporately to determine best practice and share with hospital teams and the wider organisation. Two registered staff we spoke with were unaware patient outcomes were measured, and did not know any findings.
- Long term monitoring of patient outcomes was measured using Patient Reported Outcome Measures (PROMs) and the National Joint Register programme.
- PROMs is a Department of Health led programme and is a way of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The hospital quality account 2014-2015 indicated there were better results for hip and knee surgery than the national average.

- The quality account also indicated contribution to the National Joint Registry audit. There were goals for 2015-2016 which included setting up key performance indicators and to improve performance in line with national averages.

## Competent staff

- The hospital had a system in place to ensure that consultants working under practicing privileges were competent to carry out their role. Consultants worked under practising privileges and were approved by a medical advisory committee prior to working at the hospital.
- Doctors with practising privileges were reviewed every two years by the MAC.
- If a consultant wanted to carry out additional procedures they needed to apply for support from the Medical Advisory Committee (MAC). The consultant needed to provide documentary evidence that they were properly trained and accredited in the undertaking of that procedure.
- The MAC chair told us there were minimum requirements with which a consultant must comply. Among these were GMC (general medical council) registration, medical insurance and indemnity, DBS registration (disclosure and barring service), current appraisal and revalidation and ICO membership (information commissioner's office, for data protection).
- There were 76 consultants who had been granted practicing privileges; of these, 29 had not carried out any episodes of care in the year before 1st October 2015. There had been 20 consultants who carried out more than 100 care interventions and were at the hospital on a regular basis.
- Despite not having carried out any care in 2015, the 29 consultants could continue to practice at the hospital if they had been signed off as competent during their annual appraisal. The yearly appraisal demonstrated that that consultant had maintained the competence to continue to perform the role they carried, demonstrating their fitness to practice, which ensured patient safety.
- Any concerns about consultants were discussed by the hospital management team with the MAC Chair. If necessary, this would be escalated to the BMI group medical director. The MAC chair told us any concerns

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related to standards of practice, quality or patient safety would be shared with the consultant's responsible officer, usually the director of clinical services or medical director at their employing trust.

- Senior theatre staff told us they were concerned surgeons sometimes brought in their own first assistant (or scrub practitioner). This had occurred three times between October 2014 and September 2015; there had been no way for the service to know if the first assistants were competent or appropriately qualified. Senior managers had revised this and were developing a process together with the MAC to prevent this reoccurring.
- We saw good practice in the use of association for peri-operative practice (AFPP) guidelines. Staff were allocated to theatre lists based on their skills and competencies.
- Nursing staff told us they were supported with training needs and given opportunities for development. Staff acted as link nurses in certain areas, for example IPC or wound care link nurses; they updated their colleagues in that clinical area.
- The surgical areas had student nurses on placement from local universities. Up to two students at a time would work with staff on the ward or in theatre; they had a 'sign off' mentor who assessed their competency and were co mentored by other members of the nursing team.
- Staff told us they received scenario based training to prepare for major haemorrhages.
- Staff could rotate from working on the ward to theatre if they wished to, and the ward manager told us they planned to rotate staff through pre assessment clinic to support their development.
- Staff told us they had annual performance reviews based on a framework used by BMI (know me, focus me, grow me).
- We saw 100% of ward and theatre nursing staff had received a performance review in the preceding 12 months.

## Multidisciplinary working

- Patient care was delivered in a co-ordinated effective way across different departments. Nurses from the ward collected patients from recovery to bring them back to the ward.
- A written handover was available in the patients' pathway containing information about the patients care

and status through theatre and in the recovery department. Staff told us that they also handed over verbally. They felt that this verbal communication ensured a detailed understanding of the patient and enabled staff to provide more effective care.

- We observed a handover take place on a patient's arrival into recovery. A detailed verbal handover took place between the scrub nurse recovery nurse and written documentation was also provided in the care pathway.
- We observed effective team working among administrative, clinical, nursing and support staff during our inspection.
- Staff told us they had good working relationships with the consultants and anaesthetists and would not hesitate to contact them if they had any concerns about a patient.
- We saw patients being reviewed by therapy staff and handovers being given before and after patients were seen.
- Senior staff told us they had good relationships with their local NHS hospitals.
- Discharge letters and electronic summaries were sent to the patient's general practitioner (GP) with details of the treatment provided, follow up arrangements and medicines provided on the day of discharge.
- Staff told us they liaised with NHS enablement services if patients needed extra rehabilitation after discharge from hospital.

## Seven-day services

- Elective (planned) surgery took place mostly Monday to Friday with theatre lists planned in advance. Some procedures took place on a weekend. There were on call facilities to accommodate an emergency return to theatre seven days a week if necessary.
- Consultants were expected to be available for their patients 24 hours a day for patients in their care. It was a requirement of the BMI Healthcare Practice Privileges (PP) policy that consultants remained available (both by telephone and if required in person) or arrange appropriate alternative named cover if unavailable at any time if they have inpatients within the hospital
- There was 24 hour RMO cover in the hospital to provide clinical support to surgeons, staff and patients.
- The hospital had seven day on-call arrangements for theatres, radiology and physiotherapy services.

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- During weekends and out of hours, if a prescribed medicine was not available on the ward, the RMO could access the pharmacy with a senior nurse present.
- There was a senior nurse available seven days a week (via bleep or telephone when out of hours) as a contact point for both staff and patients, to help resolve patient queries and to accept out of hours admissions.

## Access to information

- We were concerned that systems for managing information between services were not always effective or shared in a timely way. There were 12 occasions between October 2014 and September 2015 when staff did not have the information they needed to deliver effective care. Examples included;
- Anaesthetists and consultants not being told about patients complex medical histories which had been discussed in pre assessment clinic
- Clinic letters not being available in patient notes for theatre
- Consultant requests for pre-operative investigations not followed up on, so operations were cancelled after the patient had arrived in theatre.
- Management of the pre assessment clinic had recently passed to the new ward manager and there were plans to review all procedures.
- Nursing staff told us they had all the information they needed to give effective care to patients.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- For consent to be valid, it must be voluntary (the decision made by the person themselves) and informed, and the person consenting must have the capacity to make the decision.
- Minutes from a previous clinical governance committee meeting in October 2015 noted compliance with an audit for consent was just 69%. An action plan had been developed at the time. Senior staff acknowledged there was still work to do to improve the recording of consent.

- Two of the 18 sets (11%) of records we looked at had incomplete consent forms. This meant in these instances consent had not been sought in line with legislation and guidance. All the other consent forms we looked at (89%) were fully completed.
- Processes were not in place for one patient to give their consent for planned surgery as an interpreter had not been booked after pre assessment clinic. (An interpreter could not be arranged at short notice so a staff member was used).
- Compliance figures for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training for the hospital was 95% in December 2015. This was above the target of 90%.
- Staff we spoke with said they had not looked after patients who did not have capacity to make decisions. They also told us they had not needed to use DoLS, but would escalate to senior staff if they needed to.

## Are surgery services caring?

Good 

We found caring to be good. We found;

- All the patients we spoke with said they had been looked after with compassion and their dignity had been respected. A survey showed over 97% of patients were satisfied with the care they had received.
- Patients were supported to return to independence as soon as possible. Staff gave patients information in a way they could understand and allowed time for questions. Patients and their families were able to be partners in their care.
- Phone calls were routinely made 48 hours after discharge to check patients were recovering and managing at home.

## Compassionate care

- Patients and their families were treated in a courteous and considerate manner. They told us staff introduced themselves by their first name and asked patients what they wished to be called. All five of the patients we spoke with said their dignity and privacy had been respected.



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- We received 11 comment cards from previous patients who had undergone surgical treatment. They were all positive in nature and praised the compassionate care they had received from all staff including housekeepers, nursing, therapy, medical and clerical staff.
- The Patient Led Assessment of the Care Environment (PLACE) in 2015 showed 85.3% of patients felt their privacy, dignity and wellbeing was looked after. This was an increase from the 2014 results (74.1%) and slightly less than the national average of 87.7%.
- Patients told us when they had complained of pain or other symptoms, staff had responded in a timely and compassionate way.
- The nursing assessment documentation we saw had not always been completed fully but it included spaces for cultural, social and spiritual needs to be considered. "Patients were encouraged to be up and about after their procedures to promote return to everyday activities such as not eating in bed.
- We saw therapists supporting patients to be mobile and encouraging them to return to independence.

## Understanding and involvement of patients and those close to them

- We overheard staff explaining medical terms and post-operative instructions to patients and family members in a way they could understand. People were given written and verbal information about follow up care and were allowed time to ask questions.
- Patients we spoke with told us that staff always took the time to explain what was about to happen and what needed to be done and why. All patients we spoke with told us that staff always gave them the opportunity to ask questions and become active partners in their care.
- BMI Huddersfield's patient satisfaction survey was collated via an external company and showed an average of 97% of patients reported being satisfied with the overall care they received between October 2014 and September 2015. This information is not specific to surgery.
- Staff told us a previous satisfaction survey had shown negative results around patient folders being kept outside the single rooms, patients had felt they did not see staff; changes were made and the folders were now kept inside the rooms. When staff carried out hourly 'care and comfort' checks they also attended to patient needs. It had been found that patients did not need to use the nurse call buzzer as often.

- In the six month period from April 2015 to September 2015, 99.3% of people said they would recommend the hospital to their friends and family (from an average response rate of 24%). This information also applies to the whole hospital.

## Emotional support

- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.
- Prior to our inspection we received comment cards from previous patients; several of them referred to being anxious before surgery, and that staff went 'the extra mile' to support them. Admission assessments included consideration of patient's emotional well-being. This was seen in the patient records we reviewed.
- A phone call was made 48 hours after discharge to check patients were recovering. If patients had any concerns they could ring the ward at any time and were asked to come in if necessary.

## Are surgery services responsive?

Requires improvement 

We found the responsiveness of surgical services to require improvement. We found;

- From October 2014 to September 2015, a high number, 69 surgical procedures were cancelled. On 27 occasions (39%) surgery had been cancelled due to lack of equipment or broken equipment, or a breakdown in pre assessment procedures. Senior managers had recently put in process to prevent reoccurrence of these issues. Reasonable adjustments had not been made to allow wheelchair users or patients with significant visual loss to use the facilities on an equal basis. There were no rooms which had been adapted for a physically disabled patient to use. The hospital reported that wheelchairs users would be accommodated on an individual basis with an assessment of their needs undertaken prior to admission.
- Some of the premises, for example patient rooms and clinical areas were not responsive to some patient needs. There was an ongoing refurbishment programme; however staff told us BMI tended to "patch things up" rather than replace with new areas due to cost implications.

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However we also found;

- Two theatres were used six days a week in order to support patient flow and reduce waiting times.
- Private patients were able to access care and treatment at a time which was suitable to them.
- The rate of complaints had reduced slightly from 2014 to 2015. There had not been any complaints for the six months before our inspection.

## Service planning and delivery to meet the needs of local people

- The hospital was commissioned by the local clinical commissioning groups to provide services to meet the needs of NHS patients.
- The hospital carried out an average of 62% NHS work and 38% of treatments were funded by other sources e.g. private patients.
- All routine admissions were planned and patients assessed before admission to enable their needs to be met.
- The hospital received referrals through NHS Choose and Book as part of a standard acute contract. Senior staff told us they occasionally received requests from local trusts to perform 'spot work' for them as part of waiting list and winter pressures initiatives. This kind of work had been provided for three local NHS trusts.
- There were arrangements to transfer patients care to a local NHS trust in emergency situations.
- We found some of the premises, for example patient rooms and clinical areas to be quite dated. There was an ongoing refurbishment programme; however two staff told us BMI tended to "patch things up" rather than replace with new areas due to cost implications.

## Meeting people's individual needs

- The BMI hospital policies took account of the needs of different people, for example the nine protected characteristics of the Equality Act were contained within policy documents.
- Staff told us they would deliver care to someone taking account of any individual needs related to race, culture or sexuality. Some staff were not able to tell us if written patient information was available in other languages.

- Patients with advanced dementia were not treated at the hospital. If it was found someone had advanced dementia or did not have capacity, they would be triaged against exclusion criteria on receipt of referral, as the service was not designed to meet their needs.
- Staff told us they had cared for people with learning disabilities. One staff member told us an example of when staff had cared for a patient with a learning difficulty and adjustments were made to make the experience less stressful, for example, a family member was able to remain with them throughout their treatment.
- The patient rooms were not fully accessible for patients who used a wheelchair. The bathrooms did not have enough space or extra hand rails to assist with transferring onto the toilet. Some rooms had a bath without a hoist or other aids, rather than a shower.
- Staff told us a patient with significant mobility difficulties had stayed for several weeks. They had moved the bed up to the wall to allow for more space and the patient was supported to use a commode rather than the toilet.
- Reasonable adjustments had not been made to allow wheelchair users or patients with significant visual loss to use the facilities on an equal basis. There were no rooms which had been adapted for a physically disabled patient to use. The hospital reported that wheelchairs users would be accommodated on an individual basis with an assessment of their needs undertaken prior to admission.

## Access and flow

- Patients who required surgical procedures were first seen by a consultant in the outpatient department. They then received nursing assessment in pre assessment clinic on Hanson wing. Staff told us discharge planning started there, before they were admitted. Social needs and post-operative care was discussed with patients and their family.
- Staff told us if patients needed NHS enablement service post operatively, for example someone who was having a hip replacement and needed extra therapy care after discharge, these services could not be arranged until the patient was admitted. This meant those patients would need to stay in hospital one or two days longer than necessary.

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- Staff told us private patients were able to access care and treatment at a time which was suitable to them. NHS patients were seen according to a waiting list appointment system.
- GPs were sent electronic discharge information so there was no delay in giving them information about the care and treatment someone had received.
- There were two theatres which were used six days a week in order to support patient flow, (7.30 am to 8pm on weekdays and 8am to 6 pm on Saturdays). Staff told us one surgeon regularly carried out more than 25 knee procedures a day by using two theatres. They said this helped prevent patients waiting a long time for their surgery.
- An enhanced recovery programme was in place. This was intended to speed up patient recovery and achieve better outcomes. Staff told us this optimised patient's conditions for theatre before admission and reduced their length of stay. The average length of stay had reduced slightly from 2.6 days in 2013 to 2.3 days in 2015.
- From October 2014 to September 2015, a high number, 69 surgical procedures were cancelled these were ;
- 32 (46%) were for medical reasons, for example if the patient was unwell on the day
- On 27 occasions (39%) surgery was cancelled when it could not be carried out due to lack of equipment or broken equipment, failure to act on results from pre assessment tests, patients not being advised to stop medication before surgery, or pre-existing conditions not being picked up on in pre assessment clinic.
- Five occasions (7%) were patient choice
- Five occasions (7%) the patient had no symptoms on admission.
- Senior managers had recently put a process in place to check equipment was available and working, 24 to 48 hours before procedures were due to take place. They anticipated this would reduce the number of cancelled procedures.
- Ward staff told us they were encouraged to try and resolve verbal complaints at the time. They were aware they needed to escalate this to senior staff if this was not possible or if the complaint was of a serious nature.
- We saw leaflets for patients and their family called 'Please tell us.' These contained information on how to complain or raise concerns.
- Formal complaints were the responsibility of and were directed to the executive director. They were reviewed by the director of clinical services. Heads of departments were involved in the investigation process as necessary. Information was then cascaded to ward and theatre teams at monthly team meetings. Senior managers told us staff were encouraged to share their ideas as a way to reduce the likelihood of complaints happening again.
- We saw evidence that previous complaints had been discussed at weekly senior management meetings and monthly head of department meetings. Complaints about clinical care were discussed at the clinical governance committee. All complains were reviewed at the MAC.
- We reviewed three previous formal complaints, they were related to anaesthetic notes not being read prior to theatre; inaccurate information being given in pre assessment clinic and the patient chasing up their own results; the third complaint was around a lack of communication and someone waiting eight hours for surgery while they were fasted. We saw that all these complaint had been investigated thoroughly; patients had received apologies and were told how lessons would be learned.

## Are surgery services well-led?

Requires improvement 

We found the well led domain to require improvement. We found;

- At the time of our inspection the leadership was provided by an interim executive director and an interim director of clinical services. They had recently moved into these positions. They were aware of many of the issues we found and had begun to take action on improvement plans.

## Learning from complaints and concerns

- Senior staff told us there had not been any complaints for the six months before our inspection.
- The rate of complaints had reduced slightly from 6.8 per 100 patients in 2014 to 6.7 in 2015.

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- The vision, values and clinical strategy were not well developed. They did not contain elements of compassion, dignity or equality. The strategy action plan had not been updated since January 2015 and lacked having safety as a priority.
- The governance framework and risk management approach did not always support the delivery of safe, good quality care. This appeared to be at risk by the financial challenge upon the hospital.
- The risk register contained elements we highlighted to senior managers. The risks had been on the register for an extended length of time. We also found some risks were not reflected on the register, for example external theatre staff brought in by surgeons.
- Maintenance of the building and water safety did not appear to be a corporate priority. Some risks had been on the register for two to three years without full remedial action being taken despite being reported at a corporate level; for example, falling masonry, potholes in the drive, the lack of fire doors in theatre, possible theft of medical gases and an insecure waste compound. Water safety plans had not been acted upon in the required time.

However we also found;

- The senior managers had recently been in post and were aware of many of the issues. They had local improvement plans but were constrained by the corporate team.
- The new ward manager had recently taken over clinical responsibility for pre assessment clinic and had already begun to effect positive changes in a short time.
- There was positive local leadership, we saw the executive director, the ward manager and the director of clinical services were visible, approachable and accessible to staff.

## Leadership / culture of service

### Vision and strategy for this core service

- The vision, values and clinical strategy action plan were not well developed. They did not contain elements of compassion, dignity or equality.
- Senior managers told us their vision for the hospital was in line with the corporate vision, namely to be a hospital of choice and to be a good competitor against other providers.

- When we asked staff what the vision and values for the care of patients was, they told us they did not know the “official” vision, but that they were there to do their best for patients.
- There was no strategy for surgical services however we saw the clinical strategy action plan for the hospital. There were six themes; this action plan had not been updated since January 2015. The themes were;
  - Putting patients at the heart of what we do
  - Our people are our most important attribute
  - Quality should underpin everything we do
  - Working together to grow our business
  - Engaging with Consultants
  - Being as cost-effective and efficient as possible
- The hospital reported they followed the BMI corporate clinical strategy which had an associated action plan.
- We did not find the action plan was robust enough to ensure the delivery of good quality care. For example, action taken following a plan to implement the ‘6 C’s’ national nursing values (care, compassion, competence, communication, courage and commitment), was to improve the patient satisfaction scores at the hospital. These lacked the values and call to action from the 6C’s to improve safe, high quality care
- The action plan showed meetings had been held with catering to improve meal choice, and meet and greet and customer care training had been undertaken.

### Governance, risk management and quality measurement for this core service

- Governance is the system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This can be done by creating an environment in which clinical excellence can flourish.
- The governance process at the hospital was; issues raised at department meetings were raised to heads of department, the health and safety committee and the governance committee; these were then escalated to the senior management team and MAC.
- The clinical governance committee with met every other month and other committees reported into that. For example the blood transfusion committee, IPC committee, resuscitation committee and medicines management committee.
- There was a systematic corporate audit programme, but we found it had not been robust enough at times to

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manage the risks and issues which were repeated over the course of a year. It was difficult for the hospital teams to influence this programme as it was set at a corporate level.

- We found the governance framework and risk management did not always support the delivery of safe, good quality care. For example, cancelled operations due to lack of surgical equipment and only partial compliance with infection, prevention and control action plans.
- The sustained delivery of quality care appeared to be at risk by the financial challenge upon the hospital. We found the approach to improvement of the building and estates was reactive and focussed on short term issues.
- There was a new management team in place. We acknowledged they recognised the governance issues which had been escalated to the BMI corporate team; however the hospital team could not authorise repairs to the building or obtain new equipment without authorisation.
- There were 47 risks in relation to estates and facilities on the risk register. Some risks had been on the register for almost three years without remedial action being taken at a corporate level. For example, possible theft of medical gases from the storage area had been on the risk register since August 2014 and reviewed in December 2015; actions to mitigate against this risk were still waiting to be completed when we visited in February 2016.
- The risk register also included an unaddressed risk of fire from the electrical distribution board which was at full capacity and situated in the linen storeroom. (A distribution board is a panel or box with fuses, circuit breakers, and ground leakage protection units; it is used to distribute electrical power to numerous individual circuits).
- The maintenance of the building and facilities within it were unsafe at times but action had not been taken, for example in relation to the lack of fire doors in theatres despite this being escalated to corporate level. (This had been on the risk register since January 2015; and had been escalated to the corporate team). We saw minutes from the Senior Management Team (SMT) meeting of June 2015 where it was documented this risk was to be removed from the hospital expenditure and requested through 'critical' cap-ex (capital expenditure).
- We spoke with the MAC chair; they acknowledged pre assessment clinic procedures needed to improve. They

put this down to protocols not being robust and difficulty in communications between staff. They said strong personalities and logistics had also caused issues in the past.

- We found it was too early to show improvement as recent managerial changes had taken place the week before our inspection
- We found that company reps had been present and observing during theatre procedures without being required to sign any confidentiality documents. We pointed this out to the theatre manager who took immediate steps to rectify this.
- At the time of our inspection the leadership was provided by an interim executive director and an interim director of clinical services. They had recently moved into these positions and were supported by the heads of departments
- There was positive local leadership from the interim executive director and interim director of clinical services. We saw they had not been in post long and had already identified the need for extra management support in theatres and the need to improve quality and safety systems.
- Staff told us senior managers were very visible and approachable and if they had a concern they would feel able to ask for help and support.
- We saw positive local leadership on Simpson ward and that progressive changes had been embedded in recent months. The ward manager had approximately 60% of their time dedicated to the leadership and management role.
- We found ward and theatre staff had supportive working relationships. Staff told us they were happy and supported in their roles. They also told us team working and communication was good.
- Staff told us they felt respected and valued by their colleagues and by senior managers. Many staff had worked at the hospital for a number of years and told us they were loyal to the service.
- Senior managers acknowledged that some staff had more than one role within the hospital given the size and demands of the service. We found some staff had not been properly prepared or trained to take on certain roles such as carrying out root cause analysis (RCA) investigations.

## Public and staff engagement

# Surgery





- As part of the corporate plan, the hospital gathered the views of people who used the services and those who delivered the care.
- Patients were encouraged to provide feedback through the Family and Friends Test and the BMI patient survey.
- Staff said they were encouraged to give ideas and feedback in team meetings.
- Daily communication meetings known as 'comm cell' were held and attended by a person from each hospital department. Information was then cascaded to the teams by the person who attended the meeting.
- We found the physiotherapy department had introduced the use of a quality of life questionnaire for all patients to monitor the effectiveness of treatment they gave to patients.
- Senior managers told us their main challenges and concerns were around estate and facilities and the general environment of some areas of the hospital. They were aware endoscopy was an area which required further work and investment. We were told the theatre manager and IPC lead were working closely to resolve ongoing issues, maintain a safe service and prepare for application for JAG accreditation in 2016.
- We were given information to indicate recruitment of appropriately trained staff for clinical areas was a key challenge. The hospital had been unable to recruit successfully in to theatre, nursing and physiotherapy roles in the recent months before our inspection. The theatre manager told us they regularly had to scrub and work in theatres which took them away from their managerial role.

## Innovation, improvement and sustainability

- The ward manager told us one of their objectives was to set up an ambulatory care centre which could be managed by skilled health care assistants. They said uncomplicated conditions could be treated without the need for an overnight stay in hospital.



# Outpatients and diagnostic imaging

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

## Information about the service

BMI The Huddersfield Hospital had outpatient and radiology departments, which hosted a number of different specialities including orthopaedic surgery, plastic surgery, ENT surgery oral and maxillofacial surgery, ophthalmology, gynaecology, general surgery, dermatology, cardiology, endocrinology, neurology, neurophysiology, physiotherapy and sports medicine. In January 2016, senior staff had made the decision to longer treat children in the outpatient department due to low numbers of patients.

Referrals for outpatient consultations in orthopaedics, urology and ENT were seen at Oaklands Medical Practice in Holmfirth. We did not visit this location during the inspection.

Diagnostic imaging facilities provided on site included an ultrasound scanner, x-ray and fluoroscopy in theatres. An MRI (magnetic resonance imaging) scanner visited the site once a week on a Saturday.

Staff sent pathology tests to an off-site laboratory by courier twice a day, some pathology tests were performed on site using point of care testing equipment.

From October 2014 to September 2015, the hospital's outpatient department saw 13,625 patients. The hospital treated fee-paying patients and accepted referrals via choose and book and from a number of local NHS trusts. Radiology carried out 2,531 plain Xrays, 740 ultrasound scans and 810 MRI scans during the same period.

During the inspection, we visited the outpatient, physiotherapy, pathology and radiology departments. The initial inspection was carried out over two days. There were

six people in the inspection team; three CQC inspectors and three specialist advisors. We carried out an unannounced inspection eight days later, with two CQC inspectors and a specialist advisor.

We spoke with six patients and 24 staff. These included nurses, administrative staff, healthcare assistants, physiotherapists, radiographers, reception staff, the executive director and the OP and radiology managers. We observed the outpatients and radiology environments, checked equipment and looked at patient information. We also reviewed seven patient medical records in OPD and ten imaging requests in radiology, as well as performance information from the hospital.

We carried out this inspection as part of our comprehensive inspections of independent healthcare providers. The hospital had reported a never event and a serious incident in September 2015.

The interim executive director had been in post since the beginning of December 2015 and the interim director of clinical services had been in post since the beginning of October 2015.

At the time of our inspection, the provider did not have a registered manager in post. The registered manager had left and the executive director had applied to take on this role. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as the does the provider.

# Outpatients and diagnostic imaging

## Summary of findings

We rated the service as 'requires improvement' overall.

We rated the safe and well led domains as 'requires improvement', caring and responsive domains were rated as good. The effective domain was inspected but not rated.

The safety of the care and treatment delivered by the services required improvement. There was limited assurance about safety in several areas involving the premises and environment. There was no evidence that the recommendations from a legionella water hygiene risk assessment in May 2014 had been effectively implemented.

We found staff knowledge about the new duty of candour requirements was limited and some staff did not know about it.

Systems for ensuring relevant staff were aware of abnormal patient test results were not robust. This meant there was a risk that abnormal results were not acted on.

Managers carrying out root cause analysis (RCA) investigations had not received training in carrying out RCAs. This meant they did not necessarily have the right skills in this area.

The induction process for bank and agency staff working at the hospital did not assure us that patients would be kept safe at all times.

The leadership and governance at the hospital required improvement and did not always support the delivery of high quality person-centred care. The sustainable delivery of quality care was being put at risk by financial limitations.

Some staff and managers were unable to tell us about the vision and strategy for the future and were not always aware of their risks and challenges. However, staff were happy and felt supported. There was an open and supportive culture where incidents and complaints were reported, and lessons learned.

However, we also found;

Incidents were reported and investigated and we saw evidence of lessons learnt. Cleanliness and hygiene was good and there was sufficient well-maintained equipment to ensure patients received the treatment they needed in a safe way. There were sufficient well-trained and competent nursing and medical staff to ensure patients were treated safely.

Care and treatment in the services inspected was effective and evidence-based. Patient outcomes were measured, staff were competent and there was evidence of multidisciplinary working.

Staff caring for patients and their families treated them with compassion, kindness, dignity and respect and maintained their privacy. All of the patients we spoke with gave positive feedback about the service: patient satisfaction scores from surveys were high.

Outpatient and diagnostic imaging services were responsive to patients' needs. Access and flow in the OPD and radiology departments was well managed.

Translation services were available and staff knew how to access these. Sign language services were also provided for those patients that needed them.



# Outpatients and diagnostic imaging

## Are outpatients and diagnostic imaging services safe?

Requires improvement 

We rated the safety of this service to be 'requires improvement' because there was limited assurance about safety in several areas. Safety concerns were not consistently identified or addressed quickly enough. We found;

- The premises were not well maintained; this meant there was a risk to patients, staff and visitors. For example, we found large potholes in the drive were a trip hazard. Work was in progress to repair the roof of the building during the inspection.
- There was no evidence that the recommendations from a legionella water hygiene risk assessment in May 2014 had been effectively implemented.
- Management of clinical waste disposal at the hospital did not meet with the requirements for the safe management of healthcare waste.
- The height of the table in the radiology X-ray room was not adjustable. This meant some patients may not be able to get onto the table for their x-ray.
- There were carpets in clinical areas in OP consulting rooms; plans were underway to refurbish these rooms.
- Systems for ensuring relevant staff were aware of abnormal patient test results were not robust. This meant there was a risk that abnormal results were not acted on.
- The induction process for bank and agency staff working at the hospital did not assure us that patients would be kept safe at all times.

However:

- Staff planned and delivered care and treatment in a way that ensured people's health and safety, and protected them from harm. Staff knew how to report incidents and there was evidence of learning from incidents.
- People were cared for in a clean, hygienic environment. There were effective systems in place to reduce the risk and spread of infection.

- There was enough well-maintained equipment to ensure people received safe treatment and there were arrangements in place to deal with foreseeable emergencies.
- Appropriate arrangements were in place for obtaining, recording and handling medicines and accurate patient records were maintained. Medicines and records were stored securely.
- Radiology had a positive safety culture and there were clear responsibilities and accountability for safety and governance.

### Incidents

- There was evidence of learning from incidents; investigations took place and appropriate changes were implemented.
- Incident management and response was through the service's online reporting system (Sentinel).
- There had been no incidents reported in radiology; the radiology manager explained this was partly due to the low numbers of patients seen for procedures.
- There had been no never events or serious incidents reported related to OP and radiology in the previous 12 months. (Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event).
- There had been 248 clinical incidents and two serious incidents requiring investigation reported at the hospital between October 2014 and September 2015. There had been 15 incidents reported in OP, 15 in pathology and five in physiotherapy. Thirty-three of these 35 incidents had no adverse outcome.
- We saw evidence to show staff discussed clinical and non-clinical incidents at the hospital's Clinical Governance Committee (CGC) and Medical Advisory Committee (MAC) meetings. Incidents were also discussed at the hospital's 'communications cells.'

However,

- We found staff knowledge about the new duty of candour requirements was limited and some staff did not know about it. The duty of candour is a regulatory duty that relates to openness and transparency and

# Outpatients and diagnostic imaging

requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

## Cleanliness, infection control and hygiene

- The environment was visibly clean in all of the areas we visited. Hand sanitizer was readily available and we observed staff using this appropriately, we observed staff practising good hand hygiene before and after contact with each patient. Hand gel was available in the outpatient waiting area.
- Personal protective equipment (PPE) such as aprons and gloves was available and staff were observed using PPE correctly. Most staff were also observed to adhere to the 'bare below the elbow' policy. However one member of staff was observed wearing a watch, bracelet and rings in a clinical area.
- Infection prevention and control staff carried out a rolling programme of audits, including yearly quality improvement tool (QIT) audits of environment and practice.
- We saw appropriate signage on display, these included hand hygiene posters and what to do in the event of a needle stick injury.
- The majority of physiotherapy equipment was single use; this minimised the risk of infection.
- Cleaning checklists and schedules were on display and found to be correctly completed.
- The hospital had achieved a food hygiene rating of 5 (where 5 is good) when it was last inspected, on 9 June 2015.

However;

- When we asked how often the toys in the patient waiting area were cleaned, staff were unsure. The OP manager said it was once a month and the infection prevention and control (IPC) nurse told us it should be once a day. Cleaning schedules confirmed staff cleaned the toys once a week. The IPC nurse assured us this would be changed to daily cleaning. This showed staff were not always aware of IPC procedures.
- Five of the seven OPD consulting rooms had carpets; two consulting rooms had recently been refurbished. The provider was aware that carpets should not be used in clinical areas, and had an ongoing refurbishment plan in place.

- We found an approved company had carried out a legionella risk assessment at the hospital on 4 December 2015. We found their report reviewed the previous 'water hygiene risk assessment,' dated 21st May 2014. The December 2015 report documented that there was no evidence that the recommendations from the previous water hygiene risk assessment had been effectively implemented across the site. It also stated that the risk of persons being exposed on site was perceived as high. This showed us the provider had failed to take action to keep people, visitors and staff safe.
- Following the inspection, we asked for assurance about completion of the actions required to meet the recommendations in the legionella risk assessment. The provider submitted an action plan dated 1 March 2016. This showed an external company had been asked to provide quotes for carrying out the works required. Actions that could be completed by staff at the hospital were being now carried out; including removing scale from taps and showers and monitoring water temperatures.

## Environment and equipment

- The outpatients, physiotherapy and radiology departments were co-located on the ground floor of the hospital. The OPD had seven consulting rooms and the physiotherapy department had a newly refurbished gym.
- Signage throughout the internal areas and externally was clear.
- Radiology, physiotherapy and OPD shared a patient waiting area.
- We noted there was a lack of clinical wash hand basins in most consulting rooms, the OP manager told us these were due to be replaced.
- The x-ray department was small and had one general x-ray (plain film) room in daily operation. The service also had a mobile x-ray unit. There was a dedicated ultrasound examination room based within the department. A mobile MRI service, provided by an external company, visited the site once a week on a Saturday. Radiographers performed fluoroscopy in theatres, using a mobile C-arm image intensifier.
- Radiology had systems and processes place to keep patients safe from the risks associated with x-rays and other procedures within the department

# Outpatients and diagnostic imaging

- Information provided prior to the visit said the mobile image intensifier for fluoroscopy in theatre also used for limited fluoroscopy exams in the radiology department (x-ray guided injections only). The fluoroscopy unit in the diagnostic imaging department had been decommissioned at the time of the inspection and was not for repair.
- There were systems and processes in place to ensure maintenance and servicing of OP and radiology equipment. The OP manager told us there were no problems getting equipment replaced when required. They said the cardiologists had requested new equipment in order to develop their service. On-site engineers carried out portable appliance testing (PAT) in the OPD; we saw this was all up to date.
- Radiology had an up to date inventory of all of the equipment and planned preventative maintenance (PPM) schedules. Most PPM was every six months.
- During the course of our inspection, we observed specialised personal protective equipment was available for use within radiation areas. Staff wore personal radiation dosimeters (dose meters) and these were monitored in accordance with legislation. A radiation dosimeter is a device that measures exposure to ionizing radiation.
- Radiation warning signs were displayed along with the use of illuminated do not enter signs. This was to prevent staff, patients and visitors accidentally entering a controlled area.
- Radiation local rules were displayed and described the duties to be undertaken by staff in accordance with the local rules. Local Rules are written to enable work with ionising radiation to be carried out in accordance with the Ionising Radiations Regulations (IRR99). It is the primary responsibility of the Radiation Protection Supervisor (RPS) to supervise work, observe practices in order to ensure compliance with these regulations.
- There was a picture archiving and communications system (PACS) in theatre to view X-rays pre, during and post-surgery.
- There were arrangements in place to deal with foreseeable emergencies. We checked the emergency trolleys in OPD; we found medications required, including oxygen, were all present and in date. Records confirmed staff carried out regular checks on the resuscitation equipment.

- There were call buttons in the OP consulting rooms, one for crash calls (immediate urgent assistance) and one for non-urgent assistance. There were also emergency pull cords in the patient toilets.

However,

- The height of the table in the main x-ray room was not adjustable. This meant some patients may not be able to get onto the table for their x-ray.
- We found fire doors that were not closing properly, fire doors that were propped open and fire doors without appropriate strips and seals. These issues had been identified in the hospital's fire risk assessment, dated 21 May 2013. According to the action plan for the fire risk assessment, all actions were due for completion in 2013.
- We saw the fire risk assessment action plan submitted following the fire inspection was last updated on 17 December 2013; one of the nine actions remained outstanding. This action stated, 'An appropriate number of designated staff must be trained to use fire extinguishers.' Following our inspection, the hospital told us staff received this as part of their fire safety training. Hospital data showed 100% compliance for fire safety training on 6 December 2015.
- We saw the clinical waste compound was not fit for purpose. The walls of the wooden compound were not high enough to ensure the security of the waste stored and there was insufficient capacity for the number of containers used. We saw three clinical waste containers were in the car park next to the waste compound. This meant clinical waste was not stored securely. Waste was collected twice a week. All of the waste containers checked at the time of inspection were locked.
- The arrangements for management of waste at the hospital did not comply with Health Technical Memorandum (HTM) 07-01 Safe management of healthcare waste, in that;
  - Healthcare waste was not stored securely; failure to do this is a breach of the statutory duty of care.
  - Bulk storage area was not totally enclosed and secure. Bulk storage area did not have storage capacity to match the frequency of collection.

## Medicines

- Appropriate arrangements were in place in relation to obtaining, recording and handling of medicines. Medicines were prescribed and given to people appropriately.

# Outpatients and diagnostic imaging

- The radiology department did not store controlled drugs. Other medicines and contrast media were stored securely at room temperature and were all in date. Ambient temperatures were checked daily; we saw these were always below 25oC.
- The OPD had a drugs fridge in the treatment room, which was kept locked. Staff checked drug fridge temperatures; we saw the records of these checks were all up to date. We saw medicines cupboards in OP consulting rooms were kept locked.

## Records

- At the time of inspection, we saw staff managed patient personal information and medical records safely and securely. Paper records were used in OPD and physiotherapy and a mixture of electronic and paper records were used in radiology.
- We reviewed seven sets of patient case notes in OPD and found staff had completed these correctly and legibly in black ink. All entries were signed and dated by staff, where required. Documents within patient records were well organised, with tabs to help with correct filing of paperwork.
- Staff in OPD told us the patient notes were available on the day before their appointment. This meant staff could check them prior to the patient's arrival. Information submitted prior to the inspection showed no (0%) patients were seen in the OPD without a full medical record.
- We checked ten request cards for x-ray imaging; these were all completed correctly.
- In radiology, we reviewed electronic patient records specifically to check whether staff had completed radiology safety checks for MRI, pregnancy and interventional WHO safety surgical checks. Staff had completed these as required. However, we saw the radiologist had not signed two of the nine WHO checklists reviewed.
- Hardcopies of radiology request cards were stored for six months before disposal.

However;

- We found there was a lengthy multi-step paper trail for pathology results. Pathology staff told us the hospital staff were not using the 'maxims' electronic system despite being trained to use it. This meant there was a risk that staff would not be aware of, or act upon, abnormal test results for patients.

## Safeguarding

- People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse or harm and prevent it from happening.
- Mandatory training courses included safeguarding children and safeguarding vulnerable adults. All staff completed safeguarding training at level 1 every two years. Clinicians and non-clinicians in a management or supervisory role completed safeguarding level 2 and the director of clinical services was trained to safeguarding level 3.
- We reviewed mandatory training figures for safeguarding up to December 2015. Compliance for both adult and children training was 100%. The hospital did not record where staff worked, the training figures were for all departments and not specific to this core service.
- Information provided to us by the hospital (the mandatory training matrix) showed the safeguarding training module ('no secrets' guidance) was out of date. It was related to guidance produced in the year 2000 and did not have reference to the Care Act 2014 or the Mental Capacity Act 2005. Since the Care Act was implemented, the 'no secrets' guidance has not been used nationally.
- The OPD and radiology departments had not provided any treatment to children under the age of 18 years old since January 2016, however, there were children in the hospital when they attended as visitors or accompanying relatives/friends.

## Mandatory training

- Staff we spoke with all confirmed they were up to date with their mandatory training. Mandatory training was completed online and monitored within the departments. Mandatory training included moving and handling, infection prevention and safeguarding.
- Mandatory training was undertaken by;
  - all staff who spent 50% of their BMI working time working within a hospital environment
  - contractors or bank staff who worked 80 hours or more per month.
- Information submitted by the provider prior to the inspection stated that on 6 December 2015 mandatory

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training compliance was 97.2% for all the staff working at the hospital. On that date, mandatory training in radiology was 97.4% and in pathology was 100%.

Compliance rates for OP staff were not listed separately.

- The OPD manager told us mandatory training was 100% compliant against a target of 100%. Training in infection control was 100%. Records submitted confirmed this.
- Staff in radiology told us their mandatory training was 100% compliant on 31 January 2016. We saw this was the case.

## Assessing and responding to patient risk

- The OP and radiology services assessed risks and responded appropriately in order to maintain patient safety.
- In radiology, we looked at one patient electronic record on the Reporting Information System (RIS) to ensure pregnancy safety checks had been completed prior to exposures being undertaken. We saw a pregnancy check had been completed.
- MRI safety checklists were scanned into the radiology RIS.
- Radiology regularly checked all of the lead aprons used by staff. The radiology manager told us all of the aprons in theatres had been replaced in 2015 and thyroid protectors had been replaced twice during 2015. (The purpose of lead aprons and thyroid protectors is to reduce exposure to x-rays to vital organs that are potentially exposed to ionizing radiation during medical imaging that uses x-rays).
- We reviewed the radiology risk assessments for the four pieces of equipment in the department; we saw staff had last updated these in December 2015.
- An external company provided Radiation Protection Advisor (RPA) support to the radiology service. They undertook annual risk assessment inspections of the radiology services at the location. The RPA produced an annual report.
- The purpose of the inspections and reports was to evaluate compliance with legislative requirements associated with the radiation safety of patients, members of staff and the public. The findings from inspections were communicated to the hospital's radiation protection committee.

- We saw from the 2015 and 2016 radiology annual inspection reports that adequate standards of compliance were achieved which met the performance expected. There were no actions from the December 2015 inspection.
- The report from a provider visit in 2015 suggested that there should be a separate RPS for theatres. However, the annual RPA audit advised that this was not necessary.
- There was a six-point check in place in radiology. Staff checked patients' identities by confirming their details against the original referral details on arrival in the department and prior to the procedure. This minimised the risk of errors in patient identity or performing the wrong procedure.
- The pathology laboratory kept four units of blood on site. The off-site laboratory was responsible for ensuring these were in date and ready for use.

However;

- We found the induction process for bank and agency staff working in the outpatients and diagnostic department comprised a basic two-page checklist. This meant there was a risk these staff may not have the skills and knowledge of the local procedures required to keep patients safe at all times.

## Staffing

- There were sufficient numbers of qualified staff working in OPD, physiotherapy, radiology and pathology to keep people safe. There was a 0.8 whole time equivalent (WTE) nurse team leader in outpatients, and 2.7 WTE care assistants.
- There were two bank nurses working in OPD at the time of our visit. The OPD had a vacancy for a registered nurse; the OP manager told us this position was due to be advertised. There was a 56% vacancy rate of registered nurses, as the service was established to have 2.2 WTE registered nurses. Bank staff had been booked to help cover gaps in the rota.
- In OPD, the senior nurse did the staff rotas. The OPD manager told us they did not use an acuity tool.
- Different information submitted prior to the visit stated there should be three (2.2 FTE) nurses and seven (4.13 FTE) care assistants working in OP. This meant it was unclear what the planned staff for the OPD was.
- There were three part time receptionists who undertook admin duties.



# Outpatients and diagnostic imaging

- Staff worked flexible shifts in OPD and radiology. Staff told us they would stay late if patients' treatments took longer than expected. Staff could take time off on lieu or swap shifts if they did this.
- There were no vacancies in radiology at the time of the inspection. There were two part time radiographers and the radiology manager, who worked 32 hours a week. Two part time administrative staff supported them.

The OPD manager had been in post since January 2014. They had taken on the additional role of Interim patient services manager from 18 January 2016, on a temporary basis, following the recent retirement of the previous OP manager three weeks prior to the inspection. According to the management structure, the OP manager was responsible for the pre-assessment team and staff working in OP and pathology. Staff told us this had changed the previous week to the new ward manager who had become responsible for the pre-assessment clinic.

- Physiotherapy, OPD and pathology were using bank staff to cover significant gaps in the rotas.
- The hospital had been unable to recruit successfully to some nursing and physiotherapy roles in the previous six months. As a result, it was relying on increased use of bank staff to maintain aspects of the service. For example, there were six bank physiotherapists and three bank healthcare assistants in physiotherapy at the time of the inspection.
- We found there was a lack of management training for staff promoted from clinical to managerial positions. Some staff had been promoted to more senior positions at the hospital, without further training to gain the necessary knowledge and skills.
- Sickness absence was higher than average during certain months. In September 2015, there was 9% sickness in outpatient nursing staff and 7% sickness in allied health professionals. From April to September 2015 the average sickness for registered nurses in outpatients had been 5.3%. For allied health professionals the average sickness rate was 3.5 % for the same time period. The average sickness rates in 2015 at 15 other independent hospitals was between 4% to 6%. The provider did not provide sickness absence figures for healthcare assistants, or separate figures for radiology, physiotherapy and pathology.
- Pathology employed three healthcare assistants (HCAs). At the time of the inspection, one pathology HCA was off sick. Physiotherapy, OPD and pathology were using

bank staff to cover significant gaps in the rotas. The OP manager confirmed they needed to recruit another HCA for pathology (20 hours a week); they said HCAs were flexible between areas.

## Medical staffing

- There were 76 doctors and dentists with practising privileges. This meant the hospital had granted them permission to practice as medical practitioners at this site.
- The radiology service used five consultant radiologists. They covered the range of specialisms and supported the other teams within the hospital.
- Arrangements for on call and out of hours cover were in place in radiology.

## Major incident awareness and training

- Senior staff told us potential risks were taken into account when planning their services. They said staff were very flexible and most lived locally so could be called upon in cases of adverse weather or other disruptions. There was a business continuity plan which identified keys risks that could affect the provision of care and treatment.
- Senior staff also told us they had a close working relationship with local NHS trusts and would support them in the event of a major incident.
- The hospital used a variety of 'business continuity action cards' to inform staff of the actions to take in different types of emergency. For example, what do if there was a loss of power, loss of mains water or adverse weather conditions. Staff told us these were available at the main entrance reception desk.

## Are outpatients and diagnostic imaging services effective?

The effective domain was inspected but not rated. We found;

- People's care and treatment reflected relevant research and guidance.
- The outcomes of people's care and treatment was routinely collected and monitored. For example, the hospital submitted information to the Private

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Healthcare Information Network (PHIN), and physiotherapists monitored quality of life before and after treatment. Staff had the skills, knowledge and experience to deliver effective care and treatment.

However;

- We found there was a lack of management training for staff promoted from clinical to managerial positions.. Some staff had been promoted to more senior positions at the hospital, without further training to gain the necessary knowledge and skills.

## Evidence-based care and treatment

- People's care and treatment reflected relevant research and guidance.
- Physiotherapy staff followed the Chartered Society of Physiotherapy's national guidelines.
- Physiotherapists told us they followed standardised guidelines for total hip replacements, but the procedures varied for total knee replacements. They said this depended on the surgeon's preferences. Physiotherapy audited the results and outcomes of acupuncture treatments.
- In radiology, we saw that policies and procedures within the directorate had been developed and referenced to NICE and Royal College of Radiologists guidelines. These were available to all staff on the electronic shared drive and in hardcopy.
- In radiology and physiotherapy, we saw signature sheets to show that staff had read policies relevant to their job roles. This meant they were aware of the latest policies aimed to support evidence based care.
- The radiology department used the iRefer radiological investigation guidelines tool, from The Royal College of Radiologists (RCR). The iRefer tool helps referring GPs, radiographers, clinicians and other healthcare professionals to determine the most appropriate imaging investigation(s) or intervention for a given diagnostic or imaging problem. It provides practical guidance based on the best available evidence, together with expert medical and radiological opinion.
- In radiology, there was quality monitoring of annual dose audits and a review of Diagnostic reference levels (DRLs) was undertaken. Diagnostic reference levels (DRL's) are an aid to optimisation in medical exposure. Radiation exposures doses were audited on a regular basis.

- Radiology had an annual audit programme. Staff carried out regular audits of WHO checklists, consent forms, request forms, warning lights, six-point checks, theatre dose levels and personal protective equipment. The radiology manager told us the WHO checklist audit results were "almost 100%." Data submitted by the hospital confirmed this.
- Radiology audits carried out in 2014 and 2015 showed the results were good when compared against the new national levels in accordance with the relevant legislation. The audit reports included the detail of any actions required to aid optimisation in medical exposure.

## Patient outcomes

- A patient-led assessment of the care environment (PLACE) audit took place at the hospital in May 2015. PLACE scores were the same as the England average for cleanliness but lower (worse) than the England average for the other six indicators;
  - Cleanliness – 99%
  - Food – 85%
  - Organisational food – 80%
  - Ward food – 92%
  - Privacy, dignity and wellbeing – 86%
  - Condition, appearance and maintenance – 85%
  - Dementia – 85%
- Results on patient outcomes are compared with locations within the region and also the regions across BMI Healthcare through the corporate clinical dashboard, this dashboard is reviewed monthly. We could not compare these outcomes as we did not have full data for this.
- The hospital submitted performance measures to the Private Healthcare Information Network (PHIN) ([www.phin.org.uk](http://www.phin.org.uk)) to assess patient outcomes against that of other private healthcare providers. The national data from private hospitals is being collated by PHIN and will not be available until 2017. Physiotherapy were using limited outcome measures, these included range of movement achieved for joints and muscle strength measured using the Oxford scale.
- Physiotherapy interventions were effective. The service had recently introduced a nationally recognised quality of life measure to monitor the effectiveness of treatment. Patients were asked about symptoms (such as pain, mobility and anxiety) before and at the end of treatment to see how much improvement they found.



# Outpatients and diagnostic imaging

- The radiology manager told us the service did not participate in the Imaging Services Accreditation Scheme (ISAS) or accreditation for Quality in Physiological Services (IQIPS) scheme. This was because the on-site radiology service was small.
- The OP manager said there was a chaperone audit in OPD every two months; this was done to ensure patient notes matched the chaperone register.
- A minor procedures audit used to be done in OPD. The responsible person moved areas and, as a result, staff had not done this audit for nine months. The OP manager confirmed there were no environmental audits and no patient notes audits in the OPD. This meant the service could not monitor outcomes or improvements in these areas.

## Competent staff

- Permanent staff had the appropriate skills, knowledge and experience to deliver safe effective care to patients. A staff training and competence assessment programme was in place, which included induction.
- We spoke with a relatively new radiographer in radiology. They described to us their personal induction and development plan, which included performance reviews and appraisal.
- However, managers carrying out root cause analysis (RCA) investigations had not received training in carrying out RCAs. This meant they did not necessarily have the right skills in this area.
- The hospital had a system in place to ensure that consultants working under practicing privileges were competent to carry out their role. Consultants worked under practising privileges and were approved by a medical advisory committee (MAC) prior to working at the hospital. Doctors with practising privileges were reviewed every two years by the MAC.
- Senior staff in radiology and OPD told us 2015-2016 staff appraisals were due to be carried out. Staff told us their appraisals were recorded on line. All of the staff we spoke with during the inspection told us they had not undertaken their 2015-2016 appraisals yet. They said they were waiting for the senior staff to have their appraisals, as there was a new process, which required a cascade approach.
- Information provided prior to the inspection showed that compliance with appraisal completion in OPD was

moderate. For example, between October 2014 and September 2015, 73% of nurses and 66% of healthcare assistants working in the OPD had completed their appraisal.

- The radiology manager was the qualified RPS within the service. We saw evidence of their most recent update training and evidence of a competence update for their role as RPS in 2015.
- Radiology staff we spoke with told us there was a positive training and development culture and their competencies were up to date. Records reviewed confirmed this.
- Radiology held a list of non-medical referrers who could request radiology investigations; we saw the lead radiologist had approved this. The list was of qualified health professionals, including physiotherapists. The list included specimen signatures and records of professional registration.
- The provider carried out registration checks on all staff every month to ensure they were up to date with their professional registration. This included the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council. This showed staff maintained their fitness to practice.
- The nurse in OPD told us they did not get clinical supervision. We did not establish how staff were supported or performance managed in between their annual appraisals. (We could not corroborate this or speak to any other nurses, as there was only one on duty).
- Staff using point-of-care testing (POCT) equipment within the hospital undertook annual refresher training. Staff accessed the POCT equipment using a key card. If their training was out of date then staff could not use the equipment; this meant they had to keep their skills up to date.
- Healthcare assistants within the hospital were undertaking the 12-week care certificate programme. All healthcare assistants within the department were qualified to NVQ Level 2 or 3. They had a nurse mentor and completed a portfolio. The OP manager said these HCAs would undertake more tasks, such as triaging patients, minor dressings and sutures once their training was completed.

## Multidisciplinary working

# Outpatients and diagnostic imaging

- We found examples of multidisciplinary team (MDT) working in radiology, pathology, physiotherapy and OP services. For example, members of the physiotherapy team were involved in screening patients at pre-assessment clinics.
- The hospital had appropriate service level agreements (SLAs) in place. For example, there was an SLA in place between the hospital, the off-site laboratory and the local trust for the supply of blood in the event of a major haemorrhage.
- The hospital occasionally received requests from local trusts to perform work for them as part of waiting list and winter pressures initiatives.
- There were arrangements in place to transfer patients' care to the local trust in emergencies.

## Seven-day services

- The OPD was open five days a week, start and finish times varied between 8am and 9pm depending on which clinics were running. The OPD also ran Saturday morning clinics.
- The radiology department worked extended sessions into the evenings and early in the mornings, to support the other services at the site. There was also an out of hours rota for radiographers. The hospital did not have a formal out of hours rota for radiologists.
- An MRI scanner visited the site once a week on a Saturday.

## Access to information

- Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- The radiology department used a Commercial Reporting Information System (CRIS). The CRIS is a dedicated computer system which manages information about people who use services. It supports staff to deliver effective care and treatment by providing the information they need.
- The CRIS was combined with the Picture Archiving and Communications System (PACS), a nationally recognised system used to report and store patient images. Authorised user groups such as radiographers and radiologists had individual user login and password authentication.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training data submitted showed that staff in both OP and radiology were up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with knew how this legislation applied in their roles.
- The hospital had policies and procedures in place for staff to follow to obtain consent from patients receiving diagnostic procedures. General x-ray procedures were performed using implied consent from the patient.
- Written consent procedures were followed when performing more complex or interventional radiological procedures. We reviewed nine consent records for patients undergoing interventional ultrasound procedures and saw these had all been completed correctly.
- In physiotherapy, consent was implied, apart from for acupuncture treatments. We saw there was a form for patients to sign to consent to acupuncture treatment. Implied consent means the patient did not sign to consent to the treatment. By attending their appointment, they were consenting to the treatment.
- Patient records we reviewed in OPD showed consent procedures were followed correctly. We reviewed seven consent forms; they were all completed as required. The service used consent forms for procedures such as skin tag removal, mole removal and colposcopies. The OPD completed a minor procedures register.
- When we asked staff in OPD and radiology about consent for patients who lacked capacity, they told us they would not see these patients at the hospital, as staff would screen them out at the triage stage.

## Are outpatients and diagnostic imaging services caring?

Good 

We rated this core service to be good for caring because staff caring for people and their families treated them with compassion, kindness, dignity and respect. We found;

- People experienced care, treatment and support that met their needs and protected their rights.
- People understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.

# Outpatients and diagnostic imaging

- We spoke with six patients in OPD waiting area and reviewed 25 comment cards; the feedback received from all of the patients and their relatives was outstanding. There were no negative comments.

## Compassionate care

- People were treated with compassion, kindness, dignity and respect. They experienced care, treatment and support that met their needs and protected their rights. Patients were given the option of having a chaperone present when intimate examination or treatment was being given by a member of the opposite sex.
- We observed respectful interactions between staff and patients in the OPD. Staff showed a sensitive and supportive attitude when caring for patients; they were friendly, polite and courteous. We saw and heard staff introducing themselves to the patients and explaining the next steps in their treatment pathway.
- Reception staff in the main entrance were welcoming and we observed they knew some patients by name when they welcomed them on arrival.
- The physiotherapy department had an individual consulting room; staff told us they used this room for women's health appointments. This room provided privacy and respected the dignity of patients during their consultation.
- We spoke with six patients in OPD waiting area and reviewed 25 comment cards; the feedback received from all of the patients and their relatives was outstanding. There were no negative comments. One of the patients we spoke with told us, it had been a very positive experience and she had been treated with dignity.
- The provider reported that the hospital's scores in the friends and family test (FFT) were high, but the response rates were low.
- Between April and September 2015, the patient satisfaction scores were 100% in four months out of six, and 97% and 99% in June and July respectively. The response rates for the same period were between 15.8% and 32.3%.

## Understanding and involvement of patients and those close to them

- People who used the service were given appropriate information and support regarding their care or treatment. Written patient information leaflets about

the service and treatments delivered were readily available and provided to patients. This patient information was also available on the intranet (for staff) and internet.

- Staff we spoke with told us they provided patients and their families with the information they needed, both verbally and in the written leaflets.
- We reviewed seven sets of case notes in the OPD. All seven records had evidence of patients' involvement in discussions with staff about their treatment options, and the risks and benefits of the different treatments.
- People who used the service understood the care and treatment choices available to them. Patients were encouraged to ask questions about their treatments on any of their visits. One of the physiotherapy patients we spoke with told us the staff had answered their questions and were very helpful

## Emotional support

- Patients received emotional support to help them cope with their care, treatment or condition. One patient said, "Everything was explained to me clearly, so I have no anxiety issues. I am feeling very positive and optimistic for my hip operation and the future."
- We observed caring interactions between staff, patients and relatives. Staff reassured patients and relatives about the care and treatment they received.
- We saw there were chaperone notices in all of the OPD consulting rooms. Chaperones were available for patients that wanted them.

## Are outpatients and diagnostic imaging services responsive?

Requires improvement 

We rated the responsiveness of these services to be 'good' because people's needs were met through the way services were organised and delivered.

- Access and flow in the OPD and radiology departments was well managed. Patients told us their appointments were on time and they could get appointments quickly.
- Referral to treatment times (RTT) were being met and the 'did not attend' (DNA) rates were significantly lower than the national average.

# Outpatients and diagnostic imaging

- People's individual needs were being met; there were numerous leaflets and signs available. Translation services were available and staff knew how to access these. Sign language services were also provided for those patients that needed them.
- The services took account of complaints and comments to improve the service.

However;

- Patient information leaflets were not available in other languages.
- The hospital did not audit specific waiting times for patients to receive an appointment, or the length of wait when they attended for their appointment.
- Service planning and delivery to meet the needs of local people
- Services were planned and delivered to meet the needs of the people using the services. There was a car park outside the hospital and the outpatient department was clearly signed and accessible on the ground floor of the hospital.
- Radiology carried out 2,531 plain x-rays, 740 ultrasound scans and 810 MRI scans from October 2014 to September 2015.
- Radiology provided same day plain film X-ray services for direct referrals from GPs. . Ultrasound and MRI scans were provided at the hospital. MRI was undertaken using a visiting mobile MRI scanner. CT scans were undertaken either at the local NHS trust or at another BMI site.
- An interventional radiologist visited the hospital every six weeks to carry out an interventional list. Most interventional radiology was carried out using ultrasound. Interventional radiology refers to a range of techniques which rely on the use image guidance (such as X rays, ultrasound or magnetic resonance imaging [MRI] for precise therapy or treatment using fine needles, wires or tubes.
- The radiology department had a service level agreement in place with the local trust for CT scans, when these were requested for NHS patients.
- Consultations for OP referrals in orthopaedics, urology and ENT were seen at Oaklands Medical Practice in Holmfirth. This meant OP services were provided to patients closer to their home address.

- We saw the hospital had guidelines for healthcare professionals acting as referrers for imaging examinations.
- We saw the OP waiting area had a TV, hot and cold drinks, newspapers, magazines and toys. The OP manager confirmed children were not seen in the department, but may accompany adult patients.
- The OP and radiology services managed busy times by extending the working day, staff being flexible and limiting the numbers of patients attending each clinic.

## Access and flow

- Access and flow in the OPD and radiology departments was well established. The hospital received NHS referrals through choose and book. Referrals for fee paying and insured patients were received direct from GPs.
- From October 2014 to September 2015, the hospital's OP department saw 13,625 patients. Of these, 5854 were new appointments and 7771 were follow-up appointments. There were 7928 NHS appointments and 5697 private patient appointments during this period.
- The OP manager told us the pre-assessment pathway had been revised two years ago and the process was much faster now. For example, the health questionnaire and booking form was filled in straight away.
- Referral to Treatment (RTT) was within 18 weeks for admitted patients and non-admitted patients (92% target). It routinely exceeded targets and had the hospital been performing above the national average in the reporting period (October 2014 to September 2015).
- The provider achieved the target of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period (October 2014 to September 2015).
- The hospital's 'did not attend' (DNA) rates were significantly lower than the national average.
- Staff sent the majority of patients' samples to an off-site laboratory for testing. Couriers collected samples twice a day. Staff told us the laboratory dealt with between 50 and 100 samples each day. Urgent samples were sent in a red transport bag and extra courier runs could be requested as and when required.
- The resident medical officer came to the on-site pathology laboratory to check the test results each day. Staff told us these test results were now available electronically. Staff had been trained to use the electronic system, but did not use it.

# Outpatients and diagnostic imaging

- The patient services manager told us the agreed turnaround times for tests was four hours, from receipt at the off-site laboratory.
- The hospital used a small number of point of care machines for carrying out laboratory tests on site. These included urine dipstick tests, blood glucose tests and blood gas analysis. This meant patients got their results more quickly.
- Radiology staff told us reports were usually completed within 24 hours of imaging taking place. Sonographers reported ultrasound scans on the same day.
- Patients had a choice for booking the dates and times of appointments. NHS patients used the 'Choose and Book' system. Patients we spoke with confirmed appointments were offered that suited their needs.
- Staff and patients both told us the wait times for appointments in radiology were short. The radiology manager told us patients could get an appointment within one to two days, and a maximum of seven days.
- Physiotherapy staff attended the pre assessment clinics for patients having a joint replacement, or requiring a physiotherapy assessment. This meant patients did not have to come back for a separate physiotherapy appointment.
- Reception staff and patients we spoke with told us they did not have to wait long once they had arrived in the department. During our visit, we observed one elderly patient being fast-tracked to the OPD by the reception staff. This was so that the ambulance that brought them could wait and take them back.
- None of the patients we spoke with raised any concerns about being able to access appointments in a timely manner or delays in clinic. One patient told us staff had scheduled their appointment to fit in with their other commitments. We heard reception staff booking patients in for future appointments; patients were all offered a choice of times and dates.
- However, the hospital did not audit specific waiting times for patients to receive an appointment, or the length of wait when they attended for their appointment.

## Meeting people's individual needs

- Services took some account of different people's needs, including those in vulnerable circumstances, with

disabilities or complex needs. Disabled toilets were available in the OPD. However we saw the height of the x ray table was not adjustable; this meant that it could be difficult for some people to get on to it.

- Dementia training was part of the 'BMI Learn' training programme for staff. Patients with advanced dementia were not treated at the hospital. If it was found someone had advanced dementia or did not have capacity, they would be triaged against exclusion criteria on receipt of referral as the service was not designed to meet their needs.
- There were numerous leaflets and signs available and staff used translation services on a regular basis. Sign language was also available to patients using the service, at no extra cost. The interpreter service used provided photographic identification for their interpreters; staff used this to confirm their identity when they arrived on site.

## Learning from complaints and concerns

- There were systems and processes in place to acknowledge, investigate and respond to complaints within a defined period. Managers discussed complaints to share findings and identify learning outcomes at the weekly Senior Management Team meeting and at the monthly Head of Departments meetings.
- The clinical governance committee discussed complaints of a clinical nature and all complaints were discussed at the bimonthly Medical Advisory Committee (MAC) meetings. There had been 26 complaints submitted to the hospital between September 2014 and October 2015, one of which had been submitted to the Care Quality Commission. Senior staff told us there had not been any complaints for the six months before our inspection.
- The provider took account of complaints and comments to improve the service. For example, a number of complaints related to transparency around charges for self-pay and insured patients. As a result, the hospital adopted the BMI self-pay scheme. This ensured fixed price packages were transparent and the prices quoted for procedures were specific and standardised.
- Complaints were recorded on the provider's online incident reporting system. Staff told us verbal complaints would also be recorded on the system.



# Outpatients and diagnostic imaging

- Information regarding the process for raising concerns/issues was in the BMI Patient and Family Information Leaflet 'Please tell us...' We saw these were available throughout the hospital for patients, relatives and visitors.

## Are outpatients and diagnostic imaging services well-led?

Requires improvement 

We rated the well-led domain for this service to be 'requires improvement' because the leadership, governance and culture did not always support the delivery of high quality person-centred care and the sustainable delivery of quality care was put at risk by the financial challenge. We found;

- At the time of our inspection the leadership was provided by an interim executive director and an interim director of clinical services. They had recently moved into these positions. They were aware of many of the issues we found and had begun to take action on improvement plans.
- The vision and values for the services were not well developed; staff we spoke to were aware of some future developments, but not of an overall vision and strategy.
- Risks and issues identified were not always dealt with appropriately or in a timely way. Some environmental and estates issues had been on the risk register for more than three years, others had been added and no actions taken. Staff told us this was often due to financial limitations. This put the sustainable delivery of quality care to patients at risk.
- Governance processes were at times ineffective; this meant actions required did not always get completed. For example, recommended actions following a legionella risk assessment in May 2014 were still outstanding and recommended actions from a fire risk assessment in May 2013 were not all complete.
- There was a new management team in place. We acknowledged they recognised the governance issues which had been escalated to the BMI corporate team; however the hospital team could not authorise repairs to the building or obtain new equipment without authorisation.
- The governance, risk management and quality monitoring in OPD required improvement. For example,

there was no audit programme and the audits carried out were unstructured with no action plans or follow up. A service level agreement (SLA) with a taxi company, to transfer patient notes to other sites, should have been reviewed every two years. We found this SLA had not been updated since 2011.

- Not all leaders had the necessary experience, knowledge, capacity or capability to lead effectively. Staff were moved into more senior positions without the skills and knowledge required to fulfil the roles. The need to develop leaders was not always identified and action was not always taken. Leaders, especially those in interim positions, were not always clear about their roles and their accountability for quality.

However:

- Staff told us they were happy and felt well supported in all of the services we visited. There was evidence of good team working, both within and between teams, and a positive open culture.
- Governance in radiology was well established and there was an annual audit programme.

### Vision and strategy for this core service

- When we asked the OP manager about the vision and strategy for the OPD, they said. "The hospitals philosophy has been ticking along". They were not able to tell us what the vision and value were for patients.
- Senior managers told us their vision for the hospital was in line with the corporate vision, namely to be a hospital of choice and to be a good competitor against other providers. We were disappointed to not hear that quality care and safety were part of the hospital vision. The OP manager told us the hospital was expanding the services and the clinics offered. They said there was a new GP service running once a week which they were hoping to expand. This was aimed at business people.
- Other plans included medical tests for HGV drivers and medical screening. They said their rates would be competitive.

### Governance, risk management and quality measurement for this core service

- The governance process at the hospital was; issues raised at department meetings were raised to heads of department, the health and safety committee and the governance committee; these were then escalated to the senior management team and MAC.

# Outpatients and diagnostic imaging

- The clinical governance committee with met every other month and other committees reported into that. For example the blood transfusion committee, IPC committee, resuscitation committee and medicines management committee.
- The governance, risk management and quality monitoring in OPD required improvement. We found it did not always support the delivery of safe, good quality care. The sustained delivery of quality care appeared to be at risk by the financial challenge upon the hospital. We found the approach to improvement was reactive and focussed on short term issues.
- There was a lack of evidence of continuous quality improvement in OPD. For example, there was no audit programme and the audits carried out were unstructured with no action plan or follow up. The OPD manager confirmed this.
- We saw risks were not always managed in line with guidance. For example the lack of positive air pressure in the OPD treatment room was added to the risk register in December 2015. This had been a legal requirement since 2007 (Health Technical Memorandum 03-01). Positive air pressure is required in all treatment rooms where minor procedures (including changing of dressings) take place. The risk register did not identify any outstanding controls or actions for this risk. This showed the risk register did not provide assurance that timely actions were taken to keep people safe.
- We had concerns the risk register did not reflect risks we found during the inspection; for example around monitoring of working arrangements with some third parties such as the taxi company who took patient notes to other sites. The service level agreement had not been reviewed for five years despite documentation stating it was renewed every two years. This meant there was a risk taxi drivers transporting patient notes had not received the training required and the SLA had not been reviewed in the timescale required.
- The physiotherapy risk register was up to date. However, risk management for the whole building lacked evidence of timely follow up. Issues had been on the risk register for several years without any evidence of action being taken to resolve the issues.
- For example, potholes on the drive and in the car park were first identified on the risk register in 2013; we saw these were still on the risk register and were still a trip hazard for patients and staff. We saw the clinical waste compound in the car park had been discussed in meeting minutes and had been on the risk register since June 2013. The risk register stated quotes were being sought for a replacement compound; however, there was no target date for completion of this action.
- Governance in radiology was well established. Radiology had Radiation Protection Advisors (RPA's) and an on-site Radiation Protection Supervisor. Arrangements were in place to seek advice from the RPA in accordance with the local rules. The RPAs supported quality assurance, governance, radiology local rules and local risk assessments.
- The on-site Radiation Protection Supervisor (RPS) carried out an annual review of procedures, protocols, forms, lists and records in use in the radiology department.
- We saw minutes from meetings of the hospital's radiation protection committee, and the terms of reference for this group. We saw that internal and external quality assurance checks were discussed at these meetings.
- The pathology user group (PUG) met twice a year, with input from staff at the off-site laboratory.
- The hospital's Medical Advisory Committee (MAC) provided advice and assistance on matters related to the clinical use of the hospital to the Executive Director.
- The hospital received support from the BMI healthcare regional team and corporate office. However, recommended actions following a legionella risk assessment in May 2014 were still outstanding and recommended actions from a fire risk assessment of the premises in May 2013 were not all complete.
- We found risks were not always addressed, for example in relation to external quality assurance checks around point of care testing equipment.
- There was a systematic corporate audit programme, but we found it had not been robust enough at times to manage the risks and issues which were repeated over the course of a year. It was difficult for the hospital teams to influence this programme as it was set at a corporate level.

## Leadership / culture of service

- There was positive local leadership from the executive director and director of clinical services. We saw they had not been in post long and had already identified the need for extra management support in areas of the hospital and the need to improve quality and safety systems.



# Outpatients and diagnostic imaging

- The registered manager had applied to the CQC in December 2015 to be deregistered as the named person; however they were still the registered manager at the time of our inspection in February 2016, despite them no longer working at the service. A new registered manager subsequently registered with the CQC. (A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law).
- The radiology department had a radiology manager and the OPD had an OP manager who was also the patient services manager and pathology manager. The radiology manager had worked at the hospital for over 24 years. They were visible and approachable.
- Staff told us they were happy and felt supported in their roles. They also told us team working and communication was good and they felt confident to ask questions.
- Staff gave us positive feedback about the culture of the service.
- Staff told us their local managers were supportive. They said there was good team working. Local managers were visible in the departments and did regular walk rounds. These included coming in to evening and weekend clinics.
- Staff told us there were good relationships between the various grades of staff and the visiting consultants and between the departments in the hospital. They said staff working at the hospital were very friendly and supportive.
- We found there was a lack of management training for staff promoted from clinical to managerial positions.. Some staff had been promoted to more senior positions at the hospital, without further training to gain the necessary knowledge and skills.

## Public and staff engagement

- The service encouraged patients to complete patient satisfaction surveys, which were readily available in all departments. The feedback received from these surveys was reviewed monthly, anonymised and shared throughout the organisation.
- The hospital's statement of purpose, dated January 2016, stated 'As part of our commitment to continuous improvement we obtain feedback from patients.'
- Information provided prior to the inspection stated an external company collated patient satisfaction scores; these were reviewed at monthly departmental meetings.
- We confirmed that these results were discussed in the monthly heads of department (HOD) meetings. Minutes from the HOD meeting on 18 November 2015 reported that September 2015's results had been good, with a score of 98.6%.
- The OP manager told us about 'BMI SAY', which was an online system for staff to give anonymous feedback.
- The radiology and OP managers told us they held staff meetings every 1-2 months in order to engage with staff and obtain their views. However, records of OP staff meetings showed the last three meetings had been held every three months; in January 2016, October 2015 and August 2015.

## Innovation, improvement and sustainability

- The chartered society of physiotherapy (CSP) recognised the hospital's physiotherapy team in their 2014 awards. This was because of their involvement in the enhanced recovery programme for joint replacements. The average length of stay for both hip and knee replacements at the hospital was now below three days.

# Outstanding practice and areas for improvement

## Outstanding practice

- We saw evidence of good communication in the form of daily 'comm cells'. These were meetings held between the hospital's senior management team and the heads of department where patient admissions, staffing, risk and incidents were discussed.
- We also saw good practice in the form of safety 'huddles' taking place in theatres where surgeons discussed allergies and patient safety with all staff.
- The chartered society of physiotherapy (CSP) recognised the hospital's physiotherapy team in their 2014 awards. This was because of their involvement in the enhanced recovery programme for joint replacements. The average length of stay for both hip and knee replacements at the hospital was now below three days.
- We found the physiotherapy department had introduced the use of a quality of life questionnaire for all patients to monitor the effectiveness of treatment they gave to patients.
- The ward manager told us one of their objectives was to set up an ambulatory care centre which could be managed by skilled health care assistants. They said uncomplicated conditions could be treated without the need for an overnight stay in hospital.

## Areas for improvement

### Action the provider **MUST** take to improve

- The hospital must ensure compliance with the WHO 'five steps to safer surgery' procedures.
- The hospital must ensure theatre equipment is safe, available and fit for purpose.
- The hospital must put processes in place to ensure there is a robust assessment in pre assessment phase and a process must also be established so that action can be taken on investigation results from pre assessment.
- The hospital must ensure infection control policies and procedures are followed and actions from the infection control and water safety plan are implemented.
- The hospital must ensure staff receive up to date safeguarding training relevant to their roles.
- The hospital must ensure the building management system has an alarm fitted so any unsafe changes in water temperature can be immediately detected.
- The hospital must ensure checks are in place and food served is within date; review delivery dates of food from external supplier.

- The hospital must ensure premises are safe and properly maintained. In particular, review lack of fire doors in theatre, fire doors in OPD, safe storage of waste in order to comply with legislation (HTM 07-01), security of the medical gas storage area, and ward freezer checks for temperature.
- The hospital must ensure sufficient numbers of suitable competent staff in theatres and OPD, including allied health professionals.
- The hospital must ensure policies and procedures are reviewed and are in date.
- The hospital must ensure staff are suitably trained before carrying out root cause analysis investigations to optimise learning from adverse incidents.

### Action the provider **SHOULD** take to improve

- The hospital should ensure there are clear systems in place with identified responsibilities for carrying out external quality assurance checks on point of care testing equipment.
- The hospital should review the position of the endoscope washer and review the route of trollies brought into theatres from the outside and through theatres.

# Outstanding practice and areas for improvement

- The hospital should review consider using leaflets in other languages as well as in English.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider must ensure compliance with the WHO 'five steps to safer surgery' checklist.

The provider must ensure theatre equipment is available, safe and fit for purpose.

The provider must ensure actions from the infection prevention and control action plan are put in place.

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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).

#### Regulated activity

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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).

#### Regulated activity

#### Regulation

This section is primarily information for the provider

## Requirement notices

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

**The provider must ensure the safeguarding training module is updated.**

**The provider must establish a process to deliver domestic abuse training (including FGM) to relevant clinical staff.**

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

**The provider must ensure processes are in place to check expiry dates on food intended for patient use.**

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

**The provider must ensure actions from external inspections are completed. This includes fire and water safety (legionella) risk assessments and an alarm on the BMS (building management system).**

**The provider must ensure the premises are properly maintained and secure including; fire doors, waste compound, medical gas storage area and ward freezer.**

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**The provider must ensure policies and procedures are reviewed and are in date.**

This section is primarily information for the provider

## Requirement notices

The provider must ensure there are effective systems and processes in place to regularly assess and monitor the quality of service people receive.

The provider must ensure there are clear systems and processes in place to for safe assessment of patients in pre assessment, and establish a process for action to be taken on investigation results.

The provider must also ensure staff are trained and competent to carry out Root Cause Analysis investigations and develop subsequent action plans.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider must ensure there are sufficient numbers of suitably qualified staff in theatres, OPD and physiotherapy.

The provider must ensure a process is in place to determine competency of any extra staff (first assistants in theatre) brought in by surgeons.

This section is primarily information for the provider

## Enforcement actions

### 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.