BMI The Droitwich Spa Hospital

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Droitwich Spa Hospital is operated by BMI Healthcare Limited. The hospital has 46 registered beds offering ensuite facilities, satellite television and telephone amenities. Facilities include three operating theatres, an endoscopy unit, 11 outpatient rooms and diagnostic services including X- ray and magnetic resonance imaging (MRI) and a physiotherapy department.

The hospital provides a range of surgical procedures, outpatient clinics and diagnostic imaging facilities. During our inspection we visited all services within the hospital. Services included surgical procedures and outpatient appointments for preoperative and postoperative review, as well as outpatient treatments such as naso-endoscope and dermatology procedures. In the reporting period of August 2017 to July 2018, there were 683 inpatient procedures, 3,823 day-case episodes of care and 18,731 outpatient attendances. The outpatient appointments were a combination of patients accessing treatment and surgical outpatient consultations.

We inspected this service using our comprehensive inspection methodology. We carried out unannounced visits as part of the inspection on 22-23 January 2019 and 8 February 2019.

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

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 will also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

Services we rate

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

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

- Not all risk assessments were completed effectively in line with the hospital policy. All consultants are required to complete the venous thromboembolism (VTE) decision box, following assessment, to ensure that patients at risk are identified and appropriately treated
- In the diagnostic imaging service, processes were not in place to ensure quality testing programmes were completed and that diagnostic reference levels were created and monitored.
- Clinical audits were not completed within the diagnostic imaging service.
- Outstanding recommendations following external audits within the diagnostic imaging service required completion and review.
- Appraisal reviews and mandatory training compliance for some staff was below the hospital target.
- Regular reviews of the backlog of NHS patient record coding to promote assurance that future obligations are met.
- Ensure that sinks and taps conform to Health Building Note 00-10 'Part C Sanitary Assemblies', in clinical areas to allow correct hand hygiene practices.
- The World Health Organisation' five steps to safer surgery' checklist for all surgical procedures carried out in the operating theatres were not always completed within all operative specialties.
- Not all radiography staff had completed the appropriate training and competencies regarding radiation risks and regulations in line with IR(ME)R 2017.
- Processes and procedures are required to be in place to record and audit consent.

Summary of findings

- Agency staff within the diagnostic imaging department require specific induction for radiographers.
- To maximise efficiency of operating department time and available staffing resources effective working processes should be developed across departments, within the hospital.

We found good practice within the services:

- Services within the hospital such as surgery, medicine and outpatients provided mandatory training in key skills to staff.
- The surgical and outpatient services followed best practice when prescribing, giving and recording medicines. Storage of controlled medicines followed best practice. Patients received the right medication, at the right dose, at the right time.
- Surgical services in the hospital provided care and treatment based on national guidance and there was evidence of its effectiveness.
- The hospital controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- There was effective multidisciplinary working across the hospital. Staff in different teams worked together to benefit patients. Doctors, nurses and other healthcare professionals, supported each other to provide good care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment. They were communicated with and received information in a way that they could understand.
- Hospital services were planned and developed to meet the needs of the local population for both private and NHS patients.
- The service had suitable premises and equipment. Hospital premises were clean, well maintained, and suitably equipped. There was an equipment replacement programme to ensure that all large items of equipment were replaced when they became outdated.
- All services within the hospital engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The hospital was committed to improving by learning from when things went well or wrong, promoting training and innovation.
- Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- People could access the service when they needed it. Waiting times from treatment were and arrangements to admit, treat and discharge patients were in line with good practice.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. Additionally, 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 that affected diagnostic imaging, outpatient services and surgery. Details are at the end of the report.

Amanda Stanford

Acting Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	Endoscopy services were a small proportion of hospital activity and will be reported under the medical care sub heading. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good in safe, responsive and well led. Effective and caring were not rated as there was not enough evidence to do so.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good in effective, caring, responsive and well-led. The safe key question was rated as requires improvement.
Outpatients	Good	We rated this service as good in safe, caring, responsive and well led. We do not rate effective in outpatients.
Diagnostic imaging	Inadequate	We rated this service as inadequate in safe and well led. Caring and responsive key question were rated as good, the effective key question was not rated within this core service.

Summary of findings

Contents

Requires improvement

The Droitwich Spa Hospital

Services we looked at

Medical care; Surgery; Outpatients and Diagnostic imaging.

Summary of this inspection

Background to BMI The Droitwich Spa Hospital

The Droitwich Spa Hospital is operated by BMI Healthcare Limited. The hospital opened in 1988. In 2013, the hospital opened an additional wing which provided extra bedrooms and consulting rooms. The hospital is located in the town centre of Droitwich and has its own private car park. The hospital primarily serves the communities of Worcestershire. It also accepts private patient referrals from outside this area.

The hospital's registered manager has been in post since August 2013. The hospital is regulated to provide treatment of disease, disorder or injury: surgical procedures, family planning and diagnostic and screening procedures.

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day by an onsite resident medical officer (RMO). Patients are cared for and supported by registered nurses, health care assistants, allied health professionals, such as physiotherapists and pharmacists, who are employed by the hospital.

The most common procedures undertaken were phacoemulsification of cataract with lens implant (cataract removal) followed by colonoscopy and gastroscopy procedures.

We carried out an unannounced inspection on 22 and 23 January 2019 and a short-announced inspection on the 8 February 2019.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager, a lead inspector, four other CQC inspectors, and four specialist advisors with expertise in surgery, outpatients and diagnostic imaging. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about BMI The Droitwich Spa Hospital

The main service provided at the hospital was surgery. Surgical procedures were carried out under general anaesthetic, local anaesthetic, or sedation. Pre-and post-operative consultations were undertaken within the outpatient clinic services. Only patients over the age of 18 were seen at the hospital.

The hospital is registered to carry out the following regulated activities:

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

During the inspection, we visited Heritage ward, theatres, endoscopy, outpatients and the diagnostic imaging department. We spoke with 51 staff members including registered nurses, health care assistants, reception staff, medical staff, radiologists, imaging staff, operating department practitioner's consultants and senior managers. We spoke with 14 patients and two relatives. During our inspection, we reviewed 23 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital had been inspected once, and the most recent inspection took place in August 2016.

Activity (August 2017 to July 2018)

- In the reporting period August 2017 to July 2018, there were 4,506 inpatient and day case episodes of care recorded at the hospital; of these 71% were NHS-funded and 29% other funded.

Summary of this inspection

- 11% of all NHS-funded patients and 24% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 18,730 outpatient total attendances in the reporting period; of these 56.5% were NHS-funded and 43.5% were other funded.

There were 67 surgeons, 68 anaesthetists, 24 physicians and 11 radiologists working at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a weekly rota. The hospital employed 15 full time equivalents (FTE) registered nurses, seven FTE care assistants, 13 FTE operating department practitioners, six FTE allied health care professionals and49 FTE non-clinical staff, as well as having its own clinical and non-clinical bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

- Zero never events.
- Clinical incidents (the hospital does not differentiate between clinical and non-clinical incidents) 198 no harm,115 low harm, six moderate harm, zero severe harm, zero death.
- One serious incident.
- Zero incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- Zero incidences of hospital acquired Clostridium difficile.
- Zero incidences of hospital acquired E-Coli.

There were 38 complaints during the period from October 2017 to September 2018, the majority of these were communication related issues.

Services accredited:

- BUPA accreditation –a quality mark that suggest the doctors employed at the service are competent.
- ISO/IEC 27001/2013 – accredited certification Information Commissioners Office relating to information security
- Services provided to the hospital under service level agreement:
- Clinical, non-clinical and recyclable waste removal.
- Laundry.
- Pathology, microbiology and histology services.
- Sterile services for medical instrumentation.
- Clinical agency staffing.
- Radiation protection.
- Medical emergency transfers.
- RMO provision.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

We do not rate effective for ouptatients and diagnostic imaging.

Good

Medical care

Safe	Good
Effective	
Caring	
Responsive	Good
Well-led	Good

Are medical care services safe?

Good

Endoscopy services provided a small proportion of hospital activity and will be reported under the medical care sub heading.

The endoscopy unit had one procedure room and four patient bays.

Our rating of safe stayed the same. We rated it as good.(The endoscopy service had previously not been rated as an individual service – it had been included within the surgical report – 2016)

Mandatory training

- **The organisation provided mandatory training for staff in a range of subjects to ensure they were knowledgeable about systems and processes which protected patients from potential harm and abuse.**
- The overall compliance for mandatory training within the endoscopy department was 96%.
- For our detailed findings on mandatory training please see the safe section in the surgery report.

Safeguarding

- The hospital had policies in place to safeguard children and vulnerable adults who may have been at risk of abuse. Nursing staff demonstrated how they located policies on the hospital's intranet system.
- Safeguarding training was provided to all nursing staff, at the time of our inspection. Compliance with training, for adult and children, level two, was100%.
- The safeguarding lead for the hospital was the director of clinical services.
- For our detailed findings on safeguarding please see the safe section in the surgery report.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- Staff used personal protective equipment which included using eye shields, when cleaning equipment to ensure they were not at risk of any cross contamination from used endoscopes.
- Staff had defined roles and responsibilities for areas of the patient pathway and for decontamination. All staff that operated the decontamination equipment received additional training.
- Endoscopes were cleaned immediately after use and in line with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. An endoscope is a fibre-optic instrument (used to look into body cavities) for procedures such as gastroscopy and colonoscopy. Used endoscopes were passed from the procedure room to the decontamination room for initial cleaning, testing and decontamination. Staff used personal protective equipment such as aprons, gloves, gowns and face visors in 'dirty' areas and removed this before moving to 'clean' areas of the room.
- The used endoscopes were manually cleaned in a sink within the dirty area of the decontamination room, before being transferred to an automated washer disinfector unit for cleansing. When processed the endoscope was removed from the cleaning unit ready to be transferred to the drying cabinet allocated in the clean area of the decontamination room.

- Drying cabinets held clean endoscopes. The clean endoscopes were dated and stored in the drying cabinet, which guaranteed the decontamination of the endoscope for seven days, according to the manufacturer's guidelines.
- Equipment was tested weekly to ensure endoscopes were cleaned adequately this included water testing within the reverse osmosis (RO) unit. The RO equipment cleans water to ensure it is free from any bacteria. The water was tested weekly to establish that the standard of water was reliable to disinfect the endoscopes. Test reports were validated by an independent authorising engineer in decontamination and reviewed by the clinical services manager. Six monthly deep cleans were performed within the procedure room and cleaning area.
- Dirty and clean areas within the decontamination room were not separated by a door or sealed hatch system. This meant that the areas within the clean area of decontamination room could become cross contaminated. Cross contamination is where infection can be transferred from one area to another. The staff explained the clean and dirty process and how they ensured there was no cross contamination. During our inspection we were assured that all necessary steps were taken to prevent this.
- For our detailed findings on cleanliness, infection control and hygiene please see the safe section in the surgery report.

Environment and equipment

- **The service had suitable premises and equipment and looked after them according to manufacturer's instructions. Any breakdowns of equipment were dealt with promptly.**
- An independent organisation provided services to maintain the decontamination equipment. We observed records of planned maintenance visits and when they had last taken place. All electrical equipment such as suction equipment and camera 'stack' systems were labelled to indicate when it had last been checked as safe to use and when it was due again.
- Staff had training on specific endoscopic equipment from manufacturers' representatives who attended the department. For example, the staff had received training on the endoscope cleaning system from the company who had manufactured it.
- In order to comply with the joint advisory group on joint gastro- intestinal endoscopy (JAG) recommendations the unit required an adjustable sink within the decontamination room, this was being addressed and quotes had been obtained at the time of our inspection. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards.
- Equipment used for emergency resuscitation was available in the endoscopy area and was easily accessible to staff in the procedure rooms. We saw signed records by staff who had checked the equipment each day the unit was open. The recovery area was always staffed and patients were never left alone in this area.
- The recovery areas had four individual cubicles where patients were easily observed by nursing staff. Staff segregated male and female patients to prevent mixed sexed clinical areas. A small waiting area was available for patients to use which had drinks facilities, if they needed to wait for transport or relatives.
- Consent was obtained at the patient's allocated bed space. Individual cubicles were partitioned by a disposable curtain therefore the area was not private which meant that conversations may have been overheard, this had been commented on by the Joint Advisory Group, (JAG) readiness site visit. However, staff told us a separate room was available if required.
- For our detailed findings on environment and equipment please see the safe section in the surgery report.

Assessing and responding to patient risk

- The hospital used the 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. There was a WHO 'safer endoscopy checklist' used in the endoscopy procedure room. Staff said that implementing the WHO checklist had proved challenging. However, they commented that they now believed it provided a team routine to ensure safe practice.

Good

Medical care

- A set of criteria was in place to ensure patients were screened and any health status alerts responded to. Any patients whose health presented a risk were reviewed prior to their procedure and steps were taken to prevent any potential risk.
- Patients were monitored during their procedure. Staff used an early warning system to recognise deteriorating patients. This involved measuring a patient's vital signs such as temperature, blood pressure, heart rate, and consciousness which provided a numerical score. The score determined the actions staff should take if a patient deteriorated, guidance was available to support staff with this. Following their procedure, the patient's condition was monitored, until they were well enough to be discharged.
- Registered nurses had completed intermediate life support training, which included basic life support and defibrillation skills. Health care assistants within the endoscopy unit completed basic life support training. Compliance for both of these training courses was 100% overall.
- If patients deteriorated and needed urgent medical treatment that was not available at BMI Droitwich Spa, staff followed a system advising them on the transfer process. There was a standard service level agreement with the local NHS trust. There had been no urgent transfers within the past year.
- Endoscopy staff met prior to each endoscopy list to assess if there were any risks identified for the unit and patients. These 'huddles' included sharing information about health risks of patients attending for procedures and planned activities.
- Copies of the Control of Substances Hazardous to Health (COSHH) risk assessments for the endoscopy unit, which included guidance on the handling and storage of items, for example, disinfectant, were available for all staff to access. The risk assessments also covered the precautions for safe handling of cleaning chemicals, use of personal protective equipment and necessary ventilation requirements.
- For our detailed findings on assessing and responding to patient risk please see the safe section in the surgery report.

Nurse staffing

- **Staffing numbers followed recommendations from the British Society of Gastroenterology.** Capacity meetings took place weekly to assess the following week's endoscopy lists. Staffing levels and skill mixes were reviewed to ensure adequate staffing were available. When staffing levels did not meet the required recommendations, senior managers were informed and actions taken to ensure safer staffing within the unit.
- Within the endoscopy unit, the usual planned staffing levels, were two registered nurses and one health care assistant, in the procedure and decontamination area. In the recovery area, there was a registered nurse and one health care assistant to admit and discharge the patients. Staff rotated between the endoscopy unit and theatre department, although managers were working towards having specific endoscopy staff, in order to provide continuity and efficient working.
- During our inspection, we found that the actual staffing met the planned staffing levels.
- The hospital had identified a clinical endoscopy lead which was in line with JAG recommendation. The interim lead was in the process of completing management training with the support from the theatre manager and director of clinical services.
- For our detailed findings on nurse staffing please see the safe section in the surgery report.

Medical staffing

- There were a total of eight consultants who had practising privileges within the hospital to perform endoscopic procedures.
- For our detailed findings on 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 and easily available to all staff providing care.**
- Each patient was assessed by a registered nurse before their procedure and relevant health information was recorded.
- A new endoscopy and reporting system had been implemented which enabled the endoscopy team to provide data collection in line with JAG standards.
- For our detailed findings on records please see the safe section in the surgery report.

Medicines

- **The service did not consistently follow best practice when prescribing, giving and recording medicines.** Storage of controlled medicines followed best practice. Patients received the right medication, at the right dose, at the right time.
- During our inspection we found an opened bottle of mild colic relieving medicine. The bottle had not been dated when it had been opened, therefore we were unable to gauge how long the bottle had been open. This meant that the medication could have been opened longer than manufacturer's recommendation and had become out of date. This was escalated at the time of our inspection, the theatre manager assured us that the bottle had only been opened that day.
- There had been an incident in the endoscopy department regarding controlled drugs not being documented correctly in the controlled drug book. A review of the incident had been completed, preventative and corrective measures had been taken to ensure correct documentation and administration procedures were followed by all staff present in the endoscopy unit.
- For our detailed findings on medicines please see the safe section in the surgery report.

Incidents

- Staff used an electronic incident reporting system to submit incident reports. Staff we spoke with said they had been trained and were confident in the use of this system.
- For our detailed findings on incidents please see the safe section in the surgery report.

Safety Thermometer (or equivalent)

- For our detailed findings on the safety thermometer please see the safe section in the surgery report.

Are medical care services effective?

We do not rate the effective domain for independent endoscopy services

Evidence-based care and treatment

- The endoscopy service was in the process of completing all the necessary standards to achieve JAG accreditation. The review for accreditation had been deferred until March 2019. The service had created an action plan and had completed 12 out of the 26 actions at the time of our inspection, with the other 14 requirements in progress. All actions were due to be completed by the end of February 2019. Following our inspection, we were updated on the progression of the JAG action plan, staff told us that actions were still ongoing and the date for reassessment had been allocated for May 2019.
- For our detailed findings on evidence based care and treatment please see the effective section in the surgery report.

Nutrition and hydration

- For our detailed findings on nutrition and hydration please see the effective section in the surgery report.

Pain relief

- For our detailed findings on pain relief please see the effective section in the surgery report.

Patient outcomes

- For our detailed findings on patient outcomes please see the effective section in the surgery report.

Competent staff

- Managers appraised staffs' work performance and held meetings with them to provide support and monitor the effectiveness of the service. Appraisal compliance within the endoscopy department was 100% in January 2019.
- Senior staff within the endoscopy unit, were in the process of obtaining competencies to mentor other staff within the department. This meant that when they had completed their mentorship training they would have had the competency to sign required and completed skills for the other members of staff within the team.
- Staff had completed specific endoscopic competencies. This included, assisting in biopsy and polypectomy removals. This is when a small piece of tissue is removed from the stomach or bowel lining and sent for further tests.
- The interim endoscopy lead and theatre manager had enrolled on a gastro-intestinal nursing (GIN) course. The GIN course covers all aspects of education, training and service developments required within endoscopy units.
- Staff actively arranged for external representatives to provide training sessions on endoscopy equipment during monthly training afternoons.

Good

Medical care

- For our detailed findings on competent staff please see the effective section in the surgery report.

Multidisciplinary working

- For our detailed findings on multidisciplinary working please see the effective section in the surgery report.

Seven-day services

- On call services were not provided within endoscopy. The service operated between 8am and 5pm, Monday to Friday.
- For our detailed findings on seven-day services please see the effective section in the surgery report.

Health promotion

- Nursing staff provided information for patients on lifestyle choices which might relieve their symptoms when it was appropriate. We saw this was provided in written format for patients to take away.
- For our detailed findings on health promotion please see the effective section in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- For our detailed findings on consent, Mental Capacity act and Deprivation of Liberty Safeguards please see the effective section in the surgery report.

Are medical care services caring?

We had insufficient evidence to rate caring.

Compassionate care

- **Throughout our inspection, we witnessed patients within the surgical and outpatient services being treated with compassion, dignity and respect.** Patients and relatives told us that staff were kind and attentive. They felt that they were kept well informed about their care and were involved in making decisions about their treatment at each stage. However, we did not see any patients attending procedures within the endoscopy department.
- Staff within the endoscopy unit told us that they felt they had sufficient time to spend with patients and their relatives.
- For our detailed findings on compassionate care please see the caring section in the surgery report.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.** Staff understood the impact the procedures and potential diagnosis could have on patients. There was a room which was accessible from both the clinical area and the waiting room. This room was used to provide private space to discuss results and suspected cancer diagnoses.
- For our detailed findings on emotional support please see the caring section in the surgery report.

Understanding and involvement of patients and those close to them

- For our detailed findings on understanding and involvement of patients and those close to them please see the caring section in the surgery report.

Are medical care services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **The services provided reflected the needs of the population they served and ensured flexibility, choice and continuity of care.**
- The hospital had a commitment to private patients as well as agreements with the local commissioners to provide services for NHS patients, and it ensured that services commissioned from them were safe and of a required standard. Staff told us that all patients were treated equally.
- For our detailed findings on service delivery to meet the needs of local people please see the responsive section in the surgery report.

Meeting people's individual needs

- Staff told us that endoscopy lists were single sexed. Single sexed lists meant that male and female patients did not share the same pre and post procedure areas. This promoted patient experience and ensured patient's privacy and dignity was maintained. The design of the environment and the way staff cared for patients supported patient confidentiality.

Good

Medical care

- Patients were provided with a private space to discuss their condition with endoscopy staff before their procedure. The clinical area was inaccessible to the public and there was space for patients to change in private and have access to private toilet facilities.
- The service took account of patients' individual needs. Patients were offered services that were tailored to their needs in line with National Institute for Health and Care Excellence (NICE) QS15 Statement 9. For those patients who were living with diabetic conditions they were offered the first appointment in the morning, to reduce any impact fasting may have on their blood sugar control.
- For our detailed findings on meeting people's individual needs please see the responsive section in the surgery report.

Access and flow

- The hospital monitored the number of cancellations. Procedures were only delayed or cancelled when necessary. Any patients who were cancelled were rebooked as quickly as possible.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with efficient practice.
- The service had processes and systems in place to book and schedule patients. The staff told us that their system allocated patients in date order. Patients undergoing endoscopy had a telephone pre-assessment carried out. This meant patients were identified to meet the required criteria to have their procedure performed.
- The number of procedures performed from October 2018 to December 2018
  - Oesophago gastro duodenoscopy - 61.
  - Colonoscopy - 144.
  - Flexible Sigmoidoscopy - 21.
  - Banding of haemorrhoids - 1.
- Patients were admitted and discharged following their procedure on the same day.
- For our detailed findings on access and flow please see the responsive section in the surgery report.

Learning from complaints and concerns

- **The hospital had a clear process in place for dealing with complaints.** There was a complaints policy in place. Staff we spoke to were aware of the complaints' procedure.
- There were no complaints registered on the hospital wide register that related to endoscopy during our inspection.
- For our detailed findings on learning from complaints and concerns please see the responsive section in the surgery report.

Are medical care services well-led?

Good

We rated it as **good.**

Leadership

- **The theatre manager supported the clinical endoscopy team, with the overarching management being provided by the director of clinical services for the hospital.** However, during the JAG readiness site visit, it was recommended that the unit would benefit from a member of staff who led the endoscopy unit. This had been reviewed and the hospital had appointed an identified clinical lead within the endoscopy unit.
- For our detailed findings on leadership please see the well led section in the surgery report.

Vision and strategy

- For our detailed findings on vision and strategy please see the well led section in the surgery report.

Culture

- The service had a caring culture. Staff told us that they enjoyed working in the department and felt well supported by their departmental managers. Department managers told us that they had an open-door policy and that they were proud of their staff and their departments.
- For our detailed findings on culture please see the well led section in the surgery report.

Governance

- The JAG readiness site visit recommended that endoscopy unit group (EUG) meetings were held on a

quarterly basis. There had been no regular endoscopy unit meetings documented or minuted prior to our inspection. Following our inspection, dates had been arranged for quarterly endoscopy unit group meetings, commencing March 2019.

- Processes were in place which ensured all endoscopists held up to date practising privileges, which included appropriate professional indemnity insurance and competency performance reviews. The reviews were undertaken biennially by the executive director of the hospital and signed off by the Medical Advisory Committee (MAC).
- Policies and standard operating procedures were reviewed yearly. During our inspection all standard operating procedures within the endoscopy unit had been reviewed and were in date.
- For our detailed findings on governance please see the well led section in the surgery report.

Managing risks, issues and performance

- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules.
- For our detailed findings on managing risks, issues and performance please see the well led section in the surgery report.

Managing information

- For our detailed findings on managing information please see the well led section in the surgery report.

Engagement

- For our detailed findings on engagement please see the well led section in the surgery report.

Learning, continuous improvement and innovation

- The identified clinical endoscopy lead was making links with endoscopy services within the hospital group to support staff development.
- For our detailed findings on learning, continuous improvement and innovation please see the well led section in the surgery report.

Good

Surgery

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

Are surgery 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 staff.**
- The service had a mandatory training programme for all staff. This included topics such as information governance, safeguarding, health and safety, moving and handling, infection prevention and control and basic life support. The mandatory training programme was tailored to the skill requirement of staff and was dependent upon their role. For example, clinical staff received training in adult intermediate life support and non-clinical staff completed basic adult life support training.
- Training was provided using e-learning courses as well as some face-to-face sessions. Staff used an electronic system to access e-learning training modules. All staff had a login to the system which provided them with their current training compliance and access to hospital policies. Staff told us that they received email reminders when they were due to update training and that their manager also reviewed their training compliance regularly. Staff within the service understood their responsibility to complete training.
- The overall compliance for mandatory training for the hospital was 95%. The hospital target for completion of mandatory training was 90%. Overall mandatory training compliance for ward staff and theatre staff, was 93% and 96% respectively.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommends that all specialist staff within theatre recovery areas have appropriate training in advanced life support (ALS). Several places for ALS training had been secured by the hospital, as the registered medical officer (RMO) was the only staff member trained to this level. Recovery staff were being prioritised to attend ALS training as there were no staff in recovery trained to ALS level. There were no nursing staff based on the wards who had completed ALS training, although this was not a requirement.
- The company providing the services of the RMO were responsible for ensuring they had the appropriate mandatory training.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had access to training on how to recognise and report abuse and were required to complete this.**
- All staff new to the service undertook BMI mandatory adults at risk training as part of their induction programme. This included safeguarding adults, mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) awareness and Prevent (terrorism radicalisation awareness). Updates for safeguarding training were available through the online learning portal, which

covered safeguarding adults and children, dementia awareness, Prevent, conflict resolution, consent, world health organisation (WHO) safe surgery, female genital mutilation (FGM) and chaperoning.

- There was a safeguarding policy which staff knew how to access. The policy covered the principles of adult safeguarding, mental capacity, best interests, deprivation of liberty safeguards, and Prevent. However, the policy was overdue for review since the due date for review was November 2018.
- Staff completed safeguarding training. Hospital compliance for safeguarding training level one and two adults was 96%. Hospital compliance for safeguarding children level one was 96% and for level two was 94%. Safeguarding children level three compliance for the hospital was 100%. The director of clinical services completed training on children's level three safeguarding every three years. Staff in the service received mandatory training in safeguarding of vulnerable adults and children via e-learning courses and were required to update it every three years. We asked for data for safeguarding training compliance for the service, which showed that 100% of ward staff and 93% of theatre staff had completed safeguarding training
- There were processes and practices in place to safeguard adults and children from avoidable harm, abuse, and neglect that reflected relevant legislation and local requirements. Staff told us what steps they would take if they were concerned about potential abuse to their patients or visitors. The hospital had a named safeguarding lead for adults and staff said they were accessible.
- Prevent awareness training, which explains how to safeguard vulnerable people from being radicalised into supporting terrorism, or becoming terrorists themselves, formed part of the mandatory safeguarding training module.
- The hospital had a chaperoning policy and staff knew how to access it. The policy stated that patients could request chaperones for intimate examinations and care and set out roles, responsibilities and training requirements for staff acting as chaperones. However, the policy was overdue for review since September 2018.
- All registered practitioners, assistant practitioners and healthcare assistants were required to complete FGM training every three years via e-learning. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Training data showed that 95% of hospital staff had completed FGM training. Service level data showed that 94% of ward staff and 96% of theatre staff had completed FGM training

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection, however, patient bedrooms did not have clinical hand wash basins.**
- The hospital had policies and procedures in place to manage infection prevention and control. The service followed guidance in the hospitals standard infection prevention and control precautions policy. This set out the expected standards for safe practice in relation to the prevention of healthcare associated infections. The policy was in date and staff knew how to access it. In addition, there was a hand hygiene policy for staff to follow which included information on mandatory hand hygiene training and assessment requirements as part of annual mandatory infection control training.
- Staff completed mandatory training in infection prevention control annually. Hospital data showed that 89% of staff were compliant for face-to-face infection control and hand hygiene training. Service level data showed that 94% of ward staff and 93% of theatre staff were compliant with infection prevention control training requirements.
- During the last inspection the hospital was told that it should ensure that sinks and taps, which conform to Health Building Note 00 -10 Part C Sanitary Assemblies, were available in clinical areas to allow correct hand hygiene practice. During inspection we found that the ward was still not fully compliant with infection prevention control requirements for hand wash basins in all patient bedrooms. This was listed on the hospital risk register. Staff told us that the refurbishment plan had been delayed but that this was due for completion during 2019. However, there were two clinical hand

wash sinks available on the ward and hand gel points were widely available. We saw that there were hand hygiene posters on display above the clinical hand wash sinks on the ward. During this inspection we had limited opportunity to observe hand hygiene practise.

- The service completed monthly infection prevention control (IPC) audits of hand hygiene. In July 2018 results of these showed that staff observed on the wards and theatres were 100% compliant with the audit standards.
- We saw several reminder signs outside patient bedrooms prompting staff to be 'bare below the elbow'. However, nursing staff on the ward told us that it was difficult to get some consultants to comply with 'bare below the elbow' requirements when providing care to patients. However, we did observe the Resident Medical Officer (RMO), being bare below the elbow whilst interacting with patients.
- During the last inspection we found that staff did not always comply with infection prevention and control guidelines, such as wearing personal protective equipment (PPE). PPE, such as gloves and aprons, was available in dispensers on the ward corridor. We saw that staff used these appropriately, for example a doctor wore gloves whilst inserting a cannula (an intravenous device) into a patient. Theatre staff were trained in the specific 'scrub technique' and the handling of surgical instruments; scrub nurses were observed using aseptic (sterile) techniques. The theatre team were 100% compliant with sharp safety and used safety needles and safety blades.
- Staff in the operating department were wearing appropriate theatre clothing and shoes.
- There were a range of IPC observational self-assessments undertaken, which reviewed staff compliance with the IPC policy. Heads of department had responsibility to complete these assessments. Results showed that in October 2018 ward staff were 100% compliant with standard precautions. For invasive devices management there was 100% compliance for indwelling urinary catheters and 86% for peripheral venous cannulas. Aninvasive deviceis any medicalaidesthat are introduced into the body, either through a break in the skin or through an opening in the body.
- Storage of equipment was organised and there was a clear system in place for identifying which piece of equipment was clean. We saw that 'I am clean' stickers were used to identify that equipment had been cleaned after use and was ready for the next patient use.
- Patients completed a health questionnaire before they attended the hospital for a procedure. The questionnaire contained a section about infection risks including identifying healthcare workers and any previous Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile infections. This meant the pre-operative team could identify any high-risk patients and screen them prior to admission in order to make any necessary arrangements prior to the patient's arrival. This was in accordance with the hospital's Methicillin Resistant Staphylococcus aureus (MRSA) screening and management policy. There were no reported cases of MRSA (which is an antibiotic resistant bacteria), or Clostridium Difficile (which is a bacterium that infects the gut and causes acute diarrhoea) at the hospital during the reporting period of July 2017 to June 2018.
- The Patient-Led Assessment of the Care Environment (PLACE) audit results for 2018 showed that BMI the Droitwich Spa hospital achieved 100% for cleanliness of the hospital.
- The operating theatre department and ward areas were visibly clean and tidy. Standards of cleanliness were maintained through the use of cleaning schedules which were monitored by completion of cleaning checklists. We saw that cleaning of the ward and individual bedrooms was completed regularly in accordance with the schedule. Although checklists were not audited, there were spot checks to ensure compliance with cleaning schedules.
- Housekeeping staff told us that all rooms were thoroughly cleaned after a patient was discharged and re-checked prior to a new patient being admitted. Disposable cloths were used to perform cleaning tasks. Curtains were changed every three to six months and blinds were steam cleaned every three months. Housekeeping staff were also responsible for flushing taps twice a week to reduce the risk of legionella contamination.

- Staff in theatres told us that part of the healthcare assistant (HCA) role was to clean the theatre between patients and at the end of each theatre list. This included cleaning the theatre table and mopping the floors. In addition, at the end of each day, housekeeping staff did a thorough clean of the theatres. The theatre manager explained that the floor cleaner was currently on the risk register as it was too big to effectively clean the theatre floors in line with standards recommended in the BMI infection prevention and control policy for cleaning of the peri-operative environment. A new floor cleaner had been ordered in order to mitigate this risk.
- All three main theatres had laminar air flow ventilation systems. This was compliant with Health Technical Memorandum 03-01 - Specialist ventilation for healthcare premises. This meant there was an adequate number of air changes in theatres per hour, which reduced the risk to patients of infection. For the period from July 2017 to June 2018, there were eight reported surgical site infections (SSIs). Six of these SSIs were following primary hip or knee arthroplasty surgery. One was following other orthopaedic surgery and one was following breast surgery. Infection prevention meeting minutes showed that that the reported SSI's were discussed.
- The ward provided leaflets about post-operative wound care within their discharge packs in order to minimise the numbers of surgical site infections.
- The segregation and storage of clinical waste was in line with current guidelines set by the Department of Health. The disposal of sharps containers and clinical waste bags were managed in accordance with the current guidelines. However, we observed a plastic bag attached to the side of a clinical surface within the anaesthetic room in theatres, which was being usedto dispose of empty plastic vials and other equipment. Recommended practise was to use the clinical waste bin provided. This was escalated during our inspection, to the theatre manager, who removed the bag immediately and reminded staff of the recommended practice.
- Decontamination and sterilisation of theatre instruments was managed in a dedicated facility offsite, which was compliant with HTM 01-01. There was a service level agreement in place with the accredited decontamination unit. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres. All clean instrumentation was transferred to the hospital in a sealed container. When the clean instrumentation arrived at the hospital an allocated member of staff checked all the equipment to ensure that sterility had been achieved and maintained and that there were no identifiable holes within the outer packaging.
- The service had an instrument coordinator lead who was responsible for ensuring clean equipment was always available to meet the requirements of the theatre operating lists each day. All clean instrumentation was stored within a well-ventilated store room, temperature and humidity control were recorded and documented daily. There was collection of dirty equipment and delivery of new sterile equipment at 3pm each day and a process to trace the equipment through a bar code sticker system. A quarterly meeting was held between the service and the decontamination company to discuss any issues. The service reported that the arrangement was working well.
- Dirty instrumentation was transferred from the theatres in a sealed plastic bag to a dirty area within the theatre department. The dirty equipment was then placed in an allocated sealed container awaiting transportation to the offsite decontamination facility.

Environment and equipment

- **The service had suitable premises, however there was some outstanding refurbishment work in the theatre department. Access to restricted areas was not consistently secure. Some equipment in the operating department was awaiting replacement as it had reached the end of its life.**
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure, temperature monitors .
- There was an ongoing refurbishment programme in the service, which had not been completed at the time of inspection. There were dents and cracks on theatre walls and doors which staff told us were awaiting maintenance work. Since this posed an infection control risk it had been placed on the service's risk register.
- We saw that there was not always restricted access to clinical areas as we were able to freely access the

theatre department. Access was usually controlled by visitors ringing a doorbell in order to gain access through a locked door. However, during our inspection, the doorbell was broken and the theatre department door was left unlocked all the time. Visitors to the theatre department could walk into the area without challenge, although there was a staff room and office in the entrance area. All clinical equipment and medication was locked away in the operating theatres and anaesthetic rooms, which meant this was secure from unauthorised visitors. However, we were not assured that the environment was suitable secured in order to prevent unauthorised persons accessing the department.

- On the wards, the doors were left unlocked during the day but were secured at night. The main hospital building entrance was also locked out of hours and access was through a CCTV monitoring system.
- There was a regular planned maintenance and equipment replacement programme. However, in theatres, two of the three anaesthetic machines which had reached the end of their life in December 2018, were awaiting replacement. These had been requested through the BMI finance committee process and it was hoped they would be approved for ordering in March 2019. In addition, the theatre stack systems (used mostly for minimally invasive surgery) were reaching the end of their life and carried the risk of parts being obsolete in the event of equipment breakdown. One of the stack systems was replaced shortly after our inspection, and the other two were waiting to be commissioned.
- There was a process for maintaining the safety of electrical equipment and medical devices. The service kept a log of all equipment in each department and a named person was responsible for ensuring equipment remained in date for testing. The log was reviewed monthly and was reported to a centrally held hospital log. All equipment we checked on the wards and in theatres was found to be in date.
- All theatres had the appropriate anaesthetic equipment in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance. All anaesthetic equipment was checked daily prior to use, by both the theatre staff and the anaesthetist. We saw logs to evidence that these checks had been completed. In addition, we saw that the machine's breathing circuits were changed weekly and the asset number of the new circuit was recorded.
- There was appropriate resuscitation equipment available in the case of an emergency. There were resuscitation trolleys in the theatre recovery area and on the ward. They were all well organised and had a tamper evident seal in place. Records indicated that the trolleys and their contents were checked regularly in line with hospital policy. All equipment we checked on the trolleys was found to be in date.
- All clinical items of equipment we checked in the ward treatment rooms, such as dressings, syringes and blood culture bottles, were found to be within its expiry date.
- Patients who needed implants, such as hip prosthesis, had this clearly recorded in their notes alongside appropriate details such as device number and size. The hospital also recorded all implants used on national registers such as the breast implant register and the national joint register (NJR). It showed which patient received which type of implant and when. This enabled all implanted devices to be tracked in case any faults developed.
- There was a clear process for tracking surgical instruments used in theatres. The instrument coordinator lead, checked trays for completeness against a log, when they were delivered. Non-conformance forms were completed for return to the supplier where equipment was found to be missing or damaged. Trays were delivered with bar coded stickers which were placed in patient records to identify which equipment had been used. There was a log of dirty equipment returned each day which was checked against the log of items delivered the next day to ensure all the correct instruments had been returned. A reserve of stock was kept ensuring clean equipment was always available. Loan equipment items could be ordered in advance for specialist surgery.
- There was bariatric equipment available on site, for example beds and hoists that could take weight limits up to 140kg. Staff in pre-operative assessment clinics assessed a patient's weight and calculated their body mass index (BMI). The staff said they did not operate on

patients who had a BMI above 35; this was in line with prior approval for joint replacements for NHS patients. However, the hospital exclusion criteria for NHS patients was a BMI above 40.

- The Control of Substances Hazardous to Health Regulations (COSHH) 2002, state that employers need to either prevent or reduce their workers exposure to substances that are hazardous to their health. We found that all hazardous substances were kept in a locked cupboard. We found COSHH data sheets to be in date within the theatre department.
- Specimens were stored in line with hospital policy, theatre staff labelled and documented specimens prior to transfer to the out sourced pathology department. Any specimen that needed to be refrigerated was stored within the allocated specimen fridge.

Assessing and responding to patient risk

- **Staff assessed the risks to patients so they were supported to stay safe.** However, we found that consultants did not routinely complete the clinical decision tool following nurse completion of venous thromboembolism (VTE) and bleeding risk assessments.
- Patients for elective surgery attended a nurse led pre-operative assessment clinic before their operation. During the assessment all required tests were undertaken, for example, MRSA screening, group and save and routine blood tests. This was in line with NICE guidance CG3: Preoperative assessments and NG45: Routine tests for elective surgery (April 2016). A telephone appointment was made for low risk patients needing minor procedures. Health care assistants had been trained to deliver pre-operative telephone assessments. All patients who had any associated risk factors or were undergoing major operations had a face-to-face appointment with a registered nurse.
- Every patient who was referred for surgery completed a health questionnaire. This was usually given to them following their pre-operative appointment with the consultant. The questions included the patient's past medical history, allergies, current medication, and any previous anaesthetics and infection risks. Patients attending face to face appointments brought their health questionnaire to the appointment and nurses checked that the information was complete. However, the questionnaires that we reviewed on the ward, were generally incomplete and had not been checked by the pre- assessment nurse at their appointment.
- Physiotherapists provided a joint class pre-operatively to all patients undergoing joint replacement surgery. This provided education and advice for patients and enabled staff to identify any need for equipment or additional support post-operatively.
- Anaesthetists were available to provide advice for any patients who were classed as high risk for anaesthesia or had medical conditions that deemed them at risk of developing complications after surgery. If necessary, patients were seen pre-operatively by an anaesthetist.
- The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient's level of risk. For example, ASA1 was low risk and used for healthy patients, ASA3 was a higher risk, and used for patients with severe systemic disease. Grades were recorded during pre-assessment by nurses and on admission for surgery by anaesthetists. High-risk patients were more likely to have complications following surgery, and were more likely to require high dependency nursing following their procedure. Patients identified as being at higher risk or who had complications diagnosed following their test results were referred to the consultant for further review. Patients operated on in the service were classed as ASA1 or ASA2 risk. Patients graded as ASA3 were not accepted, as there were no facilities to care for patients who required high dependency care at the hospital.
- Comprehensive risk assessments were carried out on patients when they were admitted as either inpatients or day patients. Nursing staff used nationally recognised tools to assess patient's risk of developing for example, pressure ulcers (Waterlow), Malnutrition Universal Screening Tool (MUST), venous thromboembolism (VTE), falls, infection control, as well as risks associated with moving and handling. We saw that these risk assessment tools were mostly completed on admission and were repeated post operatively.
- National early warning score 2 (NEWS 2) was also used to monitor for any deterioration in patients. NEWS 2 is a tool to detect the level of illness of a patient through the recording of routine physiological observations. Its use

enabled staff to recognise and respond to deteriorating patients by prompting them to take further action where appropriate. Actions may have included increasing the frequency of monitoring vital signs and requesting a review from the resident medical officer (RMO).

- National Safety Standards for Invasive Procedures (NatSSIPs) were available in the theatre department. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). Theatre staff were aware of national and local safety standards. There had been changes made within the theatre department based on NatSSIPs which included the development of a surgical first assistant role with associated competencies, and the introduction of using operating theatres for injection only procedures. Patients having injections were admitted to the ward pre-operatively to enable safety checks to be completed prior to the procedure, such as consent and 'stop before you block.' The theatre manager described a culture of safety first based on NatSSIPs including implementation of the Association for Perioperative Practice (AFPP) guidelines for anaesthetic machine checks. They explained that if a machine failed its daily test, the start of the theatre list would be delayed until the diagnostics showed that the machine was safe to use.
- Each patient room and bathroom had emergency call bells to be used to alert staff when urgent assistance was required. These were tested weekly by the head of department to ensure they were fit for purpose. Any issues were reported to the hospital engineer immediately and any actions taken were documented on the weekly emergency call bell check log sheet.
- The emergency call bells were linked up to a number of emergency bleeps. The RMO, director of clinical services and heads of department carried them. They were tested daily and in the event of the bleep system failure, reception staff would contact all members of the resuscitation team by telephone in their department. There was a log kept of bleep testing and any bleep system failure.
- Nursing handovers occurred at each shift change and included discussions around patient needs, medication, present condition and the plan for discharge.
- We saw that patients with known allergies usually had this information recorded in their medical records.
- The hospital undertook practice emergency scenarios on both the ward and in theatre. These were run by resuscitation officers and were held every six weeks. Any concerns raised during the scenario exercise were discussed at heads of department meetings and learning was fed back to staff during team meetings.
- Staff were supported by the RMO if a patient's health deteriorated. The RMO was on duty 24 hours a day and was available on site to immediately attend any emergencies. The hospital had a transfer agreement in place with the local acute trust should a patient require a higher level of care. The RMO could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care. The RMO and staff stated that consultants were responsive and supportive.
- In an emergency, staff called an ambulance and patients were transferred to the emergency department. There had been three unplanned patient transfers to the local NHS trust from July 2017 to June 2018.
- Information was available to help staff identify patients who may have become septic. Sepsis is a serious complication of an infection. There was a notice board on the ward with information about sepsis, for example; what is sepsis, and what are the symptoms? Guidance was followed from the sepsis trust, including use of the sepsis six tool. This is the name given to a bundle of medical interventions designed to reduce the death rates in patients withsepsis. Patients suspected of having sepsis were transferred to the local NHS hospital for ongoing monitoring and treatment. Sepsis training for staff was provided as part of the intermediate life support and care of the deteriorating patient modules. The hospital had recently started producing one-page information posters for staff called 'Inci grams #', and we saw that there was one entitled 'sepsis six - spot the signs'. This was displayed on the notice board in the theatres staff room.
- Audit of completion of VTE, falls, nutrition and pressure risk assessment was carried out by ward staff. Audit results from September 2018 showed there was 86.9% compliance with risk assessment standards. Records that we reviewed during inspection showed that these were generally well completed. There were, however,

some omissions in recording risks scores, for example, one of nine records did not have a VTE score completed on admission and two of nine records did not have the heart rate recorded in the NEWS 2 assessment, with one further record not having the NEWS 2 score calculated correctly. Staff explained the process for escalating concerns about any deteriorating patients as triggered by an increasing NEWS 2 score.

- We saw that there was a decision box for consultants to complete when deciding whether to offer pharmacological thromboprophylaxis to surgical patients. This was in order to balance the person's individual risk of VTE against their risk of bleeding, and was in line with NICE guidance (NG89) for March 2018, which states that medical staff should document any VTE prophylaxis decisions made, for example, the use of medication or compression stockings. In six out of nine records we reviewed, we saw that this box was not completed. A senior nurse told us that completion of the box had been discussed with consultants but they generally did not use this section of the patient record. We raised this with the hospital director, following our inspection. They told us that the hospital had taken action to address this including sending an email to all consultants to remind them of the need to complete VTE assessments.
- During the reporting period there were four incidents of hospital-acquired VTE or pulmonary embolism. One of these was in a high-risk patient, post total knee replacement surgery. The root cause analysis investigation into this incident showed the patient had a high VTE risk score pre-operatively and had the risk assessment repeated post operatively. We saw that they had received appropriate prophylactic treatment postoperatively but still went on to develop a deep vein thrombosis. This was detected four weeks postoperatively during a follow up physiotherapy appointment. In a second incident a patient developed a pulmonary embolism after discharge home four days post shoulder surgery. The root cause analysis investigation into this incident showed that the patient had an overall low VTE risk assessment score, although scored high for risk due to age. There was no completion of the clinical decision box following consultant review of their VTE and bleeding risk assessment. This meant there was no documented decision regarding whether this patient should receive prophylactic treatment or not. It was, therefore unclear whether the consultant had reviewed the risk as there was no evidence of this process.
- The hospital had a small blood fridge in the theatre suite where three units of blood was kept for emergency purposes. They also had a service level agreement with another local BMI hospital and local independent provider for obtaining blood products. All patients undergoing major surgery were cross matched for blood pre-operatively. There were staff competencies for administering a blood transfusion, which all registered nursing staff on the ward had completed.
- There were daily 'comms cell' meetings held which all clinical leads attended with a representative from the senior management team. They reviewed staffing, activity and any incidents or concerns raised and identified who was part of the emergency team bleep holders throughout the day. In addition, the ward and theatre clinical leads had daily huddle meetings with the rest of their team to discuss any risks or concerns and ensured these were addressed. Theatre staff reviewed the lists for the day and identified which staff were working in each role (for example: scrub, anaesthetic, or circulator). This was documented on a wipe board so all staff were aware.
- The 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, was used, in line with National Patient Safety Agency (NPSA) guidelines. We saw the process being completed by theatre staff which included a briefing, sign-in, timeout, sign-out and debriefing. Staff generally demonstrated a good understanding of the procedure. However, one consultant we observed did not follow the process, stating that it was not necessary as he was only performing injections. We saw that there was no sign in, time out or sign out by this consultant and in three out of four procedures they completed, there was no marking of the site. We raised this as a concern with the theatre manager who stated that this was not the expected standard of practice, and assured us that it would be addressed with the individual involved. Following our inspection, senior managers within the

hospital told us that the consultant who did not follow the correct safety checklist process, had reflected on his practice and assured the hospital that he would comply with all necessary recommendations in future.

- WHO checklist compliance was measured by observing 30 patients every month through their theatre journey. All staff members in the theatre team were involved in completing the audit and other staff did not know when it was being done. Audit results were provided for May 2018 which showed 100% compliance with the WHO checklist.
- The surgical service complied with the Association for Perioperative Practice (AfPP) guidance for assessing and responding to patient risk for all surgical areas. This included ward admission, anaesthesia, surgery, and recovery. There were sufficient staff on duty during the patient's procedure, which included surgeons, anaesthetists, and operating department practitioners. This was in line with AfPP guidance, which meant the risk to patients undergoing surgery had been evaluated.

Nursing and support staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- Staffing and skill mix on the wards were planned so that patients received safe care and treatment. The service used the BMI nursing dependency and skill mix planning tool to assess the correct number of nurses required for each shift on the ward. Staffing was reviewed on a daily basis by the ward manager and overseen by the director of clinical services. Additionally, it was reviewed daily at a corporate level. The tool was superseded by clinical judgement if there was an additional requirement for staff.
- Staffing was based on planned activity. Rotas were prepared in advance and staffing levels were reviewed daily at the 'comms cell' meetings and ward huddles. The ward used a ratio of one registered nurse to four or five patients for planning staffing levels. During the night, there was always a minimum of two registered nurses on shift, regardless of the number of patients. In the event of there being more than eight or nine patients on the ward, an additional member of staff would be added to the rota; often, this was a healthcare assistant.
- Staff shifts in theatre were planned using the BMI theatre utilisation tool which took into account the daily activity levels for surgical lists. This included the number of procedures booked and whether they were major or minor procedures. The tool was based on guidance set out by the Association for Perioperative Practice (AfPP) in 2015 related to safe staffing levels; 'Safe Staffing Levels for the Peri-operative Environment as a staffing tool (2015)'. Theatre staffing levels were also based on nationally recognised guidelines such as the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Anaesthetic Recovery Nurses Association (BARNA). Staffing rotas were generally completed five days in advance in theatres. Some staff told us that they would like to have had rotas further in advance, but the manager explained that this was not always possible as theatre lists were subject to change.
- There was an on-call rota to cover for any emergency returns to theatre overnight. This was completed four weeks in advance. Staffing levels were reviewed daily at the 'comms cell' meetings and theatre huddles. Nursing staff in theatre each day included an anaesthetic practitioner, two 'scrub' trained staff (these could be registered nurses or operating department practitioners (ODPs)), a recovery practitioner and a health care assistant (HCA). The three-bay recovery area was staffed by two registered nurses or ODPs.
- Recruitment of clinical staff was reported to be an ongoing challenge, and was on the risk register. Vacancy rates reported for the ward for September 2018 were 10% (one full time equivalent member of staff) for registered nurses and 29% (one full time equivalent member of staff) for healthcare assistants (HCAs). However, during our inspection, the ward manager told us that there were two full time registered nurse vacancies, an additional two vacancies due to maternity leave, and no HCA vacancies. In the operating department there was a 0% vacancy rate reported for September 2018, however, during our inspection the theatre manager told us that there were two full time vacancies.

- There were staff turnover rates of between 2% and 4.8% (dependent on job role) reported for the wards from October 2017 to September 2018. For theatres, there was between a 0% and 3% turnover rate (dependent on job role) for the same period.
- There were sickness rates of between 0% and 25% across the ward and theatres from October 2017 to September 2018.
- Any gaps in staffing were covered through use of bank and agency staff. The use of bank and agency staff on the ward, as a share of total staffing, was between 0% and 16% during the reporting period from October 2017 to September 2018. The use of agency staff in the operating department, as a share of total staffing, was between 0% and 8% during the same period. There were no unfilled shifts on the ward or in theatres reported from July 2018 to September 2018.
- Bank and agency staff usually worked regularly and were familiar with the hospital. New agency staff received an orientation of the service, which included access to, and the location of emergency equipment and fire exits. The ward manager also stated that any agency staff always worked alongside permanent staff and that shifts were never covered solely with bank and agency staff.

Medical staffing

- **There were enough medical staff with the right qualifications, skills, training and experience to provide the right care and treatment all the time.**
- Patient care was consultant led. All consultants provided a 24-hour on-call cover for patients post-operatively and were within a 30-minute drive of the hospital when off site. All consultants were employed through practising privileges. Practising privileges were granted to doctors who treated patients on behalf of an organisation, without being directly employed. All consultants only carried out procedures that they would normally carry out within their scope of practice in their substantive post in the NHS.
- There was an up to date out of hours on call list for consultants. Most consultants worked in speciality groups and provided cover for one another. Staff told us that the on-call rota worked effectively and consultants were accessible when required.
- Consultants had a responsibility to ensure suitable arrangements were made with another approved practitioner to provide cover if they were not available, for example when they were on holiday.
- Anaesthetists were expected to be available for 48 hours following surgery in case a patient, whom they had anaesthetised, became unwell. Anaesthetists also provided cover for each other and the ward teams were aware of a rota to refer to, if required.
- RMOs were employed through an agency, who submitted a file including evidence of pre-employment training, and required background checks before the arrival of each RMO. This was reviewed and signed-off by senior staff. RMO's worked a rota of one week off and one week on, 24 hours a day, which was coordinated through the agency. There was a procedure in place if the RMO required relief from their shift, for example in the event of sickness. The RMO stated that they were rarely contacted overnight. The RMO had received induction training. Their duties included monitoring patients in the wards, prescribing medications, cannulation, taking blood samples and responding to emergencies.
- The RMO said they felt supported by the ward staff and medical teams and they could contact the consultant or anaesthetist responsible for a particular patient if further advice or support was needed. The RMO attended the daily ward huddle meetings.

Records

- **Most staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. However, some documentation was not always completed in line with policy and best practice.**
- The hospital used a paper-based system for recording patient care and treatment. These were stored centrally when not in use, and taken to the outpatient's department prior to patients' appointments or to the ward when patients were admitted for surgery. They were stored securely in order to protect confidential patient information. On the ward, medical records were

kept on a shelf behind the nurse's station, but were not locked away. Nursing records were kept within patient bedrooms. NHS patient's records were accessible for patients whose treatment was funded by the NHS.

- We looked at nine sets of patients' records on the ward and saw that they were generally legible, up to date, signed, dated and timed. We did, however, note, that some entries in the medical records were only initialled rather than having a full signature, and there were no signature sheets kept with records.
- The service completed audit of medical records quarterly. Data submitted for September 2018 showed an average score of 90% compliance with criteria.
- Clear pathway documents were used throughout the patient journey. Risk assessments were completed from the start of the patient's journey in pre-operative assessment through to admission on the wards. Risk assessments included VTE, nutrition, pressure care, falls, moving and handling and infection control risk. The risk assessments were generally completed although there were some omissions, for example, in the totalling of fluid balance scores.
- Staff on the ward completed and recorded intentional care rounding. Intentional care rounding is a structured process with staff carrying out regular checks with individual patients at set intervals. For example, we observed HCAs visiting patients to check that call bells and drinks were within reach and asked if the patient was comfortable or in any pain. We saw these were documented in the patients' records reviewed.
- We saw that one patient had brought a community do not attempt cardiopulmonary resuscitation (DNACPR) document into hospital which had been completed with her GP. A copy of this was filed in her medical records, although it had been raised with the consultant caring for her, that the document was not valid during her inpatient stay. It was BMI policy for DNACPR documents to be completed during an inpatient stay if appropriate, to ensure the document reflected the patient's current wishes at that time. The ward manager stated that although the consultant was aware that it was against policy, he had declined to complete an updated DNACPR document for the patient's inpatient stay.
- There were surgical pathways in place; part of the pathway included preoperative assessments. The assessments were carried out in line with NICE guidance. These guidelines were in use within the clinic. Every patient who was referred for surgery completed a health questionnaire which should be checked by nurses at pre-assessment appointments. However, the questionnaires that we reviewed on the ward, were generally incomplete as they had not been checked by staff.

Medicines

- **Staff on the ward prescribed, gave, recorded and stored medicines in line with best practice. Patients received the right medication at the right dose at the right time. However, in the theatre department, storage and administration of medicines was not consistently in line with best practise.**
- Surgery is the main service and medicines information also relates to other services we inspected.
- The hospital had an onsite virtual pharmacy. This meant that no medicines were kept in the pharmacy office. All medicines required, were ordered by the pharmacy staff as needed. The pharmacy was open Monday to Friday 8.45am to 4.30pm. There was a part time new permanent pharmacist in post who was supported by a bank pharmacist and an agency pharmacy technician. The team accessed advice and support from the pharmacy lead for BMI hospitals locally. In addition, the pharmacist had a weekly telephone call with the chief pharmacist for the BMI Hospital Group who provided guidance and further support. The pharmacist was also able to discuss any clinical concerns about patients with the resident medical officer (RMO) or consultants.
- The RMO could access and issue 'to take out' (TTO) packs from the pharmacy out of hours and at weekends, which were labelled with the appropriate directions. Nursing staff were required to complete on the label the name of the patient whom the medication was for and also the date on which the patient was discharged. In addition to this, nursing staff were required to complete paperwork within a folder, ensuring that there was a record of what item had been issued out of hours. The medications issued were then subsequently booked out to the patient by pharmacy the following day. As this was a virtual pharmacy there was no process to obtain any other medication required outside of pharmacy

opening hours. There was, however, an account held with the local community pharmacy that could provide some medications in an emergency. The process for this was detailed in a standard operating procedure.

- The pharmacy technician was responsible for the ordering and dispensing of all TTO medication. The pharmacist visited the ward daily and reviewed patient's medication history and checked medication charts for allergies and drug interactions. They discussed any concerns with the resident medical officer (RMO). They were responsible for checking and recording medication stock levels and for ordering controlled drugs (CDs) daily. Pharmacists completed medicines reconciliation and all medicine audits on the ward and in theatres. Medicines reconciliationis the process of accurately listing a person's medication. This involves recording a current list of medicines, and comparing this with the medicines the person was actually using and had been prescribed whilst in the hospital. It involved recognising and resolving any discrepancies and documenting any changes. In addition, the pharmacist completed a pharmacy intervention log which detailed any prescription anomalies that had required pharmacy intervention. From October 2018 to January 2019 there were four interventions recorded on the log, all scored as low impact.
- The pharmacy department completed a medicines reconciliation audit, safe and secure medicines audit, missed dose audit, medicines management and/or prescribing audit and a controlled drugs audit. There was limited data provided relating to these audits, with no data provided for the medicines reconciliation, safe and secure medicine storage, medicine management or missed dose audits. Audit results that were provided showed that in June 2018 there was 100% compliance with controlled drug audit standards in theatre, and 97% compliance with controlled drug audit standards on the ward in September 2018. Self-assessment of medicines management processes were completed on the ward by the ward manager. The assessment reviewed medicines storage and access, preparation and administration of medicines, emergency medicines and prescriptions. In October 2018, results showed 98% overall compliance with the assessment standards.
- Staff followed procedures for the safe administration of medicines in line with guidance from the Nursing and Midwifery Council, safe medicines management. Staff had good knowledge of safe medicines management and had access to the hospital's medicines management policy on the intranet. The policy covered obtaining, recording, using, administration, and disposal of medicines.
- Medicines, including controlled drugs (CDs), were generally stored safely and securely in the operating department and on the wards. On the ward, medication cupboards were within a locked treatment room with coded access, and were locked with a key. CD cupboards were locked separately. Keys for CDs were kept in a separate coded key safe which was only for storage of CD keys. Staff told us that only registered nurses had access to this code. All medication stored in the clinic rooms, that we spot checked, was in date. Ward staff carried out daily checks on CDs and medication stocks to ensure medicines were reconciled appropriately. CDs were checked daily by the night staff, and we saw that all checks had been completed and signed for.
- In the theatre department, medicines were stored safely in locked cupboards and refrigerators behind locked doors or in restricted areas which were only accessible to authorised staff. In the operating theatres, staff had standardised the drug cupboards. Medicines needed in an emergency were readily available; staff we spoke with knew where to find them. Protocols for anaphylaxis and resuscitation protocols were available within the department. Controlled drugs were stored and managed safely and in line with legislation. We checked controlled drugs and the register and found the required records were correctly maintained. Staff carried out and recorded checks of controlled drugs twice daily.
- Although we saw that the CD cupboards were always kept locked, we did find one of the theatre medication cupboards was left unlocked during the surgical list. No medication was left unattended whilst we were observing in theatre. However, we did observe one surgeon not checking the medication prior to administering it to each patient. Instead it was only checked once at the beginning of the list, then the nurse was responsible for checking the correct drug and its expiry date prior to individual patient use.
- Staff monitored and recorded temperatures of fridges used to store medicines and of the ambient room

temperature in the rooms where other medicines were stored. We reviewed fridge temperature record checks. These showed that fridge temperatures were checked daily to ensure they were within the correct temperature range. Medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Staff knew what to do if fridges were out of temperature range.

- Emergency medications were stored securely on the resuscitation trolleys, which had tamper evident seals. We checked a sample of the medications on the trolley and found that these were all in date.
- There were local protocols for the administration of antibiotics which were followed by the service. The pharmacist explained that they follow NICE quality standard QS61: infection prevention and control, for antibiotic prescribing for surgical prophylaxis and that there were BMI antibiotic prescribing guidelines.
- There was piped oxygen in all the patient bedrooms on the ward, including in the ambulatory care area of the ward.**Incidents**
- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**
- Staff were aware of the process for reporting any identified risks and incidents. Incidents were logged on the hospital's electronic reporting system. All staff we spoke with, except for the resident medical officer (RMO) told us that they had access to the reporting system. Staff understood what concerns should be reported as an incident and could discuss incidents they had reported. Clinical leads investigated incidents in their areas and shared any themes or learning at departmental meetings. The comms cell meetings and daily huddles were also used to discuss incidents with staff.
- We heard that a 'falls cross' system had been introduced onto the ward as a result of learning from incidents. The cross is a visual tool to monitor numbers of falls and raises staff awareness, which was introduced following a review of incidents last summer which indicated increased numbers of falls.
- There had been 247 incidents reported from July 2017 to June 2018 by the operating department and ward staff. The hospital did not differentiate between clinical and non-clinical incidents. The majority of these were categorised as no harm or low harm. There were no incidents categorised as severe harm or death. Each incident had been reported and investigated in accordance with the service's procedure for incident management.
- Serious incidents were investigated by staff with the appropriate level of seniority, such as the director of the clinical services. There was one serious incident during the reporting period which had a root cause analysis completed in order to investigate any contributory factors. The investigation found that the patient suffered a fractured surgical neck of humerus, (upper arm) intraoperatively as a result of undiagnosed metastatic (advanced cancer) disease. We saw that duty of candour was applied both verbally and in writing and that the surgeon involved was temporarily suspended during the investigation. Following our inspection, the hospital director told us that the lessons learnt document from the investigation had been shared with the medical advisory committee, regional clinical governance board and the clinical commissioning group. However, as the investigation was ongoing, the lessons learned document had not been made available to the hospital staff at the time of inspection.
- There were no never events during the reporting period.
- We saw that there was information on notice boards to share learning from investigations and external safety alerts. The theatre staff room had a board with information on recent root cause analysis investigations, NHS improvement (NHSI) patient safety alerts and medicines and healthcare products regulatory agency (MHRA) drug safety updates.

Safety Thermometer (or equivalent)

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

- The ward manager explained that they completed the safety thermometer monthly and that the results were discussed at team meetings. They reported there were no concerns relating to the results.
- The service was compliant with the reporting guidelines in relation to the NHS Safety Thermometer. They had started submitting the data in March 2016. Areas identified for reporting included:
- Venous thromboembolism (VTE) (a blood clot in the vein).
- Catheter related urinary tract infection.
- Pressure ulcers by category.
- The latest available safety thermometer data showed that in December 2018, 100% of patients were found to have harm free care, with 0% of patients having had a new VTE, fall or pressure ulcer development.
- Staff carried out risk assessments for VTE in accordance with National Institute for Health and Care Excellence (NICE) guidelines. VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients. The service audit results showed that VTE screening rates were 99.3% between October 2017 and September 2018.
- The service gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes. We did not see this displayed in the hospital. However, information provided by the hospital showed clear information about overall incidence of MRSA, a bacterium, that causes infections in different parts of the body, and C. Difficile, which is a bacterium that is one of the most common causes of infection of the colon. From October 2017 to September 2018, there had been no incidents of MRSA, Escherichia coli (a type of bacteria that normally live in the intestines of people and animals) or C. Difficile.

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 evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- The hospital used evidence-based guidance and quality standards to inform the delivery of care and treatment. For example, the pre-operative assessment clinic assessed patients in accordance with National Institute for Heath and Care Excellence NG45 'Routine pre-operative tests for elective surgery' (2016).
- Consultations, assessments, care planning and treatment were carried out in line with recognised general professional guidelines. A review of medical records and discussions with the clinicians on duty confirmed this during our inspection. Clinical pathways and risk assessments were nationally recognised and referred to the Royal Marsden manual of clinical nursing procedures.
- The service participated in relevant local and national audits which were based on national guidance, standards and legislation, including NICE, the Royal College of Surgeons, and the Health and Safety Executive. For example, the audit of surgical site infections, Patient Reported Outcome Measures (PROMS) and National Joint Registry (NJR).
- Staff followed guidance regarding the recording and management of medical implants, such as hip implants. Patients signed a consent form agreeing they were satisfied for their details to be stored on the central database; we saw evidence of this in the notes. Relevant paperwork was carried out at time of the insertion and inputted into the National Joint Register (NJR) by theatre staff within 24 hours of the procedure.
- Staff could access national and local guidelines through the hospital's intranet. This included access to hospital policies which we saw were referenced to current national guidelines and relevant evidence. Staff told us that any new policies were sent out in a monthly bulletin, which also included any safety or medical alerts.
- An audit programme was completed which was set corporately by the BMI Healthcare group, and collated evidence to monitor and improve care and treatment.

The hospital was able to benchmark the results from the audits with other hospitals within the BMI Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the World Health Organisation (WHO) safer surgery checklist, and medicines management. We saw evidence that actions were taken to improve compliance where indicated.

- BMI Healthcare participated in the Private Healthcare Information Network (PHIN). This enabled effective comparison with data available from NHS providers to assist with information transparency and patient choice. All consultants had access to the Private Healthcare Information Network (PHIN). This data was used to benchmark against local and national patient outcome results. Data from the PHIN website showed good participation in measuring health outcomes and that 99% of patients would recommend the hospital.

Nutrition and hydration

- **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 preferences.**
- Patient's nutrition and hydration needs were assessed monitored and recorded by using the Malnutrition Universal Screening Tool (MUST). This was in line with NICE guidance QS15 statement 10: 'Physical and psychological needs' (2012). We saw that these were consistently completed. Staff used fluid balance charts to monitor patients' fluid intake, although we saw that these were not always fully completed or totalled.
- Patients waiting for surgery were kept 'nil by mouth' in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Patients attending for elective surgery were given clear instructions about fasting before admission. Information was given verbally at the pre-operative assessment and in writing. Patients were encouraged to drink clear fluids up to two hours before a surgical procedure. Staff told us that following the daily review of the theatre list, anaesthetists would contact the ward to advise of any updates to fasting times, to ensure that patients were fasted for the minimum amount of time. The ward manager told us there had been a focus on improving hydration in order to reduce the numbers of patients urgently transferred out of the hospital, due to acute kidney injury (AKI). They reported that staff training to promote adequate pre-operative fluids and monitoring of fluid balance had resulted in a decrease in the numbers of patients transferred, due to AKI.
- Patients who were recovering from surgery, had jugs of water within reach. These were regularly refilled. Staff completed hourly care rounds for each patient and checked whether they had a drink.
- Patients experiencing nausea or vomiting were prescribed antiemetics (a medicine effective against vomiting and nausea). Patients were given antiemetics intravenously in the recovery area if they complained of nausea post-operatively.
- There was a variety of hot food options available, and we were told that if any patients had a specific request, this could be provided. This encouraged patients to eat and ensured their nutritional needs were met.
- The Patient-Led Assessment of the Care Environment (PLACE) audit results for 2018 showed a score of 100% for the ward food score. Patients we spoke with all reported that the food was enjoyable, there was adequate choice, and they had sufficient food to meet their daily requirements.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain. They gave additional pain relief to ease pain.**
- The surgical care pathway used, prompted staff to assess, record and manage pain effectively. Patient's records showed that pain had been assessed using the pain scale within the NEWS2 charts and via the hourly care rounds.
- Patients told us staff effectively managed their pain. During inspection, we heard a conversation between a physiotherapist and a doctor, asking for a review of analgesic medication in order that the patient could fully participate in rehabilitation. We also noted that the pharmacist and RMO were discussing a patient's analgesic medication in order to identify the most effective management plan.

- Appropriate medicines were given as prescribed and the effect of analgesia was individually evaluated. Staff assessed patient's pain regularly post operatively. Patients told us that they had had effective pain relief when they needed it.
- Consultants and anaesthetists prescribed pain relief medicines for the immediate post-operative period. This included pain relief using pumps if necessary. The RMO was available to provide further pain relief and advice for patients 24 hours a day, seven days a week.
- Staff reported that pain management was part of patient satisfaction feedback and that pain advice booklets were provided at pre-assessment. In addition, pain scores were documented every time patients' observations were completed. We saw from the pain audit results in August 2018, that there was 100% compliance with documented evidence that patient pain levels were evaluated after analgesia had been given, and with the standard for nurses to have assessed patient pain levels frequently enough.

Patient outcomes

- **The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.**
- BMI The Droitwich Spa Hospital participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- Results on patient outcomes were compared with other locations within the region and across BMI Healthcare through the corporate clinical dashboard, which used data from the incident and risk reporting database. The service was able to review their data and compare it with hospitals of a similar size within BMI Healthcare.
- The service participated in some national audits to monitor patient outcomes including the elective surgery Patient Reported Outcome Measures (PROMs) programme, and the National Joint Registry (NJR).
- The service had an 88.9% pre-operative participation rate for PROMS, which was just below the England average of 90.7%. The post-operative response rate for the service was 81.3% which was above the England average of 75.8%. The service's patient outcomes for hip replacement surgery were higher (better) than the England average based on the Oxford hip score. The service's patient outcomes for knee replacement surgery were just below (worse) than the England average, based on the Oxford knee score. For all outcome measures combined, which provided an overall health gain status for patients following joint replacement surgery, the service sat within average parameters for England and was not an outlier.
- < >he service participated in the NJR and benchmarked itself against other BMI hospitals. They submitted data for 199 hip replacements and 195 knee replacements in the submission year 2018. There was a 93% NJR consent rate. This meant that patients were being consented for being included on the national joint registry and ensured traceability of their joint. There was one unplanned return to the operating theatre from July 2017 to June 2018. The hospital reported six unplanned readmissions, to either an acute hospital or BMI The Droitwich Spa hospital, within 28 days of discharge from July 2017 to June 2018. Unplanned readmissions were reported as incidents on the hospital's electronic reporting system. Each incidence of unplanned return to theatre or readmission was reviewed individually to ensure there were no trends or learning to be shared. We saw evidence that investigations were completed and these were discussed at the medical advisory committee and clinical governance committee.
  The hospital took part in the collection of data for the private patient reported outcomes. This covered, hip, knee and hernia surgery. Private patients having this surgery had their data sent to the Private Healthcare Information Network (PHIN). The data was collected and made available on the PHIN website, so that the public could compare outcomes between different private providers. Data collected included unplanned return to theatres, unplanned readmissions and surgical site infections.
- Infection rates were collected and reported and were found to be low. The service had recorded eight surgical site infections out of 4,351 procedures within the reporting period. This was an overall infection rate of 0.02%.

Competent staff

Good

Surgery

- **There were processes in place to ensure that staff were competent for their roles. However, there was an instance where a staff member had failed to revalidate their professional registration for one year. Managers appraised staffs' work performance and held supervision meetings with them to provide support.**
- All new hospital staff attended a corporate induction and had a local orientation to their department. Depending on their role, some new staff were classed as being supernumerary for a period and this allowed them to understand their new environment before taking full responsibility. For example, a healthcare assistant (HCA) told us that they had been supernumerary for three weeks during their induction period.
- We spoke with a student nurse who said that they had an induction booklet to complete and received a named registered nurse as a mentor. They explained they spent 40% of their time with their mentor and said they had been offered good opportunities to develop whilst working on the ward. We saw that there was a student nurse information board which provided details of development opportunities.
- An agency nurse told us that they had an induction which covered orientation to the ward layout, including where records were kept and the location of the resuscitation trolley. They were also made aware of policies, and health and safety requirements on the ward. There was a checklist which was signed by the senior nurse on the ward to evidence completion of the induction.
- New staff completed a variety of mandatory and role specific training through an e-learning system and face-to-face training.
- Staff had annual appraisals and we saw that in the wards and theatres, most registered nurses and health care assistants had had an appraisal within the previous 12 months. The appraisal year ran from November to October, so data was only available for the previous appraisal year which ran from November 2017 to October 2018. During this period, we saw that 100% of nursing and healthcare assistant staff in theatres and on the ward, had received an appraisal.
- Staff told us that they found the appraisal system helpful and could identify any training or development needs through this process. Managers reviewed appraisal objectives and training needs with staff at a twice-yearly appraisal meeting. Examples of training needs that had been identified through the process included the completion of advanced life support training for theatre recovery staff, and completion of the foundation practitioner course for two healthcare assistant staff.
- There were no regular one to one or supervision meetings held between managers and staff, although staff described a supportive approach to their personal development. Staff said that there were ad hoc supervision opportunities as senior staff were always available for advice. However, there were no documented supervision sessions. Clinical leads described an informal weekly catch up meeting with their line manager in the senior leadership team, where they could reflect on difficult situations and access support. In addition, there were monthly clinical leads meetings over breakfast with the hospital director which acted as a peer support mechanism for this group of staff.
- There were specific competencies required for each role which included, for example, medicines administration, wound care and blood transfusion. Staff in the pre-assessment team were required to complete a BMI three-day pre-assessment course soon after starting in the role. Staff in theatres developed additional skills based on a competency framework in order to work in scrub, anaesthetic and surgical first assist roles.
- The theatre manager had developed a monthly half day training session, open to all staff, where development sessions were delivered. These included, for example, scenario training, managing difficult airways and resuscitation trolley checks.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were employed by other organisations such as the NHS and worked at the hospital under practising privileges. Their annual appraisals were carried out with their employer. It was the responsibility of the registered manager, with advice from medical advisory committee (MAC) to ensure consultants were skilled, competent and experienced to perform the procedures they undertook.

- RMOs had their mandatory training and annual appraisal provided by the external agency provider. Training opportunities were sent to them by email. They worked against agency and BMI guidelines to ensure they were working within their sphere of knowledge. Consultants were available to provide advice and guide their daily practice. The RMO told us that they had a one-week induction period to the hospital, when they were supernumerary and were able to shadow another RMO in post, for learning.
- Nursing staff were required to undergo a revalidation process in order to renew their professional registration and keep it up to date. The ward manager told us that there was support available for all staff through the e-learning system. Part of the appraisal process was to record registered nursing staff's revalidation date so that this could be monitored to ensure all required staff remained registered. However, although the date was recorded, there was no requirement or system in place for staff to provide evidence of their revalidation and professional registration status. We were told that there was an investigation ongoing, involving a nurse who had failed to renew their registration, which had been lapsed for one year. The nurse had been suspended pending the outcome of an investigation. We were not assured that there were sufficient processes in place to ensure that all registered staff had current registration with no exemptions and were therefore fit to practise.

Multidisciplinary working

- **Most staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. However, there were some concerns raised by staff about how the bookings team, theatre and ward staff worked together to coordinate admissions.**
- There was effective multidisciplinary working, and communication between staff on the wards. There was a daily clinical huddle meeting with all staff on the ward where the daily workload, staffing levels and any concerns were reviewed. Staff told us they had a good working relationship with consultants and the RMO. The pharmacists were present on the ward daily and the staff said that they were approachable and supported them well with advice about medications. Physiotherapists were present on the ward daily and communicated with staff about patient's progress and were involved in discharge planning of patients who had undergone joint replacement surgery. The physiotherapists delivered joint clinics pre-operatively where discharge planning could begin through the gathering of information about patients' home environment and the identification of the need for any equipment required on discharge.
- There was effective multidisciplinary working within the theatre team. Nurses, surgeons, anaesthetists and support staff worked well together to plan and deliver safe and effective care. There were daily huddle meetings to review theatre lists, instrument requirements, and to identify which staff were working in each role in the different theatres.
- We saw evidence of team communication across all services. The hospital had set up a daily huddle meeting which took place every morning. It was attended by a member of the senior management team and a representative from each department, including theatre, ward, pharmacy, outpatients, the catering department and patient services. All staff contributed to provide an overview of the hospital's activity. This included sickness, staffing levels, cancellations for theatre, patient admissions, any medical alerts, complaints, incidents and risks. Staff on call for emergencies were highlighted. Compliments and complaints were also discussed. Any relevant information was taken back to each department and cascaded to the team.
- Staff told us that there has been some team building work between the ward staff and theatre staff in order to improve working relationships. It was reported that there had been some different points of view and a lack of understanding of roles, which had impacted on team working. Clinical leads had completed various activities together, including fundraising days and a mud run, to build good working relationships across teams.
- Medical and nursing staff reported good working arrangements and relationships with the local NHS trust. There were service level agreements (SLAs) in place, for example with the local NHS acute trust and the local ambulance service. These were to ensure the prompt transfer of patients to an NHS hospital if their clinical condition deteriorated.

- Nursing handovers occurred at each shift change in order to share information across the team. These included discussions around patient needs, medication, present condition and the plan for discharge.
- Staff began discharge planning at the pre-assessment appointment so that effective plans were in place to meet patient need when discharged. There were systems in place for working with local social services and other agencies to enable support to be set up for patients who required additional support at home following their operation. When patients were discharged they were provided with information about their medication, pain control, deep vein thrombosis prophylaxis and surgical wound care. Discharge summary letters were generated electronically and all patients were provided with a copy of their summary in their discharge information pack. Information included details of the procedure undertaken, a clinical summary, medications information, follow up arrangements, and any required action from the GP.
- GPs were sent a copy of their patient's discharge letters to ensure they were kept informed of surgery that had been performed and the need for any follow up actions.

Seven-day services

- The surgical service provided some, but not all services seven days a week. Surgery was scheduled six days a week, and the ward was open seven days a week. Physiotherapists provided cover seven days a week. Pre-operative assessment and pharmacy were open five days a week, Monday to Friday.
- The hospital only undertook elective surgery, and operations were planned in advance. The exception to this was if a patient was required to return to theatre due to complications following a procedure. The operating theatres were open Monday to Saturday from 08.30 to 18.30 for planned operations.
- There was an on-call rota for theatre staff for out of hours requirements. A weekly on call rota was circulated, including details for all clinical areas and an on-call member of the senior leadership team.
- Consultants were on call seven days a week for patients under their care. Patients were seen daily by their consultant, including weekends.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed. Anaesthetists were available via an on-call rota if a patient needed to return to theatre. The RMO provided out of hours medical cover for the wards 24 hours a day, seven days a week.
- The ward accommodated overnight patients seven days a week and ward staffing levels were suitably maintained during out of hours and weekends.
- The pharmacy was open Monday to Friday from 8.30am to 4.30pm. As it was a virtual pharmacy there was no process to obtain any other medication required outside of pharmacy opening hours, however, there was an account held with the local community pharmacy that could provide some medications in an emergency.
- The physiotherapy department was staffed every day of the week, although the weekend service was a limited. Weekend cover was provided on a rota basis in order to support inpatients following surgery. There was no physiotherapist on call in the evenings or overnight.

Health promotion

- **Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery.**
- Patients attended pre-operative assessment appointments where their fitness for surgery was checked. This included the completion of a health questionnaire, and an opportunity for the nurse to provide advice or refer patients on to other appropriate services if they required it.
- Patients having elective surgery were provided with an advice booklet about their hospital stay. The booklet also contained some health promotion guidance including dietary advice, smoking cessation and alcohol consumption. Leaflets were available regarding common conditions and operative procedures.
- The physiotherapy staff saw patients who were to undergo orthopaedic surgery in a pre-operative joint clinic. These appointments provided health promotion opportunities, including how to maintain mobility by performing certain exercises.

Good

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed policy and procedures when a patient could not give consent**.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act (MCA) 2005. There was a BMI Healthcare group consent for examination or treatment policy for staff to follow. This outlined that consultants should seek consent from patients undergoing surgery as a two-stage process. The first stage should be the information and discussion stage, usually done during the initial consultation. The second stage was the decision stage, usually done on the ward on the day of surgery. The exception to this, was when one consultant performing injection procedures, did not always ensure that written consent had been obtained prior to patients leaving the ward for theatre.
- We saw from patient records that a two-stage consent process was usually obtained in agreement with the policy. We saw completed and signed consent forms during the inspection and observed consent being obtained from patients prior to their surgical procedure.
- Patients were given information about their procedure both verbally and in writing to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required.
- We were told that patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure in case they wanted to change their mind. This was in line with national guidance from the British Association of Aesthetic and Plastic Surgeons. The service told us that there was no policy for this, but consultants were aware of the requirement and did not book patients in for cosmetic surgery within two weeks of their initial appointment. There were no patients undergoing cosmetic surgery on the ward at the time of the inspection.
- Nursing staff we spoke to were clear about their responsibilities in relation to gaining consent from people including those who lacked capacity to consent to their care and treatment. There were no admitted patients who lacked capacity during our inspection.
- Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients that lacked capacity were identified during the pre-operative assessment process to determine whether they could be admitted for treatment at the hospital. Where patients could not provide informed consent, the staff would make decisions in the best interests of the patients, involving the patient's representatives and other healthcare professionals.
- Staff were aware of the legal requirements of the MCA and Deprivation of Liberties Safeguards (DoLS). There was an up to date policy regarding the MCA and DoLS. Staff were aware of where to access this.
- There was a mandatory training module on consent for all staff in a clinical role. The module had to be completed once and data showed that in October 2018 staff across the hospital were at 98% compliance for this training. We asked for service level training data but the hospital did not provide this.
- All staff received MCA and DoLS training within their safeguarding level 2 training. Staff across the hospital were at 96% compliance for this in October 2018.

Are surgery services caring?

Good

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

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We observed staff to be caring and compassionate with patients and their relatives throughout our inspection.

Staff promoted privacy, and patients were treated with dignity and respect. Staff spent time with patients, and interacted with them during tasks and clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. Staff responded compassionately to pain and discomfort in a timely way.

- Feedback from patients confirmed that staff treated them very well and with kindness.
- Staff respected patients' privacy and dignity during personal care, for example, staff pulled curtains around the bed space, and staff spoke with patients discreetly to maintain confidentiality. Patient-Led Assessment of the Care Environment (PLACE) audit for 2018 results for privacy, dignity and wellbeing were 96%. This was above the BMI average score for 2018 which was 85.9%.
- During our inspection we observed a theatre operating list with patient's names and procedures attached to a cupboard in the anaesthetic room. This meant that patients walking into the anaesthetic room could see the operating list which may have led to a breach of confidentiality. This was escalated to the theatre manager who took action to ensure that confidentiality was maintained and assured us that she would escalate this issue at the next team meeting.
- The service submitted data to the Friends and Family Test (FFT). This was a method used to capture NHS patients' perceptions of the care they received and how likely they were to recommend the service to their friends and family. Recent response rates had been low. The hospital overall had an average response rate of 6% from April 2018 to September 2018. Scores showed that on average 97% of patients would recommend the hospital. Patients we spoke with, told us they would be happy for their friends and family to come to the hospital for treatment.
- A new process had been embedded on the wards to increase the response rate of patient satisfaction feedback. All inpatients were provided with a feedback form on admission, and additionally patients were invited to complete a short feedback form with a member of staff prior to leaving the ward.
- BMI Healthcare surveyed patients' satisfaction separately to the friends and family test. BMI Droitwich Hospital reported to us that they were always in the top ten of all their hospitals for patient satisfaction. However, recently this had dropped so that they were in the bottom five of all their hospitals surveyed.
- The ward displayed 'thank you' cards, which staff had received from patients and relatives. The operating department had a notice board in the staff room where thank you letters and cards were displayed.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff told us that they had time to spend with patients to reassure them and provide emotional support.
- Patients and those close to them received support to help them cope emotionally with their care and treatment. Patients said staff generally responded quickly to their needs and talked openly with them and discussed any concerns.
- Pre-admission assessments included consideration of patient's emotional well-being.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients told us that nurses explained what they were doing, and asked for permission and agreement first. Patients said medical staff explained plans for their treatment and provided opportunities to ask questions, this included family members when required. Patients told us they were given choices regarding their treatment options at their pre-operative assessment. Family members were encouraged to attend the appointment to ensure they were aware of any post-operative care that might be required at home. Physiotherapists invited patients booked for joint replacement surgery to attend a pre-operative joint clinic. This was where post-operative care needs were discussed with patients and relatives to ensure a smooth and safe discharge home.
- Patients told us that staff clearly explained the risks and benefits of treatment to them before admission.

Patients we spoke with told us they had opportunity to ask questions about their treatment. This meant that patients were involved in making shared decisions about their care and treatment.

- Patients, who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.
- Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. Staff said they had systems in place to identify the communication needs of patients, which included access to language interpreters, when required.

Are surgery 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 services in a way that met the needs of local people.**
- The services provided reflected the needs of the population they served and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available, including orthopaedic surgery, cosmetic surgery, and general surgery.
- The hospital had service level agreements with other local providers to deliver extra services they were unable to supply themselves. This included pathology services, blood products and emergency transfers for deteriorating patients.
- The booking system aimed to offer patients choice by enabling patients to select times and dates for appointments to suit their family and/or work commitments, where possible. The operating department was open Monday to Saturday 8.30am to 6.30pm, which provided patients and consultants with some flexibility and choice of procedure times. Patients we spoke with confirmed they were given a choice of appointment times and could schedule procedures at a time convenient to them.
- The service was committed to providing surgical procedures to both private patients and NHS patients. Managers at the hospital worked collaboratively with NHS commissioners to ensure services were planned and developed to meet the needs of the local population. All patients were treated equally whether self-funded, through insurance schemes, or through the NHS.
- The facilities and premises were appropriate for the services that were delivered. There were 32 patient bedrooms, for inpatient and day surgery patients. There was an additional small ambulatory care area which could accommodate five patients undergoing minor surgery, such as injections, in beds or reclining chairs. The hospital had three main theatres, all with laminar flow. This ensured that planned services could be delivered to patients.

Meeting people's individual needs

- **Patient's individual needs were accounted for.**
- The hospital only received planned admissions. Patients' specific needs such as learning disabilities, other disabilities or mental capacity issues were identified at pre-assessment, to ensure appropriate arrangements were made to meet individual needs prior to admission.
- Patients who had complex needs had their discharges planned in advance. In the pre-operative assessment, patients were asked about their home situation. All patients undergoing joint replacement surgery saw the physiotherapist in a pre-operative joint clinic where any post-operative discharge needs, such as equipment, could be identified and put in place.
- Reasonable adjustments were made to consider the needs of different people on the grounds of religion, disability, gender, or preference.
- Patients with mobility difficulties had access to the wards from a lift. The corridors were wide, which meant there was easy access for wheelchairs.
- There was access to interpreting services for patients whose first language was not English. A telephone line was available and face-to-face interpretation services could be obtained if required.

- Staff answered call bells promptly; patients told us that nursing staff generally responded quickly to their needs.
- Clinical staff underwent dementia training as part of their mandatory training. We asked for data for dementia training compliance of staff in the service, but the hospital did not provide this.
- The service's Patient-Led Assessment of the Care Environment (PLACE) audit for 2018, which looked at how well the needs of patients with dementia, or with a disability, were met. The hospital scored 91.2% for patients living with a disability and 94.1% for patients living with dementia.
- Patients told us that they were given detailed explanations about their admission and treatment. Staff provided written information leaflets for a range of conditions and to support care given.
- Health promotion posters were displayed and information leaflets were available in some areas. We saw information was available for reducing alcohol intake, smoking cessation and healthy eating.

Access and flow

- **People could access the service when they needed it. Waiting times from treatment were and arrangements to admit, treat and discharge patients were in line with good practice.**
- The hospital's admission policy ensured that patients received a pre-operative assessment. All patients were assessed which meant patients could be identified as being safe for surgery, which helped to avoid any unnecessary cancellations. Patients with co-existing conditions were identified during this process and then given further tests, for example blood tests, or diagnostic imaging. Advice could be sought from anaesthetists and appointments could be made for higher risk patients to be reviewed by anaesthetists prior to booking in for a surgery. This meant that it was less likely that operations would be cancelled on the day of surgery due to patients being too high risk.
- Pre-operative assessment clinics were open Monday to Friday from 8am until 5.30pm. On Wednesdays, late clinics were held until 7pm. There were no clinics available at weekends.
- The ward area, which accommodated inpatients and day case patients, was usually open seven days a week for 24 hours a day. However, the number of admissions and bed occupancy rates, varied throughout the week, depending on theatre list activity. There were occasions when the ward was closed if there was no planned theatre activity, for example over Christmas.
- Patients had timely access to initial assessment and treatment and the service mostly met national targets for access to treatment. The referral to treatment time (RTT) was used for tracking times to treatment for NHS patients. Data showed that, on average, from April 2018 to December 2018, 94.9% of patients were seen within 18 weeks. The lowest RTT rates were for December 2018 (91.6%), which the service reported was due to patient choice and the closure of the service for two weeks during the Christmas period. RTT figures were reported to the local clinical commissioning group (CCG) each month; the target was 92%. This meant that from April 2018 to December 2018 there was only one month (December) when the service did not meet the commissioned target for RTTs. In addition, the service monitored the numbers of patients that breached the 18-week wait target. We saw that from April 2018 to December 2018 the service reported 87 patient breaches in total. Numbers of breaches during the time period ranged from one to 33 depending on the type of surgery service offered. The highest number of breaches was seen in the specialty of trauma and orthopaedics (33), and the lowest in surgery classified as 'other' (1). The average number of breaches for each service during the nine-month time period was 10.9 patients.
- The service monitored theatre utilisation rates through weekly reports. They reviewed theatre staffing versus activity. There was a target set by BMI healthcare for between 60% and 75% utilisation. Data provide for 2018 showed that for nine out of the 52 weeks, utilisation rates were less than 60%, and for three weeks, they exceeded 75%.
- Theatre lists for elective surgery were planned between the theatre manager and the bookings team. This helped to ensure operating lists were utilised effectively and patient choices were accommodated wherever possible. The BMI theatre utilisation tool and BMI resource model for theatres were used to allocate staffing in theatres, based on theatre activity lists. The

BMI healthcare nursing dependency and skill mix planning tools were used on the ward to ensure that enough staff were on duty to meet the needs of patients. There were weekly operational meetings between representatives from each department, to review theatre utilisation. However, we were told that these meetings had not been happening and there was a plan to reinstate them at the end of January 2019. There was no record of these meetings as they were not minuted, but they followed a template for discussion. Each department provided a review of planned activity and staffing and any anticipated issues for the four weeks ahead. There was a perceived lack of flexibility of theatre lists which was reported to have impacted on patient throughput and satisfaction. However, the theatre manager explained that late changes to theatre lists weren't always possible as staffing levels meant it would be unsafe. Ward staff reported that they wanted a more structured approach to the theatre lists, so that day case patients and specialties were grouped together in order to maximise the efficiency of staffing resources available. The theatre manager was working with ward staff, consultants and the bookings team to try and streamline consultant working patterns, in order to maximise theatre utilisation.

- The hospital monitored numbers of patients who were readmitted within 28 days of being discharged. The number of unplanned readmissions within 28 days of discharge from July 2017 to June 2018 was three and the number of patients who returned to theatre in this reporting period was one.
- Cancelling operations was avoided and staff told us they rebooked any cancelled patients as quickly as possible. During the reporting period there were 18 cancelled procedures for non-clinical reasons and of these, 94% were offered another appointment within 28 days.
- All on the day cancellations for surgery were reported as incidents. From July 2018 to December 2018 there were 32 reported incidents of surgery being cancelled on the day. 13 of these were for clinical reasons. Of the remaining 19 incidents, five were due to lack of consultant availability on the day, four were due to lack of capacity due to theatre overrun, three were due to staff sickness, four patients were found to no longer required surgery, and four for other reasons.
- Appropriate staff were on call through the night on a rota basis to attend any emergency readmissions to theatre. Additionally, in the event of a patient deteriorating and requiring higher levels of care, the patient was transferred to the local NHS trust by ambulance.

Learning from complaints and concerns

- **Concerns and complaints were treated seriously, investigated and lessons learned from the results, which were shared with all staff. However, we did not see complaints information displayed or made available to patients routinely.**
- From October 2017 to September 2018, there had been 38 hospital wide complaints. There were no identified risks relating to the surgical services.

  We saw that the hospital had a complaints information leaflet for patients and were told that this was widely available and was contained in all information folders within patient bedrooms. However, we did not see evidence of this during inspection. We did not see any complaints leaflets in patient bedrooms nor complaints information displayed. None of the patients we spoke with were aware of the leaflet and none were able to tell us about processes for making a formal complaint. However, we were provided with leaflets following our inspection that were planned to be available in patients' bedrooms
- There was a process in place for dealing with complaints, including a complaints policy. All staff we spoke with were aware of the complaints procedure. Clinical staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge in the first instance. Department leads were encouraged to attempt to resolve concerns and complaints raised, locally where possible. Data provided by the hospital showed that there had been five complaints received by the service within the reporting period; four relating to the ward and one relating to theatre. We saw that the hospital kept a log of the complaints and the actions taken, including identifying any lessons learned. We saw that none of the five complaints had been upheld.

- We saw that complaints were discussed at the ward team meetings as a standing agenda item. Action plans following complaints were shared at the meetings and lessons learned were discussed. However, we did not see evidence that complaints were an agenda item for the theatre staff team meetings.
- Numbers of complaints and any identified themes were discussed at heads of department meetings, including any actions taken and feedback of outcomes of complaint investigations.

Are surgery services well-led?

Good

Our rating of well-led improved.We rated it as **good.**

Leadership

- **The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.**
- The service had a clear management structure in place with defining lines of responsibility and accountability. There were clinical heads of each department who reported to the director of clinical services.
- Managers stated that the director of clinical services was visible and they felt well supported. Heads of department individually met with the director of clinical services each week informally. Additionally, there were monthly heads of department meetings with the director of clinical services, hospital director, director of operations and the infection prevention control, health and safety and quality leads.
- Staff told us that the hospital director was respected, visible and supportive. Nursing staff also told us that the director of clinical services was always available and visible in the clinical area most days.
- The ward and theatre managers held team meetings, which kept their staff informed. They were held monthly, followed a standing agenda and were minuted.
- Staff were motivated and positive about their work, and described all members of the senior management team as approachable and visible. Staff told us that the senior managers visited each department regularly. We heard that the hospital director had recently visited theatres to check on the staffs' well-being during a period of snowy weather.
- All grades of staff in the service told us that they felt supported by their departmental managers and that they were approachable. A number of clinical staff had worked in the organisation for many years. They told us they had stayed in the organisation for a long time because of the team they worked with. They told us there was a friendly and open culture.
- Staff told us that there was a culture of openness and honesty and they felt they could raise concerns without fear of blame.
- A BMI healthcare corporate leadership development programme was available for senior staff to attend. At the time of our inspection, some, but not all of the clinical managers in the surgical service had attended this training.
- The hospital was led by an executive director, who had overall responsibility for the hospital. Other staff within the senior managers team included a director of clinical services, operations manager and quality and risk manager. There were also heads of departments or managers for services at the hospital including imaging, theatres, outpatients, physiotherapy, pharmacy, administration and ward areas. However there had not been an imaging manager in post at the hospital from January 2018. During our inspection we were informed that a new imaging manager would be in post in February 2019.
- Whilst the hospital was waiting for the new imaging manager to take post the daily management had been overseen by the physiotherapy manager and more recently the director of clinical services. This meant that there had been a lack of knowledge and awareness relating to essential imaging requirements within the hospital
- The executive director and director of clinical services worked closely together to ensure that staff felt able to challenge poor behaviour within the hospital. The senior management team within the hospital ensured that the medical advisory committee (MAC) were made aware of any adverse behaviours from consultant's issues within the hospital. All incidents were

investigated and where necessary independent reviews took place which ensured fairness and equality. Staff we spoke with felt able to confront poor performance and conduct. They felt fully supported by the strong committed leadership within the hospital.

Vision and strategy

- **The hospital had a vision for what it wanted to achieve and strategic goals to turn this into actions. This was developed by the senior leadership team but did not have involvement from staff, patients, and key groups representing the local community. Not all staff were aware of the vision and strategy for the hospital and there was no evidence that they were embedded in staffs' day to day work. The surgical service did not have a separate vision or strategy.**
- There was a hospital wide vision and strategic goals based on the BMI Healthcare corporate vision. This was developed by the senior leadership team. We did not see the vision displayed anywhere and none of the staff we spoke with were able to tell us what it was. However, the ward manager told us the vision and values were displayed in the staff room.
- There was not a defined strategy relating to surgery but it was included in the hospital's overall strategy, which outlined the composition and function of the surgical services. However, the theatre manager had completed a self-assessment report which reviewed the strengths and weaknesses, threats and opportunities of the department. Based on this analysis, a set of aims and objectives for the department had been developed, alongside an annual theatre action plan. However, there was no consistency of these objectives across the ward and pre-assessment departments in the service. We did not see a combined approach to embedding the hospital vision and strategy throughout the surgical service.
- The hospital's vision and strategic objectives underpinned the BMI Healthcare Group strategy. This provided staff with a foundation to drive positive change and improve the quality of service provision. The aim of the strategy was to ensure an integrated approach where risk management, clinical governance and quality improvement were part of the hospital's culture and everyday practice.
- We saw the hospital's operational business plan was aligned to the corporate vision and strategic priorities. It included a quality improvement action plan, which detailed specific objectives the hospital had set in order to deliver the strategic priorities. Progress against achieving the objectives was reviewed and monitored at various committee meetings, including hospital governance and heads of department meetings.
- The hospital's vision and strategy was cascaded to teams through departmental meetings, staff forums and notice boards. A presentation board, using pictures had been produced to facilitate communication at meetings and a one-page visual strategy was posted on departmental notice boards.
- The senior managers' team was in the process of developing new values in line with the staffs' beliefs and ideas. Workshops had been held and all staff had been invited.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- The service had a caring culture. Staff told us that they enjoyed working in their departments and felt supported by their departmental managers. Staff told us that they liked their jobs and described good working relationships with their colleagues. Managers treated staff with respect and understanding.
- The head of clinical services held regular meetings with heads of department. They felt that this kept them well informed and involved in decisions. The heads of department in turn held meetings with their staff groups. Staff felt that they were kept up-to-date and were made aware of changes and developments within the hospital.
- Openness and honesty was encouraged. Processes and procedures were in place to comply with duty of candour. When incidents had caused harm, the duty of candour was applied in accordance with the regulation. Staff confirmed there was a culture of openness and honesty. They felt the senior leadership team and their managers were approachable and they could raise concerns without fear of blame.

- Staff felt valued; one example of this was the 'Droitwich stars' recognition programme. Stars were identified at the daily huddle meetings for doing something above and beyond their normal daily role. A list of all recognised 'stars' was circulated to all staff in a monthly information bulletin.
- Workforce race equality within BMI Healthcare was a key area of development which had been identified within the strategic priorities from 2015 to 2020. BMI Healthcare acknowledged that there was action required to meet necessary standards for race equality within the company. However, the hospital could show us a robust training and policy framework in place to ensure they complied with the Equality Act 2010.
- The hospital ensured that they observed the standards mapped out in the competition and markets authority (CMA). The CMA stated that all independent health providers should publish information about the quality of the service they provide. This includes patient feedback on treatment, the performance of healthcare professionals and information on infection rates, mortality rates and readmissions to hospital. The hospital submitted this information through the private healthcare information network (PHIN).
- The hospital carried out marketing that was honest and responsible as they complied with the guidance within the committee on advertising practice's (CAP). Section 12 of the CAP code sets out the rules that apply to marketing communications for medicines, medical devices and health related products.

Governance

- **The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- There was a clear governance structure in place with various committees, for example, quality and infection prevention control, which fed into the integrated governance committee. The director of clinical services held meetings with the heads of each department monthly and departmental meetings were held on the ward and in the theatre department. All meetings were structured and minuted.
- There was a communications huddle meeting held daily which involved a member of the senior leadership team and representatives from each hospital department. This meant that important and urgent information could be shared across all services at the same time to keep staff fully informed of any risks or safety concerns.
- There were one-page communication documents called 'Inci Grams #' which were used to highlight learning from incidents and national medical and drug alerts. This enabled for sharing of information about safe practise across the service.
- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and patient pathways.
- Audits were completed by each department in accordance with the audit schedule. Results were shared at relevant meetings such as the hospital clinical governance meetings.
- There was a clear governance framework in place with up to date and relevant policies and committees such as clinical governance, head of department meetings, health and safety meetings and medical advisory committee (MAC) meetings.
- Governance information was easily accessible for staff on information boards in departments. Following a recent staff survey, staff had mentioned that they did not feel involved in clinical governance. Following this the senior managers produced an information leaflet to ensure that all staff were aware of clinical governance and its importance within their hospital.
- On our previous inspection we found that practising privileges were not being reviewed in line with corporate policy. However, on this inspection we found that out of the 10 consultants records we reviewed, all of them met the required standard. The granting of practising privileges is a process within healthcare whereby a medical practitioner is granted permission to work in an independent hospital. Practising privileges were granted for consultants to carry out specified procedures according to their scope of practice. These were reviewed biennially by the hospital executive director and the MAC chairman. Registration with the general medical council (GMC), the consultants' registration on

the relevant specialist register, Disclosure and Barring Service (DBS) checks, up to date appraisals and indemnity insurance were also checked in line with recommended guidance.

- The MAC meetings were held every two months. Consultants within each specialist area were represented within the membership committee, this meant that all relevant information was cascaded effectively to all consultants who worked in partnership with the hospital. The MAC minutes showed discussions including regulatory compliance, key governance issues, such as incidents, complaints, health and safety and quality assurance. The MAC also discussed new procedures and instrumentation requests. A process was in place which required the completion of compulsory forms to be submitted to the executive director and MAC chairman, prior to any new procedure being approved and subsequently implemented.
- Clinicians working under practising privileges held appropriate indemnity insurance in accordance with the Health Care and Associated Professions (Indemnity Arrangements) Order 2014.
- The hospital had taken part in the commissioning for quality and innovation (CQUIN) national goals. This system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The hospital had submitted documentation to the local clinical commissioning group, the local CQUINS that the hospital were:
- Staff Health and Wellbeing - this included a flu vaccination programme for staff and signing up to the national programme of the Workplace Wellbeing Charter
- Sign up to Safety – the hospital was aiming to embed a safety culture and had developed a quality improvement calendar. The quality improvement calendar promoted specific training and guidance on certain topics throughout the year such as hand hygiene, safer surgery and investigation reviews.
- Preparing patients for discharge – which promoted a safe and timely discharge. The physiotherapy team had implemented a 'joint school' where patients were seen pre- operatively and given information relating to their pre- and post-operative care.
- During our inspection we found the hospital to be responsive to the concerns that were raised regarding poor quality standards within the imaging department. As a result of us raising concerns the hospital director and director of clinical services immediately suspended the X ray service within the imaging department. Senior managers told us that they had involved corporate directors aligned to the radiology speciality, in order to ensure that all actions had been taken and that patients remained safe. Following our inspection, a full investigation and action plan had been implemented to ensure that all identified recommendations be achieved.
- The diagnostic imaging service did not have a robust approach to quality standards and staff support. The service did not have a permeant radiology manager at the time of our inspection. This meant that we were not assured that processes and procedures were in place to oversee the diagnostic imaging service.
- Prior to our inspection computerized tomography (CT) services had also been suspended in July 2108 due to the inability to recruit staff to run the service effectively. To maintain standards of care throughout BMI Healthcare, the corporate directors sought assurance from each imaging service to confirm other hospitals were fully compliant with the requirements relating to quality assurance test programmes within the imaging departments.

Managing risks, issues and performance

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- The senior managers were aware of the risks relating to surgery within the hospital. The executive director and director of clinical services regularly corresponded with surgical consultants regarding their behaviours in order to reduce risks within the hospital. For example, the executive director and director of clinical services

communicated with consultants regarding the completion of VTE risk assessments. Information and guidance had been given to them to encourage the full completion of the risk assessment records.

- The diagnostic imaging service did not there.
- The heads of theatre and wards had recorded identified risks onto a local department risk register and these were up to date. Key risks from each department were placed onto the hospital wide corporate risk register. At the time of inspection, we saw that there were five open risks on the hospital risk register, relating to the surgery service. Heads of department were able to tell us what risks had been identified in their department and what actions were being taken to mitigate the risks.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS), Friends and Family Test and Patient Led Assessment of the Environment (PLACE). This demonstrated that they were monitoring their performance against national standards, set by external bodies.
- The service had criteria in place to ensure that only patients who could be safely treated at the hospital, were admitted for surgery. There was a clear process in place for screening high risk patients and completing additional investigations, where necessary, to identify any patients unsuitable for surgery.
- Heads of department monitored performance within their services, such as staff compliance with mandatory training and appraisals and audit results. Although performance information was shared at heads of department meetings, they were not on the agenda at team meetings. Referral to treatment time (RTT) data and did not attend (DNA) rates was collected by the bookings team. Leads in the pre-assessment clinic were unaware of the current wait times or DNA rates. This meant that not all staff were aware of the service's performance status and were not involved in developing action plans for any areas of required improvement.
- The hospital had a risk register which was regularly reviewed and updated to ensure risks were monitored and appropriately managed. Within the risk register there were 33 corporate risks which ensured that hospitals within BMI Healthcare had oversight of the company's risks and the strategies used to mitigate these.
- The hospital's risk register was also managed through the electronic reporting system. We reviewed this during our inspection and found each risk was adequately detailed, with a description of mitigation and controls in place.
- Examples outlined in the risk register included items, for example, staffing issues and equipment failure. The top five risks included; staffing, equipment failure, infection prevention compliance, governance related risks including failure to meet regulators requirements, and patient record storage facilities. We reviewed the risks and saw that they had been updated.
- Human resource administration was completed through an online service to external corporate business partners. The hospital had responded to a serious incident with regards to professional registration by employing a compliance coordinator to assist with staff administration. The hospital had updated their processes to ensure that all professional clinical staff, registered nurses and allied health professionals, had current valid registration.
- Senior managers assured us that patient safety was of the highest importance and that there had never been an occasion where financial pressures had compromised patient care.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards**.
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The service used paper records. Nursing, medical and therapy patient treatment entries were combined within the same record; this meant that all health care professionals could follow the patient pathway clearly.
- Results of x-rays and blood tests were available electronically which all relevant staff could access.

- Patient discharge letters were sent electronically to the patent's GP, where possible, or were printed and posted if necessary. The service kept a copy and an additional copy was given to the patient.
- Staff confirmed they received information in a variety of methods, which included; team meetings, notice boards and the 'Inci gram#' information sheets.
- Staff in the service used information technology (IT) systems which provided easy access to e-learning, and incident reporting systems and all current policies.
- IT systems were used to monitor quality of care. There was a risk management system where incidents and complaints were recorded.
- Electronic systems were used for planning of staffing levels and allocation of staffing rotas.
- There were systems in place to ensure that data and notifications were submitted to external bodies as required.
- The hospital had a formal accreditation with ISO/IEC27001:2013 that required all consultants to be registered with the Information Commissioners Office. This is a requirement for any information security management system. The hospital had a dedicated Information Security Officer who conducted regular audits and engaged with staff to ensure they were adequately trained. Consultant compliance was checked biennially within their practising privileges records.
- Staff had completed a new information governance module on BMI Learn, (the company's electronic education system) which included clear understanding around the General Data Protection Regulation.
- The director of clinical services was the Caldicott officer within the hospital. The corporate medical director held the position of the Caldicott guardian for all BMI hospitals. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**
- Patients views' and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought in various means, including the NHS Friends and Family Test (FFT), NHS Choices website, BMI patient satisfaction survey, and Patient-Led Assessment of the Care Environment (PLACE) audits.
- We saw that there was a dayroom on the ward for patients and relatives, which had some, 'please tell us leaflets' for patients to provide feedback on their experience. Feedback forms were provided to all inpatients which they were encouraged to complete prior to discharge.
- FFT response rates were low. From April to September 2018, the FFT response rate varied from 3% to 12%. However, feedback was consistently good, with between 95% and 99% of patients recommending BMI hospital as a place of treatment. In December 2018, there was an 18.8% response rate with 97% of respondents stating they would recommend the hospital.
- There were newly developed staff engagement forums where staff received updates about any changes within the BMI Hospital group. Staff were also invited to contribute their views on developments and changes within the hospital. The aim was for staff to share ideas and be able to make suggestions for improvement. This demonstrated a desire to involve staff and make them feel respected and valued through engagement. Although staff welcomed this opportunity, they could not describe any actions that had been implemented as a result of these forums.
- There were positive and collaborative relationships with external partners which provided a shared understanding of challenges among the healthcare providers within the local area. This meant that the needs of the relevant population were addressed and the hospital could deliver services to meet patients' needs.

- The hospital worked closely with the local clinical commissioning group (CCG). The CCG completed quality visits to ensure patients were being cared for and were receiving recognised standards of care.
- The hospital encouraged patients to participate in the BMI patient survey. We saw patients being offered a form to complete. There were boxes throughout the hospital where patients could place the completed forms.
- Senior managers confirmed they received support and advice from senior corporate directors. The regional director of clinical services provided support for the hospital's director of clinical services. During our inspection the senior management team told us that the regional director had been supportive to the hospital's senior team and was arranging to hold meetings to share information.

Learning, continuous improvement and innovation

- **Staff were committed to improving services by learning from when things went well and when they went wrong, and by promoting training, research and innovation.**
- All staff had access to the BMI learn system which provided both mandatory and additional training modules. There was a process for applying for funding to attend external training, which several staff told us that had been successful in accessing.
- Two healthcare assistants on the ward were being supported to complete the foundation course to become associate practitioners.
- In theatres, one practitioner had completed additional training in order to become a surgical first assistant. This meant that had developed additional knowledge, competency and skills to enable them to provide dedicated surgical assistance to the operating surgeon (under direct supervision) throughout surgical procedures.
- There was a half day training session each month within theatres which was for all staff in the department as well as any other staff in the hospital who wished to attend.
- The theatre manager described a culture of ongoing development and improvement within the department through the review of practice. They gave examples of where changes had been made to improve processes within the service.
- A daily 'Communication Cell' team brief was held to discuss the day's operational issues. The huddle meeting lasted 10 -15 minutes. Daily huddle update sheets were produced and were visible in all departments to update all staff.
- The senior management team operated an "open door" policy for staff and consultants. The senior team were visible and approachable within all the departments of the hospital. The chair of the MAC met regularly with the executive director and director of clinical services. The MAC chair had full insight of all incidents and concerns within the hospital.
- The quality and risk manager had implemented a new induction programme. This incorporated all the necessary mandatory on line training and ensured effective supernumerary allocation. This meant that staff felt supported and were given clear guidelines of their specific job roles prior to assigned working.
- Heads of departments had received developmental training days which assisted them in feeling confident to perform their roles within the hospital. Insight training had been attended. Insight training promoted understanding of different management skills and how to encourage effective working within a team. The executive director told us they used different management strategies with each individual head of department.
- The hospital was working towards JAG accreditation, which would enable the development of endoscopy services. Processes within the JAG accreditation would enable benchmarking of practice against other providers and organisations.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Outpatient services at BMI The Droitwich Spa Hospital provided a wide range of specialities including orthopaedic, general surgery, gynaecology, ear nose and throat (ENT), urology, ophthalmology, cardiology, dermatology, and plastic surgery for both private and NHS patients. From August 2017 to July 2018 there were 18,731 (81% of total hospital activity) outpatient attendances, 7530 of which were first attendances. These attendances were made up of 57% NHS patients and 43% private patients who were all adults.

There were 11 consulting rooms, a minor procedures room, and a treatment room. There were separate rooms including a phlebotomy room (where blood samples were taken), and rooms for ear, nose and throat (ENT) and ophthalmology patients.

A physiotherapy department was situated near the outpatient reception. This consisted of two private treatment rooms, two curtained cubicles, a hand therapy station, and a gymnasium.

There was a dedicated reception area for outpatients and two waiting areas located close to the consulting rooms.

We visited BMI The Droitwich Spa Hospital during an unannounced inspection on 22 and 23 January 2019. We also carried out an unannounced inspection on 8 February 2019. We spoke with 24 members of staff including managers, consultants, nurses, healthcare assistants, and administrative staff. We spoke with five patients and two relatives. We checked 10 sets of healthcare records and inspected the environment and equipment in the outpatient and physiotherapy departments.

Outpatient services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection where core services have been separated. Outpatients and Diagnostic services were previously rated as good.

Are outpatients services safe?

Good

We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last inspection.

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 received effective mandatory training in safety systems, processes and practices. The hospital delivered an internal mandatory training programme for all staff members. Staff attendance was recorded to monitor compliance. The combined training compliance for the outpatient's service was 95.9%, which included nurses, health care assistants, phlebotomy, physiotherapy and administrative staff.
- Mandatory training courses in key skills were provided to staff, and delivered either face to face or by e-learning training modules. Mandatory training topics covered key areas such as basic life support, manual handling, infection prevention and control, health and safety, fire

safety, information governance, safeguarding, and equality and diversity. A mandatory training matrix was in place which detailed the training courses required, and the frequency of the training.

- The target compliance set by the hospital for staff to complete mandatory training was 90%. Information provided showed that as of February 2019, 99.3% compliance for mandatory training in the outpatient department was achieved for nursing, health care assistants, and phlebotomy. Compliance for mandatory training in the physiotherapy department was 100%.
- Mandatory training compliance for administrative staff was below the hospital target at 85.6%. The patient services manager told us that they had recently appointed several administrative staff who had not completed all their required mandatory training, however an action plan was in place to ensure staff would be competent for their roles. Clinical outpatient services were managed by a clinical services manager and outpatient administrative services were managed by a patient administration manager, who shared responsibility for ensuring staff's mandatory training compliance. Individual staff's training needs were reviewed and non-compliance discussed within the department. Staff were reminded to complete mandatory training and refresher modules during team meetings and via email.
- Staff knew how to access mandatory training and could find out when they were next due for an update. Staff spoke positively of mandatory training modules and felt able to access further assistance if required. Staff were confident they would be supported to attend additional training if required.
- The consultants in outpatients, working for the hospital under practising privileges, did not receive mandatory training from the service. They received training from their substantive place of employment and BMI Droitwich Spa hospital had oversight of their completed training records. Practising privileges is an established process within independent healthcare where a consultant is granted permission to work in an independent hospital in the range of services they are competent to perform.
- For our detailed finding on training compliance, 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 had training on how to recognise and report abuse and they knew how to apply it.**
- The hospital had safeguarding policies and procedures available for staff, which had been reviewed and were up to date. Staff we spoke with were aware of the policies, and understood their responsibilities in relation to safeguarding. Staff could describe what would constitute a safeguarding concern and the action they would take to raise concerns.
- Details of who to contact in the event of a safeguarding concern, including contact numbers for making safeguarding referrals were displayed within the outpatient department. Staff could name the safeguarding lead for the organisation who was trained to adult safeguarding level three and could provide support to staff.
- Data provided by the hospital showed that as of February 2018, 90.1% of outpatient and physiotherapy staff were trained to adult safeguarding level two as part of their mandatory training induction programme. The safeguarding level two module included training on the Mental Capacity Act 2005 (MCA), deprivation of liberty safeguards (DoLS), female genital mutilation (FGM), and Prevent. Prevent awareness training explains how to safeguard vulnerable people from being radicalised into supporting terrorism, or becoming terrorists themselves. Safeguarding training updates were available through BMI's online learning portal.
- Staff also completed a separate FGM module alongside adult safeguarding level two training. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.
- Visitors to the hospital were required to sign in and wear a visible identification badge. This reduced the risk of unauthorised personnel entering the hospital and causing harm to patients and staff.
- For our detailed finding on training compliance, please see the Safe section in the surgery report.

Cleanliness, infection control and hygiene

Good

Outpatients

- **The service generally controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection**.
- All areas we inspected within the outpatient, physiotherapy and phlebotomy departments, including clinical and waiting areas, were visibly clean and tidy. Signed and dated daily cleaning schedules were in place throughout all areas such as the consulting rooms, minor procedures room, physiotherapy gym and phlebotomy room, there were no gaps in these schedules identified at the time of the inspection.
- Housekeeping staff cleaned all outpatient department areas daily. Nursing staff cleaned outpatient rooms after each patient use which was in line with hospital and national guidance.
- During our previous inspection we observed minimal use of hand gel sanitisers, prompting of staff or patients, or posters encouraging their use. We also found there was a general lack of hand gel sanitisers throughout the outpatient department. However, on this inspection, we found handwashing facilities and hand gel sanitisers were available in every treatment and consultation room throughout the outpatient and physiotherapy departments. Hand washing posters were displayed above hand wash sinks.
- Staff had received training on infection, prevention and control (IPC), and hand hygiene during their initial induction and as part of their mandatory training. Data provided by the hospital showed that as of February 2018, 100% of staff across outpatient services and physiotherapy had completed their IPC training either face to face or through e-learning. We were assured staff had up to date infection prevention and control knowledge.
- The outpatient hand hygiene data for September 2018 showed the service was 97% compliant with hand hygiene techniques. We observed patients and visitors applying hand gel when booking in at reception and when passing through waiting areas. Staff were observed washing their hands between patient appointments and following physical examinations. We observed staff being 'arms bare below the elbow'. Staff wearing uniforms with sleeves above the elbow improves the effectiveness of hand hygiene and helps to reduce the spread of infection.
- There were reliable systems in place to protect and prevent people from healthcare-associated infections. Data confirmed there had been no cases of hospital acquired MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) or E.Coli in the reporting period 1 April 2017 to 1 June 2018.
- Personal protective equipment (PPE), included gloves and aprons, were readily available in the consulting and treatment rooms. The examination couches present in each outpatient room were clean, intact and made of wipeable materials, which allowed them to be easily cleaned between patients. White paper rolls were used on the examination couches, which provided a protective barrier between patients and reduced the transfer of any bacteria between patient care. Disposable curtains were in use around examination couches and had been changed and dated in line with hospital policy.
- Staff in the phlebotomy service described the correct processes and hand hygiene techniques for taking blood. There were posters in the phlebotomy room reminding staff of hand hygiene, the use of gloves and ensuring the entry site is disinfected.
- Processes were in place if a patient was an infection control risk, for example, if they had diarrhoea, or a known infection. Patients would be taken straight to a separate consulting room, rather than use the waiting room. Following treatment, the areas would be deep cleaned by the housekeeping staff and all disposable items changed.
- All clinical rooms had appropriate facilities for the disposal of clinical waste and sharps. Clinical waste was separated and disposed of in the appropriate bin, all bins were foot-operated. Sharps disposal bins were clean, closed, not overfilled, were labelled appropriately and did not appear to contain inappropriate waste.
- During our previous inspection, we found that flexible nasal-endoscopes, flexible fibre optic tubes used for ear, nose and throat (ENT) procedures, were not being decontaminated in a separate room from clean endoscopes This posed a risk of cross infection. However, on this inspection, we observed good decontamination processes and a defined cleaning pathway in place for flexible nasal endoscopes, which were fully compliant with the DH Health Technical Memorandum (HTM). Appropriate techniques were used to decontaminate the scopes in-between procedures, including 'three part' wipes used to decontaminate scopes used for invasive procedures. The scopes were

decontaminated in a separate room from the clean scopes and then returned to the ENT room where they were stored. The used endoscopes were manually cleaned in a sink within the dirty area of the decontamination room in the endoscopy suite, before being transferred to an automated washer disinfector unit for cleansing. When processed, the endoscope was removed from the cleaning unit ready to be transferred to the drying cabinet allocated in the clean area of the decontamination room. Endoscopes were moved around the hospital using a trolley, which was used solely for transferring the scopes when being cleaned. We saw training records which showed all staff had received the appropriate training on how to decontaminate the scopes appropriately. There was a contract in place with an external provider to ensure the scopes were properly maintained.

- We found that the chairs in the outpatient waiting area had fabric covers which were visibly dirty. However, replacement furniture had been requested but not yet approved and was waiting for capital sign-off. Information provided by the furniture supplier stated that the fabric covers did not support microbial or fungal growth including Salmonella, Clostridium difficile, E Coli and MRSA, and could be washed easily. Therefore, we were assured that measures had been taken to minimise an infection prevention and control risk.
- During our previous inspection, we found hand wash sinks in consulting rooms could not be operated without the use of hands and did not have separate hot and cold taps, and did not comply with HBN requirements. However, during this inspection, not all hand wash sinks in the outpatient department were HBN compliant to allow correct hand hygiene. We found six hand wash sinks in consulting rooms that were non-complaint. Risk assessments had been completed and it was recorded on the hospitals risk register. There was a defined timescale for replacement of the sinks, a prestart meeting was held on 1 February 2019, and the clinical sink replacement was in progress.

Environment and equipment

- **Premises and equipment generally, were suitable for purpose and looked after well. However, not all clinical areas and equipment were compliant with health building and infection prevention and control standards**.
- The outpatient service had 11 individual consulting rooms, one treatment room, one minor procedures room, a dirty utility room and two waiting areas. Of the 11 consulting rooms, one was specialised for use by ENT, and one room for ophthalmology. A separate room was used for phlebotomy, which was located near the main outpatient waiting area. All consulting rooms had examination couches surrounded by disposable curtains, appropriate hand wash and hand sanitiser facilities, personal protective equipment dispensers, and chaperone posters on display. All consulting rooms we saw were lockable and were equipped with a desk and chairs.
- The physiotherapy department consisted of a gymnasium, a hand therapy station and two private treatment rooms. There were two curtained cubicle areas in the gym that could be partitioned to provide additional treatment rooms. The department was tidy and well equipped with hand hygiene facilities. There was a reception area by the entrance which was manned by a receptionist which provided a waiting area for patients attending a physiotherapy appointment.
- All equipment we checked was within its expiry date. The maintenance and repair of equipment, the flexible nasal-endoscopes for example, was completed through contracts with external suppliers. An equipment servicing schedule and log book was in place and equipment was assessed annually as safe for use. All equipment we observed had evidence of safety testing where appropriate, and managers in the outpatient department could demonstrate regular equipment checks were in place. Electrical equipment had been portable appliance tested was completed internally, and all equipment observed was compliant.
- There was a range of exercise equipment in the physiotherapy department, which was well maintained. Physiotherapy staff told us about competencies they completed to show they received appropriate training in the operation of the equipment.
- Fire extinguishers were visible and dated. Staff we spoke with explained the evacuation procedure and told us that they regularly attend fire prevention updates.

- Emergency equipment such as a resuscitation grab and anaphylaxis bag located in the outpatient department. The bags were in date and available to staff in a medical emergency. They were well equipped and maintained, with daily and weekly checks recorded. We found no issues or concerns with the recordings. The bag was secured with non-tamper tags, which would alert staff if the bag had been opened. This would prompt staff to checks its contents to ensure it was safe to use. The physiotherapy department did not have their own, but could easily access the resuscitation grab bag located in the outpatient department when required, as both departments were situated on the ground floor, near one another. A resuscitation trolley was available in theatre and on the ward. The resuscitation audit for January 2018 showed a score of 100% across the hospital.
- A programme of refurbishment had commenced across outpatient areas to improve the environment and reduce the potential risk of infection. This included the replacement of ripped examination couches and inappropriate flooring types. We noted that generally patient furniture in both the outpatient department and physiotherapy unit, such as chairs and couches, was in a good state of repair, however some were visibly dirty and worn-out. We were assured that measures were in place to replace furniture not compliant with HBN requirements.

Assessing and responding to patient risk

- **Systems and procedures were in place to assess, monitor and manage risks to patients.**
- All patients were required to complete a medical history questionnaire prior to their appointment, which included the patient's past medical history, known allergies, infection risks and details of medication they were taking. This information was reviewed to ensure potential risks were identified prior to treatment.
- We saw that emergency call bells were located in outpatient and physiotherapy departments. These sounded an alarm when activated, which triggered a 'crash' response from staff across the hospital so that an unwell or deteriorating patient could receive prompt assistance. The hospital tested the system weekly in addition to the fire alarm, to ensure staff knew the difference and that the system was working correctly.
- The hospital had a clear pathway and process in place for the assessment of patients who became unwell within the outpatient department. The service always had access to a resident medical officer (RMO) who provided support to the outpatient and physiotherapy staff if a patient's health deteriorated. The RMO was on duty 24 hours a day and was available on site to attend any emergencies. The was a formal transfer agreement in place with the local acute trust which allowed for patients to be moved if they required a higher level of care. In an emergency, staff called an ambulance and patients were transferred to the emergency department.
- Physiotherapy staff could provide examples of actions taken when a patient had become unwell. This meant in the event of a patient becoming unwell, appropriate action was taken to assess and respond to the patients' needs without putting them at risk of deterioration. For example, there were two incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE) between March and April 2018 which the physiotherapy department had identified and reported appropriately. The senior physiotherapist carried out investigations and the findings were feedback and shared with all departments. The physiotherapy department were also encouraged to continue to report occurrences of VTE as incidents.
- A pre-assessment joint class had been implemented by the physiotherapy department to all patients undergoing total knee and hip replacements. The class provided advice for patients and enabled staff to identify needs for equipment or additional support post-operatively. A risk assessment tool was used to identify the level of risk the patient faced post-operatively, and rehabilitation was tailored to support and reduce the risk to the patient's recovery.
- Clinical leads and members of the senior management attended daily 'Comms cell' meetings where they reviewed patient activity, staffing including agency and bank and incidents or concerns raised. They also discussed who were the emergency bleep holders for the day. Information from the 'Comms cell' meeting, was documented on a white board with several days data displayed.

Nurse staffing

- **The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**
- Staffing tools were used in line with BMI's rostering policy across outpatients, administrative and domestic

departments, which ensured safe staffing levels. The rostering policy included nursing dependencies and skill mix planning tools, and an electronic rostering tool. The staffing tools enabled managers to effectively manage rotas, staffing requirements, skill mix and senior cover.

- Staffing requirements were reviewed a month in advance of clinic sessions. Staffing levels were also reviewed daily at the hospitals 'Comms cell' meeting.
- The outpatient department had a full establishment of nurses and health care assistants in post. Data provided by the hospital showed that there were 4.5 whole time equivalent (WTE) registered nurses in post and 3.3 WTE health care assistants.
- In the phlebotomy department, there had been a vacancy for over 12 months, and whilst the hospital had tried to recruit into this post several times, they had been unable to fill the position. Staff told us they were unable to fill the vacant post due to the skills required to carry out the role, and the skill mix required was not common. Cover was provided by pre-assessment nursing staff who were trained to perform the role if required. During weekends and out of hours, nurses in the outpatient department were adequately trained to take patients' blood if required.
- Data provided by the hospital showed that there were no unfilled shifts, and agency staff use for both registered nurses or health care assistants was limited to covering five shifts between July and September 2018. Staff sickness in the outpatient department, as of September 2018, was reported at 0% for both nursing staff and health care assistants. We saw evidence of back to work interviews being completed when staff returned following a period of sickness.
- Senior staff told us that the team were flexible and changed their shifts to cover staff shortages. Regular bank staff were also used. This meant patients could be assured that staff were familiar with the service provided, the needs of the patients and that staff had completed required training.
- All new starters underwent an induction process to ensure they received adequate support and supervision. The induction process included the completion of competencies and training requirements. This extended to bank and agency staff. We saw evidence of this.
- All professional staff within the outpatient and physiotherapy department were registered with their respective professional bodies and the register was checked as part of the hospital's recruitment process.
- In the physiotherapy department, the team consisted of six members of staff, who were led by a physiotherapy manager. The team had enough staff to provide a safe physiotherapy service to patients.

Medical staffing

- **The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**
- Consultants were not directly employed by the hospital, they worked within the hospital under practising privileges. Practicing privileges were granted to consultants who treated patients in the outpatient department, that carried out procedures they would normally carry out within their scope of practice within their substantive post in the NHS.
- Consultants worked across the outpatient department and inpatient wards. In the outpatient department, consultants delivered clinics for specialties, which included orthopaedics, general surgery, gynaecology, ophthalmology, ENT, urology, plastic surgery, cardiology, dermatology, and rheumatology.
- Consultants practicing within the outpatient department were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development. In addition, they were required to provide updated documentation annually as part of their practising privileges review. Consultants employed at the hospital held substantive posts in neighbouring NHS trusts.
- The outpatient clinics were planned at least four weeks in advance. This meant the department was able to arrange appropriate nursing and administrative staffing cover to support delivery of the service.
- Consultants were responsible for ensuring arrangements were in place to cover planned leave and any other circumstances such as sickness. Consultants were required to give six weeks' notice of any leave. If leave was approved with less than six weeks' notice and clinics were cancelled, it was recorded as an incident. Consultants could view their clinic schedules on a mobile application (app) to help plan their leave around clinic times.

Records

- **Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and generally available to all staff providing care.**
- An outpatient administration service redesign and action plan had been created, which included changes to patient record storage and retrieval. A contract with an external company had been secured to scan patient records which were over 12 months old. The physical records were archived off site, and access granted for staff to view the electronic versions when required. Additional changes to patient records included a planned standard record for both private and NHS patients, as well as the transfer of records from medical secretaries to the main health records library.
- The physiotherapy department had separate patient records, these were merged with patient main health record three months after discharge from the service.
- We reviewed 10 patient records and noted that all records were clearly written, legible, signed, and dated. In each set of records, the patient's medical history, consent and allergies information was completed. Referral letters, care plans and risk assessments were available, where applicable.
- Patient records in the outpatient and physiotherapy departments were stored securely in locked cupboards, in the administration office or the health records library, both of which had pin code entry door locks which were in line with legislation. During our inspection, we saw no patient identifiable data (PID) was left unattended or in public view and computers were locked when not in use.
- Patients medical records were generally available for their clinic appointments. Data provided by the hospital stated that from July to September 2018, no patients were seen in outpatients without a medical record being available. Additional data provided showed that three incidents were reported during this period for notes not being available. A further eight incidents were reported between October and December 2018 where notes were not available for clinic. The patient services manager told us that incidents for missing notes was over-reported as staff were encouraged to report notes as missing if they were not available four hours prior to the clinic, we were told that all patient notes recorded as missing were later found, and were available for clinic appointments. Patient records were tracked in and out of the department using an electronic tagging system, which replaced a manual system previously in place.
- Staff were aware of the process to request medical records in the event that they were not available when a patient arrived for their appointment.
- An established process was in place to mitigate risk if a patient attended an appointment and their medical record was not available. A temporary medical record was created along with an additional set of patient identification labels. Copies of referrals and medical history were obtained for first appointments from the GP or the referring hospital. For follow up patients, copies of clinic letters were provided. All available hospital correspondence was printed and filed in the temporary medical record. Clinical information including diagnostic and bloods results was printed and filed in the temporary medical record.
- Patient records were managed in line with the corporate medical records policy. Staff we spoke with told us that consultants were encouraged not to remove hospital medical records from the site. Consultants had a responsibility to meet the hospital's regulatory requirements for keeping their private patient notes. All consultants were required to register with the Information Commissioners Office (ICO) and this was checked annually as part of practising privileges.
- Discharge letters to GPs were contained within the patient records, and detailed treatments provided, follow up appointments and medications to take following discharge. Consent forms completed prior to treatment were also contained within patient records.

Medicines

- **The service prescribed, gave, recorded and stored medicines in line with best practice. Patients received the right medication at the right dose at the right time.**
- The outpatients' department had appropriate lockable storage facilities for medicines, such as cupboards and fridge. Keys to the medicine cupboards were stored in accordance with national guidance and held by nursing staff to prevent unauthorised staff from gaining access.
- All medicines we inspected were within their expiry dates and records showed that the fridge temperatures were maintained within the required temperature for the safe storage of medicines, between 2 and 8°C. We saw that fridge temperatures were monitored daily and recorded.
- All medicine cupboards and fridges were clean and tidy. The medicines refrigerators were kept locked.

- We saw evidence that room temperatures were monitored and were below the recommended 25°C. Staff told us that if the room temperature reached above 25°C, pharmacy would be contacted, and the incident would be recorded. Phlebotomy stock, such as blood sample tubes, could be moved to a locked cupboard within the outpatient department, if temperatures in the phlebotomy room exceeded 25°C. This meant medicines and other temperature sensitive consumable items, were stored in a safe manner.
- We found no Controlled Drugs being stored within outpatients or physiotherapy departments. A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as prescription medications that are designated a Controlled Drug in the United Kingdom.
- We also found no patient group directions (PGDs) were being used within outpatients or physiotherapy. A patient group direction is a written instruction for the supply or administration of licenced medicines to groups of patients, without individual prescriptions.
- Prescription pads, for both private and NHS, were stored securely and systems were in place to monitor the use of prescriptions. The service kept a log of each prescription for audit and tracking purposes. The process for management of prescriptions was safe. We checked the prescription log book and found the prescription sheets were completed appropriately.
- Hospital pharmacy opening times were Monday to Friday, 8.30am until 4.30pm. Staff told us the pharmacy team dispensed outpatient prescriptions. Out of hours, the hospital had an account with a local community pharmacy from which outpatients could obtain prescribed medicines.
- For our detailed findings on medicines, please see the safe section in the surgery report

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents, however lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**
- There were no never events reported for outpatients or physiotherapy from August 2017 to July 2018. 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.
- Data provided by the hospital showed there had been no serious incidents reported for outpatient services in the period from January to June 2018.
- During the period from January to June 2018, there were 35 clinical and non-clinical incidents reported within the outpatient and diagnostic imaging departments. Actions to investigate and learn from these incidents were discussed at the clinical governance committee and departmental meetings and had been appropriately reviewed with identified outcomes. We saw for example, an incident recorded following a patient complaint in relation to a post-operative infection. This led to a detailed investigation and resulted in changes made in wound assessment and infection recognition in the outpatient department.
- Senior staff told us there had been a focus on reporting information governance incidents following the implementation of the General Data Protection Regulation (GDPR). This led to an increase in incidents between August and December 2018, of the 35 incidents reported within outpatients and diagnostic imaging between January and June 2018, 30 were in relation to information governance. The most common themes included notes not being available for clinic, the wrong patient information being found in clinical notes, and patient information being physically or electronically sent to the wrong destination. There was one example of a consultant taking notes off-site. Staff spoken with could explain the processes in place which included asking the patient to confirm their name and address. While staff were not aware of the increase in information governance incidents, the data provided by the hospital showed they were reporting information governance incidents appropriately, and there was an embedded process and positive culture.
- From April 2015, hospitals were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable

safety incidents and provide reasonable support to the person. Staff we spoke with were aware of the duty of candour regulation and their responsibilities regarding the legislation. They described how they would apply the principles by being open and honest with patients at all times, admit mistakes and provide a full apology.

- There was an electronic reporting system in place to allow staff to report incidents. There was a positive incident reporting culture in the department; all staff we spoke with had received training and were encouraged to report incidents. Staff knew how to access the system and their responsibilities to report incidents. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas through staff meetings, daily huddles, monthly reports and emails.
- Administration staff team meetings were not held consistently, and although staff received learning from incidents via other routes, we were not assured that administration staff received consistent verbal feedback.

Emergency awareness and training

- **The service planned for emergencies and staff understood their roles if one should happen.**
- National patient safety alerts when received were circulated through either an email or hard copy to each head of department who confirmed any action undertaken and signed off once completed.
- The hospital had a business continuity plan in place which was reviewed annually. Staff could access this through the hospital intranet. Staff we spoke with were aware of the plan, and understood their responsibilities in the event of an emergency or major incident.
- The outpatient department had access to an emergency grab bag, which contained a crib sheet detailing steps to follow and individuals to contact in the event of an emergency. It also contained digital two-way radios and high visibility jackets.
- Emergency beep holders were nominated daily and were responsible for coordinating the emergency response and evacuation.
- All staff we spoke with said they received regular fire safety awareness training.

Are outpatients services effective?

We inspected but did not rate effective.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- Specialities within outpatient services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) national guidelines and the Royal Marsden manual available on the hospital intranet. A corporate clinical governance bulletin identified changes in legislation relating to NICE publications and alerts (drugs, equipment). It also provided details of issues and best practice at other sites, to enable evidence-based learning to be shared and applied locally.
- The hospital audited practice against guidance; for example, the January 2018 medical advisory committee minutes reported an antimicrobial audit review found practice was in line with antimicrobial NICE guidelines.
- Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. New and revised policies were discussed at head of departments (HoDs) meetings. The HoD October 2018 minutes, recorded an action for leads to confirm new and revised policies had been discussed in departmental minutes. Staff we spoke with in outpatients and physiotherapy had a good awareness of and had read local policies. They could give us examples of how to find policies and when they had used them.
- We saw examples of policies referring to evidence-based guidance from professional bodies. For example, the chaperone policy referred to recent professional guidance from the General Medical Council, and the consent to treatment for competent adults and children/young people referred to the Mental Capacity Act 2005.
- Regular audits included patient waiting times upon arrival for outpatient appointment, patient records, consent, hand hygiene and infection, prevention and control. We saw copies of these audits. Findings were reported to the departments and through to the

management board meetings. Trends were identified, and action plans created to improve the service to patients which was communicated back to the clinical departments for their action. For example, the July 2018 medical advisory committee minutes confirmed practice had been changed to improve compliance within private patient medical records (with a full record being held on site). The service benchmarked audit results with other OPDs within the BMI group.

Nutrition and hydration

- **Although outpatients visited the department for short periods of time, staff ensured patients had enough food and drink to meet their needs during their visit.**
- Patients were provided with clear instructions in their preparation letter about the amount of fluid to drink prior to attending the outpatient department. If patients had to fast, they had access to a water fountain in reception to quench their thirst after their procedure.
- Patients could purchase food and hot drinks from the on-site restaurant.
- Reception staff offered patients who appeared anxious or distressed a drink and provided assistance to patients who required additional support to purchase refreshments. One patient told us they had been provided with a hot drink when their appointment had been delayed.
- The hospital took part in the Patient Led Assessment of the Care Environment (PLACE) audit March to June 2017, which showed the hospital scored 89.3% for organisational food which was similar to the England national average of 90%.

Pain relief

- **The service managed patients' pain effectively.**
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Patients we spoke with had not required pain relief during their attendance at the outpatient departments. Staff told us they would use a pain tool that was embedded in the national early warning score observation chart, to assess the level of pain a patient experienced if required
- Pain relief was not routinely administered within outpatients as patients attended for short periods and usually took analgesia prior to attendance. Consultants would normally prescribe relevant pain medication for patients under their care.
- If a patient attending the physiotherapy department required urgent pain relief and the consultant was unavailable, the registered medical officer would assess the patient and prescribe the relevant pain relief.
- Staff in the physiotherapy department completed treatment plans that aimed to reduce or help support patients manage their pain.
- A specialist pain clinic physician was available, if the patient had been referred to them, to provide diagnostic assessments of a patient's condition. Guidance and treatment was provided for patients with chronic and acute pain issues.
- Patients could contact the OPD directly and speak to a nurse or their consultant if they were experiencing pain after a procedure.
- GPs were advised of a patient's treatment and prescription plan to support continuity of care on discharge from the OPD service.
- Pain advice booklets were provided to patients in OPD clinics, and existing pain issues were assessed and discussed.

Patient outcomes

- **The service monitored the effectiveness of care and treatment in some areas and used the findings to improve them. They compared local results with those of other services to learn from them.**
- **Results on patient outcomes were compared with other locations within the regionand across BMI Healthcare through the corporate dashboard. Staff told us that they reviewed the data and made improvements where possible.**
- The OPD participated in national 'patient reported outcome measures' (PROMs) and in the national joint registry (NJR). Results were monitored and discussed at the hospital's clinical governance and medical advisory committees, as well as at a regional and corporate level. Outcomes were benchmarked against other comparable services and, where poor outcomes were identified, action plans were in place to improve performance. For example, the physiotherapy service had introduced post-operative group therapy classes in

August 2018 for NHS funded patients who had undergone knee replacement surgery. Data was collected to support the monitoring of patient outcomes, and a first audit was scheduled to be completed by February 2019.

- A critical review of research articles was completed by hand therapists across the BMI group, and the findings discussed to support learning and improved patient outcomes. For example, at the time of our inspection the hand therapist was reviewing an article that had evaluated the effectiveness of early mobilisation for injuries of the ulnar collateral ligament to the thumb.
- Quality accounts were produced by the hospital and were shared with the CCG (clinical commissioning group) on a quarterly basis. The hospital monitored the CQUINS (commissioning for quality and innovation payment) schemes to drive up performance, for example, the sign up to safety charter. We observed action plans included providing each staff member with personal hand gel, and an email to consultants from the director reminding them of hand hygiene and bare below the elbow requirements.
- See surgery report for further information.

Competent staff

- **The service made sure most, but not all, staff were competent for their roles. Managers did not appraise all staff's work performance. Supervision meetings were not held with all staff to provide support and monitor the effectiveness of the service.**
- The patient administration manager confirmed most, but not all, administrative employees had completed mandatory face-to-face training; an action plan was in place to ensure all staff completed mandatory training to ensure they were competent for their roles. A redesign in the administrative team meant staff were being trained in all general administrative roles to support staff flexibility within the department. Two members of administrative staff told us they had never received one to one supervision however; informal verbal feedback was regularly provided.
- Staff received a comprehensive induction and support specialist training when they started work at the hospital to ensure competence, skills and confidence. This included a hospital wide induction and local induction. The local induction included orientation to the staff member's particular area and local competencies. The hospital wide induction included information governance, infection prevention and control and fire safety. Staff said they found the inductions helpful.
- The OPD supported nurse and physiotherapy student in placements, and an induction pack and a mentor to support their learning was made available.
- The heads of department confirmed they had assessed staff to ensure they were competent in their role. We saw a competency folder in place which demonstrated staff had been appropriately assessed. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and one to one meeting with their manager.
- Staff within the OPD and physiotherapy department had attended local, external and corporate courses. Some staff had been supported to complete leadership courses.
- Throughout our inspection we found staff received training to support the delivery of care and individual's developmental needs. For example, one physiotherapist had completed women's health exercise training to support people with reducing symptoms and improving quality of life. Two health care assistants had completed optical biometry training to enable them to take intra-ocular calculations. (A measurement to determine the strength of lens required in cataract surgery).
- Therapeutic staff received clinical supervision, and peer support was also provided within corporate meetings with other professionals across the BMI group.
- The hospital ensured qualified nursing staff continued to maintain their registration. Information supplied by the hospital showed 100% completion rate of validation of registration for nurses and for doctors working under practicing privileges.
- Consultants applying for practising privileges had to demonstrate their competency prior to undertaking any new procedures in the OPD. This was done by seeking evidence from their NHS practice.

Appraisals

- Senior leaders confirmed that "very few" administrative staff had received an appraisal during 2018. We were not assured by the information provided that managers appraised all staffs' performance to ensure they were competent for their roles. Some administrative staff had

been managed within the surgical division until May 2018. A restructure brought all administrative staff under the OPD management structure at that time. Several staff told us they had not received an appraisal in over 12 months, and one staff member reported it was for a period of over five years. The patient administration manager had been in post for five months at the time of our inspection, and a plan was in place to ensure staffs' work was appraised by a newly appointed patient administration manager by February 2019. The 2018 hospital non-clinical strategy included a plan to ensure all non-clinical staff had a meaningful appraisal.

- Data confirmed 100% of clinical OPD staff had received an appraisal during 2018, which were recorded on the corporate electronic recording system. Staff told us development opportunities were identified during their appraisals and that they felt supported to request additional training at other times as required. The clinical services manager for outpatients told us two HCAs had completed 'scrub' competencies to support the minor procedures unit. They hoped to identify a third member of staff through the appraisal process to provide additional support.

Multidisciplinary working

- **Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**
- There was a strong multi-disciplinary team (MDT) approach across areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. We observed good collaborative working and communication amongst most members of the service. Staff reported that they worked well as a team.
- Staff were courteous and supportive of one another. Medical and nursing staff reported good working relationships.
- One stop clinics were not provided by the outpatient's department. This was when different disciplines of staff worked together during the patients' attendance to the clinic. However, staff told us they were able to be flexible and would make arrangements for the patients to see various members of different specialities during an attendance to the hospital, if this was required.
- The hospital had access to laboratory support from specialist off site companies for pathology. Histopathology samples were sent to the local NHS hospital laboratory under a service level agreement.
- Physiotherapists worked collaboratively with OPD and ward staff to ensure patients received a timely and streamlined service. Staff also worked alongside wound care nurses to ensure the best delivery of care and treatment options was provided.
- We observed in patient records that GPs were kept informed of treatments provided; follow up appointments, and medications to take on discharge. For example, physiotherapy discharge letters confirmed with GPs if a patient's condition had been resolved, was much improved, if there had been a deterioration, or if the treatment had not been completed.
- The service had good relations with the local NHS trust and if a patient required a test or procedure not available at BMI Droitwich Spa, they would be transferred when necessary.

Seven-day services

- The outpatient department provided a six-day service.
- The outpatient department ran clinics from 8.30am to 8pm, Monday to Friday and 8.30am to 12pm on Saturdays as required. Staff cover was provided between these times.
- The physiotherapy department opened from 8.00am to 5.00pm Monday to Friday with extended hours as required.
- The pharmacy was open from 8.30am to 4.30pm Monday to Friday. Out of hours, outpatients could obtain prescribed medicines from a nearby pharmacy that was open from 8.30am to 7.00pm Monday to Friday, and from 9am to 5pm on Saturdays.
- Resident Medical Officers (RMOs) provided a 24 hour a day, seven days a week service on a rotational basis. All RMOs working at the hospital were selected specifically to enable them to manage varied patient caseload.

Health promotion

- **The service supported people to live healthier lives and care was planned holistically using health assessments where appropriate.**
- The service demonstrated it had introduced improvements to meet the Commissioning for Quality and Innovation (CQUIN) national goals; Improvement of

health and wellbeing of staff. For example, all hospital staff were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients. As at April 2018, 52.3% of clinical staff across the hospital had received a flu vaccination.
- Physiotherapists provided patients with written exercise regimes to support their rehabilitation within the community.
- See surgery report for further information.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Health Act 1983, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients who lacked the capacity to make decisions about their care.**
- The service followed their corporate 'Mental Capacity Policy' (due for review June 2020), which included responsibilities and duties, training, key principles assessing capacity, best interest and refusal to be assessed.
- Staff in outpatients and physiotherapy told us they rarely encountered patients with dementia or who lacked capacity. However, they were able to describe the process they would follow if they suspected a patient lacked capacity, and knew who to contact for further support or advice on this.
- Staff completed mental capacity act and deprivation of liberty safeguards training within the safeguarding adult's mandatory training.
- Data showed 98% of eligible staff across the hospital were up-to-date with consent training, which was above the hospital's target of 90%. Initial consent for patient's undergoing a minor procedure was completed by the consultant providing care in an outpatient's appointment. All patients undergoing a minor procedure were required to re-sign the consent on the day of the procedure, in line with the consent policy. The July 2018 medical advisory committee minutes confirmed the consent policy would be issued to consultants. The requirement for documented evidence to be written on the consent form was discussed at the meeting.
- Patients told us they had been given clear information about the benefits and risks of their procedure in a way they could understand prior to signing the consent form.
- Patients said they were given enough time to ask questions if they were not clear about any aspect of their treatment.

Are outpatients services caring?

Good

We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- Patients were complimentary of the care they had received in outpatient services and many had used the services for a length of time. Patients and their relatives told us staff were extremely friendly and helpful.
- Patients were treated with respect and compassion throughout their care within outpatient services. Staff responded sympathetically to queries in a timely and appropriate way. We observed caring interactions with patients whilst they were booking in at the main reception or being assisted in the departments.
- Throughout our inspection, we saw patients were treated with compassion, kindness, dignity, and respect. We received comments such as "staff are always cheerful", "the nurses always provide an excellent service", and "I'm always treated with kindness and respect".
- We observed positive interactions between staff, patients, and relatives. Staff introduced themselves and took time to interact in a considerate and sensitive manner.
- The PLACE assessment for the period of March to June 2018 showed the hospital scored 93% for privacy, dignity, and well-being, which was higher than the England average of 84.2%. The place assessment for privacy, dignity and well-being, focused on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also included the practicality of male and female services such as bathroom and toilet facilities, and ensuring patients were appropriately dressed to protect their dignity.

- There were sufficient toilets within the department for use by male and female visitors, which were clean and regularly checked. Disabled toilets and baby changing facilities were also provided.
- Consulting room doors were closed with a keypad secure lock during patient care to protect the privacy and dignity of patients. Signs were used to confirm when a treatment or consulting room was 'in use', and we saw that staff knocked and asked permission before entering a room.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction. The test data for all patients in November 2018 showed 98% of the 106 respondents would recommend the hospital, against an England average of 94%. This was an improvement on the July 2018 performance, when 95% of 92 respondents reported they would recommend the hospital against the England average of 94%.
- Recent response rates had been low; the hospital had fallen from being in the top 10 to the bottom five within the BMI group. The hospital overall had an average response rate of 6% from April 2018 to September 2018, which means that the results may not be worthwhile as the response rate was so low. OPD leads told us they reminded staff to seek patient feedback to ensure service improvements could be reviewed where possible.

Emotional support

- **Staff provided emotional support to patients to minimise their distress. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. Staff had a good awareness of patients with complex needs and those patients who may require additional support should they display difficult behaviours during their visit to outpatients.**
- Patients told us they knew who to contact if they had any worries about their care, and said staff had supported them emotionally as well as physically where there had been bad news following diagnostic results.
- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.
- Staff told us that the length of appointment times was variable according to the type of consultation and the level of support each patient needed.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients and relatives said they felt involved in their care. They had been given the opportunity to speak with the staff looking after them. Relatives we spoke with said they had been given time with the nurses and doctors to ask questions. One person reported they had visited several times with the patient and that they felt the communication was "excellent".
- Appointment letters contained clear information about appointments and what to expect. One complaint was raised from April to September 2018, regarding the information contained in the appointment letter. On investigation, it was found that a telephone conversation would have improved communication as the treatment plan was not clear at the time. The learning was shared across the OPD service.
- Booking administrators sent information about how to get to the hospital and specialist information depending on which clinic they were attending.
- All patients told us they were provided with a good, clear explanation and most were provided with written information about their condition. A patient's relative told us they had had been kept 'well-informed' of the treatment plan and that they felt able to raise any concerns with the consultant. A telephone number was provided and the patient and relative were advised to request any further information once they left the hospital if they had a query.
- All outpatient services offered patients a chaperone and departments clearly displayed signs to this effect, in waiting areas and consulting rooms. Patients were given the opportunity to be accompanied by a friend or relative and there were chaperones available when personal care was provided. For example, female nurses or healthcare assistants were available to act as chaperones when required.
- Staff encouraged patients to give feedback through satisfaction questionnaires and the Friends and Family Test.

Good

Outpatients

Are outpatients services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- The outpatient services planned and developed most services to meet the needs of the local population for both private and NHS patients.
- The service had good working relationships with the local clinical commissioning group to manage services for NHS patients. The service also assisted with additional work from the local NHS hospitals to help meet increased demand. In addition, local agreements were in place with the local NHS trust to support areas of capacity concern.
- One consultant reported that a number of consultants wished to increase the services they provided to meet the needs of local people. They reported the hospital had not agreed to increase theatre capacity, which meant outpatient services would not expand.
- Two consultants told us that a lack of investment in new equipment restricted their ability to increase the number of outpatient appointments they provided in their specialties.
- The hospital was located in close proximity to an acute hospital, and offered the opportunity to engage highly skilled consultants across a wide range of specialties to deliver high standards of care and outcomes to patients.
- Scheduling of appointments was completed in line with requirements for the procedure, for example availability of equipment and specialists. The OPD and physiotherapy departments offered early and late appointments, as well as appointments on Saturdays. Patients could also telephone for advice outside of their appointment times.
- Patients attending for outpatient appointments had access to an adjacent pay and display car park.
- The OPD had appropriate facilities to meet the needs of adult patients awaiting appointments. There was sufficient seating in the waiting areas; although this was dated there was a plan for replacement.
- The waiting areas provided wheelchair accessible bathrooms, and water machines.
- Not all clinic areas were well signposted. The outpatient's department had its own reception and two waiting areas. The second waiting area had a reception desk that was not used and some patients were unsure of the booking in process. During our inspection, three patients asked an inspector if they were required to book in again. There was no sign to advise patients of the process. One patient entered by the hospital main reception and told us "I came into the other reception, I had been here 30 minutes and needed to move my car. No one came to look for us. Apparently, I wasn't booked in". Patient feedback during 2018 highlighted signposting in the OPD could be improved. The November 2018 OPD meeting minutes confirmed funding was not approved for new signs, and that old signs would not be replaced.
- Information was provided to patients before appointments, including the consultant's name and directions to the hospital.
- There were specialist clinics to meet the needs of the local population; for example, the physiotherapy service provided range of classes in the gym to suit patient's needs, which included group and individual classes. The classes were held in the afternoons and early evening and included provision for people with a sports injury. A women's health physiotherapy clinic was also available; the hand clinic provided specialist support to musicians, for example, who had sustained an injury. Sessions were also provided using an anti-gravity treadmill, which enabled people to walk or run at a lower percentage of their body weight. This enabled patients with different needs to perform rehabilitation with less pain.
- Patients could let the receptionist know if they wished to leave the waiting areas for any reason, who would inform a member of nursing staff or the consultant to ensure they did not miss their appointment.
- Most, but not all, services provided reflected the needs of the population and ensured flexibility, choice and continuity of care. The service did not provide one stop clinics where all investigations, diagnosis, and treatment planning was carried out in one day. Staff would accommodate patient's different appointments in one day when possible. Some patients attended for CT (computerised tomography) scans at an alternative

hospital, as the service was not provided at the time of our inspection due to recruitment difficulties. Patients required a second OPD appointment to discuss the outcome.

- General information leaflets relating to the hospital were available in the waiting areas. The corporate BMI Droitwich Spa Hospital leaflet was dated August 2015, and included out-of-date patient satisfaction scores from January to December 2015. A wall-chart in the OPD reception area displayed out-of-date patient satisfaction scores from 2017.
- Written information on medical conditions, procedures and finance was available and accessible throughout the department.
- There was no specific support to aid in the delivery of care to patients in need of additional support, such as those living with dementia, autism, a learning disability, or a mental health condition. Patients would however, have a choice of appointments to suit their needs. Staff told us they would offer patients and their relatives/ carers a quiet area to sit, and inform them of the facilities available at the hospital, such as the restaurant.

Meeting people's individual needs

- **The service took account of patients' individual needs**
- The service identified the communication needs of people with a disability or sensory loss at the referral or initial appointment stage.
- The BMI website explained how the service would store and use patient's personal information in patient records and of their legal rights. Consent was obtained before patient information was used to contribute to national audits, such as the national patient reported outcome measures for patients who had undergone knee replacement.
- The service provided appropriate translation services, and sign language interpreters, when required. No hearing loops (a type of sound system for people with hearing loops to reduce background noise) were available at the outpatient, or main hospital reception area. One senior member of nursing staff told us one was available, and one manager was not sure if a hearing loop was available in reception areas.
- Patients told us that they were given detailed explanations about their admission and treatment as well as written information. The hospital did not provide this information in different formats, for example in other languages for people whose first language was not English.
- High-back chairs were available in most waiting areas to accommodate older patients or those with mobility issues. Patient feedback had reported that the chairs were low, which meant it was difficult for some people to alight from them. Managers reported there was a plan to refurbish waiting areas. Bariatric chairs were available in the main outpatients waiting area, and bariatric wheelchairs and trolleys were accessible throughout the department.
- There were procedures in place to make sure patients who were self-funding were aware of fees payable. Staff told us they would provide quotes and costs, and aimed to ensure that patients understood the costs involved. Leaflets were available that explained the payment options, and procedures and gave advice of who to contact if there were any queries. The hospital website also clearly described the different payment options available. The hospital had received a number of complaints regarding the cost of treatment, and action had been taken to display costing information in consulting rooms.
- The OPDs were accessible to patients with a physical disability, as clinics were located on the ground floor. Patient lifts were available for patients who were required to attend the upper floor. Waiting areas and consultant rooms were accessible to wheelchair users.
- The PLACE assessment for the period of March to June 2018 showed the hospital scored 91.8% for disability, which was better than the England average of 84.2%. The place assessment for disability was included for the first time in 2016, and focused on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of, for example, visual/ audible appointment alert systems, which could prove helpful to people living with disability.
- The service took account of patients with complex needs. For example, NHS patients were routinely funded for a half an hour physiotherapy appointment; however, additional funding was sought for patients with complex needs, for example when a dressing change was also required.
- The physiotherapy service used a checklist assessment to identify if patients who had undergone a knee

replacement were suitable for post-operative group therapy classes. If specific criteria were not met, one-to-one classes were tailored to meet individual needs.

- The hospital did not have a dementia strategy. However, patients in the later stages of dementia with more complex needs, were not routinely treated at the hospital. The admissions process identified patients with mental health needs, or those living with dementia. Dementia awareness training was mandatory and most staff were compliant. Staff were aware they could seek guidance for patients living with dementia from the hospital's dementia 'lead'. The clinical services manager for outpatients told us they hoped to develop a lead dementia role within the department.
- Patient Led Assessment of the Care Environment (PLACE) for March to June 2018 showed the hospital scored 94% for dementia, which was better than the England average of 78.9 %. The place assessment for dementia was included for the first time in 2015, and focused on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.

Access and flow

- **People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice.**
- The service offered access to the consultation and treatment in a timely manner for both NHS and self-funding patients. The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All hospitals that treat NHS patients are required to submit performance data to NHS England, which then publicly report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments was 18 weeks from the day a patient's appointment was booked through the NHS choose and book service,or when the hospital or service received the referral letter.
- Referrals for consultation and treatment came through a variety of methods including from the local NHS trust (for NHS care), GP and local ophthalmologists.
- Data showed that the service met and exceeded the 92% RTT target in the months of April to November 2018. Senior managers reported there were no capacity issues in the OPD, and that 100% of patients were seen for their first appointment within the required 18 weeks.
- The OPD monitored the number of and reasons for clinic cancellations. From August 2018 to January 2019, there were ten clinics cancelled. Four of the ten clinics were cancelled when a consultant provided less than the required six weeks' notice. Any clinic cancelled outside of this period was entered on the electronic incident reporting system to support analysis and the monitoring of consultant performance.
- The hospital had very low 'did not attend' (DNA) rates. All NHS patients who missed their appointment were referred back to their GP, for re-referral, if appropriate. One manager told us, in exceptional circumstances, a second appointment would be provided.
- The OPD did not provide official 'hot clinics', which were the same, or next day appointments. However, they maintained they were able to be flexible and provide urgent appointments depending on patients' requests and availability of the relevant clinician.
- There was a placard displaying the consultants that were running clinics for the day, and a space to inform patients if there was any delay. Reception staff told us this was not completed and that they personally told patients if there was a delay.
- Regular engagement meetings took place between the service and local clinical commissioning group to ensure that patients were being assessed and treated in a timely manner.
- During the inspection we observed OPD clinics and saw that they flowed smoothly with very little delay.
- Patient access and flow was discussed at a daily communications cell meeting with senior staff members. The number of new and follow-up clinic appointments, and the number of patients undergoing minor treatment were discussed. The meeting enabled key safety information to be shared with each department, identified any risks to the service, for example staff sickness, and enabled information to be cascaded to staff across the department each morning.
- Patients could book appointments on the NHS choose and book system that provided patients with a choice of

appointment time. Private patients could book appointments through the BMI centralised system or the website, which also provided a 'live chat' support function.

- Access to outpatient appointments was fast and most patients told us they were more than satisfied with the amount of time it had taken to obtain an appointment. Patients also told us they were able to book appointments at times that suited them.
- On arrival, patients reported to the receptionists who logged them in via an electronic booking system and directed them towards the appropriate clinics and waiting areas. Not all patients were aware however, if they were required to book in again or inform a clinical staff member they had arrived in a second waiting area.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- The hospital had a clear process in place for dealing with complaints, and a complaints policy dated August 2018. Staff we spoke with were aware of the complaints' procedure.
- The details about how to raise a complaint were contained in the corporate leaflets, "Please tell us…", that were displayed with other leaflets in information holders. There was no information on walls/charts to advise people where they could find the information about how to make a complaint and, during our inspection, we had to search to find the information. This did not assure us patients would be able to find the information without asking for advice. The "Please tell us…" leaflet informed people of how they could provide general feedback in a patient satisfaction questionnaire, or raise a formal complaint in person, by telephone, and in writing by letter or email.
- Staff said that if a patient raised a concern or wanted to make a complaint they would try to resolve it locally to prevent escalation. Where this was not possible the complaint was referred to the head of department, manager or the patient liaison officer.
- From October 2017 to September 2018, there were 38 hospital-wide complaints. No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISACS). The OPD received 13 complaints from April to September 2018. Five of the thirteen complaints were related to administrative procedures, including the cancellation of appointments; four were related to charges and invoicing; three were related to communication with consultants; and one was regarding a delay in receiving an initial appointment.
- Senior managers were all involved in the management and investigation of patients' complaints. A letter was sent within three working days to acknowledge the complaint, and the head of department telephoned the complainant within five days to confirm the investigation process. There was an expectation that complaints would be resolved within 20 days. If they were not, a letter was sent to the complainant explaining the reason that additional time may be required for further investigation.
- Complaints were registered on the hospital trust electronic risk management reporting system. During our inspection, we observed this process was followed when a patient raised a concern that they had not been informed their appointment had been cancelled. We observed there had been one other complaint raised from April to September 2018, when a patient had arrived for an appointment and was told the consultant was not available. A letter from the consultant's private secretary had not been sent to the patient to advise them the appointment would be re-scheduled. We observed this was investigated and the consultant apologised. As the process did not involve staff at the hospital, there was no immediate learning to be shared.
- A financial complaint, arising from a patient who acquired a post-operative infection and required further treatment, resulted in changes made in wound assessment and infection recognition in the OPD. A camera was purchased to enable changes in healing progression in acute and chronic wounds to be measured, for patients who consented to this being done.
- Learning from financial related complaints included providing a price list of the most common procedures and tests in each consulting room.

Good

Outpatients

Are outpatients services well-led?

Good

We rated it as **good.**

Leadership

- **The service had managers with the right skills and abilities to support and provide high-quality sustainable care. Within the last six months, there had been a change in manager in the OPD, and some areas of service development were not embedded at the time of our inspection.**
- The OPD was led by a clinical services manager for outpatients who had been in post for six months. They reported to the director of clinical services. Staff told us since the appointment of the outpatient manager, morale had improved under their leadership. We found staff were enthusiastic and proud to work within the outpatient department.
- From 2017 until August 2018, the service did not have a patient administration manager with the right skills and abilities to provide a consistent service. Performance in non-clinical areas had deteriorated which impacted on clinical performance, and there was an increase in non-clinical staff turnover.
- Significant change was in progress in non-clinical areas since the appointment of a new patient administration manager, and a redesign of the administrative service included an imminent change of roles and responsibilities for patient administrative leads. Clarity around patient administrative lead roles had not been confirmed at the time of our inspection however, there was a clear action plan in place that had been shared with staff.
- There were clear lines of leadership and accountability within clinical areas where staff had a good understanding of their responsibilities.
- The clinical services manager for outpatients, who reported to the director of clinical services, had been in post for four months however, they provided strong leadership and all staff reported they were approachable. Nursing staff reported they had welcomed the key roles of responsibility they had been allocated within the department. In all areas of the outpatient and physiotherapy services, staff told us they could approach immediate managers and senior managers with any concerns or queries. Staff throughout the departments told us they felt supported, respected and valued by their immediate line managers, and they were visible and approachable.
- Staff saw their managers every day and told us the executive team were visible and listened to them. Any changes made were communicated through departmental meetings, newsletters and emails.
- Staff told us the unit was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did.
- Staff across the service were supported to attend leadership courses.

Vision and strategy

- **The hospital had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed.**
- The hospital had a vision statement which was to "offer the best patient experience and outcomes, in the most effective way, from their comprehensive UK network of hospitals."
- The five-year vision for 2015 to 2020 was based on eight strategic objectives which included; consistently delivering quality services and care in a cost-effective way, be the largest network of quality acute care hospital in the UK.
- OPD staff were aware that there was a vision and strategy, although did not refer to it directly. They knew how to access the information on the hospital's intranet system when required.
- Staff referred to changes within the service which were aligned to the vision and strategy. For example, they were aware of changes in the administration systems that aimed to improve efficiency across the service.
- See information under this sub-heading in the surgery report section.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff described the culture at the hospital as being open and honest and felt they were listened to by senior managers.

- Many staff had worked in the organisation for many years and there was a high staff retention rate amongst clinical staff. Staff said they felt valued by managers and colleagues.
- The nursing team, consultants, physiotherapy team and administration team communicated well together and supported each other.
- We saw that the culture of all the areas we visited during our inspection centred on the needs and experiences of the patients. For example, if a mistake happened this was handled in a sensitive and open way. Staff felt empowered to make decisions and to challenge if required to ensure patient care constantly improved.
- All staff we met were welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service. We observed staff practice and saw that they were polite and professional with all patients and families.
- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.

Governance

- **The service mostly used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- The service had governance systems that ensured there were structures and processes of accountability in most areas to support the delivery of good quality services. The clinical services manager for outpatients reported to the director of clinical services with clear lines of escalation in place.
- Senior OPD staff attended meetings through which governance issues were addressed. The meetings included senior management, heads of department (HoD), clinical governance committee, and infection prevention and control committee meetings. Minutes were descriptive and were circulated to the wider team for information. There was a list of attendance and an action log to monitor progress against identified actions. Feedback from these meetings was mostly provided to staff during team meetings. However, regular team meetings were not held with administrative staff.
- The clinical governance committee (CGC) was responsible for ensuring that the appropriate structure, systems, and processes were in place in the hospital to ensure the safe delivery of high-quality clinical services. The CGC met every month and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, risk register review. Action was taken to address areas of concern. For example, information governance training was delivered to staff following an increase in general data protection regulation (GDPR) incidents in the department during 2018.
- The MAC met bi-monthly and the minutes of meetings held in July and November 2018 were reviewed. The minutes showed key governance areas such as the clinical governance report, practising privileges, and incidents, were discussed. The HoDs met monthly and the minutes showed items discussed included complaints, incidents, clinical governance, audit results, and key departmental feedback. These meetings also shared staff experiences, and information was shared back with most staff in the departments.
- Governance processes had not been effective to ensure all non-clinical staff received an appraisal. This had been identified and an action plan was in place to ensure they were completed.
- Clinical staff members were clear on their objectives and understood how they contributed to the hospital success. Heads of departments identified training needs of staff through appraisal and supported completion of specialist training to support patient care.

Managing risks, issues and performance

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected**.
- We saw there was a risk assessment process in place and that identified risks were assessed using a standardised template which scored the risk as low, medium or high risk. The local risk registers were managed by the heads of departments who escalated risks to the senior leadership team. Senior staff spoken with had a good knowledge of what was currently on their local risk register. Risks included the safe storage and management of patient records which was under regular review.

- The risk register was discussed as part of the service performance review meeting. Staff described their understanding of what constituted as a risk and were confident they would raise any concerns that they believed impacted on safe patient care.
- The service manager had systems and processes which supported monitoring of performance and issues. We observed they had access to an online system to monitor for example; training compliance and equipment maintenance.
- Any performance issues or concerns were escalated through monthly departmental review meetings held between the HoDs, clinical lead, hospital director and finance director.
- There was a programme of internal audits used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Senior staff confirmed results were shared at relevant meetings such as clinical governance meetings.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS) and Patient Led Assessment of the Environment (PLACE).
- See information under this sub-heading in the surgery report.

Managing information

- **The service did not always collect, analyse, manage and use information to support all its activities, using secure electronic systems with security safeguards.**
- The OPD had an inefficient and outdated process for the management of medical records until change was initiated during September 2018.
- There was an increase with information governance and general data protection regulation (GDPR) incidents during 2018. Many of the thirty incidents reported in the outpatient and diagnostic imaging departments concerned patient notes being unavailable for clinics, and incorrect information being filed in patient records. In mitigation, the service was in the process of redesigning the administrative service, which had included the recruitment of additional staff.
- An electronic system had been implemented to track patient files, and a review of administration management systems was in progress. The service had not met its internal service level agreement to send NHS coding to the internal NHS coders during 2018. At the time of our inspection, a significant reduction in the number of patient files awaiting coding had been achieved and the NHS requirement to have a coding sheet for each patient was met.
- There was a clear action plan in place to ensure the safe and efficient management of information. Frustration was voiced however, by one consultant at the length of time taken to improve practice.
- Relevant staff could access NHS and private patient electronic records appropriate to the needs of the investigation being completed.
- Computers were password protected and locked when not in use. We saw that computers were not accessible to patients.
- See information under this sub-heading in the Surgery report section.

Engagement

- A monthly clinical governance bulletin was shared throughout the hospital, to support with the management of risk. Topics included changes in National Institute for Health and Care Excellence (NICE) guidance, and best practice or issues arising from other hospitals in the BMI group.
- Monthly, informal staff forums were held to share information. Pictorial 'one page' messages that provided a simple summary of incidents and identified learning, were shared electronically with staff.
- Staff attended daily communication meetings and there were regular all staff meetings. Staff we spoke with felt engaged in the service and able to raise ideas and concerns with managers.
- A patient liaison officer promoted engagement with the local population for the purposes of health promotion and attracting new patients to the clinic.
- Two consultants and a hand therapist delivered a 'hand and wrist' event to share information about the services offered with local people in October 2018, and informed the local community of services offered in the local media.

Learning, continuous improvement and innovation

- The OPD service took on board feedback following the previous inspection in August 2016. Since the August

2016 inspection, hand sanitising gel dispensers were available throughout the department and staff members had been issued with individual, portable hand sanitisers.

- Naso-endoscopes, which were flexible fibre optic tubes used for ear, nose and throat (ENT) procedures were not being decontaminated in a separate room from the clean scopes at our August 2016 inspection. This posed a risk of cross-infection. During this inspection, changes had been implemented and there was safe practice in the decontamination of naso-endoscopes.
- During this inspection, a refurbishment plan continued to improve compliance with infection control and prevention policies. For example, a ripped cover on an examination couch was repaired. The replacement of hand wash basins was in progress and all carpets in clinical rooms had been replaced with hard flooring. There was a culture of continuous staff development across the departments. Two health care assistants had completed scrub competencies to support their roles within the minor procedures unit. Some staff, including the physiotherapy department manager, had completed an institute of management and leadership (ILM) course. This demonstrated the hospital's commitment to continuous staff learning and improvement.
- New departmental reviews had been introduced in December 2018 to focus on quality of service delivery rather than commercial performance.

Inadequate

Diagnostic imaging

Safe	Inadequate
Effective	
Caring	Good
Responsive	Good
Well-led	Inadequate

Information about the service

BMI The Droitwich Spa Hospital is in the centre of Droitwich and offers a wide range of procedures from simple routine investigations to major surgical procedures.

The diagnostic imaging department had the following service; x-ray, magnetic resonance imaging (MRI), a technique used to form pictures of the anatomy and the physiological processes of the body, ultrasound and a mobile C-arm fluoroscopic x-ray system. The C-arm is an imaging device that is based on x-ray technology and can be used flexibly in operating rooms.

During the inspection, we visited the diagnostic imaging service. We did not review the computerized tomography (CT) service as this had been suspended in July 2018. We spoke with nine staff including; radiographers, health care assistants, administrators, radiologists, and senior managers. We spoke with two patients. We also reviewed four sets of patient records. 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 core service.

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good.

During our inspection the hospital suspended the X ray service in order to ensure all necessary actions and standards were adhered to maintain safe practice.

Are diagnostic imaging services safe?

Inadequate

Mandatory training

- **The service provided mandatory training in key skills to all staff. There were processes in place to monitor compliance and ensure everyone completed it.**
- The hospital delivered a mandatory training programme internally for all clinical and non-clinical staff members. Staff attendance was recorded to monitor compliance. The five-year vision for 2015 to 2020 was to ensure that compliance with mandatory training was above 90%. Training compliance for the diagnostic imaging service was at 92%.
- Mandatory training courses in key skills was provided to staff, which included “face to face” and “e-learning” training modules. Mandatory training topics covered key areas such as basic life support, manual handling, health and safety and infection control. Staff within the magnetic resonance imaging (MRI) (a medical imaging technique used in radiology to form pictures of the anatomy and physiological processes of the body) department confirmed they had received training in health and safety, information governance and safeguarding.
- At the time of the inspection, the imaging service was being overseen by the director of clinical services who ensured staffs’ mandatory training compliance. This meant that they could review staffs’ individual training

needs and discuss any non-compliance within the department. However, we did not see evidence that all staff working within radiology had received the appropriate training in the use of radiation, radiation risks and regulations. We saw the imaging service had created an action plan based on the radiation protection adviser's (RPA) report of November 2018. The action plan identified that Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 procedures had not been shared with staff but training in these was in progress. We saw this had a target date of 28 February 2019. During the re-visit on 8 February 2019, we saw that the imaging service had implemented procedures to ensure all staff undertook the appropriate training and competencies regarding radiation risks and regulations. Staff spoken with confirmed they were completing their training and we saw a folder had been created highlighting staff competencies.

- We saw training information was included in the staff newsletter called Droitwich Journal. This was a new venture with the first newsletter being launched in October 2018. For example, the training requirements for November 2018 included; moving and handling, basic life support, immediate life support and infection prevention and control. Imaging staff said they had completed their training which was confirmed by senior staff.
- Imaging staff undertook mandatory annual e-learning and practical training sessions for infection prevention. This was provided by an infection prevention and control nurse who conducted in-house training.
- The consultant radiologists, working for the hospital under practising privileges, did not receive mandatory training from the service. They received training from their substantive place of employment and BMI Droitwich Spa hospital had oversight of their completed training records. Practising privileges is an established process within independent healthcare where a consultant is granted permission to work in an independent hospital in the range of services they are competent to perform.

Safeguarding

- **Staff understood how to protect patients from abuse and knew how to recognise and report abuse.**
- Safeguarding adult's policies seen had been reviewed and were up to date. They reflected relevant legislation and local requirements. We saw details of the local safeguarding board together with contact numbers for making safeguarding referrals displayed within the imaging service.
- All staff were trained to adult safeguarding level two, which meant they could identify, support and advise those over the age of 18 who may be identified as suffering from abuse. Training compliance was at 92% within imaging.
- Adult safeguarding level three was provided to senior members of staff to ensure that they could provide the appropriate support to staff. Senior radiographers informed us they had recently been requested to complete level three training and were in the process of arranging this.
- Staff spoken with were aware of safeguarding procedures but confirmed they had very brief contact with patients, their relatives or carers. Staff told us that if they were concerned about a patient, they would contact the director of clinical services for advice.
- Radiographers told us that should they suspect physical abuse when reporting images, they would escalate their concerns to their director of clinical services.
- Prevent is one of the arms of the government's anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation. Prevent training formed part of the wider safeguarding agenda and encouraged staff to view a patient's vulnerability as they would any other safeguarding issue. Training figures across the diagnostic service showed that most diagnostic staff had completed their training.
- Staff demonstrated awareness of female genital mutilation (FGM) and confirmed they had completed their training. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Staff said that should they have any concerns they would contact the director of clinical services.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**

- The hospital had an infection control and prevention lead who with support of a consultant microbiologist developed a continuing improvement programme.
- During the August 2016 inspection we found there was a general lack of hand cleansing gels and hand hygiene processes throughout the clinical departments. In response, the hospital participated in a global hand washing day in October 2017 and displayed hand hygiene posters. During this inspection, we found these posters on display throughout the imaging service, there were no issues or concerns with hand hygiene protocols. We observed staff using the appropriate handwashing techniques.
- The radiology hand hygiene data for July 2018 showed the service was 100% compliant with their hand hygiene procedures. Imaging staff confirmed they completed the hand hygiene audit every fortnight but were unaware of their compliance and said they had not received any feedback.
- In addition to the monthly hand hygiene audits a new observational self–assessment tool had been cascaded within BMI hospitals. These audits focussed on observations conducted by the heads of departments supported by the infection prevention and control (IPC) lead. An action plan was issued if any areas of non-compliance were identified to improve the existing standards and reach given targets within agreed timescales.
- We saw the IPC observational self-assessment for September 2018 for the x-ray and MRI service which showed 100% compliance. This was based on 11 standards which included for example; all personal protective equipment (PPE) correctly removed and disposed of, all spillages of bodily fluids were removed, and the area decontaminated appropriately. We found no issues or concerns during our visit to the imaging service.
- Each housekeeper completed a form when they had cleaned an area which was signed off by the housekeeping lead. The IPC meeting minutes for October 2018 identified that cleaning schedules were not being completed daily within the x-ray service. It was felt the general x-ray room was not being cleaned according to the schedules. During the inspection, we saw completed cleaning schedules with no issues or concerns identified. This meant that we were assured that there were processes in place to oversee the cleaning of areas within the imaging service.
- Clinical waste was sorted and disposed of in appropriate, foot-operated waste bins. Sharps disposal bins were labelled correctly and not overfilled and did not appear to contain inappropriate waste.

Environment and equipment

- **The environment was suitable for the management of imaging services. However, concerns were raised regarding the reliability of the dosimetry given by the x-ray equipment during the inspection which when raised by the inspectors led to the hospital suspending the service.**
- Some of the equipment in use within the imaging service were coming towards the end of their lifespan, such as general x-ray, where breakdowns had been reported. The equipment was also affected by parts being unobtainable due to the age of the equipment. These were identified on the hospital's risk register and approval had been given for the replacement of the x-ray room and equipment. Plans were in progress for commencement of a new x-ray room to begin the end of March 2019.
- The x-ray equipment was identified as becoming obsolete in December 2019 and was included on the hospital's risk register as it presented a manual handling risk to both patients and staff. The vertical and horizontal automatic exposure control (AEC) chambers were no longer functioning and replacement parts no longer available. AEC is a radiographic density control device that terminates the exposure when a predetermined amount of radiation has been reached.
- The radiography testing report for November 2018 stated that the dose area product (DAP) meter was, "41% higher than the measured and calculated DAP which significantly exceeded the 25% remedial tolerance." DAP is the quantity used in assessing the radiation risk from diagnostic x-ray examinations and interventional procedures. The recommendation was that, "exposure factors should be noted for each view and the DAP suspended from further use."
- We discussed the 40% variance with senior staff, radiographers and the radiation protection advisor (RPA) who provided radiation advice to the hospital. The RPA confirmed that variances often occurred with the DAP meter which usually ranged about 10% but could go up as high as 35%. However, all staff spoken with confirmed they could not provide assurance that the outcome measures for the x-ray equipment were either

safe or unsafe. This resulted in the hospital management team suspending the x-ray service, to protect patients who may potentially receive an incorrect dosimetry when attending for their x-ray. Dosimetry is the measurement, calculation and assessment of the ionizing radiation dose absorbed by an object, usually the human body. During the re-visit on 8 February 2019 we saw the hospital had undertaken a patient harm review which evidenced that there was no harm identified.

- Because of the variances in the DAP meter, the imaging service had discontinued its use in December 2018 and were recording the Kilovolt peak (kVp) and milliamp seconds (mAs) for calculation by the medical physics expert monthly. The kVp controls the quality of the x-ray beam produced while the mAs controls the quantity or the amount of x-ray photons (light transmission) produced. During our re-visit on 8 February 2019 senior staff confirmed they had received the results of two month's recording which were within the diagnostic reference levels (DRLs) limit. They confirmed they required further results to ensure they could create local DRLs. Diagnostic reference levels (DRLs) are dose levels for typical examinations such as general radiography.
- The BMI Droitwich Spa capital expenditure (Capex) Plan to support strategy for service development for June 2018 identified that there had been complaints against the imaging service regarding the quality of images, turnaround times and access to the service because of frequent breakdown of the x-ray. The condition of the equipment had been reviewed because of the frequent breakdown and the risk register updated accordingly. For example; poor image quality and frequent breakdowns, resulted in written complaints from consultants. There had been 10 reported breakdowns from January to March 2018 within the x-ray service. From November 2018 to January 2019 there had been five incidents recorded for the MRI service. The managers informed us that following a review there were two incidents which resulted in two days loss of MRI service.
- Consultant radiologists spoken with confirmed that overall, they had no concerns with the imaging quality produced. However, they were not aware of the variance in the DAP meter and had not received any communication regarding the service not having local DRLs in place.
- Records showed electrical equipment in the departments had undergone portable electrical appliance testing.
- Access to the imaging department was through the hospital's main entrance and situated on the ground floor which provided adequate access for people with limited mobility. The imaging department had access to an individual reception and waiting area.
- Patients attending the department reported initially to the reception area where they remained until a member of the diagnostic team called them for their investigation.
- The imaging service had access to both a resuscitation grab and anaphylaxis (an acute allergic reaction) bag. The bags were available, which staff could access in an emergency. These were well equipped and maintained, with daily and weekly checks recorded. We found no issues or concerns with the recordings. The contents were all within their expiry date. The imaging staff could access the resuscitation trolley located in the outpatient's department when required. The resuscitation audit for January 2018 showed a score of 100% across the hospital.
- We saw that all imaging rooms were clearly signposted with "do not enter" warning lights to ensure that staff or patients did not enter rooms whilst imaging was taking place. This was in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance for access.
- Staff had access to appropriate personal protection equipment (PPE), including lead gowns and neck shields. The radiology department had clear guidelines on which specialised PPE should be used for specific procedures. We saw documentation which confirmed that PPE was routinely checked to ensure it was not damaged. Staff also wore radiation exposure devices which were analysed monthly to ensure that staff were not over exposed.
- The service stored hazardous substances appropriately and in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health. We saw evidence of up to date COSHH risk assessments to support staff's exposure to hazardous substances.

Assessing and responding to patient risk

Inadequate

Diagnostic imaging

- **The hospital did not have processes in place to ensure that staff assessed the risks to patients so they were supported to stay safe**.
- The guidance to ensure patients were kept safe were set out in the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 which is enforced under the Health and Safety Act 1974. IR(ME)R 2017 provides a framework intending to protect patients from the hazards associated with ionising radiation for example; x-rays.
- During our re-visit on 8 February 2019, we saw completed policies in line with IR(ME)R regulations. All had been approved by the radiation protection advisor (RPA).
- The imaging service had recently employed a radiation protection supervisor (RPS) in November 2018. The role of the RPS is to ensure compliance with both (IR(ME)R 2017 regulations and the Ionising Radiations Regulation 2017 (IRR17) in respect of work carried out in an area which is subject to local rules. The IRR17 helps employers comply with their duties which came into force in January 2018 while the purpose of local rules is for example; to ensure that radiation exposure limits are listed and that authorised personnel wear their radiation dosimeter film badge always when in the controlled area. Although the local rules were present, they were not on display with details of the RPS and radiation protection advisor (RPA) contact numbers. This was brought to the attention of senior staff during our visit. We saw the local rules had been updated, were on display and included details of the RPS and RPA contact numbers during our re-visit of 8 February 2019.
- Imaging staff had access to a medical physics expert (MPE) and an RPA to provide support and radiation advice. The role of the MPE and RPA was to provide consultation as appropriate on for example, patient dosimetry, quality assurance and advice on matters relating to radiation protection concerning medical exposure.
- The diagnostic imaging service were unable to provide us with any quality assurance (QA) outcomes. This was also highlighted in the radiation protection advisor's (RPA) report of November 2018 which stated that there were, "no recent records of QA having been carried out within the last three months." Senior staff and radiographers confirmed that they were unable to evidence any QA from April to December 2018. The objective of QA in radiology services is to promote patient safety and enhance patient care with accurate and timely radiological assessments. This meant that the service did not have systems, processes or procedures that were reliable to manage the risks to people who use the services to keep them safe. During the re-visit on 8 February 2019 we saw the relevant risk assessments had been completed and were currently with the RPA for review.
- All medical exposures require optimisation. IR(ME)R regulation 7(1) states that the, "practitioner and operator shall ensure that the doses are kept as low as reasonably practicable (ALARP) consistent with the intended outcome." The radiology service had no recordings of the diagnostic reference levels (DRLs) from April to December 2018 which was confirmed by senior staff. DRLs are used as a guidance and help to identify issues relating to equipment or practice by highlighting unusual high radiation doses. This was also verified in the radiation protection advisor's (RPA) report for November 2018 which stated that dosimetry records were not available. This meant that there could be a risk of patients receiving an inappropriate dose during their procedure. The service was also not compliant with IR(ME)R regulation 4(3)(c) which says the employer must establish DRLs for examinations applying to individuals undergoing; medical diagnosis or treatment, health-screening programmes, occupational health surveillance and medico legal exposures.
- Due to the concerns raised during the inspection in relation to QA outcomes and the recordings of DRLs, the executive director and director of clinical services suspended the x-ray service to assure themselves of the safety of patients. This was done pending a review by the medical physics expert.
- During our revisit on 8 February 2019 the imaging service had created a QA folder which highlighted that all pieces of equipment in use had been externally tested on 23 and 28 January 2018 which included the x-ray machine. The x-ray machine test showed inconsistency in its outputs and advice was sought from the MPE. The test result records identified the feedback from the MPE who stated that the unit could not be continually used. Senior staff confirmed this verified their decision to suspend the x-ray service pending a replacement machine being sought.
- Because of not having any DRLs from April to December 2018 the hospital was in the process of conducting a patient harm review. Senior staff informed us that they

were pulling together a sample of dose readings where they couldn't evidence any QA and asked the MPE to correlate the doses against examinations that had national DRLs. This continued to be a work in progress, but staff said the findings were positive with no harm to patients having been identified.

- Senior staff confirmed they had not informed patients attending the x-ray department of the variance in dosimetry which meant that they were not compliant with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The intention of this regulation is to ensure that the provider acts in an "open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.
- The hospital responded to our concerns regarding the x-ray service and created an action plan. During our visit on 8 February 2019 we saw the following actions had been implemented regarding QA:
  - RPS had undertaken QA training by the medical physics expert.
  - A QA calendar, folder and template were in place.
  - QA results to be discussed as part of the local clinical governance meeting with the first meeting due February 2019.
- The imaging service had obtained a mobile x-ray machine to carry out its commitment to patients regarding their x-rays. We saw the mobile machine had the relevant QA documentation and risk assessment. Staff had received training relating to the mobile x-ray machine from the company supplying the equipment.
- Due to the unavailability of skilled CT staff, the imaging service had assessed and responded to the risk to patients by suspending its GP walk in service and computed tomography (CT) service in July 2018.

Staffing

- **The service had enough staff, however, they did not always have the right skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- The hospital employed approximately 105 contracted staff. Staffing was maintained through recruitment processes including professional body and reference checks, performance reviews and mandatory training for clinical and non-clinical staff. Clinical staff recruitment within the imaging service was identified as an ongoing challenge and was identified on the hospital's risk register.
- There had been difficulty in recruiting into the imaging manager's post. The imaging service did not have a qualified imaging manager. A new manager was due to commence employment in February 2019. An interim manager with no radiology experience was overseeing the department from January to December 2018 with support from the senior management team and BMI head of diagnostics. The heads of department meeting minutes for August 2018 identified that this arrangement was identified as being non-compliant as the manager for diagnostic imaging should have a degree or diploma level qualification in diagnostic radiotherapy in line with the Health and Care Professional Council (HCPC) recommendations. We did not see what arrangements or action plans the imaging service had put in place to ensure it was compliant. The service was, at the time of the inspection, being overseen by the director of clinical services.
- The imaging service flexed their opening times to cover the needs of patients attending the service. Staff confirmed they could call on the services of the resident medical officer when required. Staff used were familiar with the department. Senior staff confirmed they block booked radiographers to maintain continuity within the service. This was confirmed by agency staff spoken with.

Medical staffing

- **The service had enough medical staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, medical staff were unaware of the issues within the diagnostic imaging service regarding the dosimetry levels to patients.**
- There were no radiologists employed directly. Radiologists worked at the hospital under practising privileges. Radiologists new to the hospital received a formal induction, and could work under practising privileges only if their scope of practice reflected what they undertook within their NHS work.
- The service had 11 radiologists working within the hospital. For radiologists to acquire and maintain

practising privileges they were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development.
- All consultant radiologists were requested to provide documented evidence of an annual appraisal so that it could be used as part of their revalidation process.
- There was a small group of radiologists working within the service to facilitate reporting on images. These were regular staff, who attended the hospital on set days according to their availability and area of expertise. Staff told us that if their specialist knowledge was required, they could be contacted directly.
- Details of radiologists working at the hospital can be found in the surgery report.

Records

- **While staff kept appropriate records of patients' care and treatment, the imaging service did not carry out any record audits to monitor compliance. Records were kept in locked cupboards and were only accessible to authorised staff, to maintain confidentiality.**
- The radiology service did not audit its patient records or referral forms. This meant that we could not be assured there were systems and processes in place to ensure imaging staff had all information needed to provide care, treatment and support.
- The November 2018 action plan identified that there was no record of operators or referrer's practitioners and operators. During our re-visit of 9 February 2019, we saw the service was updating its database of referrers which could be cross-referenced. This ensured that the referrer could request imaging and had undertaken IR(ME)R training. Imaging staff informed us the system would not allow the reviewer to move forward if the referrer was not recognised on the electronic system.
- Following our inspection in January 2019 the hospital had created a policy called, "Entitlement to act as a referrer, practitioner and operator." The policy provided guidance to staff in identifying individuals entitled to act as referrer, practitioner or operator within a specified scope of practice.
- We looked at four patient records which we found to be well maintained. Entries were dated and signed by the appropriate staff member which included details of all investigations and their findings.
- Diagnostic images were stored using an electronic database and were password protected to prevent unauthorised access. Images could be shared with external systems if necessary which was useful when a specialist opinion was required.
- Computers were locked when not in use. This prevented unauthorised access and protected patient's confidential information.
- The service could access an image exchange portal that allowed them to exchange imaging information with other colleagues which included other providers and consultants. The service could "blue-light" any request to receive prioritisation of information if required.
- Secure storage of patient records was constantly under review to ensure that the hospital was meeting the new general data protection regulation (GDPR). Imaging staff confirmed they had received information governance training and followed information governance policies. The new GDPR was implemented in May 2018 and is a legal framework that sets guidelines for the collection and processing of personal information of individuals.

Medicines

- **The imaging service gave, and recorded administered medicines according to best practice, did not carry out any medicine audits to monitor compliance.**
- The diagnostic imaging service did not carry out any medicine audits. Senior managers informed us this had been incorporated into the BMI audit programme due to commence in March 2019. During the inspection, we found no issues or concerns with the storage and recording of medicines.
- The imaging department used a small number of medicines for investigations. These were largely contrast media. We saw these were stored in locked cupboards within the diagnostic imaging service.
- The MRI service had processes and procedures in place to daily record the ambient temperature of the room and refrigerator storing medicines. We did not find any issues or concerns during our inspection.
- Radiologists were responsible for the prescribing of all medicines for patients attending the service. Both radiologists and radiographers confirmed that when administrating medicine this was in line with BMI's patient specific direction (PSD) guidance. A PSD is a written instruction, signed by a doctor or non-medical prescriber for medicines to be supplied and/or

administered to a named patient after the prescriber has assessed the patient on an individual basis. We did not find any issues or concerns with the management of PSDs during the inspection.
- Detailed findings on medicines can be found in the surgery report.

Incidents

- **The service managed most patient safety incidents well. However, staff did not always report them appropriately. Managers investigated incidents, but lessons learnt had not been shared with the whole team and the wider service.**
- There was a BMI Healthcare policy for incident reporting, which was in date. The policy identified everyone's responsibilities for reporting and investigating incidents. Imaging staff described when they would report an incident and the process used.
- There had been no never events or serious incidents reported in the diagnostics department. 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.
- All incidents involving radiation were reported on the hospital's incident reporting system. These were categorised as 'IRMER' incidents for data collection and trend monitoring. The hospital reported all radiation errors to the radiation protection advisor. Senior staff and radiographers explained and demonstrated the processes to be followed for radiation incidents.
- There had been two radiation incidents within the diagnostic service, one of which was reportable to IR(ME)R 2017 regulations". We saw copies of the reports which had been fully investigated. Radiographers spoken with were aware of the incidents and could describe the processes they had put in place which included the additional re-checking of the patient's details and their previous exposure to radiation.
- There was a total of 74 clinical incidents reported from April to June 2018 of which 15 were attributed to the outpatients and diagnostic imaging departments. Two incidents related to the imaging service which included a needle-stick injury and a security breach. We saw the incidents had been appropriately reviewed with identified outcomes. Radiographers spoken with said that they did not receive any feedback from incidents and that incidents which could be classed as a "near miss" were not reported. Examples given included wrong patient name or wrong location on the documentation. This meant that we could not be assured that senior managers had oversight of all incidents occurring within the imaging service.
- The diagnostic imaging action plan for November 2018 identified that the process for sharing lessons learned from incidents was not robust. We saw the action was to implement monthly team meetings and summaries to be provided from incidents discussed at the lessons learned board. We saw the service had created its first meeting in December 2018 and incidents were included as an agenda item.
- We saw clear directions within the BMI 'Being Open and Duty' policy which provided guidance for staff when patients were involved in an incident. This assured that if a mistake was made, patients and/or their relatives/ carers promptly received the information they needed to enable them to understand what happened. Radiographers spoken with understood their responsibilities regarding the duty of candour legislation. Radiographers said they would discuss any identified concerns with the patient and provide a full apology.

Safety Alerts

- **The service planned for emergencies and staff understood their roles if one should happen.**
- National patient safety alerts when received, were circulated through either an email or hard copy to each head of department who confirmed any action undertaken and signed it off once completed. Radiographers confirmed they had recently begun to receive details of safety alerts to ensure they were fully aware of any highlighted concerns.
- Imaging staff explained the procedures that they observed when responding to an emergency. During the inspection, we saw staff responding to an accident in a timely way within the imaging service. All staff worked effectively with each other and knew what action to take in response.
- Imaging staff confirmed they had been involved in a safety scenario in December 2018 regarding the evacuation of a patient. They said they found this very useful and helped them to structure their response in an emergency.

Inadequate

Diagnostic imaging

Are diagnostic imaging services effective?

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where these two core services have been separated. Outpatients and Diagnostic services were previously inspected but not rated.

We currently do not rate effective for diagnostic services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance. However, there was no evidence of its effectiveness.**
- Most policies, procedures and protocols seen to manage patient's safety were in date and had been recently reviewed. Policies seen were referenced against national guidance to ensure care and treatment was delivered in line with legislation, standards and evidence based guidance. It was noted that the imaging ionising radiation safety policy dated August 2017 contained reference to Ionising Regulations 1999 (IRR99) and had not been updated to refer to the new Ionising Regulations 2017 (IRR17) guidance. This was brought to the attention of senior staff who confirmed they would arrange for the policy to be reviewed.
- Staff said the aim for the service was to ensure they worked to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017 and guidelines from the National Institute of Health and Care Excellence (NICE), the Royal College of Radiologists (RCR) and other national bodies. This included all specialities within diagnostics. The RPS informed us during the inspection they were in the process of creating policies in line with IR(ME)R regulations. After the inspection, the hospital provided us with copies of these policies which included for example: optimisation of doses, reporting the outcome of over-exposure and provision of information regarding radiation doses. During our visit on 8 February 2019 we saw these had been approved by the RPA and had been implemented.
- BMI Healthcare had created a self-assessment audit which was completed annually. We saw the imaging assessment was divided into two areas which included radiation general and governance. Radiation general reviewed for example, the appointment of a radiation protection advisor and supervisor while radiation governance reviewed: policies, procedures, training and risk assessments.

Nutrition and hydration

- **Patients had access to a drink when visiting the service.**
- Patients were provided with clear instructions in their preparation letter about the amount of fluid to drink prior to attending the imaging department. If patients had to fast, they had access to a water fountain in reception to quench their thirst after their procedure.
- See information under this sub-heading in the surgery report section.

Pain relief

- **The service managed patients' pain effectively.**
- We observed staff asking patients if they were comfortable during their MRI procedure.
- If patients required pain relief during their appointment it was prescribed by the resident medical officer (RMO) and administered by a radiographer. Staff told us that the need for pain relief was very rare.
- See information under this sub-heading in the surgery report section.

Patient Outcomes

- **The service did not monitor the effectiveness of care and treatment which meant there were no processes to improve the service.**
- The diagnostic imaging service were unable to provide us with any quality assurance (QA) outcomes relating to the x-ray department which meant there were no processes in place to monitor the outcomes of care and treatment of people who use this service. This was also highlighted in the radiation protection advisor's (RPA) report of November 2018 which stated that there were, "no recent records of QA having been carried out within the last three months." Senior staff and radiographers confirmed that they were unable to find any QA outcomes for 2018. This is a requirement under IR(ME)R Regulation 4 (1) schedule 1e which requires the employer to have procedures in place "to ensure that quality assurance programmes are followed." However, we saw there were QAs carried out in MRI and ultrasound.

- Following the inspection, the service provided us with a copy of a policy they had implemented regarding quality assurance. The aim and purpose of the policy was:
  - To ensure that QA programmes were in place to review all standard operating procedures.
  - To review all standard operating procedure in relation to IR(ME)R.
  - To ensure these procedures are regularly reviewed to ensure that they are effective and applicable as well as identify any changes that may be necessary in the future.
- The imaging service did not hold discrepancy meetings. In the event of a discrepancy being identified, the service would report this to the medical advisory committee (MAC) imaging representative who would review the images with the reporting radiologist. All identified discrepancies would be recorded on the hospital's incident reporting system.
- We saw the imaging service radiation self-assessment audit for 15 January 2019. The service achieved 85% compliance. Areas covered included both radiation general and governance. The audit identified for example that there was no diagnostic reference levels (DRLs) established with comparison made with published national DRLs and no radiation protection committee meeting minutes with an action plan showing progress made in implementing actions. The audit had actions for completion against areas of non-compliance.
- Following our inspection of 22 and 23 January 2019 the imaging service was visited and reviewed by a senior clinical services imaging manager. From this visit, the service formulated an action plan amalgamating the recommendations from the RPA audit and self-assessment audit. Areas identified included; the implementation of QA processes, environmental and equipment checks and the creation of IR(ME)R procedures and protocols. We saw these had a completion date of 28 February 2019.
- The service had not carried out any clinical audits. A new BMI clinical audit programme had been created to include the imaging department. Examples of areas to be audited included medicine management, patient records and radiation safety. The action plan had a target date of May 2019. However, it was unclear what processes the service had to ensure the safety of patients prior to the target date. This was brought to the attention of senior staff who confirmed they would arrange for an audit to be completed prior to May 2019.
- A proportion of the hospital's income from April to March 2018 was conditional on achieving quality improvement and innovation goals, through the commissioning for quality and innovation (CQUIN) payment framework. Annual assurance visits were completed by the local commissioning group which were benchmarked against local trusts. The hospital participated in the following CQUINs:
  - A staff health and well-being charter. The well-being charter was an assessment tool which enabled senior management to support staff in eight key topics such as leadership, health and safety, mental health, physical activity and healthy eating.
  - The sign up to safety campaign aimed to reduce avoidable harms to patients.
- Radiographers spoken with demonstrated awareness of the sign up to safety campaign.

Competent staff

- **The service did not have processes in place to ensure staff were competent for their roles. As the service did not have a manager staff had not received an appraisal to manage their performance.**
- The imaging service did not have a manager. A new manager was due to be in post during February 2019. The service was currently being overseen by the director of clinical services who took up the post in December 2018. Imaging staff spoken with confirmed they had not had their performance reviewed.
- Radiographers confirmed they had received training relevant to their role. Senior radiographers confirmed they mentored and assessed staff's competency. However, it was unclear if staff had received the appropriate corporate training to ensure they had the relevant qualifications enabling them to sign off staff as competent. This meant there was a risk that staff may not have been appropriately assessed as being competent for their role. This was brought to the attention of senior staff.
- During the re-visit on 8 February 2019 we saw all staff were updating their competencies to ensure they had the necessary qualifications. There was a folder available within the staff office to verify staffs'

competencies. We saw staff competencies for the following; the use of the MRI scanner, the mobile C-arm, contrast media pressure injector competence assessment and administration of medicines to aid relaxation. Areas reviewed included; equipment care, patient care and safety. Staff spoken with confirmed the folder was useful and was an effective point of reference.

- The radiation protection supervisor (RPS) was new in post (November 2018) and had just completed their training from the radiation protection advisor's organisation.
- All staff administering radiation confirmed they had been appropriately trained to do so. Those staff that were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR(ME)R 2017.
- We saw evidence that all radiographers had in date health care professional registration (HCPC). This was in line with the society of radiographers' recommendation that ensured all staff were appropriately registered.
- Senior managers told us that radiologists applying for practising privileges had to demonstrate their competency prior to carrying out procedures in radiology. Staff also said that any existing radiologist wishing to undertake new procedures had to demonstrate competency. This was done by reference to their NHS practice.

Appraisals

- The head of department meeting minutes for July 2018 identified that 50% of staff across the hospital had received their appraisal. Imaging staff said that due to not having an imaging manager from January to December 2018 they had not received their appraisal or the opportunity to discuss their personal development.
- New imaging and agency staff confirmed they had received a corporate induction when they started work at the hospital. New staff spoken with confirmed their induction included the following areas; infection prevention and control, information governance and fire safety. They said they found the induction to be beneficial and helpful. The action plan for November 2017 identified that an agency specific induction was needed for radiographers. This had a target of 28 February 2019.

Multidisciplinary working

- **Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide effective care.**
- We saw that the imaging team worked closely with the visiting radiologists. Multidisciplinary team (MDT) meetings were not undertaken within radiology. MDT meetings took place at the local acute hospital trust and were not minuted by the service. Senior staff confirmed they did not receive written feedback but were informed verbally, as required. This meant there was a risk of information being lost in transition which may have impacted on the patient's individual needs.
- Radiographers said they had limited contact with their peers from other BMI hospitals but said they were available for advice and support when required.
- An allocated radiologist attended the medical advisory committee and local departmental meetings.
- For detailed findings on multidisciplinary working please see the effective section of the surgery report.

Seven-day services

- **The imaging service did not provide a seven-day service. However, the imaging service provided a radiographer on-call rota seven day a week for support when required.**
- The imaging service operated Monday to Friday from 9am to 5pm.
- The priority clinical standards for seven-day hospital service identified that under standard five hospitals must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography and microbiology. Although the hospital did not have an on-call rota for radiologists the imaging service had recently introduced radiographer on-call service seven days a week.
- The resident medical officer (RMO) was available seven days a week. Staff confirmed they would contact the RMO in exceptional circumstances such as: if a patient become unwell during a procedure or if they required a prescription to be re-written.

Health promotion

- Staff supported patients to manage their own health, care and well-being as appropriate.
- See information under this sub-heading in the surgery report section.

Inadequate

Diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood their roles and responsibilities under the Mental Health Act 1983, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients who lacked the capacity to make decisions about their care.**
- The Mental Capacity Act (MCA) protects people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.
- The hospital had an up to date policy regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff could access this on the hospital intranet.
- Patients attending the imaging department were required to give consent for their procedure. This was usually in the format of verbal consent for investigations such as x-rays.
- The radiologist responsible for an invasive investigation obtained verbal consent from the patient following a detailed account of the investigation process. We did not see any of these procedures during the inspection, and therefore we are unable to confirm the practice completed.
- The imaging service did not undertake a consent audit. We saw this had been discussed at the medical advisory meetings (MAC) of July and November 2018. The MAC minutes for July 2018 requested an overview of the discussion with the patient and confirmation that radiologists were having discussions with the patient to ensure they could make an informed choice. Feedback to the MAC (November 2018) was that the imaging service provided patients with the appropriate information prior to their procedure. However, as there was no consent audit we could not be assured that details and risks had been discussed.

Are diagnostic imaging services caring?

Good

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

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We observed imaging staff caring for patients with compassion and understanding. We saw that all staff introduced themselves to patients and ensured that they knew what they were attending the department for.
- Staff promoted privacy, and patients were treated with dignity and respect. Patients were called from the waiting room and staff used this time to talk to patients and put them at ease. We observed staff talking to patients in a respectful and considerate way. For example, we saw both administration staff and radiographers responding to the individual needs of patients attending the service.
- The hospital focussed on patient feedback to gather data from patients about their experience and their satisfaction with the services they had received. During the inspection we observed staff routinely asking patients to provide feedback during their visit and we saw evidence of feedback forms for patients, their relatives or friends to complete.
- The hospital's patient satisfaction survey for 2018 was 99% which was on par with the 2017 results and just above the England average of 97%. We saw the patient satisfaction survey for the three-month period up to July 2018 for the imaging service. The result was based on 23 responses and achieved the following results:
- Overall impression and kept informed on what was happening (87%)
- Staff friendly and caring and treated with dignity and respect (91%)
- We saw the friends and family postcard results for July 2018. The imaging service scored 95% with 63 patients saying that they would recommend the service to friends and family. Comments included; "very swift and professional service", "friendly staff" and "clear instructions, prompt and reassuring."
- Two patients spoken with confirmed they had been given the opportunity to provide feedback on the service, but due to time constraint they hadn't done so. However, they both said they would be happy for their friends and family to come to the hospital for treatment.

Emotional support

Inadequate

Diagnostic imaging

- **Staff provided emotional support to patients to minimise their distress.**
- Staff showed awareness of the emotional and social impact that a person's care, treatment or condition would have on their well-being.
- Staff understood the emotional stress of patients having a procedure. Imaging staff were not routinely involved with providing support or advice for specific illnesses, but could refer patients to their consultant or the director of clinical services if they felt that additional support was required.
- Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, "I think the staff are brilliant" and another said staff were "very friendly."

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients said they felt involved with decisions about their care and treatment and had been asked for permission and agreement which meant that the views and preferences of patients were considered. Radiologists gave advice regarding investigation reports and explained that they would need to see the referring consultant for further information.
- Patients spoken with confirmed they had been given the opportunity to speak with the consultant looking after them. Patients said the consultants had, "explained why they needed their investigation" and that they were "fully aware of what was happening." Patients spoken with were complimentary about the way they had been treated by staff.
- Patients who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.

Are diagnostic imaging 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 services in a way that met the needs of local people**.
- Patients attending the hospital's imaging services were a mix of privately funded and NHS funded patients (these patients had chosen the hospital as a location for their appointment through the NHS e-referral service). This meant that there were several patients who attended the service for an investigation without a private consultation.
- Radiology and scanning services were clearly signposted and staff directed patients to the relevant areas.
- The radiology departments offered appointments that met the individual needs of the patient. Some appointments could be offered as early as the day of referral. For other procedures, depending on the preparation and speciality, an appointment would be offered within two working days.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The waiting rooms had changing areas for the diagnostic services which provided patients with privacy. Patients were seen one at a time, which prevented waiting for appointments while dressed in in gowns and promoted dignity.
- The waiting areas were large enough to accommodate wheelchairs. We were told that when patients required a wheelchair or assistance to mobilise, staff would assist them into the imaging areas.
- The service provided, when required, a translation services, hearing assistance, sign language interpreters or other assistance to ensure the individual needs of the patient were considered.
- Patients told us that they were given detailed explanations about their admission and treatment as well as written information. Staff confirmed that written information could be obtained in other languages if required.
- Patients were sent information about any procedure they were having prior to their visit. We saw evidence of leaflets relating to different procedures and guidance for liquids to be taken prior to their appointment time. However, unless requested, the information seen was not available in other languages where English was not the patient's first language.

Inadequate

Diagnostic imaging

- Staff confirmed that they were usually unaware if the patient attending the clinic had complex needs such as mental health, learning disability or dementia. Staff explained that should a patient become anxious or restless during a procedure they would use distraction techniques to calm them. Senior radiographers confirmed they had received dementia awareness training.
- There were patient toilets located within the departments. These were suitable for the use of patients who had reduced mobility and required mobility aids or wheelchairs.

Access and flow

- **Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.**
- Patients attending the department remained in the reception areas until they were seen by a member of the diagnostic team who escorted them to their investigation.
- The MRI service had a rota for the radiologists visiting the service Monday to Thursday. Radiographers confirmed they did not have a visiting radiologist on Friday but said they could access a radiologist if required in an emergency. The imaging service did not provide a service at the weekend. Radiographers said they ensured that complex appointments were not rostered for the Friday listing. We did not see any incidents recorded because of not having a radiologist on site on a Friday.
- The hospital had a framework for managing NHS-funded elective access to consultant-led care and treatment in BMI hospitals. This was set out in the referral to treatment (RTT) access policy. RTT is the term used to describe the period between when a referral for treatment is made and the date of the initial consultation or treatment. Data provided by the hospital showed that the diagnostic imaging test waiting times for patients waiting six weeks or less from referral to a diagnostic test from May 2018 to December 2018 was 100%.
- The imaging service did not monitor the number of patients who did not attend for their appointment. Radiologists reviewed the patients not attending for their appointments and informed the administration staff who would contact the patients and communicate back to the referrer.
- The imaging service monitored turnaround times via its electronic radiology information system reports. The hospital informed us that their current data supported 96% of all modalities delivering within a month of request and 100% of all requests carried out within six weeks. There were no waiting lists for the imaging service as all scans were offered in line with turnaround times.
- Image reporting times were monitored by the service. Data seen from October to December 2018 showed that x-ray and MRI results averaged 24 hours. This was better than the trust target of 48 hours.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.**
- Radiographers were aware of the policy for the management of complaints which was accessible on the hospital's intranet.
- There had been 19 complaints against the hospital for the period April to September 2018 of which seven (37%) related to the imaging service. Five referred to cancelled appointments and equipment failure, one for the attitude of staff and another for a rushed procedure. We saw the outcome of the investigations which included providing the patients with an apology.
- Patients who we spoke with told us they did not have any reason to complain during their appointment and said they would feel confident in raising a concern or complaint if necessary. Radiographers said that if a patient raised a concern or wanted to make a complaint they would try to resolve it locally to prevent escalation. Where this was not possible the complaint was referred to the director of clinical services. Patients who made a complaint were invited to meet with members of the senior management team.

Are diagnostic imaging services well-led?

Inadequate

We rated it as **inadequate.**

Leadership

Inadequate

Diagnostic imaging

- **The service did not have a qualified imaging manager to support and provide high-quality sustainable care.**
- The imaging service did not have a qualified manager. There was an interim manager overseeing the department for the year January to December 2018 with support from the senior management team and BMI's head of diagnostics. The heads of department meeting minutes for August 2018 identified that this arrangement was identified as being non-compliant as the manager for diagnostic radiotherapy should have a degree or diploma level qualification in diagnostic radiotherapy. This meant that the leaders of the service did not have the necessary experience or knowledge to direct the service effectively. This had not been identified by the senior hospital management team or the lead for radiology for BMI Healthcare. The imaging department was, at the time of the inspection, being managed by the director of clinical services prior to a new manager taking up their post in February 2019.
- Consultant radiologists spoken with said they had concerns regarding the leadership and sustainability of the service. They said there had been a lot of transitions within the service and it had not recovered from the lack of a manager. They felt the service was not always tenable with regards to patient safety. They also stated that they had raised their concerns with the medical advisory committee (MAC) and the matter had been referred to the head of imaging within BMI Healthcare. Consultant radiologists also said that they had not had the opportunity to discuss or receive any feedback regarding their concerns with senior imaging staff corporately. We reviewed the MAC meeting minutes for 2018 and did not find any reference to concerns raised regarding the imaging service.
- Imaging staff said the executive director and director of clinical services were well respected, visible and always available and supportive when required.
- Imaging staff said they enjoyed working in the department and worked well as a team. However, they felt that the service had suffered with not having a diagnostic manager. The director of clinical services spoke with pride about the work and care their staff delivered daily.
- Imaging staff we met with were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.

Vision and strategy

- **The service had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed.**
- The diagnostic imaging service had a business plan to create a new x-ray room and equipment in March 2019.
- The hospital had a vision statement which was to "offer the best patient experience and outcomes, in the most effective way, from their comprehensive UK network of hospitals," the diagnostic imaging service shadowed this vision within the department.
- The hospital's five-year vision for 2015 to 2020 was based on eight strategic objectives which included; consistently delivering quality services and care in a cost-effective way and to be the largest network of quality acute care hospital in the UK.
- Imaging staff were aware that there was a vision and strategy, although did not refer to it directly. They knew how to access the information on the hospital's intranet system when required. Staff referred to changes within the service which were aligned to the vision and strategy. For example, the new x-ray room.

Culture

- **The interim manager for the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Imaging staff spoken with reported a positive culture. They told us they were proud to work within the hospital. Imaging staff said that although they delivered care to the best of their ability, they did not feel supported in their role.
- Openness and honesty were encouraged at all levels and staff said they felt able to discuss and escalate concerns without fear of retribution.
- Imaging staff were enthusiastic about their jobs and the team in which they worked. Staff told us that they

"worked well as a team" and "loved working at the hospital." Staff also confirmed they enjoyed working with their patients and we observed appropriate interaction during the inspection.

- Imaging staff said there had not been any team meetings for nearly all of 2018. Radiographers confirmed the director of clinical services had commenced team meetings with the first one held in December 2018. We saw staff signed to say they had read the minutes which were informative and provided guidance to staff on a range of topics which included; training, incidents and compliments. We saw dates in place for team meetings to take place in 2019.
- The hospital had launched the "safety culture" as part of the BMI Healthcare safety campaign. The aim of the programme was to encourage and empower staff to challenge anyone, including senior colleagues, who may be putting patients at risk with their behaviour. The programme included assertiveness training, and this was being rolled out to all staff. Imaging staff confirmed they were aware of the safety culture but had not attended any training.

Governance

- **The service did not have a systematic approach to support and improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- The interim manager for 2018 attended the integrated clinical governance committee and heads of department meetings. Minutes seen showed that a standardised format was used which looked at for example; health and safety and incidents. Minutes were descriptive, but imaging staff informed us they were not aware of any feedback being cascaded which was relevant to their service. There was an action log to monitor progress against identified actions.
- The imaging department had recently employed a radiation protection supervisor (RPS). Prior to this the hospital utilised the service of an RPS from within BMI Healthcare and the head of imaging within BMI Healthcare. However, it was unclear what oversight and involvement they had with the Droitwich Spa hospital imaging service which meant that we could not be assured of the procedures and processes to support the service and keep people who use services safe.
- Radiographers had access to the radiation protection advisor (RPA) service. We saw the RPA report dated November 2018 which highlighted concerns with IR(ME)R 2017 compliance being poor. The RPA also reported that actions from the December 2017 report were not available which included radiography protocols to be in put in place. This meant that there were no systems in place to review and implement recommendations identified.
- Senior staff attended the radiation protection meeting which were held annually. We saw the minutes for January 2017 and March 2018. The minutes had a set agenda which included; a review of previous actions and a summary of ongoing and new actions. The meeting minutes referred to all imaging departments across BMI and therefore it was difficult to ascertain what was relevant to BMI Droitwich Spa hospital. Examples of areas raised included:
  - Doses exposure values and accumulated dose to be included in the radiology reporting system to prevent errors in the dose audits (January 2017).
  - Quality assurance programme check list needed to ensure consistency with checks (January 2017).
  - Concerns regarding ageing equipment (March 2018).
  - Radiographic protocols continued to be a work in progress (March 2018).
- During the inspection, we identified concerns with dose exposure values and no dose audits or quality assurance programme in place. These had been highlighted as areas for action in the January 2017 radiation protection meeting minutes. This meant that we were not assured that there were processes at both local and corporate level to review key items or clarity as to how individuals were held to account. We raised this during the inspection, and the provider took immediate actions to address this.
- Radiographers spoken with said they were not aware of having been provided with any information relevant to their role or the service from these meetings. This meant that we could not be assured of the processes and procedures in place to oversee the diagnostic imaging service requirements. We raised this during the inspection, and the provider took immediate actions to address this.
- **Managing risks, issues and performance**
- **The service did not have effective quality assurance programme or clinical audits in place to oversee**

performance. This meant the service did not have systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

- The x-ray service did not have structure and processes in place to support the delivery of quality services. There was not a quality assurance programme to oversee performance. The service did not have protocols in place and had not completed any audits for 2018 in line with IR(ME)R 2017 regulations. Despite a BMI wide radiation safety committee being in place, effective oversight locally and corporately had not been carried out to support the service. This meant that we could not be assured that there were processes and procedures in place to manage the risks, issues and performance of the imaging x-ray service.
- While the self-assessment audit for the service was completed annually, the service did not complete clinical audits to oversee performance which included for example; consent, medication and records audits. This meant there were no processes in place to ascertain how the imaging service was performing to ensure they kept people who use the services safe.
- The imaging service had completed an overview of its risk register. This was RAG (red, amber, green) rated. Risks identified were recorded on a standardised template which identified actions to mitigate risks recorded.
- Following our inspection of January 2019, we noted the service had implemented many actions to ensure the service had systems and processes in place. However, as this was a work in progress it was difficult to ascertain the outcomes or sustainability of the new works applied.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Information was cascaded within the hospital to ensure staff were aware and informed of issues, opportunities and outcomes, such as a newly introduced monthly staff newsletter and a one-page document called “Inci Gram#”. Imaging staff were aware of the “Inci Gram#” and felt this was a way of communicating practice and key messages.
- Staff could access patient electronic records appropriate to the needs of the procedure being completed. Computers were password protected and locked when not in use. We saw that computers were not accessible to patients.
- The imaging service had access to the picture archiving and communication system (PACS) which allowed the acquiring, storage and transmission of radiological images. This meant that films installed onto the PACS system were filed, managed appropriately and could be accessible day and night for viewing.
- The imaging service used the radiology information system (RIS). RIS is an electronic management system for the management of medical imagery and associated data. The RIS system was used to track patient scheduling and performance tracking. The RIS system was used in conjunction with the PACS system.

Engagement

- **The service engaged with patients, the public and external organisations. However, staff felt that communication within the service was poor and they did not always feel supported**.
- BMI Healthcare launched the safe culture questionnaire in October 2017 to assess the safety culture across their hospitals. The result for BMI The Droitwich Spa Hospital for 2018 was 54% which was significantly lower than the 2017 result of 85% and below the England average of 72%. Identified focus areas were:
  - Communication.
  - Updates on monthly events and more senior management team attending departmental meetings.
  - Staff growth to include departmental action plans, and the sharing and involvement with the operational plan.
- The Droitwich Spa Hospital had a staff response rate of 41% in comparison to a corporate national average of 20%. In response to the results of this questionnaire a health and safety lead was appointed, Fire safety training sessions now run on a monthly basis and a clinical governance information booklet was sent out to staff. A staff survey had taken place in December 2018, however at the time of inspection the results were not available.
- The hospital data provided showed actions plans in place regarding the questionnaire. Areas identified included the holding of monthly staff forums, the

relaunch of the quality and social events calendar and the introduction of local reward and recognition team events. Imaging staff confirmed they had participated in the survey and were aware of the results. However, they said they were unaware of the action plans and the measures the hospital had implemented to improve the service provided. They also said that they felt that communication within the service was poor and they did not always feel supported.

- The hospital gathered patients' views and experiences to shape and improve the services and culture and we saw processes in place within the imaging service to collect feedback from patients.
- The hospital had introduced in October 2018 a newsletter called "The Droitwich Journal." This was accessible to staff and included information which included; upcoming practical training dates and an overview of the wellbeing charter.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things go well and when they go wrong.**
- The inspection of August 2016 identified areas of concern. However, during this inspection we found these concerns had been addressed and we found the following improvements:
- The department had improved their hand hygiene and we saw hand cleansing gels throughout the diagnostic service. Hand hygiene audits seen showed 100% compliance.
- Complaints received were reviewed in line with BMI guidance with any concerns discussed with patients which was line with the Duty of Candour regulations.
- Imaging staff confirmed that morale within the department was low due to the number of changes in managers. They confirmed they were looking forward to a culture of improvement and stability in the imaging service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

OUTPATIENTS:

- The provider must ensure all administrative staff receive an appraisal. Regulation 18 (1)(2).

SURGERY:

- The provider must ensure that all consultants complete the venous thromboembolism (VTE) decision box, following assessment, to ensure that patients at risk are identified and appropriately treated. Regulation 12 (2)(a).

DIAGNOSTIC IMAGING:

- The provider must ensure that outstanding recommendations and actions from previous audits are completed and reviewed. Regulation 12 (2)(b)
- The provider must ensure that there are processes and procedures to ensure that local diagnostic reference levels are created and monitored. Regulation 17(2)(b)
- The provider must ensure that it completes regular dose audits. Regulation 17 (2)(a)
- The provider must ensure there are quality assurance testing programmes in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2017. Regulation 17 (2)(b)
- The provider must ensure there is a schedule of clinical audits for the imaging service. Regulation 17 (2)(a)
- The provider must ensure that staff receive their annual appraisal. Regulation18 (2)(a).

Action the provider SHOULD take to improve

OUTPATIENTS:

- The provider should ensure OPD administrative lead meetings are minuted.
- The provider should continue to monitor breaches of general data protection regulations (GDPR) and share learning to drive up service improvement.
- The provider should continue to review the backlog of NHS patient record coding and embed new processes to ensure future obligations are met.
- The provider should review signposting in clinic areas, and provide information at reception areas of the 'booking in' process.
- The provider should ensure information leaflets and wall display information is in date.
- The provider should consider providing hearing loops in reception areas to support patients with hearing aids.
- The provider should continue to monitor the response rate to the Family and Friends Test to enable patient's views to be responded to.
- The provider should ensure administrative staff complete all mandatory training.
- The provider should provide both low and higher seated chairs in waiting areas to meet all people's needs, which are complaint with IPC standards.
- The provider should ensure that sinks and taps which conform to Health Building Note 00-10 Part C Sanitary Assemblies are available in clinical areas to allow correct hand hygiene practices.

SURGERY:

- The service should ensure that all consultants consistently follow the WHO five steps to safer surgery checklist for all surgical procedures carried out in theatres.
- The service should ensure that hand wash sinks and taps which conform to Health Building Note 00-10 Part C Sanitary assemblies are available in clinical areas to allow correct hand hygiene.
- The service should ensure that complaints information is made widely available to all patients, so that are aware of how to raise concerns and make formal complaints.

Outstanding practice and areas for improvement

- The service should ensure that there are effective working processes, across departments to maximise efficiency of operating department time and available staffing resources.
- The service should ensure that all staff consistently comply with 'bare below the elbow' requirements when providing care to patients.
- The service should ensure that access to restricted areas (theatres) is consistently secured.
- The service should ensure that all equipment that has reached the end of its life, is replaced in a timely manner.

The service should ensure that storage and administration of medicines across the service is consistently in line with best practice.

DIAGNOSTIC IMAGING:

- The provider should ensure that staff complete the appropriate training and competencies regarding radiation risks and regulations in line with IR(ME)R 2017.
- The provider should ensure there are processes and procedures in place to record and audit consent.
- The provider should ensure there is an agency staff specific induction for radiographers

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
Diagnostic and screening procedures Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This regulation was not met because: • The registered person must assess the risks to the health and safety of service users receiving the care or treatment, • The registered person must ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. Regulation 12 (2)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 - Governance** This regulation was not met because: • The registered provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). • The registered provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. • The registered provider must maintain securely an accurate, complete and contemporaneous record in

This section is primarily information for the provider

Requirement notices

respect of each service user, including a record of the care and treatment provided to the service user and of decisions take in relation to the care and treatment provided.

- The registered provider must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

Regulation 17(2)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing** Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)