BMI The Highfield Hospital

Quality Report

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

Ratings

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

Overall summary

BMI The Highfield Hospital is operated by BMI Healthcare Limited. The hospital/service has 43 beds plus three ambulatory pods, which in total hold 12 ambulatory chairs. Facilities include four operating theatres, three of which have laminar flow, two wards, an X-ray department, outpatient and diagnostic facilities and an house pharmacy service provision for inpatients and outpatients

The hospital provides surgery, services for adults aged 18 and over, outpatients and diagnostic imaging. We inspected surgery, diagnostic screening and outpatients.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 2 and 3 July 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

Summary of findings

needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

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

Services we rate

We rated this service as **Good** overall.

- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training compliance rates were high.
- Staff understood how to protect patients from abuse and the hospital 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 controlled infection risk well**.** They used control measures to prevent the spread of infection and infection rates were low.
- The hospital had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The hospital provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance. Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other hospitals to learn from them.
- Staff gave patients enough food and drink to meet their needs and improve their health. Patients were assessed regularly to see if they were in pain.
- The hospital made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them. Appraisal compliance rates in the surgery and outpatient departments were high.
- Staff cared for patients with compassion and provided emotional support to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Patients felt well informed about their care and treatment.
- People could access the hospital when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The hospital treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Complaints were low and there was evidence of shared learning.
- Managers in the hospital had skills and abilities to run a service providing high-quality care.
- Managers across the hospital promoted a positive culture that supported and valued staff. Staff reported good team working and a sense of pride in their work.
- The hospital engaged well with patients and staff to plan and manage appropriate services. The senior leadership team was passionate about engagement with staff and patients.
- However, we also found the following issues that the service provider needs to improve:
- The diagnostic imaging service did not hold regular discrepancy meetings or peer review. This meant that they were not formally evaluating the quality of the service provided and working to improve it.
- Intra-operative temperatures were not being routinely recorded and this was not in line with recognised guidelines and we could not be assured that patients were being kept at an optimum temperature for surgery and protected from hypothermia.
- Staff within diagnostics had not had an annual appraisal.
- Not all risks identified during the inspection were recorded on a risk register and risk assessments in the diagnostic department required updating. The service did not currently record the radiology report turnaround times which was raised in the Care Quality Commission's report 'radiology review' published in July 2018.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

Name of signatory

Ann Ford, Deputy Chief Inspector of Hospitals (North West)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
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 because it was safe, effective, caring, responsive and well-led.
Outpatients	Good 	Outpatient services were available for consultants with practising privileges to refer patients. We rated this service as good because it was safe, caring, responsive and well led. We inspected but did not rate effective.
Diagnostic imaging	Requires improvement 	Diagnostic imaging services were available to consultants with practising privileges who were authorised as referrers. We rated the service as requires improvement overall. We rated safe and caring as good. We rated responsive and well led as requires improvement. We inspected but did not rate effective.

Summary of findings

Contents

Good

BMI The Highfield Hospital

Services we looked at
Surgery; Outpatients; Diagnostic imaging;

Summary of this inspection

Background to BMI The Highfield Hospital

BMI The Highfield Hospital is operated by BMI Healthcare Limited. The hospital opened as a BMI Hospital in 1988. BMI The Highfield Hospital provides in-patient and out-patient care. It is located in Rochdale, Greater Manchester. The hospital has 43 beds and 3 ambulatory pods with a total of 12 ambulatory chairs, for theatres three of which have laminar flow, two wards, a large out-patients department and on-site physiotherapy including a small gym area and on-site pharmacy. The hospital primarily serves the communities of the Rochdale area. It also accepts patient referrals from outside this area. The hospital has had a registered manager in post since 2016.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal and ophthalmic treatments. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC lead inspector, two other CQC inspectors, and specialist advisors with expertise in governance, surgery, diagnostics and outpatients. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about BMI The Highfield Hospital

bMI The Highfield Hospital is an in-patient hospital located in Rochdale, Greater Manchester. The hospital has 47 beds, including enhanced care, four theatres, two wards, a large out patients department and on-site physiotherapy including a small gym area.

During the inspection, we visited both wards, theatres, recovery area and the outpatients and diagnostics departments. We spoke with 57 staff including registered nurses, health care assistants, reception staff, medical staff, radiographers, operating department practitioners, and senior managers. We spoke with 15 patients and four relatives. During our inspection, we reviewed 36 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 has been inspected twice, and the most recent inspection took place in August 2016, which found that the hospital required improvement overall.

Activity

Between May 2018 to April 2019 there were 1434 inpatient discharges from the hospital. This was a total of 4% of all patients treated by the hospital. In the same period there were 5341 day case discharges. This was a total of 14% of all patients treated by the hospital in this period.

Approximately 77% of inpatients and day case patients treated at the hospital were NHS funded patients. The remaining 23% were self-funded and privately insured patients. The proportion of patients that stayed overnight by patient group was 16% of NHS funded patients and 5% of non-NHS funded patients.

There were 6624 visits to the operating theatre from April 2018 to March 2019. Hospital data showed that there had been 73 cancelled operations during this period for a non-clinical reason. This was 1% of all procedures. Of the cancelled procedures, 68% of patients had been offered another appointment within 28 days of the cancelled appointment.

Track record on safety

- No Never events

Summary of this inspection

- Between January 2018 to December 2018 the hospital reported 569 clinical incidents 561 classed as no harm or low harm, 16 moderate harm, one severe harm, one death.

Between May 2018 and April 2019 the hospital reported

- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- 119 complaints

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- There were high levels of compliance with mandatory training, including safeguarding training.
- There were high levels of compliance in cleanliness and hand hygiene audits.
- All areas of the hospital and equipment were visibly clean and storage rooms were well ordered.
- There were appropriate procedures and pathways in place to recognise and manage the deteriorating patient and to ensure they were transferred to the NHS hospital in a timely way, if required.
- Surgical safety checklists were being carried out in accordance with recognised best practice guidelines to ensure the safety of the patient during surgery.
- There were sufficient trained nursing, support and medical staff, with an appropriate skill mix, to ensure that patients were safe and received the right level of care.
- Patient records were well-structured and legible.
- Staff knew how to report incidents, incidents were being recorded at the right level of severity and were investigated and reviewed appropriately.
- Radiographer staff provided a twenty-four hour on call service seven days a week for urgent imaging requests.

However:

- Intra-operative temperatures were not being routinely recorded and this was not in line with recognised guidelines and we could not be assured that patients were being kept at an optimum temperature for surgery and protected from hypothermia.
- Some equipment in the diagnostics department was not labelled with, 'I am clean stickers' to show when it was last cleaned.
- The flooring area in the main buildings imaging department was cracked in the imaging reception area and was visibly damaged in the cubicle changing area.

Are services effective?

Good

We rated effective as **Good** because:

- Care and treatment was evidence based and policies and procedures included up to date recognised guidance.

Summary of this inspection

- The hospital participated in national benchmarking clinical audits. Patient outcome measures were submitted to national databases where appropriate.
- Pain relief management was good and patients were offered a preference of post-operative pain relief.
- Staff had opportunities to undertake additional formal learning activities.
- Staff worked well together as a multidisciplinary team to provide good care and outcomes for patients.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005.

However:

- Patients were not fully supported in pain management post-discharge and follow-up calls were not generally being to patients within 48 hours of discharge from the hospital.
- There was no formal quality assurance process for peer reviewing of images. The new clinical services manager had added this to their action plan.
- Diagnostics staff had not received an appraisal in the last 12 months.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress and reassure them.

Are services responsive?

Good

We rated responsive as **Good** because:

- The hospital worked with other providers and stakeholders to plan and deliver its services to meet the needs of local people.
- People could access the service in a timely way. Waiting times from assessment to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Individual patient needs were taken account of.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Summary of this inspection

Are services well-led?

Good

We rated well led as **Good** because:

- The provider had managers at all levels with the right skills and abilities to run a service providing high quality sustainable care.
- The provider had a vision for what it wanted to achieve and plans to turn it into action.
- There was culture of openness and honesty with a strong focus on patient-centred care. Staff reported a positive experience of working in the hospital.
- There was a clear governance system in place.
- There was a systematic approach to continually improving the quality of services and safeguarding high standards of care.
- The provider collected, analysed, managed and used information well to support its activities.
- The provider engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborate with partner organisations effectively.
- Radiographers could access scans that had been undertaken at other hospitals, this helped to reduce duplication for patients and patient images could be transferred securely to NHS trusts.

However:

- Although risks were being managed, they were not always identified and recorded. Risk assessments in the diagnostic department needed updating. The service did not currently record the radiology report turnaround times which was raised in the Care Quality Commission's report 'radiology review' published in July 2018.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

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

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

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff undertook mandatory training courses delivered through e-learning or face to face training. The provider had an electronic e-learning system called BMI Learn that determined which staff needed to undertake each course, produced automated learning plans, according to an individual's role and accountability and monitored progress.
- The provider had an Induction and training policy that included bank and agency staff and identified the training that was considered mandatory and provided staff with information on how to access appropriate training.
- Nursing staff received and kept up to date with their mandatory training.
- The provider had a compliance target of 90% for all mandatory training including individuals who were within three months of taking up their post.
- Records showed that, at May 2019, 95% of eligible nursing staff on the ward had completed mandatory training. At the same date, 86% of theatre staff had completed their mandatory training.
- The theatres had an audit day once per month when no operations took place and staff had an opportunity to catch up with any mandatory training.
- Records showed that 79% of nursing bank staff on the wards and 77% of theatre bank staff had undertaken all of their mandatory training at May 2019.
- Medical staff received and kept up to date with their mandatory training.
- BMI connected doctors, that is doctors with practising privileges at the hospital, were solely responsible and accountable for their own mandatory training to comply with the requirements for annual appraisal and revalidation. The provider learning system outlined the mandatory training required for individuals who were connected doctors. Compliance with mandatory training was monitored for all staff with practicing privileges. At the time of inspection, 169 out of 255 medical staff (66%), were compliant with requirements which included mandatory training.
- The provider utilised two ward resident medical officers who were employed from an agency. They undertook mandatory training that was organised and managed by their agency and were required to demonstrate evidence of up to date mandatory training to the provider as and when required.
- The mandatory training was comprehensive and met the needs of patients and staff.

- Staff received mandatory training in subjects such as basic and immediate life support; care and communication of the deteriorating patient; conflict resolution; consent; equality and diversity; fire safety; infection prevention control; information governance; medical gases; moving and handling and waste management.
- Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.
- Managers monitored mandatory training and alerted staff when they needed to update their training.

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.**
- Staff could give examples of how to protect patients from harassment and discrimination, included those with protected characteristics under the Equality Act.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns.
- Staff followed safe procedures for children visiting the ward.
- The provider had a policy on safeguarding adults at risk of abuse or neglect and a policy on safeguarding children and young people. The policies covered identification of a vulnerable adult or child, types of abuse, signs of abuse, disclosure and referral. The policies also covered the PREVENT government strategy, that was developed to assist in signposting organisations where there was a suspicion of an adult or child having been radicalised and female genital mutilation.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by annual safeguarding refresher training.
- There was a safeguarding lead in the hospital. Clinical leads were trained to level three and two senior members of clinical staff will be trained to level four within the next three months. At least one member of these staff were on site, or on call, at all times.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- All ward areas were clean and had suitable furnishings which were clean and well maintained.
- Cleaning records were up to date and demonstrated that all areas were cleaned regularly.
- Staff followed infection control principles including the use of personal protective equipment.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Surgical instruments were reprocessed and decontaminated locally, off-site.
- Staff worked effectively to prevent, identify and treat surgical site infections.
- Staff used records to identify how well the service prevented infections.
- We saw that, in patient rooms, there was hand gel and hand wash available and a hand wash sink with paper towels. There were appropriate bins for the disposal of clinical and non-clinical waste in patient rooms.
- Surgical site infections surveillance service were carried out on all orthopaedic implants. Hospital records showed that there was one surgical site infections following hip replacement surgery between May 2018 and April 2019 and nine surgical site infections following knee replacement surgery in the same period. From May 2018 to April 2019, there were a total of 33 surgical site infections for all surgical procedures. Any patient presenting signs of an infection was reviewed by the

infection control link nurse and a root cause analysis was completed to determine any possible trends. Results and lessons learned were presented at appropriate committee meetings.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**
- Patients could reach call bells and staff responded quickly when called.
- The design of the environment followed national guidance.
- Staff carried out daily safety checks of specialist equipment.
- The service had suitable facilities to meet the needs of patients' families.
- The service had enough suitable equipment to help them to safely care for patients.
- Staff disposed of clinical waste safely.
- Equipment storage rooms were well ordered and tidy. A sample check of single use equipment showed that they were all within their expiry date.
- The hospital had an equipment inventory maintenance schedule in place that showed that equipment servicing was carried out regularly both internally and by external contractors.
- Emergency resuscitation trolleys were available across all areas and were checked daily.
- Suction oxygen was available in-patient rooms and was observed to be tested regularly and working.
- We observed that, before surgery, implant identifiable stickers were placed in the implant register with the patient details so that individual implants could be traced back to a patient if necessary.
- The hospital recently achieved joint advisory group for gastrointestinal endoscopy (JAG) accreditation for the endoscopy unit.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- Staff used a nationally recognised tool National Early Warning Scores [NEWS] to identify deteriorating patients and escalated them appropriately.
- Staff knew about and dealt with any specific risk issues such as sepsis, venous thromboembolism, falls and pressure ulcers.
- Staff shared key information to keep patients safe when handing over their care to others.
- Shift changes and handovers included all necessary information to keep patients safe.
- The hospital admitted patients for surgery that were considered low risk. The hospital followed a set of exclusion criteria to exclude patients at risk of requiring high dependency care post-surgery, or at higher risk of deterioration.
- An emergency telephone line was available for staff to use in the case of an emergency or deteriorating patient. There was a resident medical officer on site 24 hours a day. As part of their practicing privileges (the right to practice in the hospital), consultants were responsible for the care and treatment of their patients at all times and were accessible by telephone 24 hours a day, seven days a week for advice and guidance when required. If they were unavailable, alternative cover was arranged and communicated to the hospital.
- The hospital had a policy on the recognition and management of the deteriorating patient that included a number of pathways when deterioration in a patient was noted, such as a sepsis tool and pathway; anaphylaxis pathway; asthma pathway; hypoglycaemia pathway and acute kidney injury assessment and pathway. In the event of a patient needing to be transferred to the local acute NHS trust where there was a critical care unit available, the policy advised that an emergency ambulance should be called to facilitate the transfer.
- Staff were encouraged to challenge and speak up if they saw something that was unsafe or potentially unsafe, regardless of who the person was that they were challenging.

- During our inspection we observed theatre teams use the World Health Organisation five steps to safer surgery checklist.From the five steps, we observed one briefing, which takes place before the patient is brought into theatre; "sign-in" steps which take place before the patient is given anaesthesia and includes ensuring the patient identity is correct, the right site for surgery incision is marked, allergies are recorded and the risk of blood loss is discussed. We observed "time-out" (or surgical pause) steps which take place before an incision is made when the team double check the patient identification and incision site and any likely surgical risks are discussed and the nurse confirms the sterility of instruments. We observed "Sign-out" steps. This is supposed to take place before any members of the team have left the theatre and includes recording the name of the procedure, counting the instruments, swabs and sharps used during the procedure to ensure all are present and nothing has been left inside the patient and any specimens have been properly labelled.
- We saw that all World Health Organisation checklists were carried out well and in line with guidelines. All staff were fully engaged in the process.
- The service undertook monthly audits on the World Health Organisation [WHO] checklists. Audits from May 2018 to February 2019 showed 100% compliance with the checklists when observations were carried out in theatres. Observations were carried out for half a day per month.
- We saw that in the ten records we examined for post-operative patients, that intra-operative (during the operation) temperatures had not been recorded either at all or not fully. This went against National Institute for Care Excellence guidelines for the prevention and management of hypothermia in adults having surgery (CG65). The guidelines recommend that patient temperature should be taken before surgery so that they could be actively warmed to an optimum temperature for surgery and temperatures should be taken every 30 minutes until the end of surgery and temperature maintained to prevent hypothermia. We fed this back to senior managers who agreed to look at the processes in place.
- Ward nursing staff had undertaken a training exercise in major haemorrhage the two weeks before our inspection that involved a real-life scenario run through.
- Staff carried out risk assessments to identify patients at risk of falls and acquiring pressure ulcers and venous thromboembolism (when a blood clot breaks loose and travels in the blood) as part of the assessment carried out before patients were admitted for surgery.
- Post-discharge and follow-up calls were not being made to all patients within 48 hours of discharge from the hospital.

Nursing and support staffing

- **The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**
- At 1 April 2019 there were 13.7 whole time equivalent nursing staff and 8.7 whole time equivalent operating department practitioners and healthcare assistants working in the theatre department.
- At the same date there were 19.5 whole time equivalent nursing staff and 11.1 whole time equivalent healthcare assistants working in the inpatient wards. Staffing in operating theatres was consistent with Association for Perioperative Practice guidance.
- Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing levels were planned and reviewed using an electronic rostering system. The system enabled heads of departments to manage rotas, shift allocations, annual leave, sickness absence, skill mix and senior cover.
- The ward manager could adjust staffing levels daily according to the needs of patients. Managers told us that staffing establishments were set in advance, based on planned procedures and patient acuity. Staffing levels could be increased if a patient requiring additional support was identified during their pre-operative assessment.

- Nursing staff were allocated to theatre lists based on their skills and competencies. Bank staff were used in theatres when the need arose but there were low levels of bank staff usage.
- The number of nurses and healthcare assistants on all shifts matched the planned numbers.
- The service had low vacancy rates. The theatre department and inpatient wards had no vacant posts at 1 April 2019. The theatre department had 4 vacancies and 2 of these had applications in progress.
- The service had low turnover rates. Figures provided showed a turnover in theatre staff of 1% for nursing staff and 2% for operating department practitioners and healthcare assistants from May 2018 to April 2019.In inpatient wards the figures showed a turnover of 1% for nursing staff, 0% for healthcare assistants and 0.5% for other staff during the same period.
- The service had low sickness rates. The theatre department had 0% sickness rate from May 2018 to April 2019.The inpatient wards showed that, at April 2019, the sickness rate for nursing staff and healthcare assistants was below 2%.The sickness figures had peaked at 8% for healthcare assistants in June 2018 and at 7% for nursing staff in March 2019.
- The service had low rates of bank and agency nurses used on the wards. From May 2018 to April 2019, the theatre department had used an average of 19% per month bank and agency nurses. There had been no use of bank and agency healthcare assistants. The inpatient wards showed an average of 19% per month use of nursing staff.
- Managers limited their use of bank and agency staff and requested staff familiar with the service.
- Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.**
- The service had consultants on call during evenings and weekends.
- Medical cover on the wards was provided by two resident medical officers that worked alternate shifts of one week on and one week off. They were employed by a resident medical officer agency. During their shift the resident medical officer was based at the hospital 24 hours per day. They were expected to work on the ward floor for eight or nine hours per 24 hours a day and were on call overnight.
- The duties of the resident medical officer included the monitoring of patients on the ward and prescribing medicines. They were responsible for taking blood samples and inserting or removing patient cannulas and catheters.
- The resident medical officer cover was sufficient to meet patient needs because the majority of patients were deemed to be low risk and did not have complex needs.
- The resident medical officers were trained in advance life support and safer prescribing.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practicing privileges with BMI The Highfield Hospital.
- The consultants and anaesthetists were responsible for their individual patients during their stay in hospital. Patient records showed that consultant reviews were carried out daily.
- As of 1 April 2019, there were 240 doctors practicing at the hospital under privileges. From May 2018 to April 2019, 106 consultants carried out more than 100 procedures and 97 consultants carried out between 10 and 99 procedures. Thirty-seven consultants carried out no procedures during this period.
- There were provisions in place to review the scope of practice and competencies of consultants who did not work regularly in the hospital. A total of nine consultants had their practicing privileges removed within the last 12 months. Three had emigrated; three had ceased to undertake private work and three had their practicing privileges removed following an investigation.

Records

Good

Surgery

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- Patient notes were comprehensive in the main and all staff could access them easily.
- When patients transferred to a different department there were no delays in staff accessing their records.
- The hospital had a medical records management policy that set out the responsibilities of all staff members in the creation, handling, storage and destruction of records. It also detailed standards for confidentiality and access rights to records.
- The hospital used paper-based records which were securely stored in each area we inspected.
- We looked at the records for ten patients. Records were well structured and legible and there were well-ordered pathway booklets for completion for a number of different surgical procedures. Pages were colour coded for easy access and covered outpatient, pre- surgical, anaesthetic, surgical, recovery and post-surgical inpatient record pages.
- Patient records included appropriate risk assessments for falls, venous thromboembolism, pressure care and nutrition.
- The hospital carried out medical record audits. The service carried out a quarterly records audit on 20 cases. Each case was reviewed against 49 questions. There were 30 questions on general records completion; eight questions on clinical risk assessments; nine questions on the WHO checklist and two questions on pharmacy prescription charts.
- Results from a records audit carried out in December 2018 showed an overall compliance of 100% against all the questions on each of the 19 records audited.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.
- Staff stored and managed all medicines and prescribing documents in line with the provider's policy.
- We saw that there was a new medicines grade fridge on the ward and all medicines had been moved to alternative storage in the pharmacy department whilst the new fridge reached optimum temperature.
- We saw that audits of controlled drugs had highlighted a number of issues that had been persistent problems. We saw that there was an action plan in place to address these issues and the theatre manager undertook daily checks to ensure records and storage were in line with policy and gave feedback to staff the following day. The theatre manager told us that there had been great improvements.
- Staff carried out daily checks on controlled drugs which were checked by two registered nurses. We checked the stored controlled drugs and found that they had all been correctly reconciled.
- Staff followed current national practice to check patients had the correct medicines.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
- Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.
- The hospital had access to a pharmacist and pharmacy technician Monday to Saturday. On Sundays and out of hours a policy is in place for pharmacy support from a local community chemist and a nearby BMI hospital
- The pharmacy technician topped up stored medicines to designated levels twice weekly on the wards and three times per week in theatres.
- There was a medicines management policy in place which provided guidance for prescribing and administration of antibiotics and other medicines.
- We saw that medicines required for patients were readily available. They were stored in a secure room in secure cabinets.Medicines had been stored tidily and in separate cupboards according to use. The emergency drugs drawer was clearly labelled.

- All the medicines that we saw were within the manufacturers' expiry dates.
- There was a separate blood fridge where there was always a stock of two units of O negative blood. These were changed around every three weeks if they had not been used. Stocks of blood were obtained from an independent company in Salford.
- Medical gas cylinders were kept securely, were within the supplier's expiry date and contained sufficient levels of oxygen for use in an emergency.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- All staff knew what incidents to report and how to report them. Incidents were reported by staff using an electronic incident reporting system. Staff we spoke with understood their responsibility to report incidents and could give examples of when they had done this.
- Staff reported all incidents they should report.
- Staff reported serious incidents clearly and in line with provider policy.
- The service had no never events. 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.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.
- Managers debriefed and supported staff after any serious incident.
- Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.
- Staff received feedback from investigation of incidents, both internal and external to the service.
- Staff met to discuss the feedback and look at improvements to patient care.
- There was evidence that changes had been made as a result of feedback.
- Managers shared learning with their staff about never events that happened in other hospitals in the group.
- The hospital reported a total of 569 clinical incidents from January 2018 to December 2018.There were no non-clinical incidents reported during this period. Five hundred and fifty-one incidents were classed as causing no or low harm with 16 incidents classed as causing moderate harm, one causing severe harm and one causing death.
- We saw that clinical incident investigations had a root cause analysis and action plan in place.

Safety Thermometer (or equivalent)

- **The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**
- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and "harm free" care. It looks at risks such as falls, pressure ulcers, blood clots and catheter acquired urinary tract infections.
- Safety thermometer information was displayed on wards for staff and patients to see.
- The safety thermometer showed the services achieved over 95% harm free care for the last 12 months.
- Staff used the safety thermometer data to further improve services.
- From May 2018 to April 2019 there had been no cases of methicillin-resistant Staphylococcus aureus (MRSA); methicillin-susceptible staphylococcus aureus (MSSA); Clostridium difficile (C-diff) or Escherichia coli (E coli) hospital acquired infections.
- There had been three cases of hospital acquired venous thromboembolism identified from May 2018 to April 2019.Three hundred and ninety-eight patients had been

risk assessed for venous thromboembolism during this period. We saw that the hospital was using anti-embolism stockings to reduce the risk of blood clots.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**
- Managers told us that new national guidelines were used to update corporate policies and were disseminated to the provider via the BMI corporate governance team. New and update policies and guidance was put on the provider learning system and staff were required to indicate that they had read them. Further notification was made available to teams via the Corporate Clinical Bulletin.
- In addition, managers reviewed any new policies or guidance and made sure staff knew about any changes.
- Managers were responsible for making changes to any local policies to bring them into line with national guidelines.
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.
- BMI corporate policies based on National Institute for Health and Care Excellence (NICE) and Royal College guidelines were available to staff on the provider intranet. Guidelines from the Association of Anaesthetists of Great Britain and Ireland were utilised in theatres for checking anaesthetic equipment.
- Clinical policies and procedures which reflected national guidance were in place for staff to access on the hospital intranet. Care pathways for enhanced care and recovery were based on national guidance, including from the National Institute for Care Excellence and the Royal College of Surgeons. Staff used integrated care pathways for surgical procedures such as for hip and knee replacements.
- At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**
- Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. Patient admission letters set out the fasting times required before they attended the hospital for their operation. However, we did not see any audits around fasting times.
- Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The hospital catering department provided meals to inpatients and the chef catered for patients' individual needs by providing meals in accordance with their preferences, food allergies, medical or religious needs.
- Staff fully and accurately completed patients' fluid and nutrition charts where needed.
- We saw that there were hydration charts in patient bathrooms to help patients identify whether they needed further hydration from the colour of their urine.
- Staff used a recognised screening tool to monitor patients at risk of malnutrition. Patients were assessed pre-operatively and as inpatients using the malnutrition universal screening tool. This is a five-step screening tool, used to identify adults who are malnourished, at risk of malnutrition or obese and can be used to develop an appropriate care plan.
- Specialist support from staff such as dieticians was available for patients who needed it. Dietetic support was provided from an out-sourced team who were available 24 hours a day, seven days a week.
- Patients waiting to have surgery were not left nil by mouth for long periods.

- Patients we spoke with told us that there was a good choice of food and they had been able to eat a meal as soon as they were ready to do so post-surgery. They confirmed that they were offered regular drinks.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.
- Patients received pain relief soon after requesting it.
- Staff prescribed, administered and recorded all pain relief accurately.
- Patients were assessed pre-operatively for their preferred post-operative pain relief and this was reflected in care plans.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- Patients we spoke to confirmed that they had been given adequate pain relief and we saw that nurses asked if they needed further pain relief when checking on patients.
- Patients were given take home pain relief medicines and information on how to manage pain symptoms following discharge from hospital.
- Surgical patients should have been routinely contacted 48 hours after discharge and asked if their pain was at an acceptable level. Post-discharge and follow-up calls were not being made to all patients within 48 hours of discharge from the hospital.
- The service carried out a quarterly pain management audit on 20 cases. Each case was reviewed against 18 questions, covering such areas as whether pain was documented in the care pathway and assessed pre and post-operatively and post analgesia; whether the type and frequency of analgesia was correctly recorded and evidence of post-discharge medication and pain management advice.
- Results from a pain management audit carried out in November 2018 showed an overall compliance of 88% against all the questions. However, there was only a 60% compliance of documented evidence regarding pain in the patient care pathway and 65% compliance of opioid analgesia given when needed. There was 100% compliance against seven of the 18 questions. All other questions ranged between 75% and 95% compliance rates.

Patient outcomes

- **The hospital participated in national audits to measure patient outcomes.**
- These audits were, the National Joint Registry; Breast and Cosmetic Implant Registry; patient reported outcome measures for hip and knee replacements; surgical site infections audit; national patient safety thermometer and the Private Healthcare Information Network (PHIN). The provider told us that they also participated in patient-led assessments of the care environment (PLACE) but there was no evidence of this in published data though most other hospitals in the group had submitted data.
- The National Joint Registry collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery to provide an early warning of issues relating to patient safety. National Joint Registry data showed that, in 2018, the hospital completed 699 operations for hips, knees and shoulders with a 94% National Joint Registry consent rate. In 2019, the year to date figures at July 2019 showed that the hospital had completed 422 operations for hips, knees and shoulders, with an 89% National Joint Registry consent rate.
- Patient reported outcome measures are published by NHS England for providers on a quarterly basis. Patients undergoing elective inpatient surgery for hip and knee replacements, funded by the NHS, are asked to complete questionnaires before and after their operations, to assess improvement in health as perceived by the patients themselves.
- Patient reported outcomes measures data showed that, from April 2017 to March 2018 there were 539 eligible hospital episodes and 186 pre-operative questionnaires returned. This was a participation rate of 34.5% against an England average of 86.7%.

- Of the 184 post-operative questionnaires sent out, 131 were returned. This was a response rate of 71.2% and was higher than the England average of 70.1%.
- Data showed that the percentage of patients with improved health gain following hip or knee replacements in this period were better than the England average.
- From April 2018 to March 2019 there were 10 unplanned inpatient transfers to another hospital. The assessed rate of unplanned transfers (per 100 patient attendances) was 0.7%.
- From April 2018 to March 2019 there were 3 cases of unplanned readmissions to the hospital within 28 days of discharge. In the same period, there were 6 cases of unplanned returns to the operating theatre.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Staff were experienced. Qualified and had the right skills and knowledge and meet the needs of patients.
- Managers gave all new staff a full induction tailored to their role before they started work.
- Managers supported nursing and support staff to develop through yearly, constructive appraisals of their work.
- There were enough clinical educators to support staff learning and development. They had links with a local NHS trust.
- Managers made sure all staff attended team meetings or had access to full notes when they could not attend. We reviewed team meeting minutes and saw that the meetings had followed a standard agenda that included a review of actions arising from previous meetings; audits; compliments and complaints; risk management; equipment; link nurses; pharmacy and medicines; policies and procedures and mandatory training.
- Managers told us that they had held team meetings for those staff who worked nights.
- Managers identified any training needs their staff had and gave the time and opportunity to develop their skills and knowledge.
- Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.
- Managers made sure staff received any specialist training in their role.
- Managers identified poor staff performance promptly and supported staff to improve.
- There were procedures in place to review the suitability to practice of the resident medical officer. The director of clinical services had responsibility for reviewing the training and experience of the resident medical officer, prior to this being approved by the medical advisory committee.
- The resident medical officer undertook a period of supervised induction upon appointment and was required to undertake mandatory training courses through their agency on an annual basis. We were also informed that speciality inductions were provided. They were required to renew their certificate to practice every four years. They also undertook an annual appraisal and reviewed development objectives.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.
- Staff worked across health care disciplines and with other agencies when required to care for patients.
- Patients had their care pathways reviewed by the relevant consultants.
- There was effective daily communication between multidisciplinary teams within the ward and theatres. Nursing staff told us that they had a good relationship with consultants and the resident medical officer.
- Patient records showed that there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.

- Theatre staff carried out daily "safety huddles" to ensure that all staff had up-to-date information about risks and concerns.
- There were daily meetings between the pre-operative assessment staff and ward and theatre staff so patient care could be coordinated and delivered effectively.
- The hospital had private patient manager who communicated with patients' GPs.
- Discharge planning within the hospital commenced at the outpatient appointment, with the patient being given an information pack about admission and discharge. Most hip and knee replacement patients followed the 48-hour pathway rather than the five-day pathway from admission to discharge. Nurses liaised with district nurses and social care services to ensure that patients had the support they needed when discharged.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- There were daily ward rounds on the wards, including weekends. Patients were reviewed by their consultant or the registered medical officer, depending on the care pathway.
- Staff could call for support from doctors and other disciplines, including diagnostic tests and physiotherapy, seven days a week.
- Routine surgery was performed in the theatres during weekdays and on Saturday. The ward accommodated patients seven days a week and staffing levels were suitably maintained during out-of-hours and weekends.
- The resident medical officer provided out-of-hours medical cover at the hospital 24 hours a day, seven days a week and had full access to consultant surgeon and anaesthetist contact details.
- Patients were seen daily by their consultant, including on weekends.
- The hospital practicing privileges policy required consultants to provide 24 hour on-call cover for patients post-operatively and to be within a 30-minute drive of the hospital. When a surgeon was not going to be available they were required to have "buddy cover" from another surgeon with the same speciality. Consultant anaesthetists were also required to be within a 30-minute drive of the hospital and remained responsible for the patient for a period of not less than 24 hours post-surgery.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.
- Patients were encouraged to eat healthily whilst an inpatient at the hospital. The chef could advise on healthy dietary options and diet options for those with additional medical needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.
- Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff had the appropriate skills and knowledge to seek consent from patients. Staff were clear on how they sought verbal informed consent and written consent before providing care or treatment.
- Staff clearly recorded consent on the patients' records.
- There was a two-stage process in obtaining written consent. This ensured that informed consent was given throughout the consent process. Stage one of the consent process was carried out by the consultant during the consultation and then stage two was carried out on the day of treatment. During both stages, risks and benefits were discussed and all patients were asked

if they understood the plan of care. Additionally, we observed during the consultations that all patients were given time to absorb and ask questions about their treatment.

- The consent policy contained specific statements about patients receiving cosmetic surgery in line with General Medical Council and Royal College of Surgeons guidance and included a two-stage consent process so that patients had a two-week cooling off period between the stages to allow the patient to reflect on the decision. Where this period was not available, reasons were recorded in the patient's medical record.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Patients that lacked capacity were identified during their pre-operative assessment and staff could seek advice from other professionals in order to complete capacity assessments. Staff told us that the majority of admitted patients had the capacity to make their own decisions. Staff were aware of best interest decisions and involving the patient's representatives and other healthcare professionals where the patient lacked the capacity to give informed consent.
- Staff made sure patients consented to treatment based on all the information available.
- All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.
- The hospital had a consent policy and this set out that consent to care and treatment was on a decision-specific basis. Staff needed to consider a person's capacity to understand the information being given, the ability to retain the information in order to consider this and make and communicate their decision about consenting to treatment. The policy was in date and in line with current national guidance.

Are surgery services caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- Patients said staff treated them well and with kindness.
- Staff followed policy to keep patient care and treatment confidential.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.
- One patient told us that the care was wonderful and that all staff were very friendly. Another patient told us that they would recommend the service, the care was very good and all staff, including the hostess staff always introduced themselves.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff gave patients and those close to them, help, emotional support and advice when they needed it.
- Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.
- Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Good

Surgery

- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.
- We saw an example, where a patient had become distressed during the night and staff had acted appropriately to ensure that they, and their family were fully supported to minimise their distress and that the patient was safe. They had arranged for the patient to remain in the hospital until they could be sure that the patient's family were ready to care for them at home.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff made sure patients and those close to them understood their care and treatment.
- Staff talked with patients, families and carers in a way they could understand.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this.
- A high proportion of patients gave positive feedback about the service.
- The feedback from patients was positive for all wards.
- Patients were actively encouraged to complete a patient satisfaction questionnaire, so the service could review and improve patient experiences. The results were collated by an independent company and a monthly report was provided to the hospital. The results showed response rates and allowed for benchmarking against all other BMI hospitals.
- The patient satisfaction questionnaire results from November 2018 to April 2019 showed an average satisfaction rate of 98% and an average response rate of 57%, although in April the response rate was 87%.We were told that response rates had increased since the re-introduction of the questionnaire in paper form from online only.
- The ward areas kept a log of compliments received and comments about individual staff were given to them in cards at team meetings.
- Patients that we spoke to said that they felt fully consulted about their care and treatment and always knew what was happening and why. Patients were well informed about progress against post-operative physiotherapy goals. Patients told us that they had been able to bring their relatives into consultations if they had wanted this.

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 care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- Managers planned and organised services so they met the changing needs of the local population.
- Senior managers met with the local clinical commissioning group to review the hospital's contract, the services offered and identification of local health trends. Meetings included discussion of progress towards meeting the hospital's agreed Commissioning for Quality and Innovation programme.
- Some patients and relatives told us that car parking could be an issue with the car park being very full at certain times of the day. However, parking was free for patients and visitors to the hospital.
- Patients had an initial consultation to determine whether they needed surgery and this was followed up with a pre-operative assessment. Where a patient was identified as needing surgery, staff could plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital. Pre-operative assessment appointments were available in the evenings and at weekends.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded

from receiving treatment at the hospital. The hospital had an exclusion criteria document. This listed medical conditions and levels of fitness that would exclude patients from receiving surgery at the hospital.

- Facilities and premises were appropriate for the services being delivered.
- The service had systems to help care for patients in need of additional support or specialist intervention.
- Managers monitored and took action to minimise missed appointments.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- The entrance to the hospital was accessible to people with limited mobility. There was ramp access and automatic doors.
- The hospital reception desk was staffed by two members of the reception staff to ensure that patients arriving at the hospital were directed to the appropriate department in a timely manner. A hearing loop was in place in the reception area for those people with a sensory impairment.
- Accessible toilets for patients living with a disability were located within the main reception area.
- Most patient services were located at ground floor level. There was lift access for those patients who needed to access the day case unit on the first floor.
- Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet their needs. The service had introduced a dementia passport for all patients with Alzheimer's and other forms of dementia. Carers of patients with dementia were encouraged to stay with the patient during their stay in hospital, to minimise their distress.
- Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.
- The service had information leaflets that could be translated into different languages by an external company.
- Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. The provider used an external company to provide interpreting services. They made sure that for patients who did not speak English, an interpreter was present at the pre-operative assessments and when consent was taken from the patient. They could also be requested to attend when the patient had left surgery, when required.
- Patients were given a choice of food and drink to meet their cultural and religious preferences.
- Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

- **People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**
- Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.
- Managers and staff worked to make sure patients did not stay longer than they needed to.
- Managers worked to keep the number of cancelled appointments, treatments and operations to a minimum. When patients had their appointments, treatments or operations cancelled at the last minute managers tried to make sure they were rearranged as soon as possible and within national targets and guidance though we saw that this had only happened in the case of 68% of surgical operations being cancelled.
- Managers made sure that patient moves between wards were kept to a minimum. This occasionally happened when a patient on the day case ward needed additional monitoring and was moved to the inpatient ward if necessary.

Good

Surgery

- Managers and staff worked to make sure they started discharge planning as early as possible. Staff planned patients' discharges carefully.
- Managers monitored patient transfers and followed national standards.
- From May 2018 to April 2019 there were 1434 inpatient discharges from the hospital. This was a total of 4% of all patients treated by the hospital. In the same period there were 5341 day case discharges. This was a total of 14% of all patients treated by the hospital in this period.
- Approximately 77% of inpatients and day case patients treated at the hospital were NHS funded patients. The remaining 23% were self-funded and privately insured patients. The proportion of patients that stayed overnight by patient group was 16% of NHS funded patients and 5% of non-NHS funded patients.
- The hospital had a waiting list and management of patients accessing NHS treatment policy. The principles of the policy incorporated the NHS 18-week referral to consultant-led treatment pathway. The hospital submitted data to NHS England about referral to treatment times monthly.
- The referral to treatment time figures, published by NHS England for May 2019, show that the hospital was above the standard for England of at least 92% of patients to be admitted and treated within 18 weeks of referral for all ten surgical specialities. These were general surgery (98.0%); urology (97.2%); trauma and orthopaedics (94.7%); ear, nose and throat (100%); ophthalmology (100%); oral surgery (100%); neurosurgery (100%); gastroenterology (100%); gynaecology (96.3%) and other surgery (96.8%).
- The average waiting time for patients for all procedures to admittance was 5.5 weeks.
- Referral to treatment time data for May 2019 for non-admitted patients showed that 94.7% of patients were treated within 18 weeks of referral and the average waiting time was 5.1. weeks from referral. This was below the standard for England that was 92%.
- During May 2019, the hospital added 217 new referrals to be treated within 18 weeks of the date they were referred.
- Staff monitored the electronic referral system daily to ensure referrals were dealt with in a timely manner.
- The hospital had a referral to treatment access policy and framework for managing NHS-funded elective access to consultant-led care and treatment. The Hospital NHS team monitored patient wait times and helped to facilitate admissions to ensure that no breaches occurred and remove any patients who no longer required treatment. The provider could review internal databases to ascertain waiting times for any patient or surgical speciality and conversion rates from outpatients to surgical episodes.
- Patients we spoke with said they were happy with the waiting period before their admission for surgery and all told us that they had been offered their admission date sooner than expected.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff to manage patient flow.
- Discharge planning was covered during pre-assessment to determine how many days the patient would need to be on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.
- Discharge arrangements were covered in detail in the patient's pathway. The responsible nurse went through discharge arrangements with patients and ensured the patient understood prescribed medications; dates of follow-up appointments; arrangements for any community nurse follow-up; transport arrangements; social care requirements and equipment requirements. Consultants had overall responsibility for discharging the patient when they were fit for discharge.
- Discharge summary letters were sent to GPs within 24 hours of the patient discharge.
- Day case patients that were assessed as not being fit for discharge following surgery were kept on the ward for overnight care if required.
- There were 6624 visits to the operating theatre from April 2018 to March 2019. Hospital data showed that there had been 73 cancelled operations during this

period for a non-clinical. This was 1% of all procedures. Of the cancelled procedures, 68% of patients had been offered another appointment within 28 days of the cancelled appointment.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- Patients, relatives and carers knew how to complain or raise concerns.
- The service clearly displayed information about how to raise a concern in patient areas. The hospital had a "Please Tell Us" leaflet that was readily available to patients. There were patient information guides in each patient room that outlined the formal complaints procedure.
- Staff understood the policy on complaints and knew how to handle them.
- Managers investigated complaints and identified themes.
- The provider kept an electronic complaints log that showed the status of each complaint and how long it had taken to provide responses and whether this was in line with the provider policy.
- Initial Investigations were overseen by a head of department and relevant information was collated by the quality and risk manager.
- There was a three-stage process for dealing with complaints and timeframes, as set out in the BMI Healthcare Complaints Policy. Complaints were acknowledged within two working days and a formal response sent within 20 working days. There were a few occasions when this timescale could not be met due to the complexity of the investigation but patients had been sent a holding letter and kept informed of progress and the reasons for delays.
- The responsibility for all complaints rested with the hospital executive director. Often, patients were invited to a meeting to discuss the findings of an investigation before being sent a final response.
- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.
- Managers shared feedback from complaints with staff and learning was used to improve the service. We saw that complaints were routinely discussed with staff at team meetings, the daily "comms cell" and with individuals. Managers could give examples of where learning from complaints had led to changes and improvements.
- Learning from complaints took place between hospitals in the group and there were networking meetings at which complaints and incidents were discussed. There was a weekly complaints meeting attended by the senior management team and any other staff member involved in providing information for the response.
- Complaints were taken to the relevant committee meetings, such as the Clinical Governance Committee or Medical Advisory Committee to identify any learning and changes required to clinical practice.
- From May 2018 to April 2019 the hospital received 119 complaints. This included complaints for outpatients, diagnostics and surgical services. One complaint within this period, was referred to the ombudsman or independent healthcare sector complaints adjudication service. The assessed rate of complaints per 100 inpatient and day case attendances was 1.8.

Are surgery services well-led?

Good

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

Leadership

- **Leaders had the integrity, skills and abilities to run the service.**
- The hospital was led by an executive director who was supported by a director of clinical services, quality and risk manager and operations manager. Clinical services managers were in post for the wards, theatres, imaging, physiotherapy, pharmacy and outpatients' departments.

- The chair of the medical advisory committee was actively engaged with the hospital leadership team and met regularly with the executive director.
- Managers understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

Vision and strategy

- **The service had a vision for what it wanted to achieve and plans to turn it into action. The vision and strategy were focused on development of services and the estate to meet service needs.**
- There was a five year vision for the hospital for 2019 – 2024 and an annual business plan. These were aligned with the corporate vision and strategic objectives to deliver 'the best patient experience and outcomes, in the most effective way.'
- The vision incorporated redesign and expansion programmes to support service provision.
- Staff were aware of the vision and strategy for the hospital.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- The staff had been involved in creating BMIs purpose and values. Workshops had been held at the hospital in June 2019 and 67 members of staff at the hospital had voted on statements regarding purpose and values.
- The service promoted the values and a patient-centred culture. We were provided with examples of how any incidents of poor behaviour were managed. This demonstrated that staff felt able to raise concerns and these were appropriately acted upon.
- There was a corporate equality and diversity policy available. However, there was limited detailed information at a hospital or service level that enabled managers to ensure they provided and promoted equality and diversity in daily work and provided opportunities for career development.

Governance

- **Leaders operated effective governance processes within the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- There was a clear committee structure at the hospital with a medical advisory committee, heads of department committee and clinical governance committee reporting to a hospital committee. Members of the surgical leadership attended these meetings.
- There had been improvements in reviewing and learning from incidents since the previous inspection. A monthly governance report detailing incidents and trends, audits, complaints, and lessons learned was produced and reviewed at the relevant committees.
- We reviewed three sets of minutes from the senior management team meeting. The minutes were minimal and did not indicate items for decision and those for information. Actions and owners were identified, but there were no completion dates and limited evidence the actions were monitored at the next meeting. The executive director had identified that the records required developing and two members of staff were due to attend training on minute-taking.
- We also reviewed sets of the heads of department committee and clinical governance committee minutes which were more detailed and demonstrated decisions made and actions taken in most instances.
- Monthly theatre unit meetings had been held and notes from the meeting detailed the discussions and decisions made. Quarterly ward meetings were planned, although there had been some gaps; notes of the meetings were available.
- Quarterly medical advisory group meetings had been held. The meetings were well-attended. Practicing privilege compliance by consultants was discussed at the medical advisory group meetings.
- Daily 'comms cells' were held. Departmental 'comms cells' were held, for example, on the wards and in theatres. The heads of department then met daily in a

'comms cell' to share information, risks and incidents across the hospital. We saw positive interactions between the heads of departments during these meetings.

Managing risks, issues and performance

- **Leaders and teams mostly used systems to manage performance effectively. However, although risks were being managed, they were not always identified and recorded.**
- Risks were recorded on a risk register which was maintained as a live document. However, we were not assured that all relevant risks had been identified and recorded. For example, actions had been taken to mitigate the risk of surgeons working outside of their scope of practice and this was identified by members of the leadership team as one of the hospital's top risks. This was not recorded on the risk register. This meant the record of actions taken to mitigate the risk were not evident on the risk register or escalated as a significant risk through the reporting system to the provider. The leadership team added this risk to the register during our inspection.
- The hospital had a process for checking the practicing privileges of consultants that worked at the hospital. We saw that relevant checks were made and compliance was monitored. A database was maintained and there were systems in place to ensure that consultants who were non-compliant with the requirements were flagged to managers. We were informed that consultants who were non-compliant did not operate at the hospital until the required documentation and checks were completed.
- New procedures were reviewed and approved at the medical advisory committee.
- Although staff did not feel that financial pressures had compromised the safety of patient care, there was a recognised need to improve access and update equipment. This was incorporated into the service vision and strategy.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- Dashboards and leadership reports were produced to monitor performance. These were reviewed at the senior management meetings.
- Information was available to staff and was displayed within the hospital.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Patient satisfaction surveys were undertaken and results reviewed. Feedback was used to drive improvements.
- An inaugural consultants annual general meeting had been held to help increase clinical engagement and to share practice and lessons learned.
- Senior managers met with the local clinical commissioning group to review the hospital's contract, the services offered and identification of local health trends.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**
- Most staff reported there had been a lot of improvement at the hospital since the previous CQC inspection.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

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

Are outpatients services safe?

Good

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

We previously inspected and rated this service with diagnostic imaging so we cannot compare previous ratings.

We rated safe as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory training for all staff was 92%, which was above the services target of 90%. These figures excluded staff who were on long term sick but included all other staff in post, such as one staff member who had only been in post for two days at the time of our inspection.
- We were shown an electronic spreadsheet by the member of staff for the hospital who had oversight of all mandatory training compliance for qualified and unqualified nurses.
- Data regarding outpatients mandatory training compliance was sent to the department manager twice per month who monitored and ensured that staff attended their training.
- Mandatory training was completed via e learning modules and face to face on site and at external locations.
- All of the staff that we spoke with during our inspection told us that they were given time to complete all of their e-learning and face to face mandatory training.

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 does not provide treatment to patients under the age of 18 years. However, it has a safeguarding children and young people policy that includes a flowchart of what actions to take should any staff member have concerns about a child or young person.
- The hospital has an in date safeguarding adults policy which advices staff what actions to take and which staff member to contact in the event of a safeguarding adult concern.

- There was a designated lead for female genital mutilation (FGM) in the department and all staff have to undertake this training as an e-learning module.
- There was a safeguarding lead in the hospital. Clinical leads were trained to level three and two senior members of clinical staff will be trained to level four within the next three months.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- There were hand sanitiser gel dispensers throughout the clinical areas in the department at appropriate places.
- There were handwashing facilities at appropriate places throughout the department.
- During our inspection we observed staff and patients using these hand sanitising gels and handwashing facilities.
- We saw infection prevention and hand hygiene audits of outpatients areas including physiotherapy department from July, September and November 2018 and June 2019 highlighting 100% compliance.
- We saw cleaning schedules on treatment room and toilet doors that had all been completed appropriately.
- We reviewed the log book for cleaning of the naso endoscope and were given a demonstration by a member of staff of how this piece of equipment was cleaned both after each use and deeper cleaning over night by a separate company and this complied with health technical memorandum (HTM 01/06). Furthermore, we were shown evidence of leak testing being carried out appropriately between use on each patient which complies with HTM 01-06 also.
- Dressing trollies in the treatment rooms were clean and tidy.
- There was good waste and sharps management in place. We observed sharps bins correctly assembled, labelled and used correctly.
- We observed the correct personal protective equipment (PPE) in all of the clinical areas and staff using them appropriately.
- Curtains in the outpatients department were visibly clean and most were dated correctly.
- Most clinical areas in the outpatients department had floor coverings that were wipeable, such as linoleum. The audiology room was carpeted to, we were told by the outpatients manager, assist in soundproofing of the room for audiology purposes. However, we were told that there had been occasions when this room had had to be used. This was on the departmental risk register and they were monitoring its use.
- All of the seating and examination couches in the clinical rooms that we observed were made of a wipeable material that was in good repair and were visibly clean.
- All patients being admitted to the hospital for a procedure were risk assessed for suspected infection or their risk of developing an infection.
- The hospital has an in date policy for screening and the management of meticillin-resistant Staphylococcus aureus (MRSA) which staff follow and which highlights which patients were required to be screened for this bacteria prior to admission. These include all renal dialysis patients and hospitalised as an inpatient (for more than 24 hours) within the last 18 months.
- There were leaflets throughout the outpatient department areas that patients were able to take away regarding “infection prevention and control” that highlighted to patients about prevention and treatment of infections such as MRSA.
- The outpatients department screen patients in the preoperative period for Carbapenemase Producing Enterobacteriaceae (CPE).
- The link representative from the outpatients department attends the quarterly infection prevention control practitioner meeting along with the link practitioner representatives and we saw the meeting minutes which covered subjects such as audits, sharps bin and cleaning wipes. The link representative then feeds back to the outpatients departmental team.

Good

Outpatients

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- The outpatients department consisted of 12 consultation rooms, one treatment room, one fully fitted audiology room in Beechwood lodge and five consultation rooms in the main hospital across the car park.
- Fire exits were clearly visible in appropriate places throughout the department.
- All areas of the outpatients department appeared visibly clean and well presented. There were suitable washroom facilities in all areas and cleaning schedules in appropriate places.
- All of the equipment we saw during out inspection appeared clean and had labels on them stating that they had been cleaned.
- We observed a spreadsheet upon which all of the equipment in the outpatients department was listed, that the outpatients manager kept up to date with such information as servicing dates.
- All equipment had asset numbers affixed to them and dates that highlighted when they had been and were next due servicing. All of the equipment we saw was in date for servicing and calibration.
- The clinical areas in Beechwood Lodge were located over two floors, the ground and the first floor. The first floor was accessible by either the stairs or a lift. However, the lift was out of order during our inspection. The clinic manager had rearranged clinics within the building in order that any patient who struggled walking up the stairs was seen by the doctor or nurse in a ground floor consultation room.
- There was a reception desk at the entrance to Beechwood Lodge with seating for patients and their relatives which was never left unattended during our inspection.
- There was a large seating area on the ground floor and a smaller one on the first floor where patients and their relatives could wait whilst waiting to be seen.
- The resuscitation bag was sealed and we checked that it had been checked correctly. There was a resuscitation bag located next to the physiotherapy and ophthalmology clinical areas which had also been checked correctly.
- The resuscitation bag was large and relatively heavy and was located next to the stairwell on the ground floor of Beechwood Lodge, the main outpatients department. We were told that the defibrillator would be taken upstairs if needed for a patient and the rest of the resuscitation trolley would be taken by the lift or carried upstairs. The lift was temporarily out of order during our inspection. We were shown the report from unannounced resuscitation simulation report that had been carried out by an external assessor the previous week. The outcome would have likely been very positive." We were informed prior to leaving the inspection that the hospital had ordered another resuscitation trolley so that there would be one on each floor. Since the inspection the provider has told us that this resuscitation trolley was now in place.
- There were facilities for patients and their relatives to help themselves to hot and cold drinks.
- The outpatients at Beechwood Lodge was open from eight am until nine pm Monday to Thursday and eight am until five thirty on Fridays.
- The physiotherapy department was situated across the car park from Beechwood Lodge just inside the main hospital. This area had a seated waiting area with facilities for refreshments. There was a central area with a small reception desk and a larger clinical area for differing physiotherapy assessments and treatments to be carried out such as a staircase and exercise equipment and five curtained clinical spaces. Four of these were dedicated to treatment of musculoskeletal treatments and one was for physiotherapy of the hands.
- The physiotherapy outpatients department was open eight am until eight pm Monday and Thursday, eight am to four pm Tuesday Wednesday and Friday and Saturday eight am until one pm.

- The ophthalmology department shared the same seating area and refreshment facilities as the physiotherapy department and was located opposite. This area consisted of three consultation rooms, one of which housed the laser for eye surgery.
- We were shown a list of all the equipment located in the outpatients departments which listed such information as the servicing dates. This facilitated the clinic manager to have oversight of all of the equipment in her area and ensure that it remains in a serviceable condition for patients use.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- We saw evidence that patients were assessed for risk factors prior to and throughout their care pathway in the outpatients department. These included inclusion and exclusion criteria for acceptance for consultation which highlighted, for example, that patients whose body mass index was greater than forty and patients who were likely to require care in a high dependency unit or an intensive therapy unit would not be treated there.
- Staff we spoke to were able to articulate to us what they would do in the event of a safeguarding concern. Safeguarding leads were contactable at all times within the hospital.

Nurse staffing

- **The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**
- In the period May 2018 to April 2019 inclusive the sickness rate of nurses in the department was 9.98%
- In the period May 2018 to April 2019 inclusive the department did not use any agency nurses to staff the outpatient department.
- In the period May 2018 to April 2019 inclusive the department used an average of 9.85% bank nurses to staff the unit. Staff sickness was covered by either flexible staffing or bank staff. We were told by the outpatients manager that the bank staff used were all experienced within the department.
- There had been no unfilled shifts for the period from January 2019 up until April of 2019 inclusive.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.**
- The service employed two resident medical officers (RMO) to provide 24 hour, seven days per week medical cover in the whole hospital.
- Staff in the outpatients department were able to request the attendance of the RMO to attend patients in the outpatients department if required.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- The service had a retention of records policy which staff were able to refer to ensure that records were kept for the correct periods.
- During our inspection we reviewed six sets of patient records whom had received care in the outpatients department. These were mostly all documented appropriately. However, in two sets of notes the "health questionnaire" booklet only had the patient identification stickers on the first page. We raised this to the leadership team at the time of our inspection.
- Patient records were securely stored in locked cabinets when required for clinics but not currently being used. We observed that patient records were never left unattended at all other times.
- Medical records clerks pull the patients records in preparation for the clinics that day.

- The recent audit in the outpatients department that in the three months prior to our inspection no incidences where patients attending clinics where their medical notes were not available.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- The hospital have a safe use of medicines policy which was in date and with which all staff worked within the parameters of.
- There was a pharmacy department within the hospital and the pharmacy staff monitored and replenished the stock levels of the two medicines cabinets in the outpatients department.
- Medicines were stored in one of two lockable medicine cabinets, one in the ophthalmology department and one in the treatment room in the main outpatients department. The ambient room temperature was checked daily in both of the rooms where these medicines cupboards were located.
- The outpatients department use only one medication, Synacthen (that needed to be stored in a fridge. The lead pharmacist told us that this was ordered in by them as and when needed and kept in their fridge in the secure pharmacy department. It was then taken to the outpatients department for use only when the patient attends the clinic.
- There was oxygen available in the outpatients area if required for patients.

For our detailed findings on medicines please see the Safe section in the [main service] report

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- We were shown two examples of "48 hour flash" where learning from incidents at other BMI hospitals were shared with the department to reduce the risk of a similar incident occurring in the department.
- We observed the "incident learning points" posters for March and May 2019 which highlighted issues and learning taken from investigations. These included patient records having loose pages within and reminders to file all documentation and pathology samples not being labelled correctly necessitating a patient having to return for a repeat blood test, prompting a review of the pathology pathway and all staff being reminded to check their labelling. We observed these posters in staff rooms and staff that we spoke with told us they were discussed at team meetings and handovers.
- We reviewed an incident investigation that had as an action that communication on ultrasound request cards should be improved.
- Following a cluster of blood samples bottles being rejected due to inaccurate and/or missing information requiring patients to have to undergo repeat blood sampling, the department commenced their "read aloud two nurse check" initiative. This has reduced such incidents tenfold.

Are outpatients services effective?

We do not provide a rating for effective when we inspect outpatient departments.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance**
- There were a range of clinical care patient pathways documents for staff to follow which ensured that all patients were consistently receiving the appropriate evidence based care for their condition and minimised the risk of an aspect of care being missed.
- The outpatients department benchmarked its care provision against other comparable services within the BMI Healthcare group.

- Staff that we spoke with told us that that they were able to access both local and corporate guidelines via the intranet and specific folders in the staff office.

Nutrition and hydration

- **Staff gave patients enough drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.**
- Hot and cold drinks were available in the outpatient areas for patients and their relative at all times.
- We were told by staff that patients whom were in the outpatients department for any length of time due, for example, waiting for transport, were invited to use the canteen for food and other refreshments.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.**
- Patients attending the physiotherapy department were asked on discharge for the clinic if any pain associated with their condition had ceased following treatment. Between January 2018 and June 2019 88.21% reported that their pain had ceased which was slightly better than the northern regional average of 89.24%.
- Patients were asked to complete a questionnaire prior to hip surgery which includes specific questions about pain in the previous four weeks and they were asked to rate from none, very mild, mild, moderate and severe in areas such as walking, standing up from a chair and in bed at night.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- The physiotherapy department have, as of June 2019, introduced a new patient outcome measure entitled patient specific functional scale to assess the effectiveness of their care provision. The department manager told us that the data will enable them to identify areas of best practice and areas where service and professional development.
- We were told by the nurse lead for the outpatients department that patients seen in the department who were suspected of having cancer had their care transferred to a nearby NHS specialist cancer hospital for treatment and or surgery.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- The hospital have an induction policy which outlines that new starters in the department were given a 90 day induction booklet to work through and complete which such targets as identifying their line manager, being familiar with their working environment, only using equipment that they were competent to use and identifying their learning needs.
- All new starters have to have agreed a personal development plan with their line manager prior to completion of their 90 day induction workbook. All new starters were assigned a buddy, which was an experienced member of staff who they can approach for advice, assistance and support. Staff that we spoke with during our inspection confirmed that this was what happened at the start of their employment in the department.
- We reviewed the completed "healthcare assistant development programme" of one staff member which was a comprehensive document within which staff members had to achieve competency in various areas such as taking blood samples and correct documentation. We spoke with several members of staff who told us that they had all completed such a document and were up to date with their competencies.
- All staff have an initial competency assessment for phlebotomy (taking of blood samples) and receive two yearly updates.
- We reviewed the competency files of the five staff members who were competent to use the laser machine in the ophthalmology clinic.

Multidisciplinary working

Good

Outpatients

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- All of the staff that we spoke with told us that there was good teamwork between all the staff to provide excellent patient care.
- We were told by one of the Consultants that we spoke with during our inspection that the lead nurse was a very good leader who led a "very slick" and "very happy" multi-disciplinary team that worked very well together.

Seven-day services

- **Key services, such as physiotherapy, were available seven days a week to support timely patient care.**
- The service provided a resident medical officer whom provided cover 24 hours per day, seven days per week.
- The outpatients at Beechwood Lodge was open from eight am until nine pm Monday to Thursday and eight am until five thirty on Fridays.
- The physiotherapy outpatients department was open eight am until eight pm Monday and Thursday, eight am to four pm Tuesday Wednesday and Friday and Saturday eight am until one pm.

Health promotion

- Staff gave patients practical support and advice to lead healthier lives.
- We observed leaflets in all areas of the outpatient areas covering subjects such as "getting you back to fitness" which describes what patients should do to achieve optimum health following sports injuries and "treating iron deficiency prior to surgery" which describes how patients were able to optimise their health in preparation for surgical procedures and "breast health" advising women about breast health and screening.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- The hospital had a policy for "consent for examination or treatment" policy which outlined when and how consent should be obtained, by whom and where this should be documented. During our inspection we observed verbal and written consent being obtained that complied with this policy and our review of six sets of patient records further assured us that this was being complied with.
- All staff working at the outpatients department were required to complete their mandatory training in Mental Capacity Act (MCA) (2015) and Deprivation of Liberty Safeguards (DoLs) training as part of their initial induction training and their ongoing mandatory training.
- The hospital had an in date policy for MCA and DoLs that staff were encouraged to refer to if needed.
- Staff members that we spoke with during our inspection were able to articulate what actions they should take in the event that they had a concern regarding a patients capacity to consent to care or treatment which followed their policy.
- We were told that patients with a condition such as dementia would be seen in clinic first to minimise any potential distress.

Are outpatients services caring?

Good

We rated caring as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We observed a notice board in the staff room that was full of thank you cards and other such feedback from patients who had used the service.

Good

Outpatients

- We spoke with six patients during our inspection who all stated that their dignity and respect was maintained throughout their care and treatment provision.
- Patients that we spoke with described staff and the care they provided as "good", "respectful", "very happy with the care received" and very nice and polite".
- We observed a selection of outpatient postcard comments where patients had written comments about the staff and the service they provided such as "excellent staff – very friendly and knowledgeable" "superb service" "from start to finish they (staff) have all been amazing."
- We observed and were told by the patients that we spoke with, that patients were given time to ask questions about their care and treatment.
- All staff that we observed introduced themselves and communicated well to ensure that patients and their relatives/friends fully understood about their care.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- We observed chaperone posters in clinical rooms and in waiting areas and patients being offered a chaperone for appropriate procedures.
- Patients told us that they were given sufficient time during their respective consultations and that they did not feel rushed at all.
- We observed staff interactions with patients and noted that information and explanations were given to patients in a kind and sensitive manner.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- There was a patient notice board behind the reception desk in the main area highlighting what clinics were running and if there were any delays.
- Staff spoke with patients sensitively and appropriately dependent on their individual needs and wishes.
- Patients that we spoke with following a consultation told us that they felt they had been fully informed of upcoming treatments, test results and their next appointment.

Are outpatients services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- During our inspection there was always two receptionists present at the main out patients reception desk in Beechwood Lodge and one in the physiotherapy department in the main hospital building. There were no ophthalmology clinics running during our inspection.
- There were a variety of patient information leaflets in the reception area for patients to take away.
- We were shown evidence of ongoing work to increase the number of leaflets and signage in the outpatients areas in languages other than English.
- Patients were able to use the choose and book system to request care and treatment at the hospital.
- Patients were able to attend their appointment in one of the midweek evening slots to arrange their care around their lifestyle.
- Physiotherapist appointments were also available midweek evenings but weekends also.
- For certain pre-operative assessments, following a robust risk assessment, patients that met the criteria were able to have their pre-operative assessment completed over the telephone to save them having to travel to the department.

- The service run a one stop breast clinic supported by a specialist nurse.
- The service had in place a policy entitled "provision of chaperones during examination, treatment and care." We saw laminated signs, in four different languages, in pertinent places throughout the outpatients department highlighting to patients that they would be offered a chaperone if they wished.
- The department had recently commenced utilising the learning difficulty passport which was used in NHS hospital settings. The passport was designed to give hospital staff helpful information that wasn't only about illness and health.
- The service referred certain patients to, and works with, external agencies in the pre-operative phase to ensure care following surgery for certain procedures. For example, patients undergoing a hip replacement may need specialist equipment to ensure their toilet was at the optimum height and walking aids so they were referred pre operatively to ensure that these aids were in place before the surgery.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- Patients that we spoke with during our inspection told us that they were offered and, where appropriate, had a chaperone present during their care.
- During our inspection the lift to transport patients from the first to the second floor and back was out of order. We saw evidence that consultants and nursing staff had moved the clinic and treatment areas around in order that patients and their relatives that were unable to walk upstairs were seen by clinicians on the ground floor.
- The department used a translation service to provide care for patients for whom English was not their first language.
- The physiotherapy and ophthalmology departments had their own waiting area with accessible toilets and refreshments for patients within the main hospital building.
- Patient information leaflets were available to all patients and relatives highlighting the treatments and choices offered for differing aspects of care and treatment and, where relevant, these were given to patients about their prospective treatment options.
- We were told by the physiotherapy manager that their service became involved with patients care in the pre-operative period to contribute to the effective care provision for patients undergoing surgery for such procedures as total hip replacements, total and partial knee replacement and total shoulder replacement.
- Patients could access their healthcare at BMI Highfield via their GP and the choose and book system. This was a national electronic referral service that gives patients the choice of treatment centre at a date and time convenient for them.
- Patient feedback from the outpatients department in May 2019 highlighted that of 159 responses, 100% would recommend the service to friends and family.
- Prior to being admitted to the hospital for a procedure, patients were all given a pre admission checklist which informs them of such information as avoiding smoking 48 hours prior to admission, arranging someone to drive you home after sedation or general anaesthetic and the average length of stay for the specific procedure.
- A hearing loop was in place within the outpatients department for those with a hearing impairment.
- We were told that two staff were, at the time of our inspection, being trained to care specifically for patients with a learning difficulty and there were two learning difficulty champions in the department.
- Two staff members were trained in basic sign language to assist care for people with a hearing impairment.

Access and flow

Good

Outpatients

- **People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**
- Patients that we spoke to told us they were offered an appointment at a time convenient to them.
- We spoke with six patients and three relatives of patients in the outpatient department and all were very positive about the timeliness and effectiveness of the care they or their partner had received.
- We spoke with one patient in the physiotherapy department who told us that he had attended several appointments there since his operation and he was always seen in a timely manner at a time that suited him.
- We observed a notice board behind the reception desk in the main outpatients area that highlighted to patients and their carers what clinics were running and if there was any delay.
- All of the patients that we spoke with during our inspection told us that they had not had to wait long to get their appointment and that when they arrived at their appointment they were always seen promptly.
- The service had a policy for patients that did not attend for their appointments, within which it was highlighted that on the first occasion another appointment was made and on the second occasion they were referred back to the GP who had referred them.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**
- There was an in date complaints policy which highlighted information about the procedure to follow for receiving, recording and investigating complaints.
- The service provided a "how did we do today" leaflet in the outpatient areas that informed patients how to make a comment, compliment or complaint about the service or the care that they received.
- Between June 2018 and May 2019 there were 56 complaints pertaining to outpatients. 32 were about communication such as miscommunication about appointment times, the telephone system and recording errors. 16 complaints were about clinical care and treatment which includes consultant attitude as well as dissatisfaction with clinical outcomes. The remainder were about access and timing, consultant attitude and financial processes. Actions taken to reduce these included changes to the telephone systems with less options coming in and a dedicated pre-operative assessment line. Written communications were reviewed and the way consultants accessed test results was changed. This has helped lead to a reduction to two per month in April, May and June 2019.
- 68% of the responses were within the deadline of 20 working days or the 'holding number of days' if a holding letter was sent to advise of why there was a delay in the response. The majority of delays were due to waiting for consultant responses however this has improved in the past few months.

Are outpatients services well-led?

Good

We rated well led as **good.**

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- There were two nurse managers, one for the main outpatients and one for the physiotherapy department. Both of these leaders told us that they were fully supported by the management board.

Good

Outpatients

- All of the staff that we spoke with during our inspection were extremely positive about the leadership in the outpatients department.
- All of the staff that we spoke with told us that the lead nurse in outpatients was always approachable.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- Staff that we spoke with during our inspection were aware of the hospitals vision and strategy.
- Several of the staff that we spoke with told us about the directors plans to build a new outpatients department.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- The leadership team told us that there was an open culture where all staff could discuss ideas and concerns.
- All of the staff that we spoke with during our inspection told us that the leaders were visible and approachable at all times and that they felt they could approach them and be listened to about suggested changes or a concern.

Governance

- For the main findings, please see surgery report.
- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- Team meetings were facilitated regularly and we observed the minutes from several of these which were well attended by a variety of outpatient staff. All highlighted clear action plans assigned to a particular staff member.
- There were daily staff meetings at which pertinent learning points were disseminated to all staff.
- Staff that we spoke with during our inspection were clear about their roles and to whom they should report.
- The outpatient lead nurse attends the hospital wide governance meetings which were attended by the leaders of all departments which covers the risk register, clinical developments and NICE guidelines.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- We observed the major incident file which was located in the staff office. All staff that we spoke with were aware of the folder and their role if it needed to be actioned. There were no major incidents in the 12 months preceding our inspection.
- The service had a departmental risk register that we reviewed. There were five risks listed on it which included the carpeting in the audiology room, a piece of clinical equipment that needed replacing and a lack of a bladder scanner. There were appropriate actions to mitigate against these risks and they were all allocated to a person responsible for these actions. For example, there were plans to hold an outpatients clinic in the main hospital building for patients who

would need to have their bladder scanned and they were using the scanner from the ward in the main hospital until they had purchased one for the outpatients department.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- The outpatients department carried out a bi monthly records audit and the results for February 2019 were 88%. Communication was sent to all staff regarding the importance of good record keeping and the figures for April and June 2019 was 98% and 96% respectively.
- The outpatients department carried out a monthly audits in such areas as chaperones, minor procedures and the correct cleaning of the nasoendoscopes. We reviewed the June 2019 audits for each of these and found the results to be mostly good. Where a deficit was noted, such as the time of procedure for the minor procedure audit, the department lead had formulated an action plan to rectify the issue.
- We observed minutes of the monthly outpatients team meetings at which all team members were invited to attend. These meetings were well attended and items discussed on the agenda were audits, incidents, training, medicines and risk and governance.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- The department contributes to the hospitals "patient satisfaction dashboard" where feedback and comments from patients, combined with staff suggestions, was utilised to develop and improve the department. One example of this was that the chaperone poster had been translated into Urdu, Bengali and Polish and there was ongoing work to increase patient information leaflets in other languages also.
- There was a hospital wide weekly newsletter that features new starters, charity work that individuals or departments were involved with, a suggestions box for staff and a good news Friday in which two outpatients staff were commended for suggesting the "outpatients allocation board" which highlighted if there were any delays to the running of the clinics.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**

Requires improvement

Diagnostic imaging

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

Information about the service

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

Are diagnostic imaging services safe?

Good

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

We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it. Training was completed via e learning modules, face to face on site and at external locations.**
- Staff had twelve months to complete mandatory training which ran from April to April. At the time of our inspection the service told us mandatory training for all staff within diagnostics staff was 89%, which was just below the services target of 90%. In the imaging team compliance was at 96%.
- Staff were positive about the content and quality of the mandatory training they received.
- Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.
- In addition, staff had read and signed the local rules which comes under the ionising radiation regulations.
- At the time of the inspection staff had taken responsibility for their own mandatory training with little monitoring. The new service lead told us that they planned to have oversight of mandatory training going forward.

Safeguarding

See information under this sub-heading in the surgery section.

- **Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- Staff we spoke told us they had not made a safeguarding referral. However, the staff were aware of the types of issues that may need to be reported as a safeguarding concern or alert including information in relation to female genital mutilation.
- The hospital did not treat children however staff in diagnostics had received safeguarding training level one and two for children and adults.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they could contact the hospital lead for safeguarding adults for advice.
- The service used a 'pause and check' process which met with Ionising Radiation (Medical Exposure) Regulations 2017 and the Society of Radiographer

guidelines. Staff checked three points of the patient's identification and the intended procedure against the referral with the patient. Posters were in place to remind staff of this process.

- We observed two patients undergoing diagnostic imaging procedures and observed that the patient checks were carried out appropriately.
- Staff followed safe procedures for children visiting the service /department.

- There was information available in staff areas relating to safeguarding to guide staff with relevant information and contact numbers.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- There was hand sanitizer available on the entrance to the department and a poster advising visitors to use hand gel. We observed staff using sanitizing hand gels before providing patient care.
- Staff followed infection control principles including the use of personal protective equipment such as gloves and aprons which were available to wear during care and treatment. We observed staff adhering to 'arms bare below the elbow' guidelines and staff following the hospital's hand hygiene policy. We observed staff wash their hands between patients.

There were instructions for washing hands by the sinks.

- Infection control was included in mandatory training for staff. The clinical manager told us there was 100% staff completion of this training.
- The imaging team had an infection prevention and control link staff member who shared information with staff on infection control issues. However, we were told that infection prevention and control link staff had not had regular meetings over recent months.
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.
- Cleaning schedules were in place which included the areas to be cleaned and how frequently cleaning should be undertaken. Staff cleaned equipment after patient contact, however some equipment was not labelled with, 'I am clean stickers' to show when it was last cleaned.
- For the MRI scanner, records showed the bed, the coils and the headphones were cleaned between patients and that there was a deep clean every six months. We witnessed staff cleaning the area between patients.
- Within the radiology department patients with communicable infections would be offered appointments at the end of the day so the room could be followed up with a deep clean.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- The MRI scanner was housed in a purpose-built unit. The building was modified to take the new scanner four years ago. The flooring area was cracked in the imaging reception area and was visibly damaged in the cubicle changing area. These areas were on the action plan and were awaiting approval prior to repair.
- The service had a radiation protection supervisor (RPS) who was currently the lead radiographer and a radiation protection advisor (RPA) who was from an external company. In addition, there was a medical physics expert attached to the service. The radiation protection advisor was responsible for issues such as calibration of equipment, risk assessments and dose assessment and recording.

- Local quality assurance testing of equipment was undertaken by the designated radiation protection supervisor for the department. Results were forwarded via an online system and sent to the medical physics expert team who monitored the results. Results of local quality assurance testing were discussed at the annual radiation protection committee and the medical physics expert would raise concerns beforehand if needed. This was in line with the quality assurance policy for the service. Following concern with one piece of equipment and the quality assurance testing, the service plan to introduce a system to highlight when tests are needed and how frequently the tests should be carried out.

Diagnostic imaging

- Maintenance contracts, provided by an external company, were in place to ensure that specialist imaging equipment was serviced regularly and faults were repaired quickly. Staff carried out daily safety checks of specialist equipment to ensure it was working correctly.
- Images are acquired using Computerised imaging system. There was picture archiving and communication system in place where images were reported.
  - The contact details for the radiation protection supervisors for the hospital were displayed. This met with the Ionising Radiation (Medical Exposure) Regulations 2017. The x-ray room contained panic buttons for use in an emergency.
  - Exposure to radiation was monitored in the imaging service. Staff wore dosimeters so that radiation levels could be monitored and the lead radiographer knew how much radiation the staff had been exposed to. The manager had plans to introduce a more robust record keeping and badge exchange system.
- Waste was appropriately segregated into clinical, domestic and sharps waste. Staff disposed of clinical waste safely into appropriately labelled containers.

Assessing and responding to patient risk

- **There were systems and processes in place to reduce the risks to patients and staff.**
- Staff knew how to respond to any sudden deterioration in a patient's health and how to contact the resident medical officer, who was on site 24 hours a day.
- The service had processes to confirm the right person got the right radiological scan at the right time. The imaging department had implemented the pause and check process before every patient examination to confirm the delivery of safe and effective patient care. This included a six-point check. The six-point check included examination justification, patient's recent imaging, patient's identity (name, date of birth, postcode), pregnancy status, confirmation that the patient expected the diagnostic testing procedure and a check as to whether the patient had had a similar procedure recently. This enabled staff to check a patient's understanding about the radiological procedure, reduce duplication and potential risk of over exposure to radiation.
- The service had a permanent radiographer staff member who provided a radiation protection supervisors role. This meant that they had received additional training in the Ionising Radiation (Medical Exposure) Regulations 2017 and were responsible for ensuring compliance with the regulations and the local rules. The service had access to a medical physics expert which was provided through a service level agreement with an external organisation. Staff could access them if there were radiation concerns relating to the equipment.
- The staff were aware of the external radiation protection advisor who was contactable for concerns in relation to compliance with the regulations or incidents involving radiation exposure. The contact details of the teams were available to staff in the department.
- The service used the World Health Organisation safer surgery checklist where invasive procedures were used in the imaging department.
- All department doors were secured by keypad access. There was illuminated signage outside of the x-ray room which identified radiation risks and indicated when x-rays were in progress. This showed people it was a controlled area with limited access. All signage was in keeping with Ionising Radiation Regulations 2017.
- There was a red flag protocol in place for use by reporting radiologists. This ensured any findings of concern would be communicated to the referring consultant.
- Staff asked female patients under the age of 55 the date of their last menstrual period which was documented on referral forms. This was in line with the Ionising Radiation (Medical Exposure) Regulations 2017. We observed posters in waiting areas which provided patients with information about pregnancy and diagnostic imaging. At the time of our inspection the service was in the process of updating the policy for this to reflect the updated regulations in 2017.

Requires improvement

Diagnostic imaging

- The service had safety questionnaires that patients completed before they underwent radiological testing. The service had a magnetic resonance imaging (MRI) safety questionnaire. For radiological examinations requiring contrast, patients completed a specific questionnaire to identify if they had any renal problems which may prevent them receiving contrast. This information was then scanned into patients records.
- Any known patient allergies were noted on the electronic record and flagged up before any scanning started.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**
- The staff included radiographers of different grades and non-clinical administration staff. The main X ray and MRI department were staffed separately however staff had started working across areas to improve their skill set. The service used three regular bank radiography staff to meet the demands of the service. The bank staff were familiar with the MRI department or X ray so they knew the systems and processes.
- Radiographer staff provided a twenty-four hour on call service, seven days a week for urgent imaging requests. The rota was covered by a mixture of substantive and bank radiographer staff.
- There was a lone working hospital policy in place for staff. We did not see evidence of a risk assessment associated with staff lone working in the department and staff confirmed that there was not one in place.
- The new clinical service manager had started their induction which included both hospital and department level information.
- One of the MR radiographers participated in the on-call rota and weekend on call for general x-ray.
- Staff sickness was covered by bank staff.
- A 'meet the team' noticeboard was displayed in the waiting area, which displayed photographs of the staff team so patients understood the different staff roles.

Medical staffing

For our detailed findings on medical staffing please see the safe section in the surgery report

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The medical staff were not directly employed by the service .**
- Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. The registered medical officer was on site 24 hours a day and could provide medical support to the diagnostic imaging departments upon request.
- At the time of the inspection there were eight radiologists who worked at the hospital who had practising privileges. In addition the service had access to radiologists from a local NHS trust bank who worked at another BMI hospital.
- At the time of the inspection there was no on-call arrangement for radiologists for out of hours reporting, however we were told the demand for urgent or unexpected imaging during out of hours periods over the last 12 months had been virtually non-existent. Radiographers carried out on-call duties to cover routine imaging procedures. The service planned to assess the current coverage and availability of their own radiologists to cover on-call arrangements.
- All consultants had to nominate a standby who would cover for them during periods of absence or annual leave.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, signatures were not present on all X-ray request forms.**

Diagnostic imaging

- The patient records were mainly electronic and the imaging referral forms were paper. Diagnostic imaging information was added to the referral form during the procedure.
- All X-rays were printed onto film, and, alongside the referral forms, were held within the main patients notes. There were no patients notes stored within the department.
- We saw that if an inpatient had an x-ray, a sticker was placed in the patient's notes stating the body part x-rayed, the date of x-ray and signed by the radiographer.
- We looked at five patient's x-ray records. The request card was in paper form. The radiographer justified the exposure and signed the back of the form to confirm they had justified it. Following the x-ray, the number of exposures and the patient dose was recorded, and a check that patient ID checks were satisfactory. We found one record was not signed by the referrer and one was not signed by the radiographer. All five patient records were completed and present on the clinical record interactive system.
- Patient records were audited to check that they were appropriate for the imaging and any risks to patients were identified.
- We looked at five random patient records stored on the clinical record interactive system to check safety check forms had been scanned in and images were complete. All were scanned onto patient records.

Medicines

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

- **The service used systems and processes to safely store medicines. There were effective systems in place for the storage and management of medicines.**
- Rooms where medicines were stored were accessed by key pads and the cupboards were accessed by key pads. There were no controlled drugs in the department. Access to the medicines was restricted to authorised staff only.
- Medicine stock top ups were undertaken on a weekly basis by the hospital pharmacy team and staff could request medicines in between if necessary.
- Room temperatures were taken daily and recorded to ensure medicines were stored at an ambient temperature. Fridge temperatures and the warming cabinet temperatures were recorded daily.
- Staff stored and managed all medicines and prescribing documents in line with the provider's policy. We checked a range of medicines that were held within the department and we found that they were intact and within the manufacturers expiry dates.
- Prior to the inspection, the service had stopped using patient group directions (PGD's) for the administration of some medicines. The patient group directions for contrast had expired and there was no clinical service manager in post to review and sign this off. The new manager has already identified this as an action to address.
- A patient group direction is an instruction to administer a medicine to a list of individually named patients where each patient on the list has been individually assessed by that prescriber. The radiographers had worked with the lead pharmacist to develop the patient group directions and their competencies to administer the medicines. The radiographers were keen to get this role back.
- The radiographer was clear how they follow medicines management for radiographers for the safe administration of drugs, even though they are not administering the contrast or drugs, they have to understand and observe for any side effects.
- The Resident Medical Officer (RMO) was being notified of any contrast injections that were booked for the day. When ready, the radiographer would phone the RMO to come and administer the contrast. This could delay things if they had to wait for the RMO. The RMO went through medication safety check forms for whichever contrast medications they have administered. We observed a contrast injection and saw that all safety checks were completed.
- We looked at five patients records where patients had undergone screening and they had received contrast.

Diagnostic imaging

We saw where any drugs used the records were completed appropriately. When contrast was used for patient imaging the batch numbers from the contrast was recorded in the patient record.

- There was an audit of imaging medicines management which showed in March, April, May 2019, the department scored 100%.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- Incidents were categorised as clinical and non-clinical and were logged onto an electronic system. Staff could describe the process reporting incidents and could give examples of incidents they had reported. In diagnostic imaging, staff were aware of their responsibility to report radiation incidents to the radiation protection adviser. Two radiation incidents had occurred since June 2017, neither of these incidents met the criteria to be externally reportable.
- Staff gave us examples of near miss incidents that had happened, and improvements identified as a result. One involved improved practice in staff ensuring the recording of the patients last menstrual period date was completed.
- The service had systems to ensure staff knew about safety alerts and incidents and how to report these. Learning from incidents was discussed at 'comms cell' meetings, which took place each morning with the head of the hospital and the department leads.
- The hospital provided a monthly report which was called 'closing the loop', this included outcomes of incidents and shared learning. We saw that this was displayed in the imaging office and staff were positive about this as a form of communication.

Are diagnostic imaging services effective?

We do not provide a rating for effective when we inspect diagnostic services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.
- We saw that the service used guidance from the National Institute of Health and Care Excellence and from the Royal College of Radiologists and the Royal College of Radiographers.
- There were standard operating procedures in place which detailed how staff should undertake specified imaging procedures. We were told the standard operating procedures for imaging were due for review. The new manager had already identified this as an action required.
- Staff had access to the Royal College of Radiologists iRefer guidance, a (this is a radiological investigation guideline tool).
- The service had diagnostic reference levels for each procedure (this is the median dose of radiation a patient would receive for a diagnostic procedure). We saw these were displayed in the department in line with best practice.
- The radiation protection advisor body for the department had identified a need for a review of the dose reference levels for some common imaging procedures in the summary report undertaken in February 2019. At the time of our inspection, we observed that action had been taken and the documentation for dose reference levels had been addressed.
- We saw evidence that dose reference levels were recorded for each patient which was in line with best practice and Ionising Radiation (Medical Exposure) Regulations 2017. We were told the dose reference

levels were audited as part of the Ionising Radiation (Medical Exposure) Regulations requirements audit. At the time of this inspection we did not have the results from this audit.

- Policies and procedures were in place in line with ionising radiation (medical exposure) regulations (IRMER) 2000.

- There was a BMI Healthcare regional diagnostics clinical services group who met monthly. The group comprised of the managers at the sites where there were diagnostic services. We were told the head of diagnostics was completing a prompt sheet for the directors of clinical services to support them with imaging and diagnostics as clinical staff were not necessarily from a diagnostics background. This group would make recommendations about new guidance and shared best practice across all of the hospitals. Examples of information shared included a BMI-Imaging update following the meeting in February 2019 and updated significant accidental and unintentional exposures guidance.

Nutrition and hydration

- **Staff monitored patients to meet their nutritional needs. The service offered people appointment times to reflect their needs and preferences if they were fasting or were diabetic.**

- Vending machines were available and access to the hospitals restaurant facilities.

Pain relief

- During the positioning and throughout the procedure for patients for MRI scans, staff told us they assessed and monitored patients regularly to see if they were in pain.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**

- We were told that, due to the service having been without a clinical service manager until July, the clinical audit program had not been completed in line with BMI's audit programme by the end of May 2019. However, the lead radiographer had been relieved of clinical duties in order to undertake a new programme of audits and to address issues within the department. We saw the following completed audits:

  Imaging, general and radiation-February 2019

  imaging medicines, PACS and RIS, theatres, clinical practice February 2019

  clinical practice document audit May 2019

  imaging radiation safety audit-completed March – April May 2019

  imaging theatres- March, April, May 2019

  imaging radiation safety audits April – May 2019

  evidence of removal and disposal of old x-ray films – April 2019

- We reviewed the audit results detailed on the imaging audit programme 2019 and saw that the service had achieved 100% in the above audits, except imaging theatres which they received 95%.

- In addition to these, there was some specific audits relevant to MRI services and specific audits required as part of contractual arrangements. This included 10% of MRI scans going through a double read audit process, a radiologist checked the report and another radiologist verified the report, they checked the imaging techniques, waiting times, request to scan times, scan to report times, any recalls, technique and any scanner downtime.

Competent staff

- **The service made sure staff were competent for their roles. Managers supported staff to develop through yearly, constructive appraisals of their work.**

- However due to the absence of a manager the staff's yearly appraisals were all due for renewal. The new manager told us that he had plans to rectify this issue.

- Staff were trained in core areas such as infection control, safeguarding, information governance, medical gases, health and safety and immediate life support training. In addition, staff had completed training relevant to their specialty. We saw the

competency files for two staff members which included the signed competencies to use all the equipment and the various rooms and their completed training certificates.

- All contracted bank staff completed a hospital induction before they were able to work in the diagnostic and imaging department. This ensured staff were familiar with the working environment and local policies before they commenced work. Bank staff received the same induction and competency training framework assessments as substantive staff members.
- In MRI, the lead radiographer led on MR safety training for all new staff. Training included observing for reactions following contrast administration and scenarios for getting patients off the scanner in the event of an emergency. In addition, they were responsible to train the cleaners to clean the department. Due to MR safety, cleaners were not allowed in the scanning room.
- The radiologists for the service received appraisals through the NHS trusts that they worked for and provided evidence of this annually to the Executive Director for the hospital.
- There was an equipment training and assessment competency framework that all radiographer staff had to complete. ll of the staff that we spoke with told us that they had completed initial training and were re-assessed annually. We saw that the training covered the imaging equipment used within the department and looked at a variety of aspects such as use of the controls, image acquisition, patient care, radiation protection, administration and post image processing. Assessments and sign off was undertaken by the lead service lead.
- The lead radiographer had attended the study days and training to be the radiation protection supervisor, there were also updates every two years. There were plans for an additional staff member to attend the training.
- Team meetings had not happened regularly due to the lack of management. Plans were in place for these to recommence.
- Staff told us they were encouraged and supported in their personal and professional development and had opportunities to attend external courses. We spoke with the imaging secretary, who had worked for a number of years in the MRI department. They told us they felt well trained to carry out their role and had been supported to carry out additional training through their appraisal and competency assessment.
- Information provided by the service told us that there was a new BMI learn training course for radiographers to be completed by the MRI radiographers who inject contrast media for their patients.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Radiologists and radiographers told us they all had good professional working relationships.**
- Patients could see all the health professionals involved in their care at one-stop clinics. There was a one-stop breast clinic at the hospital where patients were able to have mammography or ultrasound as well as see the consultant at the same appointment.
- The service lead attended the daily communication cell with staff from across the hospital.
- The reception staff who booked the patient appointments told us the radiologists were always responsive to answer any queries about patients and their appointments.
- The picture archiving and communication or radiological information system in use meant that images could be immediately shared with GPs or other healthcare providers. In addition, staff had immediate access to images that may have been taken at other hospitals. Staff told us how they had recently had to transfer a patient out due to their acute condition noted following an X-ray. The radiographer was able to transfer the images over to the NHS trust via the image exchange portal to save the patient having to be re-x-rayed.

Seven-day services

- **Services were not currently available seven days a week.**

Requires improvement

Diagnostic imaging

- The standard operating hours for the x-ray department within the main building were Monday to Friday 8 am to 8 pm.
- The standard opening hours at the magnetic resonance imaging scanning department were Monday to Friday 9am to 5pm with extended hours when required. In response to a new contract, the department was open until 7pm on a Thursday. The magnetic resonance imaging scanning service was not currently open at weekends.
- There was a service provided to support the pain list on a Saturday morning on an as needed basis and these sessions were planned in advance.
- Outside of working hours, there was an on-call service provided by radiographer staff for urgent diagnostic imaging.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- The service had relevant information promoting healthy lifestyles and support in patient areas.
- Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff we spoke with had an understanding of how and when to assess whether a patient had the capacity to make decisions about their care. The service did scan patients who lacked capacity and staff used the appropriate consent forms.
- Staff said that patients without capacity were usually accompanied by a carer or there were dementia friendly advocates at the hospital.
- Staff had received training in the mental capacity act and staff we spoke with described what they would do to support a patient who lacked capacity.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Consent was gained for all patients undergoing an x-ray. We observed the process for three patients who were having an x-ray. We observed that staff made patients aware of the risks. In the notes we reviewed we saw patients consent was taken in line with hospital policy. Four patients we spoke with told us that staff explained treatment procedures to them.

Are diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. A radiographer told us how they were taking the time to find out the details of a patient's heart valve, so they could reassure them appropriately that it was safe for the MRI scanner.
- Patients said staff treated them well and with kindness. Feedback cards were left at the waiting areas. Results from patient feedback forms were displayed on the noticeboard. Comments included; 'the staff are pleasant and friendly', the consultant was very polite and down to earth' and all the staff were friendly disposition'**.**
- Staff followed policy to keep patient care and treatment confidential. The radiographer told us that if a patient had additional needs, it was sometimes written on the referral.
- Staff understood and respected the individual needs of each patient and showed understanding and a

non-judgmental attitude when caring for patients. W**e** spoke with a patient after their scan, they told us the scan was "really quite pleasant and okay, the staff were very kind and gave me the chance to ask any questions. I felt really looked after**".**

- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. In the control room for magnetic resonance imaging scanning, screens were available so that staff could protect the privacy and dignity of patients undergoing a personal procedure. We saw that these were used during our inspection.
- Staff were respectful of patients as they brought them from changing areas into treatment rooms. Staff have raised concerns regarding patients lack dignity with the X-ray gowns. Plans are in place to purchase dressing gowns to improve this for patients. Staff told us how they did their best to keep males and females separate in the three changing rooms to maintain their dignity.
- A chaperone policy was in place all patients could request a chaperone. Posters were on display in patient areas to advise patients at the right to request a chaperone, in addition this was included in patient appointment letters.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it.
- Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff welcoming patients prior to appointments in a reassuring and friendly way.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Radiographers in the MRI department demonstrated the emotional support they provided to a patient whilst undergoing a scan. The staff were exceptional in the way they spoke with the patient and supported them through this procedure.
- We observed the radiographers providing emotional support with patients through the intercom system during their magnetic resonance imaging scans to reassure them throughout the procedure.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff talked with patients, families and carers in a way they could understand. The three patients we spoke with told us they had received clear information about the procedure they were due to have.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this.
- Carers could stay with relatives when they were having a magnetic resonance imaging scan if they completed the safety questionnaire.
- Staff made sure patients and those close to them understood their care and treatment. We listened to a radiographer explaining to a patient about the magnetic resonance imaging procedure. They checked with the patient whether they had any questions, radiographer demonstrated good communication skills by providing the information in a supportive and caring way.

Are diagnostic imaging services responsive?

Requires improvement

We rated responsive as **requires improvement. Changed from good**

Service delivery to meet the needs of local people

Requires improvement

Diagnostic imaging

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- There was a clear signage throughout the hospital to guide patients to the radiology department. Reception staff directed patients to the appropriate waiting areas.
- The waiting areas for both departments included comfortable chairs for patients and relatives to wait. Some of the seating in the magnetic resonance imaging units was visibly damaged; the action plans showed that a new furniture order was in progress. The noticeboards included information about radiation protection, magnetic resonance imaging questions and queries, explanations about the radiographer and radiologists' roles, pregnancy information, how to complain and the chaperone policy. Feedback cards were made available for patients to complete. Water and vending machines were available for refreshments.
- The service monitored the appointments using an online system. The staff team would review the diary and the bookings. We saw the radiologist lists for a few weeks; staff had to be flexible as a theatre case may run over and delay the next case. If the service became additionally busy there is always the an on-call radiographer who would come and assist.
- Free car parking was available on site. The hospital have agreed access to a neighbouring church car park for staff parking to relieve the car parking pressures. In addition, there was some available parking on the local side streets.
- The magnetic resonance imaging unit had recently started a new contract which had led to later opening times.
- At the daily com cell meeting the heads of department discussed how many patients are coming through and any issues foreseen.
- To ease the pressure on the theatre and to increase the number of patients seen the service was using the fluoroscopy room as a theatre environment to carry out hand, wrist, foot and thumb injections. This environment was appropriate for this service.
- Outside of working hours radiographers provided an on-call service for urgent imaging needs.
- The staff ensured that patients who did not attend appointments were contacted. A letter would be sent out to a patient if they did not attend to advise them to contact the service. A procedure was in place for patients who did not attend three times for them to be referred back to their referrer.

Meeting people's individual needs

- **The service planned and provided care in a way that met the individual needs of patients.**
- Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff we spoke with understood the importance of supporting people with additional needs such as dementia or a learning disability and could describe adjustments they may make where appropriate.
- The magnetic resonance imaging scanner had a bore which was wider than most general scanners. This enabled patients to use the service who had claustrophobia issues as scanning experience was less confined. Staff worked with patients to support them in the scanner.
- There was a one stop clinic for patients with breast lumps and the staff worked closely with consultants and other hospital staff so that patients received their results timely so they could receive a prompt diagnosis.
- Staff were able to add an alarm on to the radiology information system to alert staff that a patient has an allergy, a learning disability or was living with dementia.
- Some of the staff had signed up to be dementia friends and a poster in the waiting area highlighted this. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Requires improvement

Diagnostic imaging

- The service had access to over the phone interpreters to assist with communication for patients who were unable to speak or understand English. Contact details were available to staff via the intranet. Staff were aware of how to use this service. In addition, the service had access to face to face interpreters. The service had developed multilingual posters and had information for Polish and Urdu speaking people which were languages commonly experienced at Highfield hospital.
- The radiographer told us that patients with a learning disability would be invited to look around the scanner prior to their appointment and they would be allocated a longer appointment time.

Access and flow

- **People we spoke with told us they could access the service when they needed it and received the right care promptly, however we found that there was no central monitoring of waiting times to highlight any gaps in the service.**
- Managers did not currently monitor waiting times to make sure patients could access services when needed and received treatment within agreed timeframes and national targets. The action plan dated July 2019 highlighted the new manager planned to monitor and audit waiting times to demonstrate any gaps in the service.
- The service did not currently have identified key performance indicators that they needed to work towards or that they measured performance against. However, we were told that the 'in-house' standard was that urgent reporting should be completed within 24 to 48 hours, and non-urgent cases within seven days.
- The service had not audited the image reporting times. Staff felt that the process for reporting images was slow and not efficient due to the length of time it took for the images to download. As part of the new managers audit plan they were considering using an external company to carry out peer review of images.
- Patients told us they were able to access the diagnostic service easily. The referrals came from GPs, the outpatient department and the wards within the hospital. All referrals to the service were on paper and they had to be signed by a verified clinician. Appointment bookings were handled and overseen by the radiology staff.
- We spoke with an orthopaedic patient who was pleased with the service they had received, they had seen the consultant, attended for an x-ray and went back to see the consultant.
- Patients who were attending the outpatient clinics could be referred for an x-ray and receive the x-ray the same day. Images were sent to the consultant for review following the x-ray but were not reported on the same day, this was due to the radiologist establishment for reporting of one day a week.
- Staff told us they were open about patient waiting times that could sometimes be up to two hours. During the inspection a patient was delayed for a number of hours however staff apologised to the patient who was waiting on the ward. The staff appreciated that patients may be anxious if they were delayed waiting for treatment.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**
- Patients, relatives and carers knew how to complain or raise concerns.
- The service clearly displayed information about how to raise a concern in patient areas.
- Staff understood the policy on complaints and knew how to handle them.
- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.
- The service reported no compliments received in the last 12 months.

Are diagnostic imaging services well-led?

Requires improvement

Diagnostic imaging

Requires improvement

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

Leadership

- **Temporary leaders had worked hard to understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**

- The service had been operating without a clinical leader for the previous six months. During this time the department had been managed by the lead radiographer for imaging and the lead radiographer for MRI services. All the staff were looking forward to a period of management stability and welcomed the newly appointed manager, who was in their first week at the hospital at the time of this inspection.
  It was evident both staff had maintained the safe operating of the services and had worked hard to develop the service. Both of these leaders told us that they had been supported by the senior management team, despite it having been a challenging time.
- The service lead reported directly to the clinical services director for the hospital and any concerns which required escalation were reported to the executive director of the hospital as necessary. The was a central lead for radiology services for BMI who the service lead had reported to for issues relating to the imaging service and was able to for radiation concerns.
- In May 2019 a CQC preparation visit was held with the imaging lead and the head of diagnostics. This meeting generated a 'deep dive' into the service and a plan for actions to be addressed was made. We reviewed the actions from the follow up visit in June 2019, which showed a number of recommendations/ actions had been addressed, however some areas remained outstanding.
- All of the staff that we spoke with during our inspection were extremely positive about the new leadership in the diagnostics department.
- Staff told us they had felt comfortable to raise any concerns and they had pulled together as a team to keep the service running in the best interests of patients.
- We were told departmental meetings with a formal agenda used to be held regularly, however these had ceased over recent months and these were on the action plan to start again.

- In the months prior to this inspection, the staff said they had felt supported by the acting senior leader within the department. Staff felt that the establishment for the team meant that the service lead did not always have the time to dedicate to management duties. The service lead for diagnostics had been taken off clinical duties to have time to start to address the shortfalls identified in the diagnostics and imaging service. Staff reported that the appointment of the new manager of the service and attendance at the morning 'comm cell' meetings had helped make the service feel more inclusive.

Vision and strategy

- **Staff within the department were aware of the vision and strategy for the hospital. The vision and values for the hospital were displayed at various places around the hospital.**
- The service had a vision for what it wanted to achieve. We were told the vision for the department was 'care, respect, teamwork, being part of a multidisciplinary team and patients always to be number one'. There did not appear to be a strategy specific to the diagnostic imaging department.
- The staff were aware there was a site development plan for the future development of the diagnostic and imaging department. Staff were able to tell us about the plans to update the department which included extending the current service and the purchasing of new equipment. Staff told us there were no clear timescales for when these plans would be addressed.

- Staff within the department were aware of the vision and strategy for the hospital.

Culture

- **Despite challenging times the staff had felt respected, supported and valued. They were focused on the needs of patients receiving care.**

Diagnostic imaging

The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- The senior team told us that there was an open culture where all staff could discuss ideas and concerns. All staff we spoke with were very proud of their service, and all felt that they provided excellent patient care.
- All of the staff that we spoke with during our inspection told us that the leaders were visible and approachable at all times and that they felt they could approach them and be listened to about suggested changes or a concern.
- The service was a small team and a number of staff had worked there for a number of years. Staff felt that they worked well together as a department and with the wider team. They described a culture where they supported each other and could be open and honest.
- All the staff we spoke with were very proud of their service, and all felt that they provided excellent patient care.

Governance

- **The leaders had not operated effective governance processes, throughout the service. The service did not always systematically monitor service quality to improve and safeguard high standards of care.**
- **Staff at all levels were clear about their roles and accountabilities however they had not had regular opportunities to meet, discuss and learn from the performance of the service.**
- The service had not held regular team meetings which included all staff, we were told this was due to the lack of leadership. There was a risk that important information and learning from other meetings was not shared across the team. This also meant that there was no opportunity for peer review and discussion to improve practice or to develop the service.
- We saw the minutes from an imaging department team meeting held in April 2019 which highlighted some clear actions for staff.
- Staff that we spoke with during our inspection were clear about their roles and to whom they should report.
- Following the review of the service in June 2019, we were told that the imaging service was to start having a routine agenda at local governance committee meetings. The lead would provide assurance formally on issues such as departmental updates, the quality assurance programme, audits and actions completed, radiology reports, workforce and staffing issues, risk, incidents and good practice. The new manager was enthusiastic to be able to attend this for managing risks and sharing information going forward.
- We saw that standard operating procedures for specific diagnostic imaging procedures were due for review. The manager had this as a high item to address on their action plan. The standard operating procedures had been recently reviewed for the magnetic resonance imaging department. These are required to reflect updated practice or evidence based care.
- We reviewed the MRI local rules folder which included the safety policy and procedures we noted the control of electromagnetic fields at work regulations risk assessment was due for review, however the others had been updated.
- The service had IR(ME)R procedures available online. Following the report by the radiation protection adviser in February 2019, it was highlighted that IR(ME)R procedures should be reviewed and the new IR(ME)R 2017 procedures should be established. The lead radiographer had updated these policies in line with up to date legislation and had taken advice from the radiation protection adviser. The new manager needed to be assured these were specific to Highfield hospital and to sign these off.
- Radiographers could access scans that had been undertaken at other hospitals; this helped to reduce duplication for patients.
- The radiographers for the service explained that there was no process in place for peer review of images or reporting within the hospital. We were told that the radiologist would flag to the imaging lead if there was a concern with the quality of images and this would be addressed informally. However, there was no formal

quality assurance process for this in place and there was a risk that concerns in relation to quality were not addressed. The new clinical services manager had added this to their action plan.

- Images could be transferred securely to NHS trusts.
- Information governance was part of mandatory training and staff told us they had completed this. Staff told us their training was up to them as individuals and there appeared to be a lack of oversight for the diagnostics and imaging service, however training compliance rates were good. The new manager told us this would be addressed as they settled into their role.
- There was a national radiation protection framework for the organisation which the local radiation protection committee for the hospital fed into. We were told that information from the national and regional committees were distributed to the service lead from the central team.
- Equipment maintenance and the Medical Physics Expert role were provided through service level agreements with external providers. These agreements were up to date and managed by the hospital leadership team.

Managing risks, issues and performance

- **The leaders and teams did not use systems to manage performance effectively. The service identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- The radiation risk assessments had expired in June 2019; all these required updating. In addition all the general risk assessments required updating. We had received information from the senior management team these were a high priority and we saw these were on the action plan.
- The departmental risk register showed the current risks regarding the facilities and infrastructure and governance. We were told plans were in place for a new ultrasound machine, a static CT scanner, mobile X-ray machine and a review of the fluoroscopy rooms. In addition, the imaging department register showed five risks listed on it which included exposure to ionising radiation, ensure all patients are MR safe, incorrectly performing procedure under incorrect patient name, WHO surgical safety checklist and patients for contrast to have kidney function test. Outcomes and updates were not clearly recorded on these risk registers.
- The hospital produced a document for staff that identified its top five risks with an appropriate risk rating. The document was well laid out and helped staff to recognise risks in their own areas of work.
- The radiography lead had completed a comprehensive programme of audit in a short time in response to the audit by the head of diagnostics.
- Staff were aware of the major incident file which was located in the staff office. All staff that we spoke with were aware of the folder and their role if it needed to be actioned. There were no major incidents in the 12 months preceding our inspection.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- The diagnostics/imaging department carried out a bi monthly records audit and the results for February 2019 were 88%. Communication was sent to all staff regarding the importance of good record keeping and the figures for April and June 2019 was 98% and 96% respectively.
- The service practiced in accordance with General Data Protection Regulations and patient confidentiality and staff received training on this annually.
- The service carried out a quality assurance for the Employer's Procedures and for local equipment quality assurance however this process required reviewing at Highfield. The data was submitted into an electronic system which could be accessed by the medical physics expert for monitoring to ensure that

radiation safety was maintained. In addition the service required to improve the handover forms and any necessary actions that may result from an engineer visit.

- Documentation recorded information that could be used to monitor service performance. Examples of this were referral times, reporting times, dose reference levels, last menstrual period date, consent and reporting times.
- The service did not currently record the radiology report turnaround times which was raised in the Care Quality Commission's report 'radiology review' published in July 2018. At the time of our inspection this had been raised to include at the next imaging team meeting and as a regular governance agenda item.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- The department contributes to the hospitals "patient satisfaction dashboard" where feedback and comments from patients, combined with staff suggestions, was utilised to develop and improve the department. One example of this was that the chaperone poster had been translated into Urdu, Bengali and Polish and there was ongoing work to increase patient information leaflets in other languages also.
- Due to the location of the magnetic resonance imaging team and the need to maintain a certain staffing level for safety, the team had found it difficult to attend team meetings or the Comms cell meeting. Staff had plans to introduce a daily huddle, to reintroduce regular team meetings and to take part in discrepancy meetings or peer review to ensure key messages were shared. Staff identified the lack of leadership and their working patterns as a barrier to this. We saw the minutes for the imaging department team meeting from April 2019 which was in anticipation of this inspection and raised these issues.
- As the team was small, the information was shared with regards to staffing, incidents, complaints and risk.
- The hospital sent out a monthly 'closing the loop' newsletter which was sent to all staff across the hospital where information was shared about all departments. We observed the most recent published 'closing the loop' report was on display and accessible to staff in the department. Staff were positive about hospital wide engagement.
- Patient feedback was encouraged, and we saw that the department had feedback forms available in the waiting area for patients to complete. Patient feedback was monitored and reported on a monthly basis. We saw that the patient satisfaction survey May 2019 was broken down into four sections these were, overall impression, were you kept informed of what was happening, were staff caring and friendly and were you treated with dignity and respect. The results demonstrated and overall average satisfaction score of 90%, with the highest score of 91% for overall impression.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. Through lack of consistent leadership the staff did not have a good understanding of quality improvement methods and the skills to use them.**
- The service was not always formally committed to improving services by holding structured sessions for learning from when things went well or wrong and promoting training.
- The service did not hold regular team meetings, discrepancy meetings or peer review meetings. This meant that they were not formally evaluating the quality of the service provided and working to improve it. We were provided examples of when concerns in relation to the quality of imaging had been raised and how the leadership had addressed this to make improvements. However, this was done informally and there was no documented evidence of this.
- There was a culture of learning and improvement in the department and a vision that the new management would improve services in the future.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that all identified and appropriate risks are recorded on a risk register and appropriately monitored and risk assessments in the diagnostic department required updating.
- The service must record the radiology report turnaround times which was raised in the Care Quality Commission's report 'radiology review' published in July 2018.

Action the provider SHOULD take to improve

- The diagnostic imaging service did not hold regular discrepancy meetings or peer review. This meant that they were not formally evaluating the quality of the service provided and working to improve it.
- Staff within diagnostics had not had an annual appraisal.
- The service should ensure that all the disposable curtains in the outpatients department are dated and changed appropriately.
- The service should ensure that the carpeted audiology room in the outpatients department is not used for other clinical work.
- We saw that in the ten records we examined for post-operative patients, that intra-operative (during the operation) temperatures had not been recorded either at all or not fully. This went against National Institute for Care Excellence guidelines for the prevention and management of hypothermia in adults having surgery (CG65). The guidelines recommend that patient temperature should be taken before surgery so that they could be actively warmed to an optimum temperature for surgery and temperatures should be taken every 30 minutes until the end of surgery and temperature maintained to prevent hypothermia. We fed this back to senior managers who agreed to look at the processes in place.
- Surgical patients should have been routinely contacted 48 hours after discharge and asked if their pain was at an acceptable level. In the 10 patient records that we examined there was no indication that a follow-up call had been made to the patient although there was a page in the care pathways to record outcomes of the call.This included a question about post-discharge pain control. Post-discharge and follow-up calls were not being made to all patients within 48 hours of discharge from the hospital.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must have systems and processes in place to assess, monitor, and improve the quality and safety of the services provided in the carrying on the regulated activity. Regulation 17 (1)(2)(a)