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

Overall summary

BMI Thornbury is operated by BMI Healthcare Limited and cares for adults and children undergoing a wide range of surgical procedures and those requiring other medical interventions. The hospital has a dedicated cancer unit offering both chemotherapy and supportive therapies to patients. Diagnostic imaging services include a 161 slice CT scanner and a 1.5T MRI scanner. A new digital mammography unit has been installed.

BMI Thornbury Hospital offers a level two critical care facility for those patients requiring additional monitoring and support. The hospital attracts consultants and is located close to a local NHS trust. The hospital offers a wide range of services including orthopaedics, general surgery, gynaecology, spinal surgery, urology, oncology, ophthalmology, ear nose and throat services, cosmetic surgery and physiotherapy.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the hospital on 23 and 24 July 2019, and on 02 August 2019.

Summary of findings

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

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

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

Services we rate

Our rating of this hospital improved. We rated it as **Good** overall. The rating for Safe stayed the same as requires improvement. Effective improved from requires improvement to good. Caring, responsive and well-led stayed the same and were rated as good.

We rated each core service - surgery, medical care, services for children and young people, outpatients and diagnostic services - as good overall. Critical care was rated as requires improvement.

The ratings for surgery, medical care and critical care stayed the same. The ratings for services for children and young people improved from requires improvement to good. Outpatients and diagnostic services were inspected as one service at the last CQC inspection. At this inspection we rated them separately.

Although the hospital was rated a good overall, we found some issues that the service provider needs to improve.

Following this inspection, we told the provider it must take some actions to comply with the regulations and it should make other improvements, even though a regulation had not been breached, to help the service improve. We issued the provider with three requirement notices. These were related to Regulations 12 (safe care and treatment) and 17 (good governance) in the critical care unit, and Regulation 15 (premises and equipment) in relation to the hospital fire safety corrective action plan Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North East)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good 	We rated this service as good because it was safe, effective, caring, responsive and well led. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
Surgery	Good 	We rated this service as good because it was effective, caring, responsive and well-led. However, we found it required improvement for being safe. Surgery was the main activity of the hospital.
Critical care	Requires improvement 	We rated this service as requires improvement overall and in safe and well led. However, we rated it as good in effective, caring and responsive. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
Services for children & young people	Good 	We rated this service as good because it was safe, effective, caring, responsive and well led. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
Outpatients	Good 	We rated this service as good because it was safe, caring and responsive and well-led. We do not rate the effectiveness of outpatient departments. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
Diagnostic imaging	Good 	We rated this service as good because it was safe, caring, responsive and well led. We do not rate the effectiveness of diagnostic imaging departments. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

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Good

BMI Thornbury Hospital

Services we looked at

Medical care (including older people's care); Surgery; Critical care; Services for children & young people; Outpatients; Diagnostic imaging;

Summary of this inspection

Background to BMI Thornbury Hospital

BMI Thornbury Hospital is operated by BMI Healthcare Limited and is a 64 bedded acute general hospital in Sheffield, South Yorkshire. The building was originally a private residence constructed in 1865, which later became a children's hospital. The children's hospital closed in the 1980's and was then acquired in 1991 by AMI.

The hospital became part of the BMI Healthcare Group in 1996. In 2002 the hospital commenced an expansion programme to ensure its facilities continued to meet patients' needs. This included a focus to meet the increasing demand for out-patients.

As a result, a consulting suite comprising of 19 consulting rooms, a minor treatment room, out-patient reception and waiting area were added, as well as an improved physiotherapy department and gymnasium. At this time, a fourth theatre was added along with a dedicated endoscopy unit.

Source: Provider Information Return

Our inspection team

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

Information about BMI Thornbury Hospital

BMI Thornbury Hospital has two wards. Mappin Ward has 24 individual rooms all with en suite bathrooms. Fulwood Ward has 27 rooms all with en suite. Three rooms are used for ambulatory care and one room is used as a children's playroom.

There are four theatres, of which three have a laminar air flow system. All theatres operated six days a week.

The critical care ward has six beds. One room has two beds, one room has one bed while the other three are all single rooms with monitors.

The oncology unit provides day-case chemotherapy treatment and outpatient clinics, and each room has an en suite bathroom. One room is designated as a family room.

Outpatient consulting suites are located over two floors, with 18 individual consulting rooms.

The hospital provides a wide range of surgical procedures and those requiring other medical interventions and offers a wide range of services including orthopaedics, general surgery, gynaecology, spinal surgery, urology, oncology, ophthalmology, ear nose and throat services, cosmetic surgery and physiotherapy.

The hospital provides surgical procedures and outpatient appointments for children and young people two days each month. Children and young people could also receive treatment in the endoscopy unit. Services for children and young people is a small proportion of the overall hospital activity and staff from the local children's hospital NHS trust provided care and treatment. In the reporting period March 2018 to February 2019, activity relating to children and young people accounted for 1% of all day case procedures and 3.5% of outpatient attendances.

The hospital is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury,

Summary of this inspection

- Surgical procedures,
- Diagnostic and screening procedures,
- Family planning

During the inspection, we visited both wards the critical care unit, the children and young people unit, four theatres and both diagnostic and outpatient departments.

We spoke with 40 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 29 patients and three relatives. During our inspection, we reviewed 41 sets of patient records.

- In surgery we spoke with eight patients and reviewed 12 sets of medical records,
- In medicine and critical care we spoke with 10 patients and reviewed 18 sets of medical records,
- In outpatients and diagnostics we spoke with eight patients and reviewed six sets of medical records,
- In services for children and young people we spoke with three children and their families and reviewed five sets of medical records,

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected before, and the most recent inspection took place in November 2015.

Activity (March 2018 to February 2019)

- In the reporting period March 2018 to February 2019 There were 2483 inpatient cases and 6655 day case episodes of care recorded at The Hospital; of these 66% were NHS-funded and 34% other funded.
- There were 16897 outpatient total attendances in the reporting period; of these 44% were NHS-funded and 56% were other funded. The hospital provided information prior to our inspection indicating the activity levels within the outpatient's department were as follows:
  - Orthopaedics - 43%
  - Gynaecology – 14%
  - General surgery - 12%.
  - Neurosurgery - 7%.
  - Gastroenterology – 3%
  - Urology - 3%
  - Dermatology - 3%
  - Neurology – 3%
  - Cardiology - 3%
  - Physiology – 2%
  - ENT, cosmetic surgery, neurophysiology, oncology, rheumatology, radiography, ophthalmology, vascular, haematology, dental and paediatrics all equated to less than 1%

There were a combined 258 surgeons, anaesthetists, physicians and radiologists who worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a 24 hour a day, seven day a week rota. The hospital employed 36 full time equivalent (FTE) registered nurses, 29.8 FTE care assistants and 32.1 FTE other hospital staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (March 2018 to February 2019):

- Between March 2018 and February 2019, the hospital reported no never events. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The hospital reported 685 clinical incidents, of which 495 were reported as no harm, 165 were low harm, 20 were moderate harm, and two were severe harm. There were three deaths reported in this period.
- There were no serious injuries reported in his period.
- There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) however, there were three incidences of hospital acquired E-Coli.
- The hospital had received nine complaints in the reporting period.

Summary of this inspection

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- < >< >
  Microbiology advice for orthopaedics
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision
- Agency staffing

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- The design, maintenance and use of facilities, premises and equipment posed a risk to people's safety. We saw a Fire and Rescue Authority regulatory reform safety order had been issued and numerous actions were outstanding from this work.
- Senior leaders recognised that investment in hospital infrastructure and equipment was needed.
- Although the service used systems and processes to safely prescribe, administer, record and store medicines, they were not always followed by staff in the critical care unit.
- We saw high rates of bank and agency staff were utilised in theatres. Although the service provided mandatory training in key skills to all staff and made sure everyone completed it, compliance rates were lower among this staff group and nursing staff from critical care.
- Staff told us that when the consulting rooms were in use on the ground floor, there was no member of nursing staff in that area. We were concerned that if a patient deteriorated in this area, the consultant would have to call for help before assisting the patient and they would not have access to any emergency equipment. The director of clinical services told us the consultant would call for the crash team and assistance would be provided immediately.
- Improvements were needed to the environment and design of the endoscopy. There was no separate recovery area and there was no separate clean and dirty room for the decontamination of endoscopes. Two patient cubicles were too small, and the unit had carpeted floors which was not compliant with infection control standards.

However:

- Services for children and young people had improved from requires improvement to good.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Summary of this inspection

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- With the exception of nurse staffing in critical care, services had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well although levels of harm were not always entered against incident records. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Are services effective?

Good

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

- Services for children and young people service from requires improvement to good.
- Critical care improved from requires improvement to good.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

However:

- The hospital's new leadership team recognised that annual appraisal compliance was an area that required improvement and they had implemented a plan to ensure that all staff had an appraisal by the end of 2019.
- We saw some patient information leaflets which were used to support staff to gain informed consent had exceeded their renewal date.

Are services caring?

Good

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

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

Are services responsive?

Good

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

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

Summary of this inspection

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However:

- Patients did not always agree they had their communication needs assessed at pre-assessment.
- Correct (clinical or non-clinical) classifications were not always attributed to cancellation records.
- The service did not clearly display information in communal patient areas, such as waiting areas about how to raise a concern or make a complaint.
- Although staff made reasonable adjustments to help patients access services where they could, the service had limited facilities for patients with individual needs.

Are services well-led?

Good

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

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Summary of this inspection

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

- The information systems were integrated and secure; however, data handling process had not always been correctly followed.
- We were not assured the service had always (historically) acted in a timely way to minimise risks; for example, with respect to ensuring compliance of ventilation and air handling units in theatres, and complying with fire safety recommendations.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

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

Good

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

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff were required to complete mandatory training in topic areas such as infection prevention, fire safety and information governance.
- Staff were able to track which training they were required to complete for their role on an electronic system and could see the date they had last completed the training and when it was next due. There was a coloured coded RAG (red, amber, green) rating which showed green for completed, amber for due to complete within the next month and red if the training was overdue.
- Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received automatic email reminders when they were due or overdue to complete a training session.
- The provider set a target of 90% for compliance with mandatory training. Data provided by the hospital showed that at the time of the inspection, overall 96.3% of hospital staff were compliant with mandatory training requirements.
- Staff in both endoscopy unit and the oncology unit we spoke with said they were up to date with their mandatory training. Staff were able to access some training online and if necessary they could do this at home. They said that their managers would allow them time back if they did this.
- For further details about mandatory training please see the Safe section in the surgery report.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**
- Staff received training specific for their role on how to recognise and report abuse. Staff working in the endoscopy unit had completed safeguarding vulnerable adults and safeguarding children training level one and level two. The clinical services manager was trained in level three safeguarding adults. Safeguarding training included units on female genital mutilation, chaperoning and PREVENT (intended to identify and reduce radicalisation).
- Nursing staff in the oncology unit had completed safeguarding vulnerable adults training level one and level two and were waiting for training dates for level three training to be arranged so they could attend.
- Staff we spoke with were confident on how to identify adults and children at risk of, or suffering, significant harm. Staff from both units were able to give an example of a referral staff had made which resulted in a positive outcome for the patient.

- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding flowcharts were displayed in the unit and included named contacts with telephone numbers.
- For further details about safeguarding, please see the Safe section of the surgery report.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- Staff followed infection control principles including the use of personal protective equipment. We observed that all staff were bare below the elbows and demonstrated good hand hygiene and aseptic technique.
- The endoscopy unit and the oncology unit appeared well organised and clean. We observed staff cleaning the equipment in the cubicles in endoscopy and the treatment rooms in oncology prior to a session and after use. Each area had a cleaning checklist and we saw these were thoroughly completed by staff.
- At the last CQC inspection in 2015, we were concerned about the environment in endoscopy. This was still a concern as the cubicles were carpeted and the windows had material curtains which was not compliant with infection control standards. However, the manager assured us that they were awaiting the final sign off for the development of a newly refurbished and purpose-built unit in another area of the hospital.Staff told us they delay was a corporate financial decision however new investors had secured funds for the environmental improvements to go ahead.
- The procedure room in endoscopy had a sealed washable floor and we saw a cleaning checklist in place which was fully completed by staff.
- Scopes in the endoscopy unit were decontaminated according to the recommendations of the joint advisory group for GI endoscopy. There was a process for separation of clean and dirty equipment within the decontamination room, however, there was no separate room to store sterile scopes.
- Equipment which was cleaned and sterilised was covered with a green bag; used equipment was covered with a red bag to ensure that this was clear to staff. The clinical services manager told us that the new unit would be fully compliant with all decontamination standards. There was a track and tracing system in place for all scopes. The service also used vac-packed scopes which would remain sterile for 100 days. Staff said they were only used in emergencies.
- We saw evidence of daily, weekly, quarterly and annual testing reports for decontamination of endoscopes in accordance with national guidance. Tests were logged and any issues in performance were reported to managers immediately.

Environment and equipment

- **The design, maintenance and use of most facilities, premises and equipment kept people safe. However, the endoscopy unit needed some improvement in its design.**
- The endoscopy unit was based on the ground floor of the hospital. Patients waited in the general waiting area and were collected by staff and brought into the unit. There were five cubicles in the unit; four patient cubicles and one which was used by staff as a storage area. There was one procedure room. Each cubicle had disposable curtains round to ensure patients had privacy. Gowns and dignity shorts were given to patients were appropriate.
- There was no separate recovery area for patients following their procedure. Patients were consented in the cubicle then taken into the procedure room. Following their procedure, they returned to the same cubicle for recovery.
- Two of the cubicles were quite small and we were concerned whether in the event of an emergency staff would be able to gain access with equipment necessary for resuscitation. Staff demonstrated to us that the patient bed could be removed from the cubicle in the event of an emergency, however, this would not be ideal as this would take time and there would be little privacy.
- There were separate male and female toilets in the endoscopy unit. Staff told us they always tried to ensure that a male and female patient did not pass each other whilst on the unit.

- Waste was appropriately segregated into clinical and non-clinical with clear signage displayed. Most sharps bins were correctly labelled, signed and dated, however, some larger sharps bins did not have a label on for staff to complete. We discussed this with hospital managers who told us that these sharps bins were bar coded and the date and location of the sharps bin was recorded electronically.
- We checked 20 pieces of equipment and found that they had been tested for electrical safety and received timely maintenance checks. However, not all equipment had stickers or labels on to indicate they had been safety tested and maintained. Hospital managers told us that some equipment was checked and maintained by an external company who did not use stickers/labels to show when equipment had last been checked. The hospital held a database of all equipment with asset numbers which included dates for review and utilised a red/green system to alert service managers if a piece of equipment needed maintenance/annual checks.
- Resuscitation trollies were tagged for security and had been checked daily by staff on dates when the units were open. Staff clearly documented when the trolley was not checked to indicate that the unit was closed. Staff signed to show weekly checks of the entire contents of the trolley had been completed and recorded the new security tag number. Emergency drugs were on the trolley and were within their expiry date.

Assessing and responding to patient risk

- **Staff assessed risks for each patient and ensured they were removed or minimised.**
- Staff monitored patient's observations and knew how to escalate a patient who was deteriorating. The endoscopy pathway did not include a national early warning scores (NEWS) chart, however staff told us this would be used if they had concerns about a patient.
- The hospital had a care of the deteriorating patient pathway and clinical escalation policy in place. If a patient deteriorated staff were able to contact the patient's consultant. The requirement to attend within 30 minutes was a stipulation in each consultant's contract.
- In addition to this staff could contact the resident medical officer (RMO) who was on site 24 hours a day, seven days a week. A major haemorrhage flowchart was displayed on the endoscopy unit, with clear steps for staff to follow in the event of this happening. Staff told us they had carried out scenario-based training sessions, so they were clear on what to do if this occurred. An emergency kit and two units of blood were kept onsite.
- Staff attended annual face to face training in the care and communication of the deteriorating patient which included sepsis training. Staff we spoke with were clear on the signs and symptoms of sepsis and could describe what actions to take if a patient was showing signs of sepsis.
- Health care assistants were required to complete basic life support training on the endoscopy unit; however, they could attend intermediate life support training if they wished. Qualified staff on both units were trained to a minimum of intermediate life support. The RMOs were trained in advanced life support (ALS) and staff told us that there were two other hospital staff trained in ALS. We saw an advanced life support flow chart by the Resuscitation Council, displayed on the wall in the endoscopy unit.
- During the inspection, we observed staff completing an adapted version of the World Health Organisation (WHO) surgical safety checklist in endoscopy.This was effective and used appropriately.
- We saw that all patients had access to call bells, so they could alert staff if they were feeling unwell or required assistance. Staff tested the call bells prior to each session to ensure they were all working correctly.

Nurse and medical staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.**
- There were no qualified nurse vacancies in the endoscopy unit and one health care assistant vacancy which had recently been recruited to. Staff worked flexibly to meet the needs of the service.
- The clinical services manager told us that they aimed to have seven staff on duty for every session; two staff to

work in the decontamination room, two staff to work in admission/recovery and three staff work in the procedure room.The service used bank staff to cover some shifts but did not use agency staff. There were plans to increase staffing numbers once they moved to the new unit which had more capacity.

- For the 12-month period from July 2018 to June 2019, monthly bank staff usage in the endoscopy unit varied between 14% and 22%. The average bank staff usage over this period was approximately 17%. The manager explained that the bank staff were regular staff and/or staff who already worked there. This helped with their flexibility to respond to additional clinics.
- There were three registered nurses (two whole time equivalent) working in the oncology unit and no vacancies. One nurse was the clinical lead for the unit. The service did not have any health care assistants. Staff worked their hours flexibly to meet the needs of the service.
- The oncology service was consultant led. Treatment was offered for the following specialties; breast, gynaecology, colorectal, upper gastrointestinal, prostate and haematology.
- The resident medical officer was on site 24 hours a day seven days a week.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- The hospital used paper records for recording patients care and treatment. At the previous CQC inspection in 2015, we had concerns with accuracy and completion of patient records in oncology and endoscopy. At this inspection we reviewed ten sets of records, six oncology and four endoscopy and found that overall, they had improved. Risk assessments were completed when appropriate and entries and reviews of patient treatment and care were legible, dated and signed. However, there were some inconsistencies in the medical staff entries in oncology patient records. We saw that staff names were not printed, and the time of the consultation was not always recorded.
- Paper records were stored securely in both the endoscopy and oncology unit and when records were no longer required, they were sent to medical records for storage.
- The hospital carried out regular audits of compliance with the completion records. An audit carried out in May 2019 showed that overall compliance was 92.5%.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- The hospital carried out an antimicrobial audit in January 2019 which showed good results. The audit showed 100% of patients prescribed antimicrobial agents had a review date or duration of treatment documented and compliance with antimicrobial prescribing guidance was 100%.Compliance with patients prescribed an antimicrobial agent having a clearly documented indication for treatment was 96%.
- The pharmacy team carried out a medicines reconciliation audit in June 2019 which showed that 95% of patients had their medicines reconciliated within 24 hours of admission. This represented an improvement from the October 2018 audit results which were 87%.
- Medicines were stored securely with access restricted to authorised staff members. Drugs fridges were checked daily and we saw that staff had contacted the pharmacy department when fridge temperatures were out of the required range. Room temperatures were also monitored and recorded. Staff escalated to pharmacy if the temperature exceeded 25 degrees.
- Controlled drugs (CDs) were correctly stored and stock books were safely locked away. Endoscopy staff checked CDs twice a day, at the beginning and end of a list. We checked the CD stock book from 1 April to 23 July and found that stock checks were accurately recorded, and controlled drugs administered were countersigned by a second checker except for on two occasions.
- The pharmacy department carried out a quarterly audit of controlled drugs in all clinical areas. An audit carried out in April 2019 in endoscopy did not identify any areas for improvement.

Good

Medical care (including older people's care)

- The service used patient group directions (PGDs) to administer some medicines. We saw that all PGDs were in date and signed by relevant staff.
- Following an endoscopy procedure if a patient required any medications, there was a private prescription pad which the consultants used. We saw that the pad was stored in a locked cupboard and staff kept a register to provide an audit trail.
- All prescriptions for chemotherapy were electronic. The onsite pharmacist checked all prescriptions and if they were off site, they could do this remotely. Nurses took the prescription to the patient's bedside on an electronic device and added an electronic signature once they had administered it.
- For further details about medicines please see the Safe section in the surgery report.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.**
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Medical care services reported no incidents classified as never events.
- Staff we spoke with knew how to report incidents on the electronic system. Staff told us that if they reported an incident, they received an acknowledgement and feedback. Incidents were discussed at the staff meetings and the daily communication cell meeting to share any learning and prevent a reoccurrence. We saw that incidents were discussed in minutes of the monthly endoscopy users group meeting.
- Between June 2018 and June 2019 there were nine incidents reported by staff in the endoscopy unit. This included incidents related to clinical communication, equipment issues and incorrect test results.
- Effective arrangements were in place to respond to relevant external safety alerts. We saw this was a standing agenda item at team meetings. Safety alerts were also included in the clinical governance, quality and risk bulletin which was circulated to staff and displayed on notice boards.
- Staff understood the principles of duty of candour, being open and honest and told us that if they made a mistake, they would inform the patient and then report it as an incident.
- For further details about incidents please see the Safe section in the surgery report.

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

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice.**
- Staff worked to national polices for the BMI group. National policies were stored on the intranet which staff were able to access easily.At the previous CQC inspection in 2015, we found not all policies were in date. At this inspection we reviewed five polices on the intranet and found these were all within their review date.
- Polices, protocols and pathways were based on national guidance, such as the National Institute for Health and Care Excellence and the British Society of Gastroenterology guidelines. Oncology staff followed national and local cancer network protocols for prescribing cancer treatments.
- Staff were informed about the latest NICE guidance via the clinical governance, quality and risk bulletin. We saw a copy of the bulletin displayed on notice boards in the unit.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.**

- Patients in endoscopy were offered drinks and snacks following their procedure and staff provided information, prior to procedures, about fasting times.
- Patients receiving chemotherapy treatment were assessed for risk of malnutrition and their weight was monitored at each appointment during their treatment regime. Specialists nurses provided general advice to patients on nutrition and hydration.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**
- Patients attending the oncology unit were prescribed medication by the consultant for symptomatic relief and discomfort. This was prescribed on the electronic prescribing system and issued by the pharmacy department and checked by nurses with the patient prior to the patient leaving the unit.
- Staff told us that all patients were offered the option of gas and air during endoscopy procedures. Some patients opted for conscious sedation. Pain relief medication was not routinely prescribed for patients in endoscopy but could be prescribed following the procedure if they had discomfort.
- Clinical staff were required to undertake pain assessment as part of their mandatory training.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- The hospital had a regular clinical audit programme which included handwashing, venous thromboembolic event (VTE), surgical safety (WHO) compliance and controlled drugs.
- Staff working in medical care services were involved with the audit process and we saw evidence that outcomes of audits and action plans were shared with staff at unit meetings and in team briefs.
- The endoscopy unit were working towards Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation. The service was achieving standards in most areas however the current facilities including the decontamination environment, were not compliant with JAG standards. There was a plan to relocate to new purpose-built facilities within the hospital to ensure JAG standard were met.
- The endoscopy unit carried out an annual internal 'JAG' audit. The audit report for the period January 2018 to June 2018 showed good results which met most standards. There was an action plan for any areas which required improvement.
- The endoscopy audit report for the period January 2018 to June 2018 showed that the hospital had not been informed of any readmissions within eight days or mortality within 30 days of any GI endoscopic procedure.
- The hospital was accredited with the Macmillan Quality Environment Mark (MQEM). The award meant that the hospital met the needs of patients in several areas, for example, respect for patients' privacy and dignity, welcoming accessible facilities, focus on patients' comfort and wellbeing, giving choice and control to patients, listening to what patients think and need.

Competent staff

- **The service made sure staff were competent for their roles.**
- Staff we spoke with had completed their annual appraisal and told us they found it useful. Staff told us they had a clear development plan agreed with their line manager. Throughout the year, therapy staff received regular clinical supervision. Nursing staff had more informal supervision with their line manager.
- Information provided by the hospital showed that the proportion of staff on track to have appraisals completed within the year (October to October) was 85.8% for contracted staff and 81.8% for bank staff.
- The hospital had a standard induction check list for agency or bank staff which included health and safety, orientation, polices and mandatory training.
- New staff to the endoscopy unit had a period of being supernumerary. There was a comprehensive

competency package which nursing staff were required to complete. Each competency would be signed off by the clinical support manager or the lead nurse. Bank staff were also required to complete competencies.

- We spoke with a member of staff in the endoscopy unit who had been in post for four months. They confirmed that they had received a thorough induction and felt well supported by their mentors.
- Staff received regular training sessions from suppliers of specialist pieces of equipment in endoscopy.
- Staff in the oncology unit had attended specialist training and were all competent in chemotherapy administration. Staff had attended training at a specialist cancer care hospital including a course in breast cancer.

Multidisciplinary working

- **Professionals worked together as a team to benefit patients.**
- Staff worked well with each other to provide patient care. Staff told us working relationships were good between the nursing, medical and therapy staff.
- Staff in the oncology unit attended multidisciplinary meetings to discuss patients care and treatment. The service worked collaboratively with the local cancer networks and NHS hospitals.
- We saw evidence of input from the multidisciplinary team written in patient records.
- Endoscopy staff referred patients onto the NHS and to specialist nurses following their tests.

Seven-day services

- **The service worked flexibly to support timely patient care.**
- The endoscopy unit was open Monday to Friday, however, there was an on-call rota to provide out of hours cover. Staff said it was rare to be called in out of hours and if they were, any scoping would be done in theatres.
- Patients receiving cancer care could contact the hospital out of hours. Staff on the Mappin Ward were trained to triage patients over the phone (using a recognised tool) and advise patients what action to take. Patients could be admitted to the ward if necessary.A consultant was available on-call 24 hours, seven days a week and a resident medical office was always on site if needed.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Health promotion material was available to patients in the waiting area, for example, a practical guide to living with type two diabetes.
- Health promotion information on well-being and lifestyle was available on the hospital website on several topics. For example, there was information on the top seven warning signs of diabetes and healthy heart recipes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005. Staff were able to describe the decision-making processes if they were caring for a patient who did not have capacity.
- Staff received consent training as part of their mandatory training requirements. Mental capacity and deprivation of liberty training were covered within the organisation's safeguarding training.
- Patient consent for an endoscopy procedure was gained at the pre-assessment appointment. On the day of the procedure the consultant discussed the procedure with the patient in the cubicle and gained second stage consent. Patients were able to withdraw their consent at any time and request for the procedure to be stopped. A withdrawal of consent poster was displayed in the procedure room. The clinical services manager told us that this had only happened once since she had been working on the unit.

Good

Medical care (including older people's care)

- Consent was clearly documented in patients notes in the oncology unit.

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

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We found staff to be focused on the care and needs of patients.
- Staff introduced themselves by name to all patients and we saw they established a good rapport with them.
- The hospital participated in the friends and family test. We saw questionnaires displayed in the all areas of the hospital. Overall hospital results for months October 2018 to March 2019 inclusive were 98% and 99% (response rate between 17% and 38%).
- Patient feedback was captured in the endoscopy unit annual patient survey. The results of the survey showed that 100% of patients felt their privacy was respected. In addition to answering questions in the survey, patients left individual comments about their experience at the unit. All comments received were extremely positive and included; 'Exceptional service from all staff, kept informed and received excellent care' and "Everything was handled very professionally, no problems at all".
- Patients we spoke with in the oncology unit were extremely positive about the care and treatment they had received from staff the unit.
- Chaperones were available for patients if required and if requested by staff. Staff said they offered patients the choice between a male or female chaperone where possible. In the oncology unit chaperones were provided to support patients when they were receiving bad news.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- We saw that patients' emotional, cultural, social, and spiritual needs were an integral part of their assessment and care plan.
- When patients received bad news in endoscopy about a condition, they would be referred onto specialist nurses for advice and support.
- Patients were offered emotional support in the endoscopy unit. Three members of staff were present in the room during a procedure, so that one member of staff could support the patient. We observed staff offering support and reassurance to patients who were anxious about their procedure.
- The oncology unit provided a cold cap service to patients to prevent or minimise hair loss.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Patients felt well informed and involved in decisions about their care. Staff talked with patients, families and carers in a way they could understand. We saw that patient involvement in care decisions was clearly documented in patient's notes.
- Patients booked in for a test in the endoscopy unit were sent a booklet explaining about what the test involved and bowel preparation instructions if appropriate.
- Patients and their families could give feedback on the service and their treatment, and staff supported them to do this.

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

Good

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

Good

Medical care (including older people's care)

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- The hospital worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.
- A screening process was in place pre admission for patients with complex needs to minimise the risk of these patients being treated at the hospital. Staff gave us examples of how they may support patients with additional needs, for example those people living with dementia or learning difficulties although this was rare.
- There were good links with local networks and other BMI hospitals to ensure patients received good care.
- There was a restaurant on site which relatives could use if they needed something to eat and drink.

Meeting people's individual needs

- **The service took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services.**
- BMI Thornbury had a dementia strategy for 2019 to 2021 which clearly set out how they would review and monitor progress relating to safety, experience, and effectiveness of dementia care provision. However, on inspection staff told us they did not routinely treat patients with dementia at the hospital.
- The front cover of patient folders had symbols with a tick box next to them to alert staff to patients' individual needs. For example, there was symbol for dementia and one for mental health, however, not all staff we spoke with knew what the symbols represented.
- Translators were available to attend appointments with patients, and staff knew the importance of making sure these services were offered and not relying on family members to act as translators. Staff told us they could request a British sign language interpreter for hearing impaired patients.
- Staff told us letters could be produced in a range of community languages on request and information leaflets were available in large print for visually impaired patients.
- Staff in the oncology unit told us they had patient information leaflets tailored to the needs of patients with a learning disability. However, they said it was rare for them to provide treatment for patients with learning difficulties at the hospital.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Most patients attended the endoscopy unit as an outpatient although staff told us that occasionally a patient from the wards would be brought down to the unit for a procedure. Treatment was offered to both private patients and NHS and patients were booked and managed according to the availability of the consultants. Staff told us that there were no waiting lists for procedures in endoscopy and no breeches in two week and six week waits.
- The endoscopy unit was normally open Monday to Friday between the hours of 8am to 8.30pm. The service was flexible to meet demand and staff were planned to be on duty to cover the consultant clinics. Staff told us there were normally two evening lists on Tuesdays and Wednesdays.
- Oncology treatment was offered only to private patients. Appointments were effectively managed and tailored to the patient's treatment regime.

Learning from complaints and concerns

- **People were able to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- We discussed complaints with staff. They told us formal written complaints were uncommon. When patients had complaints, staff told us they would try to resolve them at the time and would involve someone more senior if necessary.
- We did not see any information clearly displayed to inform patients and relatives how to make a complaint.

Good

Medical care (including older people's care)

A 'please tell us' leaflet was available in waiting areas which contained some information on how to make a formal complaint. None of the patients we spoke with had felt that they needed to make a formal complaint about their care.

- The hospital set a target of five days to acknowledge a complaint and 20 days to respond. We looked at six complaint files during the inspection and saw that all were acknowledged within the correct time scales and five out of six responses were sent within the target of 20 days. Response letters were thorough and included what action the hospital had taken as a result of the complaint.
- Complaints was a standard item on the agenda for the endoscopy users group meeting.
- Staff told us that a patient receiving treatment from the oncology unit had complained about car parking and because of this, patients were issued with a parking permit for the front of the car park.
- For further details about learning from complaints and concerns, please see the Responsive section in the surgery report.

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

Good

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

Leadership

- **Leaders had the skills and abilities to run the service.**
- The endoscopy unit was led by a clinical services manager who had been in post for four years and a lead nurse. Staff we spoke with said they respected the local leaders and found them supportive.
- The oncology service was consultant led and there was a lead nurse to manage the day to day activities of the unit. The lead nurse provided nursing leadership to the specialist nurses and reported to a clinical services manager who also managed the inpatient ward.
- Staff told us they thought the hospital currently had a strong management team. They spoke highly of the executive director and told us they were visible, approachable and enthusiastic and had made some positive changes in the hospital.
- For further details about leadership, please see the Well-led section in the surgery report.

Vision and strategy

- **The service had a vision for what it wanted to achieve and plans to achieve it.**
- The BMI hospital's vision was displayed on notice boards around the hospital including patient waiting areas; 'Our vision is to offer the best patient experience in the most effective way, from our comprehensive UK networks of acute care hospitals'.
- Staff we spoke with were familiar with the vision and values of the hospital and how they related to their role. Staff said the hospital values formed part of their appraisal.
- The endoscopy unit had its own philosophy of care. We saw this displayed on notice boards in the unit. The long-term strategy for the unit was to expand its services once it had relocated to the new facility.
- For further details about vision and strategy please see the Well-led section in the surgery report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.**
- Staff we spoke with were proud of the services they provided and were optimistic about the investment in the hospital infrastructure. Teams worked well together, and staff said they enjoyed coming to work.
- Staff told us they felt supported by their line manager and were able to discuss any issues with them. Morale was high in this service.
- Staff felt able to raise concerns without fear of retribution. However, not all staff were aware of the local policy for raising concerns at work, the freedom to speak up guardian or local freedom to speak up champions.

Good

Medical care (including older people's care)

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- A daily 'communication cell' meeting was held each morning at the hospital. This was attended by a representative from each team. Key messages, staffing issues, patient risks, incidents and issues were discussed at these meetings.
- Endoscopy user group meetings were held monthly. The meeting was chaired by the endoscopy clinical lead consultant and attend by the clinical support manager for endoscopy, the director of clinical services, the endoscopy lead practitioner and consultants. We saw that there was a comprehensive agenda with quality updates, audits, consultant validation, incidents, complaints and staffing included. Actions from the meetings were recorded and followed up. Any member of staff not able to attend the meeting would be given a copy of the minutes.
- Monthly clinical governance reports were thorough and covered areas such as patient feedback, incidents, staffing and staff training. Audit results were also included in the report with action plans to further improve audit results. The hospital benchmarked their results on patient outcomes with other locations within the region and across BMI Healthcare through the corporate clinical dashboard.
- For further details about governance please see the Well-led section in the surgery report.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- The hospital operated a hospital risk register which was regularly reviewed and updated to ensure risks were monitored and appropriately managed. Heads of department managed departmental risk registers which fed into the hospital risk register. Performance and risk management was discussed through the committee meeting structure, including monthly heads of department, clinical governance, health and safety and the medical advisory committees.
- The endoscopy unit had a risk register which highlighted four main risks in the unit. These were infection control, lone working, insufficient investment resulting in lack of storage and the replacement of diathermy equipment. All risks were regularly reviewed with mitigating actions recorded. Risks scoring 12 or above were escalated onto the hospital register.
- Staff in the oncology unit were aware of their risks. They had a concerns board to record ongoing concerns and risks were escalated to the hospital risk register. Their biggest risk was related to infection control due to carpeted areas in the unit. Risk assessments were in place for all risks in oncology including cytotoxic drugs and cytotoxic waste. Mitigating actions were in place to reduce risk were possible.
- Staff had completed risk assessments for activities taking place within the endoscopy unit. This included twelve risk areas such as manual handling, sharps/ needle stick injuries, medical gases. We saw that actions to mitigate and reduce the risk to staff and patients were documented.
- Risks, issues, and performance were discussed with staff at the hospital daily communication cell meeting and fed back to staff at handover and at team meetings.
- For further details about managing risks, issues and performance please see the Well-led section in the surgery report.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.**
- The service had systems in place to collect information about performance and share it with staff, for example, data on incidents, audits and admissions.
- The hospital had invested in a new reporting system for the endoscopy unit. Staff told us the new system would

allow for more accurate reporting and audit. The system produced a computerised report which was attached to the patient's notes and one copy was sent to the patient's GP.

- Information governance policies and procedures were in place to ensure that information was stored securely, and patient and confidentiality was maintained.
- We saw that patient records were stored securely and computers where locked to prevent unauthorised access to confidential data.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services.**
- The service used friends and family feedback to evaluate the service. In addition to this staff encouraged patients to complete a patient satisfaction survey. We saw surveys and collection boxes throughout the hospital and patients could also return them by pre-paid post. The surveys were analysed by an independent third party and the results were communicated back to the hospital monthly for learning and action.
- The endoscopy unit carried out an annual patient survey. The results of the survey were analysed and compared to the previous year's results. The results of the survey were shared with staff and an action plan was prepared for any areas requiring improvement. The unit were also in the process of setting up a user's forum and were trying to recruit members.
- The hospital conducted an annual staff survey (BMI say) to monitor staff feedback and satisfaction. Following completion of the survey an action plan was drawn up to address areas of concern. The results of the patient satisfaction survey were shared with staff.
- A monthly communication message was sent by the executive director to all staff within the hospital to keep them up to date with recent information and changes. We saw that positive feedback was given to staff both individual members of staff and to the whole group of hospital staff.
- Staff told us they were consulted on changes in their clinical areas. Staff in endoscopy had been involved in the plans for the new unit and felt they had been listened to.
- Key messages were shared with staff daily. We observed key messages being delivered by a manager to staff on the oncology unit and heard information being shared on current issues, complaints, and training, as well as team successes. A daily huddle was held in the endoscopy unit to deliver key messages to staff.

Learning, continuous improvement and innovation

- **Staff were committed to continually learning and improving services.**
- The clinical services manager for endoscopy was the regional lead for endoscopy and had visited the other units in the region to advise them on achieving accreditation with the Joint Advisory Group on GI endoscopy.
- A new reporting system had been introduced in the endoscopy unit to assist with the data collection and reporting of all procedures in the unit.
- The endoscopy unit were planning to expand their services once they moved to the new unit and had more capacity. In addition, there were plans to implement a direct access service for gastroscopy and flexible sigmoidoscopy procedures.
- The oncology service had moved to an electronic prescribing system for all chemotherapy drugs. Staff said this was a much improved system.

Good

Surgery

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

Are surgery services safe?

Requires improvement

Our rating of safe went down.We rated it as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure all contracted staff completed it. However, we saw low mandatory training compliance rates amongst bank staff, especially in theatres.**
- The hospital had a system, to ensure staff received mandatory training, comprised of e-learning and face-to face-training.
- Staff were required to complete mandatory training in topic areas such as life support training, infection prevention, fire safety and information governance. The compliance target was 90%.
- Staff were able to track which training they were required to complete for their role on an electronic system and could see the date they had last completed the training and when it was next due. There was a coloured coded RAG (red, amber and green) rating which showed green for completed, amber for due to completion within the next month, and red if the training was overdue.
- Managers monitored mandatory training compliance and alerted staff when they needed to update their training. Staff received automatic email reminders when they were due or overdue to complete a training session.
- During our inspection, we saw evidence that showed the overall compliance rate for nursing and medical hospital staff was 96%, and the overall compliance rate for bank staff was 64%. For surgical staff (both contracted and bank), the overall compliance rate (July 2019) was 84% for the surgical inpatient ward, 90% for the pre-assessment unit, 93% for the day-case ward, and 67% for theatres (the actual compliance rate for contracted theatre staff was better at 83%).
- Staff we spoke with during our inspection said that the low mandatory training compliance rate observed amongst theatre staff was due to the number of bank staff that had not completed all mandatory training requirements. Senior staff we spoke with said that there had been a concerted effort to improve bank staff mandatory training compliance at the hospital, and this programme of work was ongoing.
- Agency staff completed their relevant mandatory training with an external provider. Managerial and lead staff we spoke with said that agency staff qualifications were checked prior to deployment during their induction period, and on an ongoing basis, as required; and we saw evidence of this.
- Senior staff we spoke with during our inspection said that consultant staff attended mandatory training at their employing NHS trust, and this was evidenced and monitored through the appraisal process. However, we did not see evidence of mandatory training in all of the

consultant files we reviewed. We also learned that the new executive director had recently written to all consultants to remind them they needed to provide a breakdown of their current mandatory training compliance undertaken with their substantive employer to the hospital.

- Residential medical officers (RMOs) were employed through a national agency and completed mandatory training with the agency. The hospital received confirmation of the training and kept a record of attendance. We reviewed staff files for two RMOs, which evidenced their qualifications and experience; and we observed they were advanced life support (ALS) and European paediatric advanced life support (EPALS) certified.
- All ward and contracted theatre staff we spoke with during our inspection said they had completed their mandatory training or were booked onto outstanding courses.
- We observed a training calendar was displayed in the staff office on the inpatient surgical ward which detailed training courses for the months of June and July 2019. We saw that upcoming training included adult intermediate life support, fire safety, moving and handling, and medicines management training courses.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- The service had systems in place for the identification and management of adults and children at risk of abuse. We reviewed hospital incident data for June 2018 to June 2019 and saw four safeguarding incidents had been logged in this timeframe.
- The hospital had separate safeguarding policies for adults and children, which were accessible on the intranet. These followed relevant national legislation and guidance. Policies detailed the different types of abuse, what concerns could potentially be a safeguarding concern, issues which staff should report, and how to raise concerns.
- Information about female genital mutilation (FGM) and PREVENT (protecting people at risk of radicalisation) was included in the safeguarding adults' policy. There were no separate safeguarding instructions for staff to follow but the policy did highlight that the police must be informed if FGM was suspected.
- All staff were required to complete safeguarding training and the compliance target was 90%.
- For all eligible staff across the hospital. We saw training compliance rates as of March 2019 were 88% for both vulnerable adults' level one and level two, 85% for PREVENT, and 83% for FGM training modules.
- All ward and theatre staff we spoke with during our inspection said they were up to date with their safeguarding training.
- The hospital had implemented a safeguarding vulnerable adults' level three training programme earlier in the year; for which 122 members of staff were eligible as of March 2019. This training programme was in progress at the time of our inspection.
- We saw that discussion of safeguarding incidents was a standing agenda item in clinical governance committee meeting minutes we reviewed.
- During our inspection, staff we spoke with in different areas of the service said that safeguarding link nurses and the safeguarding lead were available to offer safeguarding advice and support.
- Staff we spoke with in theatres and on wards could all describe their role in relation to identifying and reporting a safeguarding concern; and gave examples of things they might report. Some staff mentioned a recent safeguarding incident which had arisen at the hospital, with regard to FGM concerns around a young patient who was being taken abroad; and we saw this had been logged as an incident, and appropriately acted upon.

Cleanliness, infection control and hygiene

- **Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- The hospital had an infection prevention and control (IPC) policy, this directed staff to other policies and

protocols for guidance about cleaning, decontamination and use of personal and protective equipment (PPE). The policy was available on the provider's intranet.

- There was an IPC lead for the hospital, and IPC link nurses were available for advice and support in different areas of the hospital.
- Staff completed IPC training as part of their mandatory training programme. The current compliance rates among all eligible staff were 100% for IPC awareness (parts one and two), 85% for IPC in healthcare, and 80% for IPC high impact intervention, care bundles, and aseptic non-touch technique training.
- During our inspection, we saw all areas we visited were clean and had suitable furnishings which appeared clean and well-maintained. Rooms and clinical areas had laminate flooring which meant they could be easily cleaned to prevent the risk and spread of infection.
- Staff followed infection control principles including the use of personal protective equipment (PPE). We observed that clinical staff were compliant with hand hygiene policies, including 'bare below the elbows', and use of PPE. Staff had access to at the point of use alcohol gel.
- Hand hygiene compliance was monitored through observational hand hygiene audits. As of March 2019, compliance was 92% among inpatient ward staff, 96% among day case ward and ambulatory care staff, and 100% among theatre staff. We saw action plans were in place to improve performance in relevant areas.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We inspected reusable equipment stored on the ward, and all items were visibly clean and ready for use. We reviewed ten pieces of reusable clinical equipment and found these to be clean.
- The service score for cleanliness was better than the England average. We reviewed patient led assessments of the care environment (PLACE) reports for the hospital (published August 2018) and saw the hospital scored 99% for cleanliness, which was better than the England average (98.5%).
- The hospital reported no cases of hospital acquired MRSA from January to December 2018. The hospital reported no cases of hospital attributed Clostridium difficile (C. diff) in the same reporting period. There were three reported cases of hospital acquired E-coli.
- Day case and inpatient rooms were all single with ensuite facilities; and appropriate for patients requiring isolation, if needed. During the inspection, no patients had required isolation.
- During our inspection of theatre three, we saw the temperature was 28 degrees Celsius, and raised this with senior staff. We saw senior staff had taken action on this and alerted engineering services; when we returned to the theatre the following day, the temperature was 20 degrees Celsius.
- However, we were not assured the service had always acted in a timely way to minimise infection risks. For example, some actions from a review undertaken in 2017, which identified issues in relation to theatre ventilation, had not been addressed until 2019 when senior leaders had contracted an external company to undertake microbiological sampling and air system calibration in theatre two, and the anaesthetic room. A report showed that results were within limits. We also saw another external company had been contracted to carry out the deep cleaning and disinfection of (all) theatre air handling units and supply and extract ductwork serving the hospital. However, we also noted that (more minor) work to doors and pressure systems in theatre two, door binding in theatre three, and door adjustment in theatre four had not yet been completed.
- One of the highest risks on the hospital risk register was a risk of patients contracting Legionnaires disease; as legionella had been isolated in water samples taken throughout the hospital. We saw that a management action plan had been put in place and there were appropriate control measures; which included frequent flushing and testing of all outlets and ongoing review by the bi-monthly water safety group. We saw evidence of frequent flushing and temperature checking of outlets by hospital engineers, who had received legionella awareness training. We saw re-testing of outlets had been completed by a specialist company; and we reviewed certification of cleaning and chlorination, undertaken by an external contractor in May 2019.

- Water safety group meeting minutes for May 2019 detailed that capital approval was in place for boiler and hot water tank upgrades; however, there was uncertainty around the timescales of the project.
- The hospital had a policy to screen surgical patients for MRSA and some patients for methicillin-sensitive staphylococcus aureus as per best practice guidance.
- Results of IPC audits and key performance measures were discussed at quarterly IPC committee meetings, and results were monitored by the committee; with oversight by the clinical governance committee.
- The hospital carried out surgical site infection surveillance data. Data supplied by the hospital showed there were 23 surgical site infections (SSI) during the reporting period January to December 2018; equating to an SSI rate of 0.27%. The highest proportion of surgical site infections were reported for breast surgery at 7.90%, while primary knee arthroplasty, orthopaedic and trauma gynaecological cranial and spinal equated to less than 1%No SSIs were reported as having occurred in other surgical specialities.
- Following our inspection, we requested SSI data for the period January to June 2019. Over the period, we saw the SSI rate for breast surgery had improved (4.8%) from the previous year.
- During our inspection, we observed that theatre two did not have a laminar flow system. We saw that breast implant surgery had recently taken place in the theatre. DoH guidance, 'Heating and ventilation systems Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises', does not explicitly mandate the use of theatres equipped with laminar flow systems for breast implant surgery. British breast and plastic surgical professional association (Association of Breast Surgery, and British Association of Plastic Reconstructive and Aesthetic Surgeons) guidance advocate that this is best practice. However, this is not mandated; and differing opinions are evident in the research literature as to the effectiveness of laminar flow systems to reduce SSIs for these, and other types, of surgeries. Between June 2018 and June 2019, only one breast surgery SSI case had been conducted in theatre two; and this was not a breast implant surgery.
- The hospital participated in national surgical site infection (SSI) surveillance, overseen by Public Health England (PHE). Data we reviewed for the period October 2017 to December 2018 showed an 0.3% SSI rate for primary hip replacement surgery, which was better than the England average (0.9%).
- Over the same period, data submitted to PHE for primary knee replacement surgery showed an SSI rate of 0.6%, which was better than the England average (1.3%).

Environment and equipment

- **Senior leaders recognised that investment in hospital infrastructure and equipment was needed. However, the design, maintenance and use of facilities, premises and equipment posed a risk to people's safety. Staff managed clinical waste well.**
- During our inspection, we observed that all patients had access to and could reach call bells, and staff responded quickly to these when called.
- However, staff we spoke with described there had been ongoing problems with the aging call bell system, which had resulted in instances of call bell failure. We reviewed incident data and saw that "entire nurse call system failure" had occurred in May 2019.
- We saw the risk was reflected on the hospital risk register and was also reflected on individual ward-based 'causes, concerns, and countermeasure' logs. The entry on the hospital risk register highlighted that the call bell system was increasingly unreliable, with servicing and repairs difficult to maintain. Control measures that had been put in place following the May 2019 failure included installation of an interim (contingency) wireless nurse call system with handsets in case of loss of connection. Leaders recognised that this system was "effective but should be improved", and replacement of the call bell system and integration with the emergency bleep system was required.
- The design of the environment followed national guidance; however, senior leaders recognised that investment in hospital infrastructure was needed.
- We observed an entry on the hospital risk register that noted the 12 electrical distribution boards in the hospital were all over 25 years old and posed a risk of causing fire; as fuses were obsolete and arcing between live and neutral.

Good

Surgery

- We reviewed health and safety committee meeting minutes, which included discussion of fire risk assessment as a standing agenda item. The July 2019 meeting minutes contained a Fire and Rescue Authority regulatory reform safety order, issued following an inspection conducted by the authority in June 2019.
- The fire safety order highlighted eight areas requiring immediate attention, and it identified several issues that had not been addressed since 2016. The fire system did not meet the standard required in healthcare premises. For example, automatic detection was missing in some hospital areas, compartments and fire alarm zones were not aligned and there were some issues with inappropriate storage of combustible materials, faulty fire doors, and a lack of sufficient emergency lighting in some areas of the hospital.
- Following our inspection, we requested the hospital's fire safety corrective action plan. We saw that out of the 56 issues identified by the fire and rescue authority, 18 actions had been marked as completed; for example, secure storage of combustible materials, removal of materials from fire exit routes, and out of hours evacuation testing. Four actions were yet to be actioned, and the remainder were in progress and due for completion by September 2019. We saw external companies had attended the site in August 2019 to test and review fire alarm systems and provide quotes for repair and corrective works. However, as of October 2019, we saw around two-thirds of actions were yet to be completed.
- Environmental issues and risks were discussed and overseen at the monthly health and safety committee meeting, which was attended by directors, leads and their representatives from different hospital departments.
- We saw a risk register entry on the hospital risk register in relation to insufficient investment in facilities. As of July 2019, the risk was the highest risk on the register. We saw control measures included having a facility engineer on site, a planned program of maintenance activities, committee oversight and a business continuity plan. During our inspection, senior managers and leaders described that a programme of investment had commenced to install or refurbish critical systems, and this was part of an ongoing programme of work. Recently completed works included replacement or refurbishment of heating systems and new roofing.
- A ward environmental audit undertaken April 2019, which included review of the environment and ward maintenance showed floors, furniture, fixtures and fittings, and maintenance sored between 78% and 88% for compliance; and was designated low to medium risk.
- During our inspection, we saw senior managers had acted on refurbishing some ward and patient areas of the hospital and we found wards and ambulatory care environments were of an acceptable standard. However, we saw that attention was needed to infrastructure (including doors and paintwork) in theatre areas.
- We reviewed patient led assessments of the care environment (PLACE) reports for the hospital (published August 2018) and saw the hospital scored 89.6% for condition, appearance and maintenance, which was worse than the England average (94.3%).
- Staff carried out safety checks of specialist equipment. Resuscitation equipment was regularly checked and tested in line with hospital policy.
- Emergency equipment we reviewed on wards and in theatres was clean, tidy, and ready for use. Staff had checked equipment as directed by daily, weekly and after use criteria on nearly all occasions, with only very minor omissions noted. Resuscitation trolleys we inspected were locked, appropriately stocked, and equipment was in date.
- We saw an external review of resuscitation equipment at the hospital had taken place in March 2019; which found compliance to be good overall, with only minor issues identified.
- We saw difficult airway trolleys were checked on a weekly basis as per the unit procedure.
- The theatre department used a checklist to record checking of anaesthetic machines in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommendations. Records we reviewed provided assurance that the machines had been checked daily.

- Overall, the service had enough suitable equipment to help them to safely care for patients. However, we saw that some clinical equipment had surpassed its life expectancy and we observed some reported incidents which had involved equipment failures, or lack of equipment.
- During our inspection, we saw that some theatre equipment, such as a tourniquet machine (a tourniquet is a device which applies pressure to a limb or extremity so as to limit – but not stop – the flow of blood) and a cell salvage machine (the machine processes blood from an operating site to give back to the patient) had surpassed their life expectancy. We saw these were reported on the risk register and had been raised at the BMI Northern theatre manager meeting, with a view to looking at equipment needs and procurement across all sites. Following our inspection, senior leaders reported that the cell salvage machine was due for disposal, and was not in use.
- Actions undertaken by the service to mitigate equipment risks included an ongoing review of requirements, and development of a red-amber-green (RAG) rated list of equipment requirements for review and discussion at governance and theatre meetings; to understand any immediate requirements for replacement or purchase.
- We looked at 12 pieces of equipment and where indicated (five cases), found these to have been safety tested within the review date. In other instances, we saw that equipment was bar coded with asset numbers and did not have a dated safety test sticker displayed.
- Staff we spoke with across wards and theatres said that equipment servicing was centrally monitored and completed by the electrical and biomedical engineering team. Where required, servicing was outsourced to an external company for more specialised testing.
- Hospital managers told us that the hospital held a database of all equipment with asset numbers, which included dates for review and utilised a red/green system to alert service managers if a piece of equipment needed maintenance or an annual check.
- Staff disposed of clinical waste safely. We saw processes for segregation of waste including clinical waste and staff were able to segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment.
- Sharps bins in the areas visited were secure and stored off the floor. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.
- We found that cleaning chemicals hazardous for health were stored securely.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration**
- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.
- During our inspection, we saw that the hospital used the national early warning score (NEWS 2) tool. Nursing staff escalated any patient of concern to medical staff. Nursing staff we spoke with could articulate the deteriorating patient and were able to describe when they would escalate to medical staff.
- We reviewed seven sets of medical records and found NEWS scores to be correctly calculated and documented. However, none of the patients had required escalation.
- We reviewed an audit of 40 patient records that had been completed in December 2018 and saw 94% observational NEWS score compliance. However, none of the patients had required escalation. An audit of 40 patient records in June 2019 showed 93% overall compliance across all metrics, with compliance seen to be 98% across NEWS audit measures. Two of the records audited had required escalation, and audit data showed 100% compliance for correct calculation, escalation and communication of NEWS scores.

- A resident medical officer (RMO) was on duty 24 hours a day, seven days a week, to respond to any concerns staff might have regarding a patient's clinical condition. RMOs were advanced life support (ALS) and European paediatric advanced life support (EPALS) certified.
- In theatres, we saw that an advance ALS certified practitioner was identified on each shift.
- Staff undertook unannounced simulated resuscitation scenarios organised by an external training provider. We reviewed feedback reports from two recent scenarios, one of which related to adult resuscitation. Positive feedback was observed across some measures, however, the assessor found team roles were poorly defined and there was a significant delay in administrating blood. Staff had developed an action plan in response and all but two of the actions had been completed at the time of this inspection.
- Blood was held on site, should patients require emergency transfusion. As of March 2019, data showed that 86% of all eligible staff (both contracted and bank staff) had completed blood transfusion training. Staff within the hospital had access to a major haemorrhage trolley.
- Theatres were typically available six days a week (Monday to Saturday). There was not a designated theatre for emergencies, and senior staff informed us that the most suitable would be utilised should an emergency arise, depending on vacancy and clinical needs.
- Emergency theatre cover was available seven days per week, 24 hours a day, and provided through a combination of 'on-site' and 'on-call' arrangements.
- The hospital had a service level agreement with a local NHS trust to transfer patients in the event of an emergency or if a deteriorating patient required an increased level of care. Data we reviewed showed from July 2018 to June 2019 there were 12 unplanned transfers of inpatients to other hospitals. This equated to 0.15% of all theatre cases.
- Staff completed risk assessments for each patient on admission or arrival and updated them when necessary and used recognised tools.
- Records we reviewed showed that patients were assessed for surgery in accordance with effective pre-assessment pathways. A combined risk-assessment was conducted at pre-assessment that incorporated the malnutrition universal screening tool (MUST), and assessed pressure ulcer, falls and moving and handling risks. We reviewed seven medical records and, in each case, found robust assessment and documentation of these risks were completed.
- We saw patients who were identified as higher-risk, or who might require additional pre-operative tests, were appropriately identified at pre-assessment and escalated to consultant surgeons or anaesthetists for review.
- A weekly multi-disciplinary team meeting was held to discuss the care of patients who had attended pre-assessment, this included the RMO and senior members of the nursing team.
- Staff we spoke with said that they had received sepsis training, and this was delivered as part of care and communication of the deteriorating patient training.Staff we spoke with could articulate the signs of sepsis and were aware of actions required for escalation and treatment. We were not able to review any records of patients on sepsis pathways.
- Venous thromboembolism (VTE) assessments in records we reviewed showed good levels of completion; and we saw patients were appropriately assessed, escalated, and administered treatment where indicated.VTE risk assessment audit data for February 2019 to July 2019 showed compliance was 98% to 100% over the period.
- Patient safety briefings were carried out pre-operatively; these included introductions from the clinical team, the order of the list, additional equipment anticipated and the addition of emergency patients.
- During our inspection, we observed five occasions when the World Health Organisation (WHO) surgical safety checklist was in use, and on all occasions saw this was effective and used appropriately. We reviewed seven sets of completed checklists in patient records on wards, and five completed checklists in theatres, and saw that these were completed appropriately. In one instance we saw that the scrubs practitioner had not documented the final equipment counts, but all other sections had been completed.

- We reviewed monthly WHO surgical safety checklist audit data for February 2019 to July 2019, where patient records were checked after surgery to see if the steps to safer surgery checklist had been complied with and accurately documented. Results showed compliance to be 98% to 100% over the period.
- Staff shared key information to keep patients safe when handing over their care to others. For example, we observed nursing staff discussing patient mobilisation and therapy planning with physiotherapy staff, and consultants feeding back to nursing staff about patient prognosis and recovery.
- We observed a staff handover, which was attended by the ward manager, nursing staff, healthcare assistants, and the RMO. We saw staff suitability identified and discussed patients clinical, social, and psychological circumstances and needs. Conversations included topics such as post-surgical care, medications, therapy input, and discharge arrangements.
- At discharge, patients were given ward contact details and advised who to contact if they had concerns. Results from the hospital's survey showed that from April to June 2019, 98.8% of patients reported they were provided with written information about who to contact if they felt they were worried about their condition after leaving hospital.

Nursing and support staffing

- **The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, we saw high rates of bank and agency staff were utilised in theatres.**
- The service had enough nursing staff of all grades to keep patients safe.
- The hospital used a corporate healthcare nursing dependency and skill mix planning tool to calculate and plan the numbers and skill mix of clinical staff. A corporate resource model was in use in theatres which incorporated Association for Perioperative Practice (AfPP) guidelines for safer staffing.As of June 2019, the number of established full-time equivalent posts was 19.7 for registered nurses on wards, 10.5 for health care assistants on wards, 14.4 for registered theatre nurses, 5.6 for registered theatre practitioners and 7.6 health care assistants.
- Staffing tools were populated five days in advance, so that staff levels could be reviewed and planned in a timely manner. In addition, a five-day booking rule was in place, and any deviations from this had to be agreed by the senior management team. Schedules were reviewed by senior leaders and managers to ensure appropriate allocation of resources to meet the clinical dependency of patients. An electronic roster tool was in use across all departments.
- During inspection, we saw the number of staff on duty on wards and in theatres matched the planned numbers.
- The 28-bedded inpatient ward was at full capacity at the time of inspection. We saw that some day case patients had been allocated to the ward, as the day case unit had too few patients to warrant operationality. Day case staff had been rotated to the ward to care for the day case patients relocated there.
- We saw each theatre was staffed by one theatre nurse, one anaesthetic practitioner, one theatre support worker ('runner'), and one healthcare assistant.
- Registered nurses allocated to shifts included a manager, who was responsible for coordinating care. The nurse manager could adjust staffing levels daily according to the needs of patients.
- Managers attended the daily hospital 'communication cell' meeting, which was attended by every department, and included review of patient numbers, acuity and staffing needs.
- Senior nurses attended a mid-morning bed meeting on the ward to review and discuss staffing, patient acuity and bed allocation. We also saw staffing was discussed at staff handovers, which took place three times a day. Staff reviewed the number of inpatients, patient acuity, expected admissions and discharges.
- Information dated to March 2019 showed two whole-time-equivalent (WTE) vacancies on wards. The theatre risk register (dated to July 2019) also detailed

eight WTE registered theatre practitioner vacancies. Senior leaders said that recruitment to vacancies was in progress, and existing team members were also being upskilled.

- Staff we spoke with said that staffing levels, patient dependency and staff to patient ratios were escalated to senior management, if required.
- The service had comparatively low turnover rates. From April 2018 to March 2019 there was an average turnover rate of 1.2% for registered nurses on wards, 1.0% for healthcare assistants on wards, 0% for registered theatre nurses, and 3.1% for registered theatre practitioners and health care assistants.
- The service had variable staff sickness rates. For the month of June 2019, these stood at 2% for registered nurses on wards, 10% for healthcare assistants on wards, 6% for registered theatre nurses, and 9% for theatre health care assistants.
- Staff were flexed according to patient need and bank staff were utilised when required to ensure the appropriate number and grade of staff were on duty.
- There were comparatively low rates of bank and agency nurses used on the wards, however, usage was high in theatres. From April 2018 to March 2019, the average use of bank and agency staff as a proportion of total staff was 53.6% for registered theatre nurses, and 25.8% for registered theatre practitioners and health care assistants.
- Following our inspection, we requested current bank and agency usage rates for departments and saw that for the month of June 2019, the equivalent 6.86 whole time equivalent (WTE) registered bank nurses or operating department practitioners, and 1.15 WTE registered agency nurses or operating department practitioners were used in theatres.
- Managers and nursing staff on wards and in theatres said that the bank and agency staff utilised predominantly consisted of staff familiar with the service, many of whom had worked with the service for long periods of time. The theatre manager said that they block-booked bank staff, which helped to ensure staff familiarity with the service.
- Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.**
- All patients were admitted under the care of a named consultant. Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care.
- As of March 2019, there were 258 consultants with practising privileges with more than six months service in post, who provided a range of specialities for patients at the hospital. The term “practising privileges” refers to medical practitioners not directly employed by the hospital, but who have been approved to practice there.
- The hospital required consultants to review patients at weekends and be accessible out of hours. The hospital’s practising privileges policy required consultants always remain available when they had inpatients in the hospital; or that appropriate, alternative, and named cover was arranged if they were unavailable, at any time.
- There were two resident medical officers (RMOs) at the service, who worked a ‘one week on, one week off’ rota basis. There was an RMO on duty 24 hours a day, seven days a week to respond to any concerns staff might have regarding a patient’s clinical condition.
- The RMO said that the response from consultants was usually good, should they need alerting about their patients’ care. In addition, that it was not unusual to have a consultant visit an unwell patients two to three times during the day. The RMO also described that anaesthetist presence was always evident in the hospital.
- There was a weekly radiographer on-call rota in place. Any procedures required out of hours were discussed between referring clinician to radiologist and then the radiographer.

Records

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

- Patient notes were comprehensive, and all staff could access them easily. Paper records were available for each patient that attended the wards and departments; and key information, such as contact details, and referral information, were available electronically.
- Staff we spoke with said that they could access records out of hours with ease; and when patients transferred to a new team, there were no delays in staff accessing their records.
- We reviewed seven sets of records on wards during the inspection and observed that staff used black ink, handwriting was legible, and documentation occurred at the time of review or administration of treatment.
- We found robust documentation of risk assessments were completed for patients at pre-assessment; this included use of the malnutrition universal screening tool (MUST) tool, falls, moving and handling, VTE, and pressure ulcer risk assessments.
- We saw that patient records held individualised plans of care; for example, pressure area prevention and falls care plans.
- We received medical records audits undertaken by the provider, which showed records were audited for completeness. An audit of 40 patient records in May 2019 showed overall compliance was 92.5%, and an audit undertaken June 2019 showed 93% compliance.
- We saw records were stored securely in all areas of the service we visited.
- All staff had access to IT and confidentiality policies relating to the safe transfer of data and images between services. The head of clinical services was the Caldicott Guardian for the hospital.
- All staff were required to complete information governance training every year. As of March 2019, training records showed 88% of all hospital staff had completed information governance training. During our inspection, we saw the overall compliance rate for all mandatory training was 96% for contracted hospital staff.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Pharmacy services were available seven days a week, with an on-call service available out of hours. The RMO was also able to access pharmacy and supply medicines out of hours.
- There was a hospital policy for the management of medicines that covered all relevant areas.
- Staff stored and managed all medicines and prescribing documents in line with the provider's policy. We saw controlled drugs cupboards, medicine fridges, and pharmacy cupboards in theatres and on wards were locked and secure, with access restricted to authorised staff.
- We saw controlled drug registers and stocks on wards and in theatres were checked in line with hospital policy and no discrepancies were observed.
- An audit undertaken in March 2019 showed controlled drug balances were correct in all registers across clinical areas with no discrepancies identified by pharmacy staff. We saw minor issues identified (for example, no record of time of destruction of part used vials) had been acted on.
- The drugs fridges we reviewed showed there was a process in place to record daily fridge temperatures. Minimum and maximum fridge temperatures and the temperature of rooms with medicine cupboards were recorded daily and were within the correct range.
- Staff in pre-assessment had access to guidance and had completed competencies for administering medication under patient group directions (PGDs). A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without the need for individual prescriptions. During the inspection, the lead pharmacist explained that PGDs were rarely used in the hospital; however, PGDs were in place for oral bowel-cleansing preparations and a topical local anaesthetic. Staff completed e-learning modules to evidence PGD competency.
- We looked at the medicine administration records for seven patients on the ward. We saw arrangements were in place for recording the administration of medicines, medicines were suitably reviewed, and allergies were clearly documented.

- The pharmacy team had conducted a medicines reconciliation audit in June 2019. Results showed that of the 39 patient records audited, 95% had their medicines reconciled within 24 hours of admission.
- A missed dose audit was undertaken by pharmacy on the inpatient ward in May 2019. This identified that 33% of drug omissions reviewed did not have appropriate documentation to support the rationale behind the omission. However, the service reported that nursing staff were able to provide clinically appropriate reasons for these drug omissions; which suggested audit results reflected sub-optimal documentation, as opposed to poor medicines management practices. We saw a post-audit action plan had been developed and was being acted on. At inspection, records and prescription charts we reviewed showed medicines were appropriately prescribed, documented and administered.
- We reviewed a random selection of patients' medicines on discharge and found these were clearly labelled with the patient's name, and dosages and frequencies.
- Results from the hospital's patient survey showed that from April to June 2019, 93.5% of patients reported they were satisfied they had been told about medication side effects to watch for.
- We observed there was a robust system for logging medications provided to patients, and evidence of pharmacist reconciliation of medications administered against patient prescriptions.
- We saw that a pharmacy intervention audit was in place. An audit undertaken in March 2019 of 84 patients medicine charts found 32 of these (38%) were found to require intervention. The potential significance of pharmacy intervention was categorised as minor in 62% of cases, moderate in 33% of cases, and serious in 5% of cases. We saw an action plan had been developed and was in progress.
- Staff in theatres had access to both paediatric and adult resuscitation medicines.
- An antimicrobial audit undertaken in February 2019 showed 96% of patients were prescribed an antimicrobial agent where there was a clearly documented indication for treatment. In addition, 100% of patients were prescribed antimicrobials which had a clear review date or duration of treatment, and 100% of patients were prescribed antimicrobial agents which were compliant with antimicrobial guidance.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Clinical alerts (for example, medical devices and safety alerts) were discussed at clinical governance meetings and the medicines management committee, which were attended by the lead pharmacist and cascaded to pharmacy staff.
- Medicines incidents were documented on the hospitals electronic risk management and incident reporting tool; and we saw evidence of this. We reviewed incident data from June 2018 to June 2018 and saw 18 medications incidents had been logged.
- We also observed a medicine incident involving loss of one 5mg vial of diamorphine within an operating theatre (recorded register discrepancy) was reported and investigated as a serious incident. The hospital pharmacy lead described that the loss was reported to the police and learning was shared with the controlled drug local intelligence network (CDLIN).
- Medication incidents and audit results were discussed at the medicines management committee. Pertinent incidents, issues, themes and trends were reported to the hospital clinical governance committee; as part of a clinical sub-committee and working group standing agenda item.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- The service reported one never event in the period June 2018 to June 2019. Never events are serious patient safety incidents that should not happen if healthcare

providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- The never event occurred May 2019 and concerned a wrong (right side knee) implant used in a left knee replacement procedure. We reviewed the root cause analysis (RCA) investigation report, which detailed the surgeon immediately liaised with consultant colleagues, and a decision was made (following x-ray) that the patient would not come to any harm or experience physical difficulties if the implant remained in situ. The main causes were identified as failure to accurately check prostheses boxes prior to start of the operating list and during the procedure and mixing of the cement before final prosthesis checks were confirmed as correct. We saw that an action plan had been developed to mitigate the risk of a similar incident occurring; this was in the process of being completed at the time of inspection.
- Managers shared learning about never events with their staff and across the hospital. Details of the never event and immediate actions taken had been discussed at the May 2019 clinical governance committee meeting and at hospital communication cell meetings. We also saw details of the event had been shared with staff, for example, at team and departmental communication cell meetings. The investigation report had been completed and signed-off shortly before our inspection; hence, learning and recommendations had not yet been shared with the wider team.
- We observed that duty of candour had been documented as completed. Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) when things do not go as planned.
- Staff we spoke with were aware of the duty of candour regulations, and they could provide us with examples of when they would use this. For example, if the wrong type or dose of medicine had been administered, or if surgery had not gone as planned.
- Incident investigation reports we reviewed showed duty of candour had been actioned, where applicable.
- Staff reported serious incidents clearly and in line with hospital policy. Serious incidents (SI) are incidents that require further investigation and reporting. In accordance with the Serious Incident Framework 2015, the hospital reported two SIs in surgery which met the reporting criteria set by NHS England from June 2018 to June 2019.
- One serious incident related to an unexpected patient death, following deterioration and transfer to another hospital site. We saw that the patient death had been investigated by the coroner, and the patient was found to have died from natural causes. The other serious incident was classified as no harm and concerned a drug incident, where the running balance for dimorph 5mg vials was found to be incorrect.
- The hospital had an incidents policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents.
- The hospital had an electronic reporting system in place, and staff we spoke with could describe how they would report incidents, and the types of incidents they might report.
- Between June 2018 and June 2019, data provided by the hospital showed 728 incidents were recorded. Of these, 67% (489) were classified as no harm, 22% (159) were classified as low harm, 2% (12) were classified as moderate harm, and one (unexpected) patient death was reported. In 9% of cases (67) we saw that level of harm had not been attributed to data entries.
- Of the 67 uncategorised entries reviewed, summary descriptions indicated that no harm had occurred in these cases. Most entries were related to equipment failure, information governance, and administration errors. However, it is good practice to consistently enter levels of harm against incident records.
- We reviewed dates incidents were reported and investigations were completed and saw these had been investigated and closed in a timely manner.
- Managers investigated incidents thoroughly. We reviewed two serious incident reports and three (level

two) incident investigations and we found these to include contributing factors, identification of lessons learned and recommendations to prevent reoccurrence of the incident.

- There were designated sections in incident investigation reports to document what involvement and support had been provided to the patient and their relatives, and how managers had debriefed and supported staff after any serious incident.
- Staff we spoke with said that if a serious incident occurred, they would be involved in the root cause analysis process and receive feedback; and we saw evidence of this.
- We saw incident feedback, learning, and action plans were discussed at hospital committees and groups; such as the medical advisory committee, clinical governance committee, and at hospital communication cell meetings. Incidents of relevance to working groups were discussed as appropriate; for example, at the IPC meeting, and theatres group meeting.
- Ward and theatre staff we spoke with said that they learned about incidents and lessons learned at departmental team and communication cell meetings, and at staff handovers.
- There was evidence that changes had been made as a result of incident investigations. For example, we observed email alerts reinforcing practice or about changes to practice, provision of additional training, supplementary audit, and changes to policies and standard operating procedures.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.
- We reviewed a selection of hospital clinical protocols and patient pathways in use for patients on surgical wards; these included standardised surgical pathways. We saw that patients' treatment was based on national guidance, such as the NICE, the Royal College of Anaesthetists and the Royal College of Surgeons guidance.
- Policies and guidelines were stored on the intranet, and staff we spoke with said they could access them with ease.
- New clinical guidelines were monitored corporately and disseminated to hospitals in the group. We saw that review and discussion of new policy, NICE guidelines and other national guidance was a standing agenda item at monthly clinical governance meetings.
- At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.
- We observed a staff handover, which was attended by the ward manager, nursing staff, healthcare assistants, and the RMO. We saw staff identified and discussed patients clinical, social, and psychological circumstances and needs; social and emotional aspects discussed included topics such as therapy input, and discharge arrangements.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**
- Staff used the malnutrition universal screening tool (MUST) to identify patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes; and we saw this documented in patient records we reviewed.
- Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.
- Daily menus were offered to all patients with a variety of dietary requirement options available. All patients we spoke with said that the food was good, and water was replenished as required.

- We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted 92.7% compliance for food and hydration which was slightly better than the England average (92%).
- We reviewed seven patient records and saw that staff fully and accurately completed patients' fluid and nutrition charts where needed.
- Fluid balance charts were audited monthly. Criteria for inclusion included patients having undertaken major orthopaedic, abdominal, urological, spinal or gynaecological surgery; who may or may not have had a stoma or been catheterised. Results from February to June 2019 showed compliance varied from 62% to 73%. We saw an action plan had been developed to improve results; especially around totalling of figures at 24 hours.
- Patients who require assistance with nutrition and hydration needs were supported by the nursing team. If specialist input was required, dietetic support and speech and language therapy was provided from an outsourced team, who were available seven days a week, 24 hours a day.
- Pre-admission information for patients provided them with clear instructions on fasting times for food and fluid prior to surgery. Current guidance recommends fasting from food for six hours and fluid for two hours.
- Patients waiting to have surgery were not left nil by mouth for long periods. We reviewed seven medical records that showed that patients had adhered to fasting times prior to surgery going ahead; and only one of these had exceeded the six-hour fast time for food.
- Audit data from June 2019 showed that of the 40 records reviewed, 100% of patients were found to have had clear oral fluids within two to three hours before undergoing surgery.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**
- We observed staff using pain scoring tools to assess patients' levels of pain; and staff recorded this information on the NEWS 2 record.
- Senior managers informed us that clinical staff were required to undertake pain assessment training as part of their mandatory training.
- Patients we spoke with said that staff offered them pain relief at regular occasions and that staff checked that pain relief administered had been effective.
- Pain relief was audited as part of the NEWS 2 audit, and as part of the patient satisfaction survey. We saw that 40 patient records were audited in June 2019, and overall compliance against the 18 pain relief metrics measured was 89% on average.
- Patient satisfaction survey data for April to June 2019 showed that, on average, 97% of patients were satisfied the likelihood of post-operative pain was explained to them, 92% were satisfied their postoperative level of pain was assessed, and 92% were satisfied staff did everything possible to help control pain.
- Staff prescribed, administered and recorded all pain relief accurately. We observed evidence of appropriate pain and post-analgesia assessment, documentation and administration in records we reviewed.
- We saw that the pharmacy team provided pain management support for in-patients, where needed.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- There was a comprehensive internal clinical audit programme in place at the hospital to measure patient outcomes.
- The service also participated in relevant national clinical audits. External audit participation included patient reported outcome measures (PROMS), the National Breast Registry (NBR), Commissioning for Quality and Innovation (CQUINS), and the National Joint Registry (NJR). In addition, the hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS.
- We reviewed PROMS data for the period April 2017 to March 2018 (the most recent finalised data available). Results showed adjusted average health gains for total

hip replacement were in line with or better than England averages. . Adjusted health gain for primary hip replacement was better than the England average. Additional primary hip measures, and adjusted health gain results for all total knee replacement and knee replacement primary metrics were supressed in the data, due to the low number of eligible cases (less than 30).

- NJR data for the latest reporting period was suppressed, due to the comparatively low number of eligible data counts in some areas. However, we reviewed longer-term outcome data for patients who had undergone hip or knee surgery and found outcomes were within expected range or were better than expected. For hip surgery, the 90-day mortality hospital ratio and the revision rate ratio were better than England averages for operations undertaken between August 2013 and August 2018. For knee surgery, the 90-day mortality hospital ratio was the same as the England average for operations undertaken over the same period.
- The hospital reported two cases of hospital acquired cases of pulmonary embolism in the period July 2018 to June 2019. We reviewed summary details of cases which showed both patients had been appropriately venous thromboembolism (VTE) risk assessed at admission, fasting guidelines had been adhered to, and hydration maintained.
- The service had a low expected risk of readmission for elective care. Data we reviewed showed that from July 2018 to June 2019 there were 7868 visits to theatre and nine unplanned returns to theatre (0.11%).
- In the same reporting period, the hospital reported 12 unplanned transfers of inpatients to other hospitals (0.15%), and eight unplanned readmissions within 28 days of discharge (0.10%).
- From July 2018 to June 2018, the hospital reported one expected and one unexpected death.
- We saw evidence that outcomes of audits were collated and shared with relevant teams through daily hospital and departmental 'communication cell' meetings, departmental meetings, and team briefs and safety huddles.
- Exceptions were reported at to the clinical governance committee, and relevant sub committees. Downward trends or unexpected deviations were reviewed by the medical advisory committee (MAC), if required.
- Managers used information from the audits to improve care and treatment. We saw evidence of action plans being developed following audits to improve patient outcomes. For example, we saw action plans had been developed in response to VTE risk assessment (March 2019), consent (May 2019), and infection prevention control (May 2019) audits.
- Clinical audit result reports and action plans were embedded in the monthly clinical governance meeting minutes; and discussed and monitored as part of the clinical effectiveness standing agenda item.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- There was an induction and training policy in place at the hospital. Staff we spoke with said that they and colleagues received a full induction when they joined the service or moved department. For example, upon moving to another ward, a senior nurse described they had been given a two-week supernumerary period in which to complete their induction and familiarise themselves with the new systems and processes.
- Senior managers confirmed that new bank and agency staff were given an induction to departments; and we saw evidence of this.
- Managers made sure staff received any specialist training for their role. Nursing and healthcare assistant staff files we reviewed contained competence assessment workbooks and competence certification relevant to their areas of work; for example, for gaining consent, medicines management, catherisation, and blood glucose training.
- Registered staff we spoke with that they had been supported through revalidation by the hospital; and we saw 'essential clinical competency assessment logbooks for registered practice' present in staff folders we reviewed.

- Nursing and support staff rotated between inpatient and day case wards, which helped to keep their competencies up to date.
- In theatres, staff working as surgical first assistants had further training and competencies to undertake the role.
- The appraisal year at the hospital ran from October to September. In data submitted by the hospital prior to our inspection for the previous appraisal year (2017 to 2018), we saw that appraisal rates were low among staff groups. For example, only 41% of registered nursing staff on wards, 44% of health care assistants, and 25% of practitioners and support staff in theatres had received an appraisal. All (100%) registered nursing staff in theatres had received an appraisal.
- The hospital's new leadership team recognised that the process of annual appraisal was an area that required improvement and said they had implemented a plan to ensure that all staff had an appraisal by the end of 2019. Appraisals were comprised of two parts, which included a mid-year appraisal and final appraisal prior to close out. At the time of inspection, we saw 181 of 211 eligible hospital staff (85.8%) had completed their mid-year appraisal and were on track to have their appraisal completed by October 2019.
- We saw appraisal completion schedules were displayed for nursing and health care assistant staff in staff offices on the wards we visited.
- Registered nursing staff we spoke with described an increased managerial focus on the appraisal process and felt more assured the revived process would address their learning needs. When asked, most staff we spoke with described that they had a personal development plan in place; which had been renewed at their mid-year appraisal. They also said they given opportunities to attend courses to further their development.
- The service accommodated student nurse placements; and we spoke with a senior nurse who had been allocated as a preceptor. The nurse described the service facilitated student nurse rotation to different hospital departments (including, wards, theatres, and diagnostic departments); and students reported a good overall experience.
- We saw that monthly departmental team meetings were scheduled, and the minutes of these were made available in staff offices for those unable to attend. However, some staff said that team meetings were sometimes cancelled due limited staffing and workload capacity. For example, we saw that a recent departmental meeting scheduled for June 2019 had been cancelled.In the February 2019 meeting minutes, we saw the January 2019 meeting had been postponed due to staffing commitments.
- There was a policy and set criteria in place for granting, maintaining and withdrawing practising privileges. As of March 2019, there were 258 consultants with practising privileges with more than six months service in post, who provided a range of specialities for patients at the hospital.
- We reviewed four sets of staff files and found there was an effective process in place for granting practicing privileges to consultants and reviewing and removal of these; which was overseen by the hospital director and MAC chair. We saw oversight of disclosure and barring service checks, GMC registration, professional indemnity insurance; occupational health, qualifications, and appraisal information in all consultant files we reviewed.
- As of March 2019, data showed all 258 consultants had their registration validated in the last 12 months.
- The hospital director and MAC chair was responsible for liaising with the General Medical Council and local NHS trusts about any concerns and restrictions on the practice for individual consultants. Any concerns about a consultant was shared with their responsible officer within their NHS employment.
- In the period April 2018 to March 2019, we saw that no staff (of any grade) had been subject to supervised practice or subject to a fitness to practice hearing.
- RMOs were employed through a national agency. The agency was responsible for their ongoing training and provided continuing professional education sessions throughout the year. The chair of the MAC provided clinical supervision when required.

Multidisciplinary working

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

- Staff worked across health care disciplines and with other agencies when required to care for patients. We observed close working relationships between nursing and physiotherapy staff; and staff described effective multidisciplinary working relationships across all the areas we visited. If specialist input was required, dietetic support and speech and language therapy could be accessed from an outsourced team.
- Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. These included weekly pre-assessment MDT and weekly joint clinic meetings attended by different health care professionals; including the RMO, clinical services manager, senior members of the nursing team, pharmacy, and physiotherapists.
- Nursing and theatre staff could call for support from doctors and other disciplines, including out of hours. There was an RMO in the hospital 24 hours a day with immediate telephone access to on-call consultants, and there was a weekly radiographer on-call rota in place.
- Pharmacy services were available seven days a week, with an on-call service available out of hours; and we saw extensive evidence of pharmacy services supporting nursing staff to care for patients.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- The service had relevant information promoting healthy lifestyles and support on every ward/unit.
- General health promotion information was available within the hospital, for example, in relation to diet, exercise and smoking cessation. This was presented on display boards and inpatient information leaflets.
- A range of more targeted patient information leaflets were also available; for example, with respect to monitoring of surgical wounds for infection.
- Staff assessed patients' medical histories and health needs and offered focused written and verbal advice about recovery periods, leading healthier lives, and expectations for different procedures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, and they knew who to contact for advice.
- There was a consent for examination or treatment policy in use at the hospital, which staff could access on the hospital intranet. We observed nursing and medical staff obtaining consent prior to carrying out treatment on patients.
- As of March 2019, 91% of all eligible hospital staff had completed consent training.
- Staff made sure patients consented to treatment based on all the information available. There was a wide range of treatment specific patient information leaflets available to support staff to gain informed consent. These were comprehensive and had the mark of approval of national bodies such as the Perioperative Association, and the Royal College of Surgeons. However, we observed some of these had surpassed their review date; for example, those relating to laparoscopic gastric banding, facelift, and epidural anaesthetic.
- Staff clearly recorded consent in patients' records. Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards.
- We did not see any records saw any records where patients had 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders in place.
- Consent was audited as part of the hospital's documentation audit. A consent audit undertaken in May 2019 showed 85% compliance. Following the audit, an action had been identified for the clinical services manager to raise awareness with consultants about ensuring evidence of first stage consent was recorded in

patient notes. Results from 40 patient records audited in June 2019 showed 100% compliance for evidence of informed consent and signing and legibility of consent forms.

- There was a Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards policy, which staff could access on the hospital intranet. The legislation is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.
- MCA and DoLS training were included in safeguarding vulnerable adults training modules. As of March 2019, 88% of all eligible hospital staff had completed vulnerable adults' level one and level two training.
- Staff we spoke with could explain how they might assess a patient's capacity, the steps taken, and the importance of recognising how ill health could impact on patients' capacity. Staff said that they would approach the lead nurse on duty should they require any support.
- The director of clinical services was the safeguarding lead for the hospital and was trained to safeguarding vulnerable adults' level four and was available to offer support to staff, if needed.

Are surgery services caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- In wards and departments we visited we observed staff caring for patients and found that they were compassionate and reassuring. We heard staff introducing themselves by name and explaining the care and treatment they were delivering.
- Patients we spoke with said that staff answered buzzers quickly, and during the inspection we did not hear buzzers ringing for long periods of time.
- Patients said staff treated them well and with kindness. During our inspection, we spoke with eight patients and their companions, who all described staff care and interactions positively; for example, they said they were "very happy with care", and "staff have been lovely" and "staff are great".
- We saw that qualitative feedback from FFT (friends and family test) comment cards were captured and analysed by the service. Comments we reviewed were overwhelmingly positive, for example, care was described as "excellent" and "very good".Staff were described as "professional and friendly", "very caring and attentive", "very nice", and "extremely friendly [and] capable".
- Staff followed policy to keep patient care and treatment confidential. All patients we observed were comfortable, looked well cared for and had their privacy and dignity maintained.
- Patient satisfaction survey results for the period April to June 2019 showed 100% of patients agreed they were given privacy when discussing their condition or treatment, and 99.5% reported they were treated with respect and dignity.
- Staff understood and respected the individual needs of each patient. We observed a staff handover and saw that staff discussed patients' emotional, cultural, social, and spiritual needs alongside their clinical needs and care planning.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with said that staff were available to talk to them, as required.

- We saw that the ward and unit managers, or their deputies and representatives, were visible on wards and departments we visited, and patients and relatives could speak with them.
- Patient satisfaction survey results for the period April to June 2019 showed 97.8% of patients felt there was someone in the hospital to talk to about any worries they might have.
- We observed that staff were reassuring and empathetic when communicating with patients, and their relatives and friends.
- Communication training was interspersed amongst different mandatory training modules. As of March 2019, we saw that 86% of all staff had completed conflict resolution training, and 91% had completed consent training.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We overheard conversations between patient and therapy and nursing staff, and heard staff providing comfort and support to patients and their relatives.
- We saw that qualitative feedback from FFT comment cards showed patients felt staff provided them with emotional support. They described staff "had time for me", they "felt reassured and at ease", and "put my mind at rest, assured me".

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with said they had been involved in decision-making and felt informed about all aspects of their care.
- A range of information leaflets and advice posters were available on wards we visited. These provided information about topics such as, discharge, specialist services, and general advice about care and treatment.
- Staff talked with patients, families and carers in a way they could understand. We observed staff used clear, concise and easy to understand language when communicating with patients and their companions.
- Staff supported patients to make informed decisions about their care. We saw that qualitative feedback from FFT comment cards showed patients felt well-informed. For example, patients said they were "well informed of procedure", staff "explained all procedures and what to expect", and staff were described as "kind and helpful, and answered all of my questions".
- Patients we spoke with said that they were aware of their plans of care, had been given the time to ask questions, had received satisfactory answers to these, and felt listened to.
- Patient satisfaction survey results for the period April to June 2019 showed 99% of patients felt involved in their consultant consultation and the decision to treat, 99% agreed they had been given all relevant information, and 99.5% felt their proposed treatment had been satisfactorily explained to them. In addition, 92.5% of patients on average felt the relevance of information provided by nursing staff was satisfactory.
- Over the same period, patient satisfaction survey results showed high proportions of patients gave positive feedback about pre-admission communication: 96.5% of patients reported they had received an information pack from the hospital, 100% felt instructions were clear and easy to understand, and 92.3% were satisfied with the quality of instructions provided.
- On average, 90.9% of patients were satisfied in the level of involvement in consultants' decisions about their care whilst in hospital, and 89.9% were satisfied in the level of involvement in nursing decisions about their care.
- The feedback from the FFT was positive for all wards. Data showed that from June 2018 to June 2019, 95.3% of insured and self-pay patients, and 98.3% of NHS patients would recommend the service to friends and family; equating to 97.5% of all patients.

Are surgery services responsive?

Good

Surgery

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- Managers planned and organised services so they met the changing needs of the local population. The hospital worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.
- A screening process was in place pre-admission for patients with complex needs to minimise the risk of these patients being treated at the hospital. Staff gave us examples of how they may support patients with additional needs, for example those people living with dementia or learning difficulties, although this was rare.
- The hospital had effective arrangements in place for planning and booking of surgical activities, ensuring patients were offered choice and flexibility.
- The service had systems to help care for patients in need of additional support or specialist intervention. For example, there was a dedicated physiotherapy team available on site, and dietetic support and speech and language therapy was provided from an outsourced team, if required.
- Managers monitored and took action to minimise missed appointments; for example, text messages were used to remind patients of upcoming appointments.
- Managers ensured that patients who did not attend appointments were contacted. Administrative staff we spoke with said they would always try to reach the patient by telephone should they have not attended for their appointment. If this was not possible, it was hospital policy to send a letter by post confirming the rescheduled appointment.
- The service relieved pressure on other departments when they could treat patients in a day. There was an ambulatory care and surgical day-case unit. In addition, there was flexibility to relocate these patients to the inpatient ward, if required; to reduce the number of areas in operation should demand not meet capacity.

Meeting people's individual needs

- **The service took account of patients' individual needs and preferences, and we saw some evidence of staff making reasonable adjustments to help patients access services. There was some evidence of inclusivity; however, patients living with mental health problems, dementia, and patients with learning disabilities were not routinely treated at the hospital.**
- The needs of patients living with mental health problems, dementia, and patients with learning disabilities were assessed at pre-assessment. However, staff said that these types of patients were not routinely treated at the hospital.
- One ward manager we spoke with told us a patient with mild learning disabilities was to attend for a procedure soon, and that they had spoken with the patient and their relative to understand their needs. They said that care planning included placing the patient at the end of a surgical list and allowing the patient's relative to access the post anaesthetic recovery unit, if required.
- The hospital had a dementia strategy (for 2019 to 2021), which clearly set out how they would review and monitor progress relating to safety, experience, and effectiveness of dementia care provision. We saw that wards were not designed to meet the needs of patients living with dementia; however, staff said these patients were very rarely treated at the hospital. Correspondingly, inpatient and day case ward managers we spoke with could not recollect treating or caring for a patient with dementia or learning disabilities in the 12 to 18 months prior to our visit.
- We reviewed patient led assessments of the care environment (PLACE) reports (published August 2018) and saw the hospital scored 74.9% for being dementia friendly, which was worse than the England average (78.9%).

- We also saw that accessibility for patients with limited mobility and people who used a wheelchair was limited. For example, although a communal shower was available for use, all ensuite bathrooms had a shower over the bath. This meant that people with some disabilities could not access the service on an equal basis.
- Senior managers reported that contact with family and friends for support and assistance were encouraged for patients with additional needs; and staff ensured that visiting times for these patients were flexible.
- PLACE reports (published August 2018) showed the hospital scored 76.0% for being disability friendly, which was worse than the England average (84.2%).
- Staff were not able to separate male and female patients in the recovery area, post-surgery, however, staff used curtains to screen patients.
- Specialised equipment for bariatric patients was available in theatres, and in ward areas.
- The service had information leaflets available in English, but we did not see that these were available in other languages. However, managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. Translation services were available for patients whose first language was not English, and staff we spoke with knew how to access these services.
- Patients' communication needs such as hearing, sight or language difficulties were identified at pre-assessment. We could not identify that hospital staff had access to communication aids (if required) to help patients become partners in their care and treatment. We did see that if specialist input was required, speech and language therapy was available from an outsourced team; who were available seven days a week, 24 hours a day. However, were we not assured that the service was compliant with accessible information standards (AIS).
- Patient survey data for the period April to June 2019 showed 63.1% of patients were satisfied that their communication needs had been discussed at pre-admission, and 36.9% were not satisfied.
- Patients were given a choice of food and drink to meet their cultural and religious preferences.
- We also saw there was room on the day case ward that could be used for prayer; and which contained a prayer mat, if needed.

Access and flow

- **People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**
- In the reporting period March 2018 to February 2019, 9138 patients were treated at the hospital. Of these, 66% were NHS-funded and 34% were other funded.
- There were 2483 inpatient episodes of care recorded at the hospital; of which, 70% were NHS-funded and 30% were other funded. There were and 6,655 day case episodes of care recorded at the hospital; of which 65% were NHS-funded and 35% were other funded.
- Staff held a daily 'communication cell' and bed meeting to discuss staffing levels and clinical needs. Staff reviewed the number of admissions, discharges and patient dependency throughout shifts and at handover to assess on-going capacity.
- Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.
- The hospital did not have waiting lists for surgery for private patients. NHS patients were treated within the 18-week referral to treatment time (RTT) pathway; and patients were offered surgery according to their availability and the clinical need/urgency for the surgery. The RTT pathway is the key access target for NHS-funded patients, it stipulates that no patient should wait longer than 18 weeks from referral to the start of their treatment. The hospital NHS team monitored patient waiting times and helped to facilitate admissions and care to ensure no breaches occurred.
- From April 2018 to March 2019 the hospitals referral to treatment time (RTT) for admitted pathways for surgery was 91.7%; which was better than the hospital target of 90%. Over the 12-month period the hospitals performance ranged from 87.5% to 95.4%.

- Managers and staff worked to make sure patients did not stay longer than they needed to. Patient satisfaction survey results from April to June 2019 showed 93.1% of patients reported they did not experience a delay in discharge.
- Take home medications were prepared by the pharmacy team, and dispensing times were monitored. An audit undertaken in April 2019 showed the average dispensing time for take-home medications was 14 minutes.
- We requested, but were not provided with, average length of stay data.
- Managers worked to keep the number of cancelled operations to a minimum; however, we saw the reasons for cancellations were frequently categorised incorrectly in data we reviewed.
- Following our inspection, we requested details of hospital cancellation rates; however, the hospital provided absolute number data. The hospital reported that from April 2018 to March 2019, 211 operations were cancelled. They reported that of these, 164 operations (77.7%) were cancelled for clinical reasons, and 47 operations (22.3%) were cancelled for non-clinical reasons. In the period April 2018 to March 2019, 8803 patients were treated at the hospital (2482 inpatient, and 6321 day case patients); equating to a cancellation rate of 2.4%.
- However, we observed incorrect categorisation of cancellation type was frequently applied in the data; predominantly among 'clinical cancellation' entries. For example, numerous 'clinical cancellations' were observed to have occurred because of staff sickness or absence, theatre lists running late, equipment failure or lack of correct equipment.
- We reviewed clinical governance meeting minutes, which identified cancelled operations as a recurrent incident trend. However, we saw that actions had been implemented to reduce these. The service had implemented a CQUIN (commissioning for quality and innovation) with the CCG (clinical commissioning group). This involved review of the pre-assessment system and the introduction of a multidisciplinary team (MDT) meeting. Data showed 81 clinical cancellations for elective surgery on the day of admission were recorded (for NHS patients) from April 2018 to March 2019, compared to 106 from April 2017 to March 2018.
- Managers ensured that patient moves between wards were kept to a minimum. The service routinely allocated day case and ambulatory unit patients to the inpatient ward, where this made sense to do so. For example, if low numbers of these patients were scheduled, and there was capacity to accommodate them on the inpatient ward. However, this was arranged prior to admittance; patients were not routinely moved from one ward to another during their episode of care.
- Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning began during pre-admission, and we saw patients were asked about who would transport them to and from the hospital, and who would be at home with them following discharge.
- We saw patients and their companions were informed of expected recovery times and given information leaflets reiterating key information; which were specific to their procedure.
- Staff planned patients' discharge carefully. Post-operative discussions of discharge arrangements took place between patients and their companions, consultants, and nursing staff. We also saw plans to discharge patients were discussed at staff handovers.
- Arrangements were in place for early physiotherapy assessment, where indicated; and follow-up appointments with medical and physiotherapy staff were scheduled in advance of discharge.
- We saw patient outcomes and care plans were clearly communicated to other health professionals, such as general practitioners.

Learning from complaints and concerns

- **People were able to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- The hospital had a complaints policy and a process that addressed both formal and informal complaints raised by patients or relatives. If the complaint was not

resolved at local level, it was made clear that patients had the option to escalate; and this would be investigated by the corporate team. If they remained dissatisfied, private patients could take their complaint to the Independent Sector Complaints Adjudication Service (ISCAS). For NHS patients, complaints could be escalated to the Parliamentary and Health Service Ombudsman (PHSO), for an independent review.

- Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with said that they would initially raise any concerns they had with a member of staff on duty; and would feel comfortable making a formal complaint, if necessary.
- The service provided information about how to raise a concern or make a complaint, however, this information was not clearly displayed in communal patient areas. Information about how to complain and details of the complaints process was documented in patient guides provided in patient rooms. We saw there were a range of information leaflets available in clinical areas which detailed how patients could provide feedback. However, these did not offer specific information as to how patients, their relatives and carers could formally raise a concern or make a complaint.
- Senior staff said that surgical inpatients and day case patients received a 48-hour discharge call, where they were able to express any concerns. We reviewed patient satisfaction survey results from April to June 2019 that showed only 53.7% of patient agreed they had received a follow-up call after discharge. However, following our inspection, senior leaders reported that if a patient completed a satisfaction survey on or prior to discharge, they were not able to comment on having received a follow up call; and excluding these patients, data showed 96-98% completion.
- Staff understood the policy on complaints and knew how to handle them. Staff we spoke with said that they would try to manage complaints locally and immediately address any concerns, wherever possible. However, if this was not possible, they said they would always advise patients of their right to complain formally and escalate to their manager.
- Managers investigated complaints and identified themes. The quality and risk manager had day-to-day management responsibility for the administration of complaints; and this was overseen by the senior management team. The senior management team chose a head of department to investigate a complaint.
- Complaints were logged and managed electronically. Data showed that from May 2018 to June 2019, 73 ('stage one') complaints had been made. This equated to an average rate of 0.88 complaints per 100 admissions. No complaints had been taken forward as a 'stage two' complaint or had been escalated to ISCAS or the PHSO in this timeframe.
- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed six complaints, and in each case saw these were acknowledged within five days. All complaints were responded to in a timely manner and within the 20-day target.
- Response letters to complainants included an apology when things had not gone as planned. This was in accordance with the expectations of the service under duty of candour requirements.
- Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were a standing agenda item at clinical governance committee meetings; and we saw that the number and type of complaints received were analysed to identify themes and trends. We also observed that the details of any 'significant complaints' were discussed in detail, including actions taken to date and any learning.
- Complaints were also discussed at medical advisory committee (MAC), as part of the clinical governance report review, and at heads of department meetings.
- Staff and managers we spoke with said that themes from complaints were identified and shared with ward and theatre staff during departmental communication cell and team meetings, and we saw some evidence of this in team meeting minutes we reviewed.

Good

Surgery

Are surgery services well-led?

Good

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

Leadership

- **Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- The senior management team (SMT) had undergone changes since our last inspection of the service, and there was a new team in place. Leaders said that the previous SMT had been replaced in September 2018, mainly due to promotion; and senior hospital staff had acted up into these roles.
- The SMT was headed by an executive director, who had been in post for approximately four months at the time of inspection. The executive director was supported by a director of clinical services, and an acting director of operations.
- The leadership team were supported by eleven service managers. These included theatre, physiotherapy, imaging, pharmacy, and endoscopy clinical services managers, and a quality and risk manager.
- Senior leads and clinical managers we spoke with understood the issues the service faced and had made inroads to manage and prioritise these. For example, they discussed securing infrastructure and equipment investment was a high priority; and we saw a programme of work had commenced.
- The SMT recognised nursing leadership as an area that required strengthening, and they were in the process of recruiting two nurse managers; one for inpatients and one for outpatients and pre-assessment. At the time of inspection, senior nurses (sister's) were acting up into these roles. The nursing manager role had previously covered both inpatient and outpatient departments, however, a decision had been reached by the SMT to split the role into two.
- Staff we spoke with said the senior management team was approachable and visible on the wards and departments. Many of the staff we spoke with said the new executive director was very visible and had visited most areas of the hospital to speak with staff, including in those in theatres.
- The resident medical officer (RMO) we spoke with said they felt supported by senior colleagues.
- We found mangers on the wards and departments we visited knowledgeable and professional. They appeared visible and approachable for junior members of staff they supported.
- All staff spoke positively about the SMT and department managers.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- The service followed the corporate clinical services framework for nursing and allied health professionals, which set out the principles of safe, high quality care, attracting and retaining the best workforce with, education supporting the care we deliver. This reiterated that the '6 C's' (care, compassion, commitment, competence, courage, and communication) were the value base of the service sought to deliver. The framework drew on 10 leading change and adding values and the triple aim of achieving better outcomes, better experiences for people, and better use of resources.
- There was a corporate clinical strategy in place to improve clinical safety, improve clinical effectiveness, develop leadership and culture, ensure robust clinical and consultant governance, and develop services.
- The hospital produced a local vision comprised of eight core aims, with several objectives for each, which detailed how these would be achieved. Core aims included prioritising patient safety and quality of care,

- We saw staff had been involved in the development of a new hospital purpose statement ("we are here for you – because we care") and core hospital values, which were; for our patients and people we will: keep you safe, care for your needs, value who you are, listen and be honest.
- Staff we spoke with could reiterate the ethos of the hospital vision and values; and relate these to their role at the hospital. Staff said adherence to the hospital values formed part of their appraisal.
- We saw the new SMT had implemented a five-year site development plan, which aimed to improve the patient pathway and fully refurbish the hospital. In addition, a capital expenditure plan for equipment replacement had been submitted. We saw there had been recent infrastructure investment; which had included hiring of chillers and generators, new flooring, and new roofs over theatres and pre-assessment and oncology areas.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Ward and theatre staff we spoke with said they felt supported by their line managers and that morale was good. They were enthusiastic and proud of the work they did for patients.
- Staff at all levels we spoke with were positive about the SMT. Staff told us there had been a distinct change of leadership style and culture and described a "fresh" approach. One staff member said, it felt like "a new chapter" in the life of the hospital.
- We observed that the SMT encouraged an open-door policy. They said they were focused on supporting a positive culture where staff were empowered to take responsibility, make decisions in the best interest of the patient, and learn ensure patient care was constantly improving.
- We saw there was an open culture, where patients, their families and staff could raise concerns without fear. This was evidenced through managing and handling of patient concerns and complaints, and responses to staff survey results and action planning to improve workforce experience.
- We observed that managers and staff on wards and in theatres felt comfortable supportively challenging consultant practice, and we saw evidence of where this had occurred.
- As well as staff who had been given the opportunity to act up into more senior roles, we saw that staff were supported to develop in other areas of the hospital. For example, six surgical first assistants were being developed and upskilled in theatres; this included undertaking advanced life support training, which was additional to requirements. One member of ward nursing staff had completed an associate nurse course, and three other healthcare assistants had completed the first year of the course.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.**
- Clinical quality and governance matters were reviewed by the medical advisory committee (MAC). The minutes and actions from monthly clinical governance meeting and the various sub-committees (such as the health and safety, infection prevention control, and water safety committee) were reported to the MAC.
- The MAC was held quarterly and chaired by a lead consultant. We reviewed six sets of meeting minutes and saw the meeting was attended by the executive team and clinical specialty and representatives from each hospital department. We saw incidents, quality assurance audits, quality improvements, and new clinical services were discussed. The review of actions from previous meeting minutes was a standing agenda item.
- The conditions of practising privileges were closely monitored for compliance and records held up to date

evidence of appraisal, indemnity insurance and registration. We saw consultant applications for practising privileges, and removal of practising privileges, were discussed at the MAC.

- We also saw evidence of detailed discussion about the importance of having oversight of consultant performance following findings and recommendations from the Paterson Verita report (commissioned by the Spire Healthcare Group) in the January 2019 MAC meeting minutes. In addition, the importance of introducing the new executive director (when they came into post) to medical directors at neighbouring NHS trusts, to support good working relationship and open channels of communication was highlighted.
- Heads of department (HoD) committee meetings were held monthly. We reviewed meeting minutes for the six months prior to our inspection and saw attendance included the SMT, clinical and non-clinical service managers and the infection prevention and control lead and training coordinator. Standing agenda items included staffing, HoDs monthly reports (which featured incidents, patient transfers, and returns to theatre data), feedback from national and hospital committees, appraisals and mandatory training compliance, complaints, risk register review, and staff survey result updates.
- We reviewed monthly clinical governance meeting minutes for the six months prior to our inspection and saw standing agenda items included audit results, and significant incident and patient events, (such as, unplanned transfers of care, re-admissions, and unplanned returns to theatre). We saw that patient events were classified, analysed, and trends were identified; and an accompanying 'incident overview' report was embedded in the main meeting minutes.
- There were subcommittees and working groups, which fed pertinent findings to key hospital committees, including the clinical governance committee. These included an infection prevention and control committee, health and safety committee, water safety committee, theatres steering group, pain, and patient satisfaction committee.
- We reviewed departmental meeting minutes for theatres (February and March 2019) and wards (December 2018 and February 2019) and saw membership and attendees were detailed. Standing agenda items in theatre meeting minutes included discussion of the communication cell board, recruitment, quality and risk, risk register, and infection prevention control. Standing agenda items in ward meeting minutes included clinical governance and quality, complaints and significant events, health and safety, risk register, human resources, and policy updates.
- Staff we spoke with at all levels were clear about their roles and responsibilities and had regular opportunities to meet and discuss and learn from service performance. However, some ward staff reported that team meetings were sometimes cancelled due limited staffing and workload capacity.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- We observed that the previous senior management team (SMT) had not always implemented action plans and acted on risks facing the service in a timely manner; for example, with respect to some infection prevention and control (IPC) and environment and equipment issues. We saw considerable evidence of the new SMT working to improve oversight of and mitigate against risks facing the service. For example, they had overseen refurbishment of several hospital areas, which had included some significant infrastructure work. They had also implemented more stringent oversight of Legionella and theatre air handling units; and had recently contracted external companies to assess, mitigate against and/or remedy these risks. However, we saw a Fire and Rescue Authority regulatory reform safety order had been issued and numerous actions were outstanding from this work.
- The hospital audited a range of performance indicators and outcome measures, which were monitored through the hospital's clinical governance framework and subcommittees. Examples of key indicators included VTE risk assessment compliance, theatre starve times,

effective discharge, NEWS 2, pain scores, surgical site infections, unplanned returns to theatre, and patient transfers to other hospital sites. We saw these were reviewed monthly at the hospital's clinical governance committee.

- We saw evidence of actions plans being used to improve performance; for example, with respect to cancellation rates, and consent compliance.
- Pertinent risks, issues, and performance were discussed at the hospital communication cell meeting; which was attended by the SMT and heads of departments and mangers, or their representatives. These were fed back to teams during daily departmental communication cell meetings, manager bed meetings, and at staff handovers.
- Risks were managed on an electronic system; which was overseen on a day-to-day basis by the hospital quality and risk manager. Heads of department managed departmental risk registers which fed into the hospital risk register. Registers highlighted current risks and documented mitigating actions to reduce them**.**
- Each department completed risk assessments, and if the risk was deemed to score 12 or above, it was entered onto the departmental risk register; however, any risk (regardless of score) could be considered for entry. The hospital quality and risk manager reviewed new and ongoing risks and communicated these at the daily hospital communication cell meeting. If it was agreed that a new risk should be added to the register, the SMT decided which head of department and committee or working group should have primary oversight.
- Data we reviewed showed that there were currently 31 open risks entered on the hospital risk register (correct to 17 July 2019). These ranged from risks categorised as having the potential for major significance, to those of moderate, or minor significance.
- The top five hospital risks were:
- Insufficient investment in facilities and critical equipment - critical infrastructure and refurbishment (risk scored 16);
- Failure of infection prevention and control processes – risk of patients contracting Legionnaires Disease (risk scored 15);
- Major or critical building or equipment failure – chiller failures in theatres (risk scored 12);
- Failure to recruit adequate and appropriate staff - particularly in theatres and on wards (risk scored 12); and
- Insufficient investment in facilities and critical equipment – fire risk of distribution boards (risk scored nine).
- Assigned risks were reviewed by members of the SMT, or heads of departments at relevant committees, subcommittees and working groups. The electronic system issued an automated prompt to the risk owner, when risks were due for review.
- We saw the risk register was reviewed as part of standing agenda items at the clinical governance committee, heads of department committee, and health and safety committee. Clinical governance reports (which included risk register oversight) were a standing agenda item for review by the MAC.
- We observed staff of all levels participated in discussions about financial standing and use of resources in various meetings; including committees, subcommittees, working groups and team meetings.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure; however, correct data handling process had not always been followed.Data or notifications were consistently submitted to external organisations as required.**
- We observed that the service collected reliable data and analysed it; as evidenced through the collation and analysis of key performance indicator and audit results. We saw data was submitted in a timely manner to committees and working groups, and senior staff and managers examined at the accuracy and validity of data by thematically analysing results and drawing out reasons for any changes.

- We saw high levels of participation in key external audits. For example, National Joint Registry (NJR) compliance and quality measures for the period 2017 to 2018 showed that the hospital was performing far better than expected.
- We also observed data was submitted to third parties as required; for example, referral to treatment rates were reported to the CCG.
- The results of patient surveys were managed and collated by an independent analytics company.
- The hospital used communication cell boards. The main cell board was situated in the SMT board room, with individual cell boards located across departments, including theatres. In the main, we found cell boards contained relevant and up to date performance information; presented in easy and accessible formats, for staff to access.
- There were policies and processes in place governing information governance, security and personal data protection.
- Information provided by the hospital showed that 88% of hospital staff had completed information governance training, as of March 2019.
- Computers were available on wards. During the inspection, all computers were locked securely when not in use.
- Senior leaders recognised that there was a long-standing historical issue of the consultant outpatient record not being part of the entire medical record for patients. Key information, such as referral and discharge letters, were able to be added; but not the entire medical record. The hospital had recently embarked on a project to implement a single set of medical records for every patient.
- However, we noted a risk register entry (dating to 2019) which described identification of 41 boxes of medical records which had been sent to a data handling and medical records storage company without following the correct process. The entry stated that the hospital could not accurately identify which patient records were in each box. We saw that an action plan had been developed to resolve this. Mitigation of hospital information security and governance risks on the risk register included a corporate information governance champion, refreshing staff training, and targeted and ongoing information security audits,
- Senior leads discussed that a fire had occurred at the medical records storage facility, operated by the third-party company, in early 2019. Hospital records had been destroyed in the fire. They said affected patients had been written to inform them of the loss. We saw a complaint had been submitted in April 2019, which related to a patient requiring further information into the provision of their medical records, following the fire.
- We saw corporate systems were in place that allowed the secure transfer of patient information via email to/ from NHS.net email accounts. In addition, consultants could use a secure electronic application to remotely access clinic and theatre lists; no data was stored on the device and a 'time out' was applied.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- At inspection, we saw a formal feedback processes were in place to collect patient or relative feedback. For example, patients and relatives could respond to friends and family tests, complete a ('longform') patient survey, and patients received a follow-up telephone call 48 hours after discharge (data showed 54% reported receiving such a call). Patients surveys could be manually completed or submitted online.
- The response rate to FFT at the hospital from April to June 2019 was 66.7%, which meant that over two-thirds of patients who were eligible to complete the survey did so.
- The response rate to the ('longform') patient survey over the same period was 11.3%.
- A detailed monthly patient satisfaction report was produced, which was cascaded to teams through our clinical governance committee, and head of department meetings.

- There was a patient satisfaction group, which we observed senior leads had committed to reviving in meeting minutes we reviewed. We saw the May 2019 meeting was well attended, and members included the executive team, managers, and senior staff, and the patient liaison officer. Staff discussed monthly patient feedback response rates, results, and means of improving these.
- We saw a patient satisfaction action tracker had been developed, dated to May 2019. This was comprised of 10 actions (for example, to put more staff through human factors training, and methods to improve response rates); with heads of departments and managers assigned to relevant actions for their areas.
- We observed hospital communications during our inspection that showed staff had been invited to participate in staff forums, and the hospital 'BMISay' (staff) action plan had been updated following staff feedback. The communication detailed responses highlighted changes around investment, communication, and employee recognition.
- We reviewed a 'BMISay' (staff) action plan dated to September 2018, and saw actions included updating departmental communication cell boards, introducing a staff suggestion box, for every department to hold a monthly team meeting, and for SMT and HoDs to be more visible around the hospital.
- Senior leads we spoke with said they had introduced quarterly staff forums, a hospital staff newsletter, and were planning to introduce an employee of the month award.
- We saw the hospital also engaged with the public, patients, staff and external health professionals via social media channels.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**
- We saw the new SMT were focused on learning and continuous improvement of the service and had identified key areas which required focused quality improvements; such as staff engagement and appraisal and critical infrastructure and equipment investment.
- Staff were encouraged to undertake additional training. For example, we saw some senior staff had undertaken accredited leadership raining, healthcare assistants had undertaken associate nurse training, and surgical first assistants had been 'up skilled'.
- We saw evidence of learning from incidents that had occurred at other hospital sites in committee meeting minutes we reviewed. For example, we saw discussions about never events, serious incidents, and a (coroner's) regulation 28 report to prevent future deaths that had occurred at other BMI sites were documented in MAC and clinical governance meeting minutes we reviewed.
- The hospital had introduced monthly multidisciplinary (pre-assessment) team meetings to review the appropriateness of patients to undergo surgery, and to ensure all relevant tests had been performed prior to admission. This followed from engagement with a CCG to reduce cancellations for elective surgery on the day of admission.
- A member of the physiotherapy department had introduced a 'joint school'. This is a service specifically for people who are about to undergo a hip or knee replacement. It focuses on patient education and lets patients know what to expect, from admission through to recovery.
- The pharmacy lead and members of the pharmacy team had conducted research exploring the impact of patient summary care record use on medicines reconciliation and patient care. This had involved developing a quality assessment tool to allow users to record data from medicines reconciliations. An article was published in a pharmacy journal.
- We saw that clinical staff frequently delivered lectures and workshops to referrers, such as general practitioners, both on and off site. For example, surgeons with practising privileges at the hospital delivered talks on orthopaedic procedures, and the infection prevention and control (IPC) lead had spoken to GPs about good IPC practice.

Requires improvement

Critical care

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

Are critical care services safe?

Requires improvement

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

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff were required to complete mandatory training in topic areas such as infection prevention, fire safety and information governance.
- Staff were able to track which training they were required to complete for their role on an electronic system and could see the date they had last completed the training and when it was next due. There was a coloured coded RAG (red, amber and green) rating which showed green for completed, amber for due to complete within the next month and red if the training was overdue.
- Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received automatic email reminders when they were due or overdue to complete a training session.
- The overall compliance for the critical care high dependency unit (HDU) was 91%.
- We found that one registered nurse on the HDU was up to date with all the required training, however, the other registered nurse had joined the hospital in October 2018 and had not yet completed eight of the required training modules. The nurse told us that it had been agreed with her line manager to complete the modules during her first year at the hospital and she was on track to do that.
- For further details about mandatory training please see the Safe section in the surgery report.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**
- Staff received training specific for their role on how to recognise and report abuse. Staff working in the HDU had completed safeguarding vulnerable adults and safeguarding children training level one and level two. Bleep holders were all trained in level three safeguarding adults which included the registered nurses on the unit. Safeguarding training included units on female genital mutilation, chaperoning and PREVENT (intended to identify and reduce radicalisation).
- Staff we spoke with were confident on how to identify adults and children at risk of, or suffering, significant harm.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding flowcharts were displayed in the unit and included named contacts with telephone numbers.
- For further details about safeguarding please see the Safe section in the surgery report.

Cleanliness, infection control and hygiene

Requires improvement

Critical care

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- The unit appeared visibly clean. Daily and weekly cleaning schedules were displayed in all areas and staff had signed and dated the lists to show that tasks had been completed on the days the unit was open. We observed staff cleaning equipment with disinfectant wipes.
- At the previous CQC inspection in 2015, we found staff did not always adhere to infection prevention and control practices. At this inspection we found this had improved. Staff followed infection control principles including the use of personal protective equipment. We observed that all staff were bare below the elbows and demonstrated good hand hygiene.
- Handwashing audit scores were displayed on the notice board and showed 100% for the May 2019 audit.
- Beds had disposable curtains around to provide privacy. The curtains were labelled with the date they were last changed. Staff told us they were replaced every six months or earlier if they became soiled.
- To reduce the risk of legionella there was a schedule to flush taps in areas which were infrequently used. We observed a member of staff carrying out a timed flush of the taps in the two bedded room on the unit.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe.**
- The unit had facilities to accommodate six patients requiring level one or level two care. There were two monitored beds in one room which was connected to a room with one monitored bed and a bathroom. There were an additional three side rooms with monitors which could be used if required. Side rooms had ensuite bathrooms and all rooms had handwashing sinks, which was an improvement since our last inspection in 2015.
- At the previous inspection we were concerned that the unit was cramped and that two beds in one of the rooms did not allow emergency access to one patients bed. We found this had been rectified at this inspection as the second bed had been removed.
- We checked 16 pieces of equipment and found that not all equipment had stickers or labels on to indicate they had been safety tested and maintained. Hospital managers told us that some equipment was checked and maintained by an external company who did not use stickers/labels to show when equipment had last been checked. The hospital held a database of all equipment with asset numbers which included dates for review and utilised a red/green system to alert service managers if a piece of equipment needed maintenance/ annual checks.
- There was one resuscitation trolley on the unit which was stored in the two bedded room. If this was needed for the patient in the one bedded room one it could be taken a short distance down the corridor or staff could access the trolley on the adjacent ward. We checked the trolley and found that it was tagged for security and had been checked daily except for one day in March and two days in July. Staff signed to show weekly checks of the entire contents of the trolley had been completed and recorded the new security tag number. Staff clearly documented when the trolley was not checked to indicate that the department was closed.
- Staff carried out weekly checks on equipment in the unit and recorded this on a weekly checklist sheet. Between March 2019 to July 2019 we found there were gaps in the weekly checklist for the transfer bag, the ventilator and the blood sampling machine. We also found a high-pressure suction control unit filter had not been changed and was due to be changed in October 2018.
- Waste was appropriately segregated into clinical and non-clinical with clear signage displayed. Sharps bins were correctly labelled, signed and dated except for one sharps bin on the bloods collection trolley which had no label on for staff to complete and was full. We discussed this with hospital managers who told us that the sharps bins were bar coded and the date and location of the sharps bin were recorded electronically.

Assessing and responding to patient risk

Requires improvement

Critical care

- **Staff assessed risks for each patient and ensured they were removed or minimised. However, they did not follow their own policy on detecting the deteriorating patient.**
- All patients had risk assessments in place for falls, malnutritional, pressure areas and moving and handling.Staff updated them when necessary and used recognised tools.
- Staff monitored patient's observations and recorded these on a chart. We were concerned that the unit did not use the National Early Warning System (NEWS) to identify if a patient was deteriorating. Staff told us this was because patients on the unit had different parameters for measuring deterioration. This had been identified as an issue as the last CQC inspection. We checked the operational policy for the critical care unit which stated that the unit should utilise the NEWS graded trigger response as a tool for assessing the acutely ill adult patient. Therefore the unit was not following its own policy.
- Staff attended training in the care and communication of the deteriorating patient training which included sepsis training. Staff we spoke with were clear on the signs and symptoms of sepsis and could describe what actions to take if a patient was showing signs of sepsis.
- The hospital had a care of the deteriorating patient pathway and clinical escalation policy in place. If a patient deteriorated staff were able to contact the patient's consultant. In addition to this staff could contact the resident medical officer (RMO) who was on site 24 hours a day, seven days a week.
- If a patient required a higher level of care (level three), staff had the skills and equipment to maintain a patient at level three prior to transfer to the local acute hospital. There was an agreement in place to transfer patients to the local acute hospital intensive care unit. We saw the clinical protocol agreement for emergency transfer of adult transfer policy displayed in the wall of the unit office so that it was easily accessible to all staff.
- All staff on the unit were trained to a minimum of intermediate life support. The RMOs were trained in advanced life support (ALS) and staff told us that there were two other hospital staff trained in ALS. We saw an advanced life support flow chart by the Resuscitation Council, displayed on the wall in the unit office.
- A major haemorrhage flowchart was also displayed on the unit, with clear steps for staff to follow in the event of this happening.
- At the previous CQC inspection in 2015, we found patients did not have access to call bells. At this inspection we noted the service had taken appropriate action. We saw that all patients had access to call bells, so they could alert staff if they were feeling unwell or required assistance. Patients we spoke with told us staff responded to them promptly.
- Staff told us they had carried out a simulation of a patient collapse in the bathroom and because of this they removed a bed from the two bedded room.

Nurse staffing

- **The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- There were two substantive registered nurses (1.8 whole time equivalent) for the unit and one full time vacancy which had been advertised but had not been filled. Staff told us it was rare to have more than two patients in the unit at any time and there was normally one qualified nurse on duty to provide care.
- On both days we visited the unit there was only one nurse on duty and one patient receiving care. Although the staff to patient ratio of one nurse to two patients was met in line with the guidelines for the provision of intensive care services, the unit was not following their own policy on nurse staffing levels. The operational policy for unit stated that there should always be two appropriately trained nurses on duty when the unit was occupied in order to relieve each other for breaks, check drugs and provide support for each other, even when only one patient was occupying the unit.
- The unit used agency staff to cover vacant shifts or if patient numbers increased. The lead nurse told us they used regular agency nursing staff some of whom had previously worked substantively on the unit. For the 12-month period from July 2018 to June 2019, monthly agency staff usage varied between 0% and 42%. The average agency usage over this period was approximately 19%.

- Demand for beds in the unit was low and inconsistent therefore nursing staff were flexible in the hours they worked.
- Qualified nursing staff from the adjacent ward provided cover for staff breaks. The lead nurse told us that staff who provided cover were all trained in intermediate life support.
- Staff handed over patients at shift changes. A verbal handover was also given to staff from the wards who covered the unit whilst staff had a break. They were qualified nurses from the adjoining wards who were trained to provide intermediate life support in the event of an emergency.

Medical staffing

- The unit had dedicated critical care consultant support on an advisory basis for two days per month.
- The unit had 24 hours, seven days a week onsite cover from a team of associate specialist and specialty doctors and intensivist anaesthetists and consultants. The unit operated a duty rota for on call consultant intensivist cover. An intensivist is a physician who specialises in the care of critically ill patients.
- The hospital also provided an onsite specialist surgical resident medical officer (RMO) to support patients 24 hours a day, seven days a week. If any level two patients were on the unit, a critical care RMO with advanced life skills and advanced airway management would provide medical cover for the unit.
- Level one patients remained under the care of their admitting consultant.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- The hospital used paper records for recording patients care and treatment. We reviewed eight sets of records and found that overall, they were of a good standard. Risk assessments and evidence of assessment of fluid state and indwelling lines were correctly documented. The records we looked at were completed with legible daily entries and reviews of patient treatment and care. However, we found that not all entries were signed and dated in three out of the eight sets of notes.
- The decision to admit patients to the unit was made at the multidisciplinary meeting prior to admission. This was clearly documented in patient records.
- We also reviewed eight prescription charts and found they were legible with all prescriptions signed and dated. A reason was documented for all omitted doses and venous thromboembolic event (VTE) prophylaxis was prescribed were indicated. However, we found that allergies were not documented on three of eight charts we reviewed.
- Paper records were stored securely in the unit office apart from the observation charts which were kept next to the patient's bed. When records were no longer required, they were sent to medical records for storage.
- The hospital carried out regular audits of compliance with the completion records. An audit carried out in May 2019 showed that overall compliance was 92.5%.
- If it was necessary to transfer a patient from the unit to the acute trust, the unit would supply copies of all nursing and medical records including diagnostic results, relating to the patient at the point of transfer or up a maximum of 24-hours following transfer.

Medicines

- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- At the previous CQC inspection in 2015, we had some concerns about the safe management of controlled drugs. At this inspection we found that although controlled drug stock books were safely locked away, there were still some issues with the recording of daily stock checks and administration. From 1 March 2019 to 23 July 2019 we found three gaps in daily stock checks and four episodes of controlled drugs being administered but not countersigned by a second checker. This was not in line with the hospital policy which stated that all preparation, administration and destruction must be witnessed by a second competent practitioner. We also found that staff were recording stock checks on blank sheets at the back of the stock book with no headings as the headed sheets had run out in 2016. One nurse we spoke with told us there was often only one nurse on the unit and sometimes it was difficult to get another qualified nurse to countersign the book.

Requires improvement

Critical care

- The pharmacy department carried out a quarterly audit of controlled drugs in all clinical areas. We looked at the results of an audit which was completed on the unit in April 2019. The audit looked at the last five pages of the controlled drugs stock book. The box in the audit tool was ticked to show that the pages in register were correctly headed and that entries correctly were completed in the register with two signatures. It did not identify the issues we found during the inspection.
- All medicines we checked were in date and stored correctly, however, we found that staff had not recorded the date of opening for two oral solutions of controlled drugs and one other oral medicine.
- For further details about medicines please see the Safe section in the surgery report.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.**
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The unit reported no incidents classified as never events.
- Staff we spoke with knew how to report incidents on the electronic system. Staff told us that if they reported an incident, they received an acknowledgement and feedback. Incidents were discussed at the critical care meetings and the daily communication cell meeting to share any learning and prevent a reoccurrence.
- We reviewed an investigation report for a patient who had been transferred from the unit to the acute hospital. The incident was thoroughly investigated and showed no lapses in care. The report concluded that staff had staff responded appropriately and in line with the hospitals policies and procedures.
- Effective arrangements were in place to respond to relevant external safety alerts. We saw this was a standing agenda item at team meetings. Safety alerts were also included in the clinical governance, quality and risk bulletin which was circulated to staff. We saw the bulletin was displayed on notice boards in the unit.
- Staff understood the principles of duty of candour, being open and honest and told us that if they made a mistake, they would inform the patient and then report it as an incident.
- For further details about incidents please see the Safe section in the surgery report.

Are critical care services effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice.**
- Staff worked to national polices for the BMI group. National policies were stored on the intranet which staff were able to access easily.At the previous CQC inspection in 2015, we found not all policies were in date. At this inspection we reviewed five polices on the intranet and found these were all within their review date. However, we saw a paper copy of the critical care unit operational policy on the unit noticeboard which was overdue for review (March 2019). Staff told us this was currently being reviewed and updated.
- Polices, protocols and pathways were based on national guidance, such as the National Institute for Health and Care Excellence, the Intensive Care Society and the Faculty of Intensive Care Medicine.
- Staff were informed about the latest NICE guidance via the clinical governance, quality and risk bulletin. We saw a copy of the bulletin displayed on notice boards in the unit.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- Staff used a nationally recognised screening tool to identify patients at risk of malnutrition. We saw this was completed in the notes we reviewed.
- We saw staff offering patients food and drink and recording fluid balance charts appropriately.

- Patient we spoke with told us that they were happy with the food they had been offered and always had access to plenty of drinks.
- A dietician was available to advise patients following weight loss surgery. Some patients were referred to the community dietetics service to be followed up at home.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**
- Post-operative pain relief was prescribed for patients by the consultant or the anaesthetist. The resident medical officer was also available if additional or alternative pain relief was required.
- At the previous CQC inspection in 2015, pain scores were not routinely recorded in the unit. This time we saw that staff recorded patients' pain scores and used them to administer appropriate pain relief medication.
- Clinical staff were required to undertake pain assessment as part of their mandatory training.
- Patients we spoke with told us their pain was well managed and staff responded quickly to requests for pain relief.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- The hospital had a regular clinical audit programme which included handwashing, venous thromboembolic event (VTE), surgical safety (WHO) compliance and controlled drugs.
- Staff working on the unit were involved with the audit process and we saw evidence that outcomes of audits and action plans were shared with staff at unit meetings and in team briefs.
- The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC). Data submitted for the period April 2018 to September 2018 showed good results. The hospital was better than expected in five of the seven indicators which they were eligible to complete and better than the similar comparator group in six of the seven indicators.

Competent staff

- **The service made sure staff were competent for their roles.**
- The unit had a dedicated lead nurse in line with standards for intensive care units.
- Staff we spoke with had completed their annual appraisal and told us they found it useful.
- Information provided by the hospital showed that the proportion of staff on track to have appraisals completed within the year (October to October) was 85.8% for contracted staff and 81.8% for bank staff.
- Staff on the unit told us that new bank or agency staff would receive an induction to the unit. The hospital had a standard induction check list for agency or bank staff which included health and safety, orientation, polices and mandatory training. Not all staff on the unit were aware of the checklist and told us they normally used regular agency staff who were already familiar with working on the unit. The service provided evidence of completed induction checklists for two agency staff.
- The lead nurse told us that all agency staff were trained and qualified to care for level three patients and their ongoing training and mandatory training was provided by the agency. Some agency staff already worked for a neighbouring acute trust in the intensive care unit. We saw evidence of their qualifications in critical care.
- Staff on the unit were able to carry out blood gas analysis at the patient's bedside. Staff had undergone specific training to do this. We saw evidence of completed training competencies and ongoing refresher training. We also saw evidence that staff had additional training and competencies in cannulation and venepuncture.
- The lead nurse for the unit told us there was an agreement between BMI and the local NHS acute trust for staff to work on the intensive care unit providing care for level three patients. This was to ensure staff updated and refreshed their skills.

- Physiotherapy staff told us they had regular supervision which included peer and group supervision. They had opportunities for learning which included access to training on the BMI Intranet and they also planned in house training.
- One registered nurse from the unit was involved with providing teaching sessions on basic life support and care and communication of the deteriorating patient.
- We saw evidence that one nurse had completed a national competency framework for registered nurses in adult critical care.

Multidisciplinary working

- **Professionals worked together as a team to benefit patients.**
- Staff worked well with each other to provide patient care. Staff told us working relationships were good between the nursing, medical and therapy staff.
- A multidisciplinary meeting was held on the unit every Wednesday to discuss current patients and planned admissions to the unit.
- Physiotherapy staff visited the unit to assist patients to mobilise following surgery. They also provided chest management if needed.
- We saw evidence of input from the multidisciplinary team written in patient records.

Seven-day services

- **The service worked flexibly to support timely patient care.**
- The unit could provide a 24-hour service, seven days a week. However, most admissions to the unit were planned and staff told us it was rare for the unit to be open at weekends as patients were normally ready to be discharged home before then.
- Patients were reviewed post operatively by the consultant and the anaesthetist and were seen daily by the consultant until they were discharged. The resident medical officer was available 24 hours a day, seven days a week.
- Physiotherapy staff provided an on-call service out of hours for chest management.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Patients' health education needs were assessed as part of the surgical pathway. This included assessment and advice on diet, exercise, stress, management of heart disease and self-care. An alcohol assessment was also completed which prompted staff to carry out a more in-depth assessment if a patient scored two or above.
- Health promotion information on well-being and lifestyle was available on the hospital website on several topics. For example, there was information on the top seven warning signs of diabetes and healthy heart recipes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005. Staff were able to describe the decision-making processes if they were caring for a patient who did not have capacity, for example, if they were hypoxic.
- Staff received consent training as part of their mandatory training requirements. Mental capacity and deprivation of liberty training were covered within the organisation's safeguarding training.
- We saw that staff gained consent from patients for their care and treatment in line with legislation and guidance. Verbal consent was obtained from patients prior to carrying out an intervention.

Are critical care services caring?

Good

We rated caring as **good.**

Requires improvement

Critical care

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We found staff to be focused on the care and needs of patients.
- Staff introduced themselves to patients and we saw they established a good rapport with them.
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- We spoke with two patients whilst on the unit and interviewed four patients following their discharge from the unit. All patients we spoke with said staff treated them well and with kindness. They told us that staff maintained their dignity and treated them with respect.
- The hospital participated in the friends and family test. We saw questionnaires displayed in all areas of the hospital. Overall hospital results for months October 2018 to March 2019 inclusive were 98% and 99% (response rate between 17% and 38%)
- We saw a member of staff checking with a patient that they were comfortable when using a nebuliser.
- Staff followed policy to keep patient care and treatment confidential.
- Chaperones were available for patients if required and if requested by staff. We saw a male nurse acting as a chaperone for a female patient during an examination by the registered medical officer. Staff said they offered patients the choice between a male or female chaperone.
- Staff ensured that patients had access to call bells and responded to them quickly.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- We saw that patients' emotional, cultural, social, and spiritual needs were an integral part of their assessment and care plan.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.
- One patient told us that they had trouble sleeping and the nurse on duty had been very attentive and had spent a long time sitting and talking with her which they found comforting.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Patients felt well informed and involved in decisions about their care. Staff talked with patients, families and carers in a way they could understand.
- Patients told us that staff had been very accommodating in letting their loved ones visit them especially if they worked unsociable hours.
- New patients to the unit were given a 'guide to your stay' booklet.
- Patients told us they received enough information prior to being discharged home. Some patients said they had received a follow up phone call from staff a few days after they returned home to ask if they had any questions or queries.
- Patients and their families could give feedback on the service and their treatment, and staff supported them to do this.

Are critical care services responsive?

Good

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

Service delivery to meet the needs of local people

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

Requires improvement

Critical care

- The hospital worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.
- A screening process was in place pre admission for patients with complex needs to minimise the risk of these patients being treated at the hospital. Staff gave us examples of how they may support patients with additional needs, for example those people living with dementiaor learning difficulties although this was rare.
- The service worked closely with local NHS hospitals and other BMI hospitals in the area.There was an agreement in place with the local trust to ensure patients requiring a higher level of care could be transferred to an intensive care unit.
- All admissions were planned which allowed patients needing high dependency care post operatively to be identified. Staff in the unit worked flexibly to meet the demands of the service.
- There was a restaurant on site which relatives could use if they needed something to eat and drink.

Meeting people's individual needs

- **The service took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services.**
- BMI Thornbury had a dementia strategy for 2019 to 2021 which clearly set out how they would review and monitor progress relating to safety, experience, and effectiveness of dementia care provision. However, on inspection staff told us they did not routinely treat patients with dementia at the hospital. Staff said that one to one care would be arranged a patient if needed, for example, if they had delirium.
- The front cover of patient folders had symbols with a tick box next to them to alert staff to patients' individual needs. For example, there was symbol for dementia and one for mental health, however, not all staff we spoke with knew what the symbols represented.
- Translators were available to attend appointments with patients, and staff knew the importance of making sure these services were offered and not relying on family members to act as translators.Staff told us they could request a British sign language interpreter for hearing impaired patients.
- Staff told us letters could be produced in a range of community languages on request and information leaflets were available in large print for visually impaired patients.
- Staff had previously cared for a patient with a learning disability on the unit and had made provision for the carers to stay overnight at the hospital.
- Patients having weight loss surgery were routinely admitted to critical care high dependency unit (HDU) post operatively. The unit had suitable equipment to accommodate bariatric patients.
- All rooms had a television and patients were supplied with a list of programs and channels they could access.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Admission to the unit was normally planned for patients undergoing elective surgery. Patients were identified at pre-assessment and those having bariatric surgery or with sleep apnoea were routinely admitted to the unit.
- Between 1 April 2018 and 31 March 2019, a total of 164 patients had been received in the critical care high dependency unit (HDU). Of these, 152 were planned and 14 were unplanned. There were no readmissions within this time. One patient had been transferred out to the acute hospital during this period (April 2018) due to a deteioration in their condition.
- Staffing levels were planned around surgical lists and staff worked flexibly to ensure enough the unit was staffed when needed. Additional agency staff could be arranged at short notice if needed.
- Information provided by the hospital showed that bed occupancy in the unit was low. Between December 2017 to November 2018, bed occupancy rates were between 0% and 20%.

Requires improvement

Critical care

- Most patients were discharged home directly from the unit. If a patient needed an extended stay in hospital but no longer required level one or two care, they would be de-classified and moved to the general ward.
- Staff were not aware of any cancellations due to the unavailability of critical care beds.

Learning from complaints and concerns

- **People were able to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- We discussed complaints with staff. They told us formal written complaints were uncommon. When patients had complaints, staff told us they would try to resolve them at the time and would involve someone more senior if necessary.
- We did not see any information clearly displayed to inform patients and relatives how to complaint. A 'please tell us' leaflet was available in waiting areas which contained some information on how to make a formal complaint. None of the patients we spoke to had felt that they needed to make a formal complaint about their care.
- The hospital set a target of five days to acknowledge a complaint and 20 days to respond. We looked at six complaint files during the inspection and saw that all were acknowledged within the correct time scales and five out of six responses were sent within the target of 20 days. Response letters were thorough and included what action the hospital had taken as a result of the complaint.
- Staff told us that any complaints about the service would be discussed at the team meetings.
- For further details about learning from complaints and concerns, please see the Responsive section in the surgery report.

Are critical care services well-led?

Requires improvement

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

Leadership

- **Leaders had the skills and abilities to run the service.**
- A clinical service manager was responsible for the overall management of the ward including the beds on the critical care high dependency unit (HDU). The was a lead nurse for the unit who had been in post since October 2018.
- The unit had dedicated critical care consultant support on an advisory basis for two days per month.
- Staff spoke highly of the executive director and told us he was visible, approachable and enthusiastic and had made some positive changes in the hospital.
- For further details about leadership, please see the Well-led section in the surgery report.

Vision and strategy

- The service did not have a vision for what it wanted to achieve and plans to achieve it.
- The unit did not have its own mission statement or vision and strategy. Staff told us they worked to the vision and strategy of BMI Thornbury Hospital
- The BMI hospital's vision was displayed on notice boards around the hospital including patient waiting areas; 'Our vision is to offer the best patient experience in the most effective way, from our comprehensive UK networks of acute care hospitals'.
- Staff we spoke with were familiar with the vision and values of the hospital and they related to their role. Staff said the hospital values formed part of their appraisal.
- The operational policy for the critical care unit stated that the service aimed to provide the highest possible standard of care for level one and level two post-operative patients, until they were assessed as medically fit to return to the ward.
- For further details about vision and strategy please see the Well-led section in the surgery report.

Culture

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

Requires improvement

Critical care

- Staff working on the critical care unit said they were well supported by staff on the surgical ward and there were good relationships between members of the multidisciplinary team.
- Staff told us that the culture had recently improved, and this was due to changes in the senior leadership, particularly the executive director, who they said was visible, approachable and enthusiastic.
- We found staff were patient centred and had time to provide good care to patients, often on a one to one basis.
- Staff felt able to raise concerns without fear of retribution. However, not all staff were aware of the local policy for raising concerns at work, the freedom to speak up guardian or local freedom to speak up champions.

Governance

- **Leaders operated governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, not all policies were in date or being adhered to.**
- The operational policy for the critical care unit was out of date and the policy was not being followed by the service for nurse staffing levels and for the use of the national early warning scores. Staff were also not following the medicines policy for the administration of controlled drugs.
- A daily 'communication cell' meeting was held each morning at the hospital. This was attended by a representative from each team. Key messages, staffing issues, patient risks, incidents and issues were discussed at these meetings.
- Critical care committee meetings were held monthly. The meeting was chaired by the critical care advisor consultant and attend by staff from the unit, the clinical support manager, lead recovery practitioners, resuscitation leads for adults and children and a quality and risk manager. We saw that incidents, policies and audits were standard agenda items and that actions from the meetings were recorded and followed up. Any member of staff not able to attend the meeting would be given a copy of the minutes.
- Monthly clinical governance reports covered areas such as patient feedback, incidents, staffing and staff training. Audit results were also included in the report with action plans to further improve audit results. However, we were concerned that the controlled drugs audits had not identified the issues we found which offered no assurance to managers.
- The hospital benchmarked their results on patient outcomes with other locations within the region and across BMI Healthcare through the corporate clinical dashboard.
- For further details about governance please see the Well-led section in the surgery report.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance. However, they did not identify and escalate relevant risks and issues or identify actions to reduce their impact.**
- The hospital operated a hospital risk register which was regularly reviewed and updated to ensure risks were monitored and appropriately managed. Heads of department managed departmental risk registers which fed into the hospital risk register. Performance and risk management was discussed through the committee meeting structure, including monthly heads of department, clinical governance, health and safety and the medical advisory committees.
- Staff working on the unit told us that risks were discussed at governance meetings, but they did not have a separate risk register for the unit. Staff said that risks would be escalated onto the hospital register. However, staff had not identified the risks we found on inspection and there were no current risks specific to the unit on the hospital risk register. We saw that risks to the service were not discussed at the critical care committee meetings.
- Staff had completed risk assessments for activities taking place within the unit. This included twelve risk

areas such as manual handling, sharps/needle stick injuries, medical gases. We saw that actions to mitigate and reduce the risk to staff and patients were documented.

- For further details about managing risks, issues and performance please see the Well-led section in the surgery report.

Managing information

- **The service did not always collect reliable data and analyse it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.**
- The service had systems in place to collect information about performance and share it with staff, for example, data on incidents, audits and admissions. However, we found that the data collected in the controlled drugs audit was unreliable.
- Information governance policies and procedures were in place to ensure that information was stored securely, and patient and confidentiality was maintained.
- We saw that patient records stored securely and computers where locked to prevent unauthorised access to confidential data.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services.**
- The service used friends and family feedback to evaluate the service. In addition to this staff encouraged patients to complete a patient satisfaction survey. We saw surveys and collection boxes throughout the hospital and patients could also return them by pre-paid post. The surveys were analysed by an independent third party and the results were communicated back to the hospital monthly for learning and action.
- The hospital conducted an annual staff survey (BMI say) to monitor staff feedback and satisfaction. Following completion of the survey an action plan was drawn up to address areas of concern. The results of the patient satisfaction survey were shared with staff.
- Staff told us they were consulted on changes and plans to improve and develop the hospital.
- A monthly communication message was sent by the executive director to all staff within the hospital to keep them up to date with recent information and changes. We saw that positive feedback was given to staff both individual members of staff and to the whole group of hospital staff.

Learning, continuous improvement and innovation

- **Staff were committed to continually learning and improving services.**
- The lead nurse for the unit had implemented some changes and improvements since joining the hospital. For example, there were plans to introduce grab bags for use during invasive line insertions for the unit and the surgical ward.
- Staff on the unit were involved in providing training and support to staff in the hospital. One member of staff provided training on the deteriorating patient module.
- Staff told us they were always keeping up to date with new products available for patient care and they had introduced some to the unit.

Good

Services for children & young people

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

Are services for children & young people safe?

Good

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

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The mandatory training provided to staff was comprehensive and met the needs of both patients and staff. Mandatory training included paediatric life support, care of the deteriorating patient, infection prevention and control, and manual handling.
- Mandatory training was not provided to make staff aware of potential needs of people with mental health conditions, autism or learning difficulties. Staff told us that they received this training in their substantive NHS posts as all ward staff were employed on zero hours contracts. Ward staff were unable to give examples of patients with these conditions being treated at the location. The provider ensured that all staff employed on zero hours contracts also completed the BMI hospitals induction package.
- We spoke to staff who told us that they were up to date with all mandatory training. Mandatory training was completed online and with classroom based sessions.
- During inspection we saw training compliance data which showed that 96% of all staff had completed their mandatory training.
- We saw that there was a policy for sepsis management and staff were aware of it.
- All staff completed a structured induction programme prior to employment.

Safeguarding

- **Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- There was a safeguarding policy for both adults and children.
- The director of clinical services was the safeguarding lead for the hospital and was trained to safeguarding children and safeguarding vulnerable adults' level four.
- All staff within the children and young people service had completed children's safeguarding training level three. The majority of staff worked at the local NHS children's hospital and provided the hospital with evidence to demonstrate compliance. Level three training for bank and agency staff was delivered online, via an e-learning package and therefore did not meet guidance recommended by the Royal Collage of Paediatrics and Child Health intercollegiate guidance. The safeguarding lead for the hospital informed us that they planned to introduce 'train the trainer' safeguarding workshops to mitigate this risk and deliver face-to-face training in future.
- All staff would report any safeguarding concerns to the safeguarding lead.

Good

Services for children & young people

- The safeguarding lead attended regional safeguarding meetings and would feedback to staff with any safeguarding issues, learning from incidents and any training opportunities.
- We saw safeguarding flow charts on display in staff areas to assist staff in the required process to follow if any concerns were raised.
- Staff were aware of issues surrounding child and sexual exploitation (CSE) and female genital mutilation (FGM).
- There were no examples of safeguarding referrals being made by the children and young people service.
- Any child protection issues were documented within the patient notes.
- Chaperones were available if required.
- There was a designated children and young people ward which was secured through swipe card access and CCTV.
- Staff were able to support a patient with mental health needs and would be assessed at pre-assessment appointments and if the service was unable to support the level of patient need, arrangements would be made for them to be seen at the local NHS trust.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- All clinical areas were clean and had suitable furnishings which were clean and well-maintained.
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.
- Staff followed infection control principles including the use of personal protective equipment (PPE). All staff adhered to the bare below elbow (BBE) policy.
- We saw results from hand hygiene audits which showed 95% compliance over the preceding six months.
- Appropriate facilities were available for staff and visitors to clean their hands, including hand wash basins and hand gel dispensers.
- For further details about cleanliness, infection control and hygiene in theatres, please see the Safe section in the surgery report.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- At the previous CQC inspection in 2015, we found that paediatric resuscitation equipment was not stored appropriately and was not immediately accessible to all staff. At this inspection we found all paediatric resuscitation equipment was stored appropriately and was easily accessible.
- Ward staff carried out daily safety checks of specialist equipment. The paediatric resuscitation trolley was housed on the children's ward and moved to the outpatient's department if there were any children's appointments. These appointments were scheduled for when there was no ward based activity. We saw completed checklists for the paediatric resuscitation trolley. We did note that there were dates when the trolley had not been checked, these dates corresponded to the resuscitation trolley being used in the outpatient's department.
- There was a dedicated recovery area that was separated from the adult area.
- The environment was safe for the age of patients. There were safety precautions on all windows and access to areas such as the kitchen were beyond locked doors which required swipe card access.
- Within the outpatient department the service had suitable facilities to meet the needs of patients and their families. We saw that daily environmental risk assessments had been completed, which included windows having restricted openings and sharps bins attached to walls out of the reach of children.
- For further details about environment and equipment in theatres, please see the Safe section in the surgery report.

Assessing and responding to patient risk

Good

Services for children & young people

- **Staff removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.**
- At the last inspection we found that comprehensive risk assessments were not completed. At this inspection we found all children and young people were pre assessed prior to treatment. If any concerns were raised they were reviewed by the consultant and anaesthetist. Any children that had pre-existing conditions or deemed to be high risk would not be accepted for surgery/ procedures.
- All procedures were undertaken by specialist paediatric consultants, supported by trained paediatric nurses.
- At the previous CQC inspection in 2015, we found that the hospital did not maintain comprehensive documentation in relation to early warning scores and risk assessments. At this inspection, we saw that the ward used a paediatric early warning system (PEWS) to identify the deteriorating patient. We noted that PEWS was audited monthly and results were consistently 100% compliant.
- There was a deteriorating patient policy in place which included the use of a specialist paediatric retrieval team for the transfer of a patient who required urgent critical care. There were no examples of this being required.
- There was always a member of staff on duty who was qualified in advanced paediatric life support. This was provided by either ward staff or through the resident medical officer.
- We saw the sepsis care bundle was in place for the management of patients with presumed or confirmed sepsis. There was clear information on the recognition and treatment of sepsis and all staff were able to describe how it was used on the ward.
- For further details about assessing and responding to patient risk, please see the Safe section in the surgery report.

Nurse staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- At the previous CQC inspection in 2015, we found that not all theatre staff involved in the care and treatment of children and young people had received child-specific training. At this inspection, we found there was always a children's nurse in the post anaesthetic care unit.
- At the previous CQC inspection in 2015 we found that there were occasions were a children's nurse would not be on site when children attended outpatients' appointments. We were told during inspection that a children's nurse is always on site when children have appointments. The lead children's nurse told us that she participated in appointment planning to ensure that she was on site for outpatient's appointments and we saw evidence online which demonstrated this.
- Staffing on the ward was always a minimum of two registered children's nurses at all times. Ward capacity would not exceed six patients per shift.
- There was always one registered children's nurse on duty per shift with either advanced paediatric life support or European paediatric life support training.
- The lead nurse had a substantive contract, all other nursing staff were specialist nurses on zero hour contracts who held substantive contracts at the local NHS children's hospital. All training that had been undertaken in their substantive contracts was evidenced on completion and documented by the lead nurse. We saw examples of this when reviewing staff files.

Medical staffing

- All procedures were undertaken by specialist paediatric consultants .
- There was a specialist paediatric radiologist available when required.
- For further details about medical staffing please see the Safe section in the surgery report.

Records

- At the previous CQC inspection in 2015, we found that the hospital did not maintain comprehensive records and complete all sections. At this inspection we found staff completed individualised care records which included nursing and medical notes, consent, early warning scores, risk assessments and safety checklists. We reviewed five sets of notes during inspection and found that all were completed fully.

Good

Services for children & young people

- We reviewed audit data concerning records for the preceding six months which demonstrated 99% record compliance.
- Any child protection issues would be highlighted within the patient notes and all staff knew where to access this information.
- For further details about records please see the Safe section in the surgery report.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- At the previous CQC inspection in 2015, we found that not all staff adhered to the hospital policy for the administration of controlled drugs. At this inspection we checked controlled drug registers and stocks on wards and theatres and found these were checked in line with the policy; and no discrepancies were observed.
- We saw allergy status recorded in all patient notes that we reviewed.
- We saw patient's weight being documented in all patient notes that we reviewed.
- For further details about medicines please see the Safe section in the surgery report.

Incidents

- **The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**
- There had been no never events reported in the children and young people services. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- No safeguarding incidents had been reported within the children and young people service.
- Incidents were discussed at start of each shift and relevant information was cascaded down to staff. Any learning from incidents that had taken place at other BMI hospitals was shared with staff.
- Staff knew what incidents to report and how to report them.
- For further details about incidents please see the Safe section in the surgery report.

Are services for children & young people effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance and had child-specific pathways in place.
- Sepsis screening was completed effectively in line with national guidance. We saw evidence of this within the patient notes that we reviewed.
- For further details about evidence-based care and treatment please see the Effective section in the surgery report.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for children, young people and their families' religious, cultural and other needs.**
- Staff made sure children, young people and their families had enough to eat and drink.
- We saw that age appropriate nutrition was provided.
- We saw that dietary requirements, food allergies and intolerances were recorded.
- Specialist dieticians were available if required.

Pain relief

Good

Services for children & young people

- **Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way.**
- Staff assessed children and young peoples' pain using a recognised tool and gave pain relief in line with individual needs and best practice.
- We saw patients being asked if they were in pain but no examples of pain relief being required.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.**
- Although there was a comprehensive internal clinical audit, the service did not routinely complete audits for children and young people. The service did monitor outcomes and these were followed up by consultants in clinic. Managers explained this was due to the low levels of activity. This information was included within the wider audit programme.
- For further details about patient outcomes please see the Effective section in the surgery report.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families.
- Managers gave all new staff a full induction tailored to their role before they started work.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.
- Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.
- For further details about competent staff please see the Effective section in the surgery report.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.**
- The senior children's nurse was available on call when children were being seen or treated.
- The ward had links with the local children's hospital to access specialist paediatric advice if required.
- For further details about multidisciplinary working please see the Effective section in the surgery report.

Seven-day services

- The children and young people service only operated on two days per calendar month.
- For further details about seven-day services please see the Effective section in the surgery report.

Health promotion

- **Staff gave children, young people and their families practical support and advice to lead healthier lives.**
- The service had relevant information promoting healthy lifestyles, we saw health promotion information on the ward.
- Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle.
- We observed staff giving health promotion advice to patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported children, young people and their families to make informed decisions about their care and treatment.**
- Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.
- Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance.

Good

Services for children & young people

- Staff made sure children, young people and their families consented to treatment based on all the information available.
- Staff clearly recorded consent in the children and young peoples' records. We saw no omissions in the records we reviewed.
- Staff understood Gillick competence and Fraser guidelines and supported children who wished to make decisions about their treatment.
- We saw examples of young people being supported to consent to treatment.
- We saw an example of staff taking into account differing wishes, cultures and traditions.

Are services for children & young people caring?

Good

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

Compassionate care

- **Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way.
- Children, young people and their families said staff treated them well and with kindness.
- Staff followed policy to keep care and treatment confidential.

Emotional support

- **Staff provided emotional support to children, young people and their families to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's, wellbeing.

Understanding and involvement of patients and those close to them

- **Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.**
- Staff made sure children, young people and their families understood their care and treatment.
- Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. We saw communication aids on the ward and staff were able to use them effectively.
- Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. There was a separate friends and family test survey specifically for children, young people and their families.
- A high proportion of children, young people and their families gave positive feedback about the service in the friends and family test survey.
- Staff supported children, young people and their families to make informed decisions about their care.

Are services for children & young people responsive?

Good

Responsive services are organised so that they meet your needs.

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

Service delivery to meet the needs of local people

Good

Services for children & young people

- Facilities and premises were appropriate for the services being delivered. Since the last CQC inspection in 2015 a dedicated children's inpatient area with six beds which allowed for care to be given in individual rooms had been created.
- There was a dedicated children's bed space in the post anaesthetic care unit which was screened off from adult bed spaces.
- The service had worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the children and young people.
- Within the outpatient department there was not a separate waiting area for children attending clinics and there were minimal toys available in the department.
- For further details about service delivery to meet the needs of local people please see the Responsive section in the surgery report.

Meeting people's individual needs

- **The service was inclusive and took account of children, young people and their family's individual needs and preferences.**
- The ward was designed to meet the needs of children, young people and their families. There was a dedicated playroom in the designated children's inpatient area..
- Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss.
- Managers made sure staff, children, young people and their families could get help from interpreters when needed.
- Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. We saw menus which addressed cultural and religious preferences.
- Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. We saw that communication aids on the ward which staff were confident in using.

Access and flow

- **People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.**
- Surgical lists were prioritised so that the youngest patient was first. We saw this documented within the children and young people service plan and we observed it in practice during inspection.
- In the reporting period March 2018 to February 2019, 12.7% of all outpatient appointments related to children and young people.
- Managers monitored and took action to minimise missed appointments.
- Managers ensured that children, young people and their families who did not attend appointments were contacted.
- For further details about access and flow please see the Responsive section in the surgery report.

Learning from complaints and concerns

- **People were able to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.**
- No complaints had been received that referenced the children and young people service.
- Children, young people and their families we spoke with knew how to complain or raise concerns if they needed to.
- The service provided information about how to raise a concern or make a complaint, however, this information was not clearly displayed in communal patient areas. Information about how to complain and details of the complaints process was documented in patient guides, and were provided in patient rooms.
- Staff understood the policy on complaints and knew how to handle them.

Good

Services for children & young people

- Staff knew how to acknowledge complaints. The complaints policy was that children, young people and their families would receive feedback from managers after the investigation into their complaint.
- Managers shared feedback from complaints from the wider hospital group with staff and learning was used to improve the service.

Are services for children & young people well-led?

Good

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

Leadership

- **Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- Staff we spoke with spoke positively about their leaders. Staff felt the senior leaders in the hospital were visible and approachable. They spoke positively about the new executive director and said all managers had an 'open door' policy.
- Since the previous CQC inspection in 2015, following the concerns we raised with the service, a permanent paediatric lead nurse was employed to lead the service. All staff spoke positively about the work that had been undertaken and the improvements in the service.
- For further details about leadership please see the Well-led section in the surgery report.

Vision and strategy

- **The hospital had a vision for what it wanted to achieve and a strategy to turn it into action.**
- BMI Healthcare had a corporate five-year vision 2015-2020, which was to be achieved through eight strategic objectives.
- The hospital had strategic objectives which aligned with the corporate strategic objectives.
- Staff had been involved in forums, where they could put forward their ideas for the hospital vision and values.
- There was no additional vision or strategy specific to the children and young people service.
- For further details about vision and strategy please see the Well-led section in the surgery report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- All staff we spoke with described a positive culture and that they worked well as a team.
- Staff felt able to speak up and described an open culture.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations**.
- Daily communication cell meetings took place. A representative from each area of the hospital attended and key messages would be fed back to staff in the department.
- Communication cell information boards were present in each area. These contained relevant information, such as incident feedback, risk registers and key messages.
- There was a clear governance framework in place, including heads of department meetings, clinical governance committee meetings and medical advisory committee meetings.
- There was a specific children and young people committee meeting. Consultants and anaesthetists worked at the local NHS children's hospital and shared any new practice or changes within this forum. The senior children's nurse also met regularly with BMI

healthcare colleagues and shared, updated and implemented any changes to practice through this meeting. For further details about governance please see the Well-led section in the surgery report.

Managing risks, issues and performance

- There was a hospital risk register, which did not have any specific risks pertaining to the children and young people service.
- Steering group meetings were held across the BMI hospitals for staff to share current practice and skills. Information was shared and quality of work was reviewed and monitored.
- For further details about on managing risks, issues and performance please see the well-led section in the surgery report.

Managing information

- Staff completed information governance training as part of their mandatory training.
- All computerised records were password protected. All paper based notes were stored securely.
- For further details about managing information please see the well-led section in the surgery report.

Engagement

- Staff meetings were held once a month. The meeting minutes were held electronically, and all staff could view them.
- Staff told us there were emails and newsletters sent from the executive director. Staff we spoke with found these beneficial and informative.
- Staff we spoke with told us that communication had improved in the last three years.
- The hospital participated in the friends and family test (FTT) to gain feedback from patients.
- Staff completed an annual staff survey.
- For further details about engagement please see the well-led section in the surgery report.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**
- For further details about learning, continuous improvement and innovation please see the well-led section in the surgery report.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

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

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The mandatory training was comprehensive and met the needs of patients and staff. Awareness of mental health, disabilities and autism was included in the safeguarding training.
- Staff we spoke with during our inspection were up to date with their mandatory training. Staff told us that mandatory training was completed online and face to face. Time was given back to staff if they completed training in their own time.
- During our inspection we saw training compliance data, which showed that 88% of staff in outpatients had completed their mandatory training.
- For further details about mandatory training please see the Safe section in the surgery report.

Safeguarding

- **Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- All staff had completed safeguarding adults and children training.
- We saw safeguarding information, including female genital mutilation (FGM) information, displayed on the wall in the nurse's office. Safeguarding adults and children flow charts were available to assist staff in the process to follow if they had concerns.
- Staff told us they would report any safeguarding concerns to the safeguarding lead.
- Staff gave us an example of when they had concerns about domestic abuse and this had been appropriately escalated to the safeguarding lead.
- For further details about safeguarding please see the Safe section in the surgery report.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- All clinical areas were clean and had suitable furnishings which were clean and well-maintained.
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.
- Staff followed infection control principles including the use of personal protective equipment (PPE).
- Staff cleaned equipment after patient contact. We saw some equipment in the dirty utility room had labels indicating cleaning had taken place.

- Appropriate facilities were available for staff and visitors to clean their hands, including hand wash basins and hand gel dispensers.
- We saw results from a hand hygiene audit undertaken in March 2019, these showed 100% compliance for staff in outpatients.
- A standard operating procedure (SOP) was in place for the cleaning and disinfecting of nasendoscopes. During our inspection, we saw that an out of date paper copy of this SOP was held, along with an up to date electronic version. We raised this with staff at the time of our inspection and they took immediate steps to remove the out of date paper copy.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- Staff carried out daily safety checks of specialist equipment. We saw completed checklists for adult and paediatric resuscitation trolleys. However, for the paediatric trolley we saw that daily checks had been missed on seven dates in June 2019 and the weekly check had not been carried out consistently, weekly checks had only been completed twice in June 2019.
- The service had suitable facilities to meet the needs of patients and their families. We saw that daily environmental risk assessments had been completed, which included windows having restricted openings and sharps bins attached to walls out of the reach of children.
- The service had enough suitable equipment to help them to safely care for patients. We saw equipment had up to date electrical testing. Whilst on inspection, we observed some equipment had stickers to indicate testing had taken place, whilst other equipment did not have stickers. We raised this at the time of inspection and we were assured that all equipment had been tested and a record kept. We saw that scales had been calibrated.
- Staff disposed of clinical waste safely. We saw sharps bins were not overfilled. We saw completed records to indicate weekly flushing of water supplies had taken place.
- The outpatient consulting rooms were on two floors, the main area consisted of 15 consulting rooms and there were four consulting rooms and a minor procedures room on the floor below. During our inspection, the lower consulting rooms were not in use as they were replacing the flooring.

Assessing and responding to patient risk

- **Staff identified and quickly acted upon patients at risk of deterioration**.
- Staff told us that if a patient deteriorated in the department, the emergency team would be contacted. We saw emergency contact information displayed in all areas.
- A resident medical officer (RMO) was always available in the hospital, who could support the outpatient department with unwell patients.
- Staff completed mandatory training for care of the deteriorating patient. Staff had completed basic life support training and some staff had completed intermediate life support training.
- Staff told us that when the consulting rooms were in use downstairs there was no member of nursing staff in that area. We were concerned that if a patient deteriorated in this area, the consultant would have to call for help before assisting the patient and they would not have access to any emergency equipment. The director of clinical services told us the consultant would call for the crash team and assistance would be provided immediately.
- Adult and paediatric resuscitation grab bags and emergency adrenaline kits were kept in the minor procedures room.

Nurse staffing

- The outpatient's department had a newly appointed sister, there had been a period of around eight weeks before this without a sister in the department.
- There were seven qualified staff, seven healthcare assistants and two phlebotomists that worked in the department. Staff told us, and we saw from rotas that each shift was normally staffed with one or two qualified members of staff and one or two health care assistants. There was normally one phlebotomist on a shift.

- Staff we spoke with told us that it sometimes felt like they needed more staff, as some shifts could be particularly busy, depending on the clinics that were booked. They also told us there were not enough staff to cover the consulting rooms downstairs when consultants were using them.
- Managers used an electronic tool to determine staffing requirements, based on activity.
- The department was open 7.30am until 9.30pm Monday to Friday and 7.30am until 1pm on two Saturdays per month. Staff worked various shift patterns to cover the service.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment**
- Several consultants held outpatient appointments at the hospital for a wide range of specialities, including orthopaedics, gynaecology, general surgery, neurosurgery, gastroenterology, urology, dermatology, neurology and cardiology.
- The hospital had a resident medical officer (RMO) who was able to provide medical cover to the outpatient department in an emergency.
- For further details about medical staffing please see the Safe section in the surgery report.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- Outpatient records were paper based. Some consultants also kept their own electronic records. Carbon copy documentation was used so that one copy was filed in the patients notes and the consultant could keep a copy. Records were kept in the department in a filing cabinet in a locked room.
- Staff told us there had been occasions when records were not available for clinics, however, this was now improving, and staff obtained records from medical records when needed. If any notes were missing these would be reported as an incident. In the last three months there had been no patients seen in clinic without the relevant medical records being available.
- We reviewed six sets of records and found them to be fully completed. We saw pre and post -operative checks had been completed and world health organisation (WHO) checklists had been completed.
- We saw an appropriately completed minor procedures register in the minor procedures room.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Medicines were kept in locked cabinets. We saw evidence of daily checks of fridge temperatures and ambient room temperatures. Staff told us they informed pharmacy if there were any deviations in temperature.
- Prescription pads were kept in a locked medicine cupboard. A prescription log was kept which indicated when prescription pads were signed out and back in again.
- There were no nurse prescribers in the department and they did not use patient group directions (PGD's), all medicines were prescribed by the consultant.
- A pharmacy audit carried out in April 2019 for prescription turnaround times, showed that the average waiting time for an outpatient prescription was 8.16 minutes. This meant that patients did not have long waits for medication to be dispensed.
- For further details about medicines please see the Safe section in the surgery report.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**
- There had been no never events reported in the outpatient's services. Never events are serious patient

safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need to have happened for an incident to be a never event.

- There had been no serious incidents reported between January 2018 and December 2018.
- Data provided by the hospital showed that there had been 90 clinical incidents between January 2018 and December 2018, however this number was combined with diagnostics.
- Staff we spoke with were aware how to report incidents on the electronic reporting system. Staff told us they received feedback from incidents from managers via email and meetings.
- Incidents were discussed at the daily communication cell meeting and relevant information was cascaded down to staff in the department.
- Staff we spoke with were aware of the principles of the duty of candour and the need to be open and honest with patients when something went wrong.

Are outpatients services effective?

We do not rate effective in outpatient services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice.**
- Staff had access to policies and procedures online. We saw that guidance was up to date. Staff told us the quality and risk manager for the hospital monitored review dates on guidance to ensure documents were reviewed in a timely manner.
- Policies and procedures were based on national evidence-based guidelines, including National Institute for Health and Care Excellence (NICE) guidance.
- The standard operating procedure for the cleaning of scopes was in line with Department of Health (DH) guidance.
- Physiotherapy staff followed Chartered Society of Physiotherapy national guidelines.

Nutrition and hydration

- Hot and cold drinks were available in the waiting areas. A restaurant was available to buy food onsite.

Pain relief

- Pain relief was not routinely administered in outpatients. Patients were encouraged to self-administer pain relief if needed.
- Prescriptions for pain relief could be given, if required, for the patient to take to pharmacy.

Patient outcomes

- The outpatient department did not specifically measure patient outcomes.
- For further details about patient outcomes please see the Effective section in the surgery report.

Competent staff

- **The service made sure staff were competent for their roles.**
- Staff received annual appraisals. Staff told us they were supported with time and funding for new courses that were relevant to their practice.
- There was an induction process in place for new starters. New staff started their mandatory training as soon as they were employed. They would shadow a staff member for around two weeks before being included in the staff numbers.
- Some of the outpatient staff were trained to undertake health screening.
- The outpatient's department had a trainee nursing associate who had been supported by BMI Healthcare to undertake the training.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.**

Good

Outpatients

- The physiotherapy team had developed a new service, joint school, which provided a multidisciplinary approach to pre-operative hip and knee joint replacement patients, providing education about the journey from pre-assessment through to discharge.
- Although there were no multidisciplinary meetings specific to the outpatient department, multidisciplinary meetings took place in the hospital to discuss the management of patients.
- Staff from different disciplines worked well together in the outpatient department, consultants working in clinic were supported by the nursing staff. We observed positive interactions between them.

Seven-day services

- **The outpatient department did not provide seven-day services but provided evening appointments and some Saturday clinics.**
- The outpatient department was open 7.30am until 9.30pm Monday to Thursday and 7.30am until 6pm on a Friday. Clinics were held from 7.30am until 1pm on two Saturdays per month.
- The physiotherapy department was open Monday to Friday.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Health promotion leaflets were available in the department. These included advice on smoking, alcohol, stress management, managing diabetes and cancer.
- The outpatient department offered health assessments, where health and lifestyle were discussed.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.**
- Consent and mental capacity were incorporated in to the safeguarding training.
- Staff we spoke with told us it was rare for them to see anyone in clinic without capacity to make decisions for themselves. Clinic patients were triaged and most with mental health issues and learning disabilities would not be offered appointments. Staff told us this was being addressed by the senior team.
- We saw appropriately completed consent forms in the records we reviewed.

Are outpatients services caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs**.
- We observed staff greeting patients in a friendly manner. Patients we spoke with told us all the staff were kind and caring, and they had been treated with dignity and respect.
- We saw posters displayed around the outpatient's department offering patients a chaperone, if required.
- Clinic rooms had busy/free signs on the doors. We observed staff knocking on doors before entering rooms. All rooms had privacy curtains to maintain privacy and dignity.
- The hospital participated in the friends and family test (FFT). Recommendation rates for the hospital were between 97.5% and 98.7% between October 2018 and March 2019.

Emotional support

- **Staff provided emotional support to patients.**
- Phlebotomy staff we spoke with described how they would provide support to those patients who may be anxious, spending time explaining the procedure to them.

Good

Outpatients

- Patients we spoke with had not needed emotional support but felt this would be provided if needed.
- Staff we spoke with told us they would take a patient to a consultation room if they became visibly distressed in the waiting area.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Patients we spoke with felt involved in the decisions about their care. Information was provided to them in a way they could understand.
- Patients we spoke with felt they had been provided with enough information. Families were able to attend the consultation if the patient wanted them to.
- Patients did not feel rushed during their consultations and felt time was given for them to ask any questions they needed to.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people.**
- The outpatient department provided appointments for a wide range of specialities. Clinics ran at times which allowed patients to attend after work hours if needed.
- Patients could access the department via stairs or lift. The waiting areas had magazines available and a television. Hot and cold drinks were available.
- Patients told us the hospital was convenient and easy to find. There was parking available, although one patient we spoke with told us that parking was becoming more of a problem.
- The information provided to patients before their appointment was variable. Private patient referrals went through a central booking centre, and an advisor rang the patient with an appointment, so no appointment letter or other information was sent out to the patient before their appointment. NHS patients booked through the online 'choose and book' system. We spoke to one patient who had been provided with additional information on how to get to the hospital, with their appointment letter.
- There was no separate waiting area for children attending clinics and there were minimal toys available in the department.

Meeting people's individual needs

- **Although staff made reasonable adjustments to help patients access services where they could, the service had limited facilities for patients with individual needs.**
- Staff could access interpreting services for those patients who did not speak English as a first language.
- Patient information leaflets that we saw in the waiting areas were all in English. When we asked staff whether they had leaflets in different languages, they told us they could probably access them online, but had never done so.
- Staff we spoke with told us they had a set of bariatric scales, but there were no chairs or examination couches suitable for bariatric patients.
- All areas were wheelchair accessible. Staff told us if a patient attended the department on a trolley they would arrange for the patient to wait in a bed on the ward.
- Facilities were limited for patients with learning disabilities or dementia. The environment was not dementia friendly. The director of clinical services told us they had held a dementia workshop and they were looking at improvements to be made to care for those patients with learning disabilities and dementia.
- Staff we spoke with told us if a patient with additional needs attended and needed a quiet place to wait, they would find a room for the patient to wait in. However,

some staff we spoke with also told us that clinic patients were triaged and most with learning disabilities or mental health problems would not be seen in the clinic.

- When we spoke with staff, there did not appear to be a process in place to identify, record and highlight any communication needs. This did not meet the Accessible Information Standard for NHS patients. All organisations providing NHS care must follow the Accessible Information Standard, which aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Patients we spoke with told us they did not have any problems booking an appointment and had been seen in good time. For example, one patient had been referred by their GP and had an appointment at the clinic for the following week.
- Data provided by the service showed no waiting times for private/self-pay patients. The average waiting time for NHS patients was six to nine weeks, which was in line with the 18-week NHS referral to treatment time standard
- Between April 2018 and March 2019, the average percentage of new outpatient appointments where the patient did not attend, as a percentage of all new appointments was 4.9%. For follow up appointments the did not attend rate was 6%. The service had guidance for staff to follow to deal with patients that did not attend.
- We saw notices on display in the waiting room, which informed patients that they should speak to the receptionist if they had been waiting longer than 20 minutes from their appointment time.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, we did not see any information displayed that told people how to make a complaint or raise a concern.**
- We did not see any prominent information displayed in the department that informed patients how to make a complaint. We saw a leaflet entitled 'Please tell us…', which contained some information at the back of the leaflet about what to do if they wanted to make a complaint. However, it was not clear from the front of the leaflet that this would contain information on how to make a complaint.
- Patients that we spoke with told us they did not know how to make a complaint, but they would find out how to, if they felt they needed to.
- Staff we spoke with told us they would try to resolve any complaints at service level in the first instance, if patients wanted to make a formal complaint they would provide them with an email address.
- Staff told us they would receive feedback from any complaints that were discussed at the communication cell meetings.
- For further details about learning from complaints and concerns, please see the Responsive section in the surgery report.

Are outpatients services well-led?

Good

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

Leadership

- The outpatient department had seen several changes in leadership since our last inspection in 2015. Leadership in the department was acknowledged as a risk by the executive team although they had taken appropriate action to mitigate the risk.

Good

Outpatients

- Prior to this inspection, the outpatient department had been without a manager and a sister since March 2019. During this time the department had been supported by a sister from the inpatient ward and the infection prevention and control lead.
- At the time of our inspection there was still a vacancy for the service manager of outpatients. Prior to the current recruitment campaign for this post, there had been one management position responsible for both the inpatient and outpatient provision. Senior hospital managers had undertaken a review of service management resources and a decision was made create one dedicated service manager post for the outpatient department (and one for inpatients). A new sister had been in post for six weeks.
- Most of the staff we spoke with felt the department had continued to run effectively without a management team in place, whilst a minority felt that there had been too much movement of senior staff and they felt unsettled.
- Staff we spoke with felt the senior leaders in the hospital were visible and approachable. They spoke positively about the new executive director and said they had an 'open door' policy.
- Staff were supported to undertake leadership courses. The physiotherapy manager was undertaking a leadership and management course.

Vision and strategy

- **The hospital had a vision for what it wanted to achieve and a strategy to turn it into action.**
- BMI Healthcare had a corporate five-year vision 2015-2020, which was to be achieved through eight strategic objectives.
- The hospital had strategic objectives which aligned with the corporate strategic objectives.
- Staff had been involved in forums, where they could put forward their ideas for the hospital vision and values.
- There was no additional vision or strategy specific to the outpatient department.
- For further details about vision and strategy please see the Well-led section in the surgery report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Most of the staff we spoke with told us they worked well as part of a team. Despite changes in management they felt the team had continued to work well.
- Staff felt able to speak up and described an open culture. Most of the staff had worked in the department for many years, they told us the hospital was a good place to work.
- For further details about culture please see the Well-led section in the surgery report.

Governance

- **Senior leaders operated effective governance processes, throughout the service and with partner organisations**.
- Daily communication cell meetings took place. A representative from each area of the hospital attended and key messages would be fed back to staff in the department. Staff told us they received all of the information they needed and that this system worked well.
- Communication cell information boards were present in each area. These contained relevant information, such as incident feedback, risk registers and key messages.
- There was a clear governance framework in place, including heads of department meetings, clinical governance committee meetings and medical advisory committee meetings.
- There had not been any recent outpatient department team meetings, due to the changes in leadership. However, we saw that there was a schedule for future meetings. We also saw evidence that key messages had been cascaded to staff in this time from the senior management team of the hospital.

- For further details about governance please see the Well-led section in the surgery report.

Managing risks, issues and performance

- There was a hospital risk register. There were no risks identified specific to outpatients or physiotherapy. However, when we spoke with the director of clinical services they told us the biggest risk for the outpatient department was the leadership. A recruitment plan was in place.
- Following our inspection, we requested the outpatient department risk register. The risks identified on this were not specific to the department but included information security, infection prevention and control, and risk of staff injury.
- The department carried out risk assessments, these would be escalated on to the risk register if they scored 12 or above.
- There were clear processes to escalate performance issues and risks
- For further details about managing risks, issues and performance please see the Well-led section in the surgery report.

Managing information

- Staff completed information governance training as part of their mandatory training.
- BMI patient records were not taken off site. Consultants were responsible for their private patients' notes. It was a requirement for consultants to be registered as independent data controllers with the Information Commissioners Office, for them to be granted practicing privileges, and we saw evidence of this in our review of consultant personal files.
- For further details about managing information please see the Well-led section in the surgery report.

Engagement

- **Leaders and staff actively and openly engaged with patients and staff.**
- Staff told us there were emails and newsletters sent from the executive director. The new executive director had held staff forums.
- The hospital participated in the friends and family test (FTT) to gain feedback from patients.
- We saw 'You Say' comment cards available in waiting areas for patients to complete.
- Staff completed an annual staff survey and managers and staff had developed appropriate action plans in response to the results.
- For further details about engagement please see the Well-led section in the surgery report.

Learning, continuous improvement and innovation

- **Staff were committed to continually learning and improving services.**
- There were plans for site development, which would see the minor ops room and consulting rooms downstairs being relocated.
- The physiotherapy department had started a 'joint school', which provided education to patients about joint replacements from pre-assessment through to post operatively.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

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

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The mandatory training was comprehensive and met the needs of patients and staff. Awareness of mental health, diabilities and autism was included in the safeguarding training.
- Staff we spoke with during our inspection were up to date with their mandatory training. Staff told us that mandatory training was completed online and face to face. Time was given back to staff if they completed training in their own time.
- During our inspection we saw training compliance data, which showed that 96% of staff in diagnostic imaging had completed their mandatory training.
- For further details about mandatory training please see the Safe section in the surgery report.

Safeguarding

- **Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- All staff had completed safeguarding adults and children training.
- Safeguarding adults and children flow charts were available to assist staff in the process to follow if they had concerns.
- Staff told us they would report any safeguarding concerns to the safeguarding lead.
- Processes were in place to ensure the right person received the right radiological scan at the right time. We observed staff checking a patient's identification according to the pause and check guidelines from the Society and College of Radiographers.
- For further details about safeguarding please see the Safe section in the surgery report.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- All clinical areas were clean and had suitable furnishings which were clean and well-maintained.
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.
- Staff followed infection control principles including the use of personal protective equipment (PPE).
- We saw results from hand hygiene audits undertaken in June 2019, these showed that staff in imaging and scanning scored 100%.

- Appropriate facilities were available for staff and visitors to clean their hands, including hand wash basins and hand gel dispensers.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.**
- The imaging department was on the ground floor of the hospital. The scanning department was in a separate building in the hospital grounds. The scanning department had some ceiling tiles that had damp patches on them. Staff told us this had been identified and they were waiting for this to be resolved.
- Staff carried out daily safety checks of specialist equipment. We saw completed checklists for resuscitation trolleys. The imaging and scanning departments had adult resuscitation trolleys. Staff told us in the event of a paediatric emergency, the crash team would bring the paediatric trolley with them.
- During our inspection, we saw that equipment in the MRI scanning room, such as a wheelchair, trolley, chair, bin and preparation trolley was not labelled as MR safe, in line with Medicines and Healthcare products Regulatory Agency (MHRA) recommendations. We brought this to the attention of staff at the time of our inspection and they took immediate steps to rectify this.
- Lead aprons were available in rooms and used by family members/carers if they stayed in the room to support the patient. We saw these were audited and screened annually. Dosimeters were worn by all radiographers to measure how much radiation they were exposed to.
- Warning lights were present and working on the outside of rooms, to restrict access when imaging and scanning were underway.
- Equipment had monthly checks done for quality assurance. Radiation output was documented monthly.
- We checked the imaging department equipment service logs and found that all equipment had been recently serviced.

Assessing and responding to patient risk

- **Staff removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.**
- We saw posters clearly displayed telling patients about the importance of informing staff if they were pregnant.We checked a request card for a patient of childbearing age and saw that the date of the last menstrual period had been checked and recorded as per Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- There were posters displayed on understanding radiation and clear x-ray signage outside rooms informed people about areas where radiation exposure would take place.
- Two radiation protection supervisors were appointed and a radiation protection advisor, although not on site, was available for radiation protection advise. Regular meetings took place between the radiation protection advisor and the radiation protection supervisors.
- The service had local rules (IRR) and employers' procedures (IR(ME)R) which protected staff and patients from ionising radiation. We saw these were up to date, signed and displayed.
- Patients attending for an MRI scan completed a safety checklist form. The contents of the safety checklist forms, consent, last menstrual period, dose and contrast information were recorded on the electronic patient record in a timely way.
- All patients were asked to change in to standard healthcare trousers and tops to reduce the risk of their skin touching the scanner and minimise the risk of burns.
- A standard operating procedure was in place for the resuscitation team when responding to emergencies in the scanning unit. This ensured that the patient was brought out of the MRI scanning room and other staff did not enter the room when responding to an emergency. An extravasation pack was available on the resuscitation trolley for use in the case of extravasation of contrast. All staff in the department were immediate life support (ILS) trained and paediatric immediate life support (PILS) trained.

Good

Diagnostic imaging

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- Staffing levels were assessed and changed according to patient needs.
- The radiology department employed one lead and five radiographers, all part time. One bank radiographer was used when needed in theatres. Three echo radiographers covered ultrasound lists.
- The scanning department employed one lead and five radiographers.
- Several different radiologists covered the service. However, there was no on call radiologist to cover the weekends. The service was in the process of setting up on call cover with an external company. A paediatric radiologist was available when needed.

Records

- The imaging services used an electronic record that stored all patient information, including consent, all checks and safety forms.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- All radiographers in the scanning department injected contrast under patient group directions (PGD). Patient group directions allow healthcare professionals to supply and administer specific medicines to pre-defined groups of patients, without a prescription. We saw PGD's that were up to date and signed.
- Medicines were stored securely locked away. Checklists were completed for expiry dates. Room temperature checks and temperature checks of the warming unit were appropriately completed. Staff told us they would contact pharmacy if there were any deviations in the temperature.
- We saw contrast in the warming unit had been labelled with the date and time when it had been placed in the warmer.
- For further details about medicines please see the Safe section in the surgery report.

Incidents

- **The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, there was a risk that some staff were not reporting all incidents.**
- There had been no never events reported in the diagnostic imaging services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need to have happened for an incident to be a never event.
- Data provided by the hospital showed that there had been 90 clinical incidents between January 2018 and December 2018, however this number was combined with outpatients.
- There had been two incidents involving ionising radiation in the last 12 months. These had been appropriately reported to CQC under IR(ME)R requirements.
- We reviewed the incident forms and found that there was evidence of duty of candour being applied in one case. However, the form had subsequently changed and for the second incident it was not evident that duty of candour had been applied. We raised this at the time of our inspection and staff took immediate steps to change the form. The duty of candour means, as soon as reasonably practical after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Staff we spoke with were aware how to report incidents on the electronic reporting system. Staff told us they received feedback from incidents from managers via email and meetings. However, some staff we spoke with said it was sometimes difficult to determine the threshold to decide what was an incident and what wasn't. For example, if a request

was received and the requester had indicated the wrong side to be x-rayed, they would not routinely report this as an incident, if this was corrected before the x-ray was done.

- Incidents were discussed at the daily communication cell meeting and governance meetings and relevant information was cascaded down to staff in the department. Any learning from incidents that had taken place at other BMI hospitals was shared with staff.

Are diagnostic imaging services effective?

We do not rate effective in diagnostic imaging services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice**.
- Staff followed guidance from the Society and College of Radiographers and the National Institute for Health and Care Excellence (NICE).
- Staff followed the unit's employer's procedures and protocols for medical exposures which met with IR(ME)R 2000 and IR(ME)R 2017 regulations. We looked at several standard operating procedures (SOP) and found they were up to date and contained relevant guidance. The quality and risk manager for the hospital was responsible for informing staff when guidance was due for review.
- Local and national diagnostic reference levels (DRL's) were displayed. We observed the dose for a patient scanned and found it was within the local DRL's displayed.

Nutrition and hydration

- Hot and cold drinks were available in the waiting areas. A restaurant was available to buy food onsite.

Pain relief

- Pain relief was not routinely administered in the diagnostic imaging services.

Patient outcomes

- The service did not participate in the Imaging Services Accreditation Scheme (ISAS).
- The radiation protection advisor (RPA) completed regular audits. We saw the results and action plan from the most recent audit. Most actions had been completed, with seven actions due for completion in September 2019.
- The service participated in an audit undertaken by an external provider, where 25% of their work was looked at and criteria checked, including image review and the quality of images. We did not see results from this audit.

Competent staff

- **The service made sure staff were competent for their roles.**
- Staff received annual and mid-year appraisals. Staff told us they were supported with time and funding for new courses that were relevant to their practice.
- We saw staff competency files, these were updated yearly and used as part of the appraisal process. We saw that staff were not allowed to practice unless they had the required training and competencies.
- We saw a list for training of radiologists for a new piece of equipment. Most of the radiologists had completed the training. Staff told us that those who had not yet completed the training would not use that specific equipment, until they were fully compliant with the training requirements. Surgeons were required to bring their competency certificate to use the mini C arm in theatre (a - is an imaging scanner intensifier. The name derives from the -shaped to connect the x-ray source and x-ray detector to one another).
- An induction file was available, which contained an introduction to the hospital and department, local rules and relevant information.
- The unit had radiation protection supervisors (RPS) who had overall responsibility to ensure staff were working within their competencies. The RPS ensured that safety and quality checks of the unit were performed and that ionising radiation procedures were performed in line with national guidance and local procedures.

Good

Diagnostic imaging

- Arrangements were in place to seek advice from an external radiation protection advisor (RPA) through a service level agreement.

Multidisciplinary working

- **All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care.**
- Staff told us there were good working relationships between the radiographers and radiologists.
- Radiographers liaised with other departments in the hospital to ensure patients received the diagnostic imaging service they needed.
- Theatre meetings were held every week, there was good communication with the radiology department to ensure that staff were available for theatre cases when required.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- The department was open Monday to Friday 8am until 8.30pm.
- Staff participated in an on-call rota for the weekends. Staff were on call for one weekend out of six.

Health promotion

- We did not see any health promotion information on display in the diagnostic imaging services, due to the transitory nature of care in the department.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.**
- Consent and mental capacity were incorporated in to the safeguarding training.
- We saw that staff gained appropriate consent, including verbal and written. Written consent was obtained for procedures such as joint injections. We saw completed consent forms signed by the radiologist, radiographer and patient.
- Staff we spoke with understood their responsibilities in relation to the mental capacity act.

Are diagnostic imaging services caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs**.
- We observed staff greeting patients in a friendly manner. Patients we spoke with told us all the staff were kind and caring, and they had been treated with dignity and respect.
- Patients were able to talk to the receptionist without being overhead, as the reception desk was separate to the waiting area.
- We saw posters displayed around the department offering patients a chaperone, if required.
- The hospital participated in the friends and family test (FFT). Recommendation rates for the hospital were between 97.5% and 98.7% between October 2018 and March 2019.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- We observed a sonographer taking time to explain the examination to a very anxious patient. They put the patient at ease and the patient thanked them for their understanding.
- In the scanning department, we observed a patient explaining to the radiographer that they were claustrophobic. The radiographer took time to show the patient around and make them feel comfortable. The patient told us that they felt that the staff were calm and friendly.

Good

Diagnostic imaging

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff spoke to patients in a way they could understand and took time to explain the procedures to them.
- Staff we spoke with told us that, if needed, a friend or relative could accompany the patient whilst having their x-ray or scan.
- Appointment times were long enough that patients did not feel rushed and had time to ask questions.

Are diagnostic imaging services responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people.**
- The department was open until 8.30pm, this meant that there were convenient times for patients to attend after work.
- The imaging department and scanning department were both located on ground floor level. Both had comfortable seating areas, with hot and cold drinks available.
- There was no separate waiting area for children attending the department and no toys were available.
- Appointments were booked over the phone and no letters or information leaflets were sent to the patient before their appointment. The text reminder system was not available in radiology. Staff told us they would discuss the procedure with the patient on the phone when booking the appointment.

Meeting people's individual needs

- **Although staff made reasonable adjustments to help patients access services where they could, the service had limited facilities for patients with individual needs.**
- Facilities were limited for patients with learning disabilities or dementia. The environment was not dementia friendly. The director of clinical services told us they had held a dementia workshop and they were looking at improvements to be made to care for those patients with learning disabilities and dementia.
- Staff we spoke with told us if a patient attended with additional needs they would spend time with them and allow them to look around the environment. Radiographers in the scanning department told us about a patient they had with learning disabilities who they had allowed to visit the department before their scan, so they could become familiar with the equipment and environment.
- When we spoke with staff, there did not appear to be a process in place to identify, record and highlight any communication needs. This did not meet the Accessible Information Standard for NHS patients. All organisations providing NHS care must comply with the Accessible Information Standard, which aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services.
- The department could accept bariatric patients, with x-ray tables able to accommodate patients weighing up to 46 stone. A walking frame, step and transfer board were available for those patients that required extra support.
- Staff could access interpreting services for those patients who did not speak English as a first language.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Staff we spoke with told us patients generally never waited longer than five or ten minutes. However, one patient we spoke with told us they had gone in for their appointment 30 minutes late.

Good

Diagnostic imaging

- Reception staff we spoke with told us most patients were booked for an appointment within seven days of the request being sent. The longest waiting list was for vascular ultrasound, which was two weeks. Data provided by the service showed that for July there was same day availability for each modality for most weeks.
- The service aimed to have all radiology reports completed within 48 hours. Data provided by the service showed that for the month of July there had been 40 cases where the reporting time had exceeded 48 hours, 27 of these were because they were waiting for a specific radiologist to report on them, eight were delayed due to a weekend. One of these scans took 13 days to be reported on, but the majority were eight days or under. However, it is unclear from the data how many scans were completed overall for the month of July.
- The service had guidance for staff to follow to deal with patients that did not attend. We saw information to show that in June 2019, there had been 32 patients that did not attend, of those 32 patients, 20 had attended a rebooked appointment.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, we did not see any information displayed that told people how to make a complaint or raise a concern.**
- We did not see any prominent information displayed in the department that informed patients how to make a complaint. We saw a leaflet entitled 'Please tell us…', which contained some information at the back of the leaflet about what to do if they wanted to make a complaint. However, it was not clear from the front of the leaflet that this would contain information on how to make a complaint.
- Patients that we spoke with told us they did not know how to make a complaint.
- Staff we spoke with told us they would try to resolve any complaints at service level in the first instance, if patients wanted to make a formal complaint they would provide them with an email address.
- Staff told us they would receive feedback from any complaints that were discussed at the communication cell meetings.
- For further details about learning from complaints and concerns, please see the Responsive section in the surgery report.

Are diagnostic imaging services well-led?

Good

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

Leadership

- **Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- At the time of our inspection, the service manager for imaging was also acting director of operations. Two members of staff, one for radiology and one for scanning had stepped up in to management roles to oversee the departments on a day to day basis.
- Staff we spoke with spoke positively about their leaders. Staff we spoke with felt the senior leaders in the hospital were visible and approachable. They spoke positively about the new executive director and said they had an 'open door' policy.
- The organisation had a corporate imaging manager who provided support. They had visited the location and had suggested ideas for improvement. The service had produced an action plan following this visit.

Vision and strategy

Good

Diagnostic imaging

- **The hospital had a vision for what it wanted to achieve and a strategy to turn it into action. There was no specific strategy for the diagnostic imaging service.**
- BMI Healthcare had a corporate five-year vision 2015-2020, which was to be achieved through eight strategic objectives.
- The hospital had strategic objectives which aligned with the corporate strategic objectives.
- Staff had been involved in forums, where they could put forward their ideas for the hospital vision and values.
- There was no additional vision or strategy specific to the diagnostic imaging service
- For further details about vision and strategy please see the Well-led section in the surgery report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- All staff we spoke with told us about the positive culture and that they worked well as a team.
- Staff felt able to speak up and described an open culture. Most of the staff had worked at the hospital for many years and were proud of their team.
- For further details about culture please see the Well-led section in the surgery report.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations**.
- Daily communication cell meetings took place. A representative from each area of the hospital attended and key messages would be fed back to staff in the department.
- Communication cell information boards were present in each area. These contained relevant information, such as incident feedback, risk registers and key messages. During our inspection, we witnessed staff been given feedback from a meeting.
- There was a clear governance framework in place, including heads of department meetings, clinical governance committee meetings and medical advisory committee meetings.
- Regular team meetings took place. We reviewed minutes of meetings and found that standing agenda items included complaints, significant events, risk register updates, policies and patient satisfaction.
- We saw a service level agreement (SLA) that was in place for scanning of patients from an NHS provider.
- For further details about governance please see the Well-led section in the surgery report.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- There was a hospital risk register, which contained a risk related to potential loss of radiologists due to the introduction of a new fee structure. There was also a departmental risk register, which contained three risks; two related to staff safety and one related to patient safety from ionising radiation.
- We did not see any risks documented on the risk register related to equipment failure or reactions to contrast. Staff we spoke with told us they would be put on to the risk register if there had been any incidents. Staff told us any incidents showing a level of harm as moderate or above would have a risk assessment completed. Any risks scoring 12 or higher were entered on to the risk register.
- Staff we spoke with were aware of their local risks and had plans in place to reduce or mitigate risks. We saw that risk assessments were in place.

Good

Diagnostic imaging

- Risk of power failure was clearly documented on the hospital risk register. Controls were in place to ensure that services could continue if this occurred. The service had back up emergency generators which were regularly tested and maintained.
- Steering group meetings were held across the BMI hospitals for staff to share current practice and skills. Information was shared and quality of work was reviewed and monitored.
- For further details about managing risks, issues and performance please see the Well-led section in the surgery report.

Managing information

- Staff completed information governance training as part of their mandatory training. The service lead told us that for new starters this training would be a priority.
- The service ensured that any incidents related to ionising radiation were appropriately reported under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- Scan results, images and reports were held electronically. These were password protected.
- For further details about managing information please see the Well-led section in the surgery report.

Engagement

- **Leaders and staff actively and openly engaged with patients and staff.**
- Staff meetings were held once a month. The meeting minutes were held electronically, and all staff could view them.
- Staff told us there were emails and newsletters sent from the executive director. Staff we spoke with found these beneficial and informative.
- Staff we spoke with told us that communication had improved in the last three years.
- The hospital participated in the friends and family test (FTT) to gain feedback from patients.
- Staff completed an annual staff survey and managers and staff had developed appropriate action plans in response to the results.
- For further details about engagement please see the Well-led section in the surgery report.

Learning, continuous improvement and innovation

- **Staff were committed to continually learning and improving services**.
- The service learned from external reviews and audits. Action plans were in place.
- Steering group meetings were held between the different BMI hospitals, where current practice and skills were shared.
- The service lead had a vision to start a continuous professional development (CPD) club to help staff stay up to date.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure they implement and close out actions on the hospital fire safety corrective action plan; following the Fire and Rescue Authority, regulatory reform safety order, dated 02 July 2019 (Regulation 15).

In Critical care:

- The provider must ensure that all staff adhere to the hospital policy for the administration of controlled drugs particularly in the critical care unit (Regulation 12).
- The provider must ensure that the critical care unit uses the National Early Warning System (NEWS) to identify if a patient is deteriorating, as per their policy (Regulation 12).
- The provider must ensure that a minimum of two appropriately trained nurses are always on duty in the critical care unit when the unit is occupied, in line with hospital policy (Regulation 12).
- The provider must ensure that there are systems and processes in place in the critical care unit to ensure that risks are identified, monitored and mitigated. This includes ensuring that policies are up to date and being followed by all staff. (Regulation 17).

Action the provider SHOULD take to improve

- The provider should consider the needs of individuals with learning disabilities, dementia and bariatric patients. (Regulation 9)
- The provider should consider displaying patient information leaflets (Regulation 9).
- The provider should ensure they display information on making complaints so that it is more visible to patients (Regulation 16)
- The provider should continue to monitor and undertake maintenance and upgrading of hospital infrastructure, environment and equipment (Regulation 15).
- The provider should ensure there is oversight of all medical staff mandatory training undertaken with their substantive employer (Regulation 18).
- The provider should ensure all staff receive an appraisal (Regulation 18).

In Medical care:

- The provider should ensure that the plans to relocate the endoscopy unit to a newly refurbished and purpose-built unit are carried as soon as possible to ensure the environment meets infection control standards and the risk to patients is reduced (Regulation 15).
- The provider should ensure that medical staff record their printed name and the time of the consultation consistently, in patient records (Regulation 17).

In Surgery:

- The provider should improve the proportion of patients who have their communication needs assessed at pre-assessment and consider how staff are able to meet these needs (Regulation 9).
- The provider should monitor completion of resuscitation scenario action plans and ensure changes to training and practice recommendations are embedded (Regulation 12).
- The provider should ensure staff are clear on what should be reported as an incident and levels of harm are consistently entered against incident records (Regulation 17).
- The provider should continue to monitor and test ventilation and air handling units in theatres, to ensure these are compliant with Health Technical Memorandum minimum standards (Regulation 15).

Outstanding practice and areas for improvement

- The provider should continue to monitor and test water samples throughout the hospital and ensure controls are in place to minimise the risk of service users contracting Legionnaires Disease (Regulation 15).
- The provider should ensure patient information leaflets which are used to support staff to gain informed consent are renewed and do not exceed their review date (Regulation 17).
- The provider should ensure correct (clinical or non-clinical) classifications are attributed to cancellation records (Regulation 17).
- The provider should provide mandatory training in key skills to all bank staff, and make sure they complete it (Regulation 18).
- The provider should seek to reduce the high proportions of bank and agency staff utilised in theatres (Regulation 18).

In Critical care:

- The provider should ensure that all staff are up to date with mandatory training (Regulation 18).
- The provider should ensure that staff complete weekly checks on all relevant equipment and sign the checklist (Regulation 15).
- The provider should ensure that staff sign and date all entries in patient records and record allergies on all prescription charts including the documentation of no allergies (Regulation 17).

In Outpatients:

- The provider should ensure paediatric resuscitation equipment is checked consistently (Regulation 12).
- The provider should ensure there are enough nursing staff to provide cover to the downstairs consulting rooms (Regulation 18).

In Diagnostic imaging:

- The provider should ensure staff are clear on what should be reported as an incident (Regulation 12).

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 Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment · The provider must ensure that all staff adhere to the hospital policy for the administration of controlled drugs. The preparation and administration of controlled drugs must be witnessed by a second competent practitioner. Daily stock checks of controlled drugs must be carried out and documented and staff must record the date of opening for oral solutions of controlled drugs. · The provider must ensure that the critical care unit uses the National Early Warning System (NEWS) to identify if a patient is deteriorating, as per their policy. · The provider must ensure that a minimum of two appropriately trained nurses are always on duty in the critical care unit when the unit is occupied, in line with hospital policy.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance · The provider must ensure that there are systems and processes in place in the critical care unit to ensure that risks are identified, monitored and mitigated. This includes ensuring that policies are up to date and being followed by all staff.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and equipment · The provider must ensure they implement and close out actions on the hospital fire safety corrective action plan; following the Fire and Rescue Authority, regulatory reform safety order, dated 02 July 2019