

BMI The Alexandra Hospital

Quality Report

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Date of inspection visit: 30 July - 1 August 2019
Date of publication: 27/01/2020

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?

Requires improvement 

Overall summary

The Alexandra Hospital is operated by BMI Healthcare. The hospital was built in 1981 and is currently using 128 of its 172 registered beds for inpatient/day case activity. The hospital has an urgent care centre, seven theatres, an endoscopy unit, a minor procedure unit, dedicated children and young person's ward, a complex range of diagnostic imaging services, a physiotherapy department, on site pharmacy, a five bedded level three/level two critical care ward and three progressive care beds and outpatients.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 30 July to 1 August 2019.

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

Summary of findings

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

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

Services we rate

Our rating of this hospital stayed the same. We rated it as **Good** overall.

- Staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital.
- The hospital 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.
- 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.
- 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.
- The hospital had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- The hospital 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.
- The hospital provided care and treatment based on national guidance and evidence-based practice.
- 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.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- 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.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Leaders ran services well using reliable information systems. Staff understood the vision and values, and how to apply them in their work. Staff felt respected and valued. They were focussed on the needs of patients receiving care. The hospital engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However, we also found the following issues that the service provider needs to improve:

- The children's and young peoples service did not always provide safe care and treatment to those using the service. During inspection, we identified a

Summary of findings

number of concerns that had not been escalated to the senior management team prior to our inspection despite opportunities available to do this. In response to the risks raised on inspection, senior managers voluntarily closed the service to review the provisions and mitigate any risks.

- The staffing provision in children and young people services was not always meeting national guidance to ensure there were enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The senior management team were not aware the service did not meet paediatric staffing standards. On inspection the service was suspended until the ward was staffed with a minimum of two registered paediatric nurses.
- The children and young people services was not always inclusive in taking account of children, young people and their families' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.
- Information received post inspection confirmed the senior leadership team were reviewing the children and young people service leadership structure. They had also reviewed policies and processes to ensure the service was safe.

- In children and young people services governance processes required strengthening to ensure risks and issues were identified and escalated and identified actions taken to reduce their impact.
- Although staff completed patients' fluid and nutrition charts where needed they did not always fully record the total fluids given or recorded what actions they had taken.
- Information was not always easily accessible to patients and their relatives in formats that met their individual needs.
- In medicine not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care under the Mental Capacity Act 2005
- Not all medical staff complied with the 'bare below the elbows' policy.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected services for children and young people. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals North

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Good 	<p>The Private Walk in Centre in centre is located on the ground floor of the hospital and adjacent to the reception area, separate access is available for patients using this service. The centre is open seven days a week, Monday to Friday 8am-8pm and Saturday and Sunday 8am-6pm. This is a private walk-in service providing care for a range of minor illness and injuries. Patients, who attend with major injuries or complicated illness, are medically reviewed and stabilized before being transferred by ambulance to the local accident and emergency (A&E) department. The team can see patients over the age of three. The team offer private onward referral to specialist BMI consultants for further investigation. This is a fee-paying service.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well led.</p>
Medical care (including older people's care)	Good 	<p>Medical care services were a small proportion of hospital activity. The main service was surgical services. Where arrangements were the same, we have reported findings in the surgery service section.</p> <p>Medical service included delivering chemotherapy, TAVI (transcatheter aortic valve replacement) and endoscopic procedures to insured, NHS funded and self-paying patients.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well led.</p>
Surgery	Good 	<p>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.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well-led.</p>
Critical care	Good 	<p>The critical care service supported the hospital's main surgical services; it accepted both planned and unplanned admissions.</p> <p>We rated the critical care service as good overall.</p>

Summary of findings

Services for children & young people

Requires improvement



Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as inadequate in well led and requires improvement in safe and responsive. The service was rated good in effective and caring.

Outpatients

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 this service as good because it was safe, caring, responsive and well led. We inspected but did not rate effective.

Diagnostic imaging

Good



Diagnostic imaging services were available to consultants with practising privileges who were authorised as referrers. We rated the service as good overall. We rated safe, caring, responsive and well led as good. We inspected but did not rate effective.

Summary of findings

Contents

Summary of this inspection	Page
Background to BMI The Alexandra Hospital	8
Our inspection team	8
Information about BMI The Alexandra Hospital	8
The five questions we ask about services and what we found	10
<hr/>	
Detailed findings from this inspection	
Overview of ratings	14
Detailed findings by main service	15
Outstanding practice	114
Areas for improvement	114
Action we have told the provider to take	116
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Good 

BMI The Alexandra Hospital

Services we looked at

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

Summary of this inspection

Background to BMI The Alexandra Hospital

The Alexandra Hospital is operated by BMI Healthcare. The hospital opened in 1981. It is a private hospital near Stockport. The hospital primarily serves the communities of Greater Manchester and Cheshire. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 27 November 2018. The hospital is registered to provide the following regulated activities, diagnostic and screening procedures, surgical procedures, treatment of disease, disorder or injury.

The hospital was last inspected in July 2016.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, seven other CQC inspectors including a pharmacy specialist, and specialist advisors with

expertise in critical care, surgery, diagnostic imaging, children and young people, medical care and governance. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about BMI The Alexandra Hospital

During the inspection, we visited wards and units. We spoke with 81 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 47 patients and one relative. During our inspection, we reviewed 59 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 four times, and the most recent inspection took place in July 2016.

Activity (March 2018 to February 2019)

In the reporting period March 2018 to February 2019 there were 16,827 inpatient and day case episodes of care recorded at the hospital; of these 33% were NHS-funded and 67% other funded.

There were 40,624 outpatient first attendances and 65,278 follow up attendances in the reporting period; of these 81% were other funded and 19% were NHS-funded.

660 medical staff worked at the hospital under practising privileges. There were six regular resident medical officers (RMOs). Ward RMOs did a 12 hour shift for seven days and then had a full week off. Cardiothoracic RMOs worked on ad-hoc basis only. They did 12 or 24 hour shifts only. The

employed RMO in the urgent care centre completed 37.5 hours per week. The hospital employed 134.7 registered nurses, 100.3 operating department practitioners and care assistants and 189 other staff as well as having its own bank staff.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- one Never event
- Clinical incidents 741 no harm, 389 low harm, 22 moderate harm, 1 severe harm, 3 deaths
- 12 serious injuries
- 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
- 198 complaints

Services accredited by a national body:

Summary of this inspection

Macmillan Quality Environment Mark - Accreditation for oncology services

BUPA accreditation for breast surgery

Resuscitation Council Accreditation for intermediate life support & paediatric intermediate life support

Services provided at the hospital under service level agreement:

Radiation and Laser Protection Support and Advice

Catering

Dietetic Services

RMO provision

Perfusion Services

Clinical and or non-clinical waste removal

Interpreting services

Maintenance of medical equipment

Pathology and histology

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?

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff assessed risks to patients, acted on them and kept good care records.
- They managed medicines well.
- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

However, we also found the following issues that the service provider needs to improve:

- The critical care service did not meet the core standard requirement of twice daily consultant intensivist led ward rounds on the ward.
- Not all medical staff observed the bare below the elbow's guidance.
- The patient records did not consistently include details of the consultant's pre-operative notes.
- Staff in the children and young people service were unable to articulate the specific risk issues about sepsis and the protocols in place.
- The staffing provision in children and young people services was not always meeting national guidance to ensure there were enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This was raised on inspection and senior managers immediately suspended the service so that they could review staffing provisions. The action plan provided by senior managers after

Good



Summary of this inspection

their review showed, staffing would be reviewed on a two weekly basis so that it could always be aligned to admissions to the children's ward and to ensure the ward would be staffed with a minimum of two registered paediatric nurses.

Are services effective?

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

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- 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 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.

However, we also found the following issues that the service provider needs to improve

- In surgery staff did not always use pain scores to assess patients' pain levels. Staff told us they did not have access to alternative tools to assess pain for non-verbal patients.
- Surgery did not routinely submit data to external organisations in a timely way.
- Patient records did not always contain enough information to establish whether informed consent had been obtained.
- In medicine although staff completed patients' fluid and nutrition charts where needed they did not always fully record the total of fluids given or recorded what actions they had taken.
- In medicine there were no arrangements to monitor outcomes of people's care and treatment as it was not routinely collected and monitored, which meant that we were unable to say if the intended outcomes for people were being achieved.
- Not all staff in medicine understood how and when to assess whether a patient had the capacity to make decisions about their care under the Mental Capacity Act 2005.

Good



Summary of this inspection

Are services caring?

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

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

Good



Are services responsive?

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

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- People could access the service when they needed it and did not have to wait too long for treatment.
- 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 most staff.

However, we also found the following issues that the service provider needs to improve

- The children and young people services was not always inclusive in taking account of children, young people and their families' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.
- Information was not always easily accessible to patients and their relatives in formats that meet their individual needs.

Good



Are services well-led?

Our rating of well-led went down. We rated it as **Requires improvement** because:

- Leaders in the children and young people services did not have the necessary experience and knowledge to lead effectively. They did not always understand and manage priorities and issues the service faced.
- Managers were not aware of the concerns we raised in children and young people services until they were raised at the inspection which led to the suspension of the service until

Requires improvement



Summary of this inspection

further action was taken. For example, leaders in this service did not understand the challenges to quality and sustainability or escalated risks to the senior management team and therefore these were not acted upon appropriately.

- There was a lack of leadership and understanding of risks and governance in children and young people services. Governance and management of performance of risk needed strengthening to ensure staff identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The surgical service was 'below the expected standard' for submitting data to the National Joint Registry. It did not always meet the Patient Reported Outcome Measures target for submitting data.

However, we also found the following:

- The hospital had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress. Wards and departments their own departmental vision.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. All staff we spoke with told us that there had been a positive change in culture at the hospital over the last 12 months.
- Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There were close working relationships with medical directors of neighbouring trusts to share any concerns about a doctor's practice.
- Staff were committed to continually learning and improving services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Urgent and emergency services

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

Are urgent and emergency services safe?

Good 

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Mandatory training for staff was a mixture of online e-learning and face to face sessions.

Information we received pre-inspection showed staff in the private walk-in centre had completed 93% of their mandatory training up to 30 July 2019. Six percent of incomplete training was in progress and one percent needed completion. We were told this training shortfall was due to one new member of staff who would soon complete all their training. Staff told us they were given protected time to complete their mandatory training.

All private walk-in centre nurses had been assessed as competent to treat children and a paediatric nurse was always available within the hospital during private walk-in centre opening hours should there be a need for additional support.

Training was monitored on-line and each staff member had a password protected training account. This meant the staff could be alerted when a module was due to be completed. Managers had access to this and would maintain an oversight of all training completed.

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.

One agency resident medical officer (RMO) we spoke with lacked some knowledge of local procedures.

The hospital had up-to-date safeguarding policies and procedures for both children and adults. Staff knew the safeguarding leads in their areas and how to contact them.

Staff we spoke to understood how to raise a safeguarding. They told us for adults they would complete a capacity assessment and contact the GP if there were any safeguarding concerns. The regular agency RMO we spoke with during the inspection was unaware who the safeguarding leads were within the hospital.

Safeguarding training was mandatory for all staff and all registered nurses were required to complete level three as a minimum, this was in line with national guidance and all staff were up to date with their training. Staff we spoke with were aware of types of safeguarding issues they may encounter including female genital mutilation (FGM) and domestic violence.

Staff had undertaken training courses to better understand the religious and cultural needs of patients, including “equality and diversity.”

There was no access to the local authority children’s risk register. Staff told us they would contact the child’s school and GP if there were concerns.

Urgent and emergency services

The hospital had a chaperone policy, which was visible in all patient care areas and the presence of a chaperone was documented in patients notes.

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.

One of the health care assistants (HCA) we spoke to told us that the private walk-in centre was cleaned daily. On our arrival we saw one HCA cleaning work surfaces and telephones. Everywhere we examined was visibly clean. We saw checklists had been completed to indicate areas that had been cleaned.

Hand hygiene audits were completed. Hand hygiene compliance was 100%.

There were hand washing facilities in each of the private walk-in in centre rooms and hand gel in all patient areas. Personal protective equipment (PPE) including gloves and aprons was available for staff in all clinical areas and we saw that staff used this appropriately.

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 private walk-in centre had a dedicated entrance not far from the main reception; the waiting area had a reception desk which was staffed during the time we were present.

The space in the reception was limited; the waiting area was small with a small table for children books, all patients sat together; this included children. There were two consulting rooms and one treatment room.

There was an adult resuscitation and paediatric trolley in the walk-in centre this was checked daily with no equipment noted as missing. All emergency medicines we examined were within their "use by" date and there was a system in place for ensuring this. We checked some of the equipment available for use in the treatment room, most had been checked within appropriate timescales, however two pieces of equipment had not been

calibrated in line with manufacturer's guidelines, a sphygmomanometer, (also known as a blood pressure meter) and a thermometer. Both these pieces of equipment had been due for re-calibration in April 2019.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration and had been trained in recognising various symptoms of conditions including for sepsis.

Reception staff told us they had completed training in identifying the deteriorating patient but would immediately ask the nurse in charge or RMO for advice if they were concerned.

In the walk-in centre the target was for patients to be seen within 15 minutes of arrival and we saw evidence of audits that showed that this was met in most cases.

There was an exclusion policy clearly displayed in the reception area and on the service website. This policy listed certain conditions and cases that the walk-in centre would not treat.

Nursing staff told us there was a formal triage system and nurses were trained to perform this function. If necessary, at busy times, the nurse would do a walk round of the waiting room to identify any deteriorating or acutely unwell patients. Staff used an assessment and management tool to help formalise information gathering and risk.

Should any patients present with life threatening illness/injury the nurses were trained to a level where they are able to identify this, and the resuscitation policy would then be followed.

The walk-in centre had exclusion criteria for patients who were not appropriate to be seen in the department. It included those with acute major illnesses, very complex medical problems and children under the age of three. These criteria ensured patients were seen safely by staff.

If a patient became acutely unwell during their time in the walk-in centre an ambulance would be called. Staff

Urgent and emergency services

would stabilise the patient and then they would be transported to the nearby accident and emergency. Staff told us they had good relationships with the local hospitals.

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, there was no need for agency or bank staff as other staff within the hospital had the skills and experience to cover as necessary.

Nursing staff in the walk-in centre staff rotated within the hospital to maintain their skill levels in different areas. Staff working in the walk-in centre had received annual competency checks from the senior paediatric nurse.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

There were two RMOs covering the walk-in centre with one on duty at any time. One was employed by the hospital and the other who was on duty the day of the inspection was employed via an agency. We were told and this RMO confirmed that this was their regular place of work and they had been undertaking the role for some time. When we spoke to the agency RMO during the inspection they told us they enjoyed the role and generally found the hospital supportive, however they said they had little feedback from the clinical teams at the hospital. They were not invited to clinical meetings and therefore didn't have sight of any learnings or updates on areas like significant events and complaints. We spoke with the Associate Director of Clinical Services about the issue and we were told the matter would be addressed.

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.

During inspection we looked at three sets of walk-in centre patient's records. Each included observation, pain assessments, nurse assessment and past medical history. These had times, dates and legible signatures documented. They contained a complete patient history and the care that the patient had received.

We saw that paper records were kept securely for 12 months in case a patient re-attended in this time and the clinical staff could review their past attendances. These were moved to the medical records secure room once 12 months had passed.

Medicines

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

Prescription pads were kept securely within a safe in the walk-in centre. All prescriptions were monitored and audited to ensure safety.

The walk-in centre kept some pre-packed medications for patients to take home if required. The stock levels were recorded on a spread sheet and when the levels were low staff would order more stock. This meant the team knew which member was responsible for ordering and ensuring the medications arrived. There was a hospital pharmacy where patients could collect any prescribed medicines.

Emergency drugs were checked daily and fridges were locked, and temperatures checked.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with teams 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 noted that the management team had not included the long-term agency RMO in their information dissemination, we were told this would be addressed.

Urgent and emergency services

Safety Thermometer (or equivalent)

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

Are urgent and emergency services effective?

(for example, treatment is effective)

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Clinical staff we spoke to were aware of relevant clinical guidelines in their areas including the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM).

Standard operating procedures we viewed were referenced with evidence of best practice and national guidelines.

Guidelines were easily accessible on the hospital intranet or as a hard copy although staff were aware this may not be the most up to date version. We saw that policies and procedures referenced NICE and RCEM.

There was evidence of a range of local clinical audits including infection control and waiting times.

Nutrition and hydration

Fresh water was available for patients during their time at the walk-in centre.

Pain relief

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

Assessment and management tools were used to monitor all patients.

Appropriate pain relief was offered for patients attending the walk-in centre including paracetamol and ibuprofen.

Patients were advised to contact their GP if they required further pain relief on leaving the department.

Patient outcomes

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

Patients could be referred to specialist consultants at the hospital for further investigations if required and could be admitted from the walk-in centre. In the month of June 2019 prior to inspection, 271 patients were seen in the walk-in centre. Nine patients were admitted to the main hospital, 70 were referred to a consultant and 17 re-directed (due to inappropriate attendances or acute illness).

The hospital provided on-site imaging, plastering of simple breaks/fractures, pathology testing, pharmacy and physiotherapy to support patients.

The hospital carried out audits of waiting times in the walk-in centre. Audits we reviewed evidenced that the 15-minute target was almost always met.

Competent staff

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

There was always a paediatric nurse available in the hospital during walk-in centre opening hours and all walk-in centre nurses had been assessed as competent to treat children.

The nurses we spoke to had completed re-validation and had competencies assessed by senior clinicians to ensure they were skilled and competent to perform their role. Nursing staff we spoke to felt well supported in preparing for revalidation.

Medical revalidation for RMOs was managed by themselves through the hospital or through the agency with which they were employed.

Urgent and emergency services

Appraisal rates were recorded for the walk-in centre and all staff had received an appraisal within the last 12 months.

Staff we spoke to said their appraisal had allowed them to ask for further courses and discuss their progressions within the department, their welfare and how they contributed to the hospital and departmental visions. We saw some completed appraisals, which showed learning and improvements.

Staff we spoke to had the opportunity to attend courses such as intermediate life support (ILS) and advanced life support (ALS) to improve their ability to care for all patients including children safely.

All newly appointed permanent staff had an induction programme.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The walk-in centre worked closely with patients and their GPs to ensure all follow up and concerns were communicated appropriately. This meant care for these patients was safe and continuous.

Seven-day services

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

The walk-in centre was open from Monday to Friday 8am – 8pm and Saturday and Sunday 8am – 6pm.

The pharmacy department could keep the department open out of hours to provide support to patients and staff. There was a 24 hour on-call service.

Health promotion

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment.

Patients who lacked capacity to make their own decisions were excluded from treatment at the walk-in centre.

Staff we spoke to had mostly sound knowledge about the Mental Capacity Act 2005 and the deprivation of liberty safeguards and had completed training on the subjects. Staff were clear about gaining and recording consent. However, the nurse on duty lacked knowledge about the judicial ruling regarding Gillick competencies and Fraser guidelines.

Are urgent and emergency 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.

Patient feedback was generally positive across the areas we inspected, patient feedback was not specifically published regarding the walk-in centre and was more generally relating private walk in Centre to the hospital.

We observed receptionists being kind and courteous to patients. We observed nursing staff were empathetic and supportive to patients.

During our inspection we noted staff were able to use the consulting room to gather personal information from patients if there was more than one patient present in the reception area.

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 staff giving emotional support to patients and their families. They were encouraged and supported through treatment by ensuring both patients and relatives were given up to date information.

Urgent and emergency services

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.

Fees were visible throughout the department and discussed during consultation, so patients knew how much their consultations were likely to cost.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Good 

Our rating of responsive improved. 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.

The walk-in centre catered for minor illness and injury seven days a week. It was open from Monday to Friday 8am to 8pm and Saturdays and Sundays 8am to 6pm.

Meeting people's individual needs

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

Translation services were provided through a telephone language line service. Staff told us they would use this if necessary, but it was rarely required.

There was a hearing loop in place for those with hearing difficulties.

The chaperone policy was visible in all waiting and treatment rooms.

There were parking spaces for those with mobility issues and for patients in a wheelchair. Patients using a wheelchair who attended the walk-in centre could be seen in all areas as there was easy level access.

Dementia friendly toilets had recently been installed, where toilet seats were coloured to be more user friendly. Staff had received equality and diversity training.

Patient leaflets were readily available throughout the walk-in centre.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Patients attending the walk-in centre would book in at the reception desk. HCAs took the patients' details and their reason for attending before they were seen by the on-duty nurse for triage.

We saw completed audits on patient waiting times in the department. They showed almost all patients were seen within the 15-minute target.

The hospital had recruited Health Care Assistants within the walk-in centre, they were trained in the booking systems and were able to book patients directly into the department, removing the additional step of booking in at reception. This also supported waiting room patients as they were able to constantly observe, take initial observations, provide basic first aid where indicated and support patients whilst in the waiting area.

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.

Information on how to complain was visible in the waiting areas. Staff understood what to do if a patient wanted to make a complaint.

We saw there was a complaint procedure which provided patients with clear information on how and when their complaint would be dealt with.

There had been no complaints about the walk-in centre in the previous 12 months.

Staff told us complaints were dealt with by senior managers. There was a paper form to complete for all complaints including informal complaints.

Urgent and emergency services

If the complaint could not be resolved informally a full investigation would take place.

Hospital management had identified a complaint theme regarding communication of finance. A price chart was now displayed at the walk-in centre reception desk and additional copies were available at a patient's request. Staff were involved in engagement sessions with the self-pay team to strengthen confidence and understanding of pricing structures. As a result of this intervention management had noted a decrease in finance related complaints.

Are urgent and emergency services well-led?

Good 

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

Leadership

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

Staff we spoke to told us they felt valued and appreciated as team members. Managers were visible during our visit and staff felt able to discuss issues and concerns openly. One staff member told us they would be comfortable speaking face to face with the Executive Director and had done on several occasions when they wished to discuss an issue.

Staff told us there had been a significant change in culture when the new leadership team had been introduced. Staff were able to tell us who their managers were and who the senior hospital managers were. They told us they were more supportive and felt there was a culture of openness.

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. Leaders and staff understood and knew how to apply them and monitor progress.**

We saw that the hospital and departmental vision was on display in the reception and waiting area. Staff told us that they had been instrumental in producing the departmental vision, which was "We welcome patients and give them access to a 1st class network of highly trained consultants. We strive to deliver a comprehensive quick triage service to identify the needs of the patient with our urgent care doctors having access to diagnostic imaging and blood tests to support quick diagnosis and treatment. Our goal is to provide the highest standard of patient care in a caring safe and calm environment.

Staff discussed changes for the walk-in centre, they told us that there were plans to provide a service of travel vaccinations.

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.

Governance

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

The walk-in centre had a daily morning meeting which staff and managers attended. They discussed current issues such as incidents, training and any new procedures. These were un-minuted meetings and were a way of keeping staff up to date and giving an opportunity for any feedback or concerns. Staff told us this was useful as they could always be kept up to date with issues.

There were monthly governance meetings within the hospital. These were attended by the walk-in centre

Urgent and emergency services

manager and the executive team including the Director of Clinical Services. We saw recent meeting minutes, which included discussion of all incidents across the month, complaints and new clinical developments. They were well attended by senior staff.

Feedback from the governance meetings for walk-in centre staff was provided by the manager in their daily meetings. Anything significant was also communicated via email.

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 saw a hospital wide risk register which documented operational, leadership, clinical and governance risks including staff training and equipment maintenance. Staff we spoke to told us the risks within their area and about the use of the risk management system to record incidents, complaints and risks.

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.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We were told that management regularly discussed patient feedback. We saw examples of changes made because of these meetings, one related to waiting times for patients to have X rays taken. The team had identified that walk-in patients were not prioritised, which meant these patients had a potential wait to be offered a slot in between planned work. To improve this process and ensure that walk-in centre patients received a prompt diagnosis, the radiology department now ensured they always had X-ray availability and prioritised walk in patients.

Patient feedback indicated that there was frustration at having to wait at the main reception and book in there before moving into the walk-in centre where there was further booking in process. The hospital had created a separate entrance for the walk-in centre, so patients could access the facility without ever visiting the main hospital reception.

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.

We saw minutes of meetings where quality and continuous improvement were discussed.

Staff told us there had been positive changes since the last inspection and since the introduction of the new management team. We were told by the ward manager that the introduction of a sluice room was imminent, and we were shown where the room would be located.

We were informed by the management team that the walk-in centre were runners up for a “The Laing Buisson Awards 2018”, an award that recognises and celebrates industry excellence and innovative services.

Medical care (including older people's care)

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

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

Good 

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

Mandatory training

The service provided mandatory training in key skills to all staff within the different speciality areas and made sure everyone completed it. Mandatory training was comprehensive and met the needs of patients and staff.

All staff received and kept up-to-date with their mandatory training. Staff reported that they were given time and support to undertake mandatory training. They also reported that if they identified other learning opportunities relevant to their role the service supported them to do these. This could include learning in a different area as part of career progression opportunities. Mandatory training rates for the service were an average of 97%. Overall the service was meeting the hospital target of 95%. Oncology was the highest at just over 99%, Catheterisation Lab was just over 97%, endoscopy was just under 96% and York ward was just over 94%.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff spoken with told us they had recently had training which they found to be of value.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers

reported that bank staff needed additional support to meet mandatory training. They had informed any bank staff they needed to update their mandatory training before undertaking any further work in the service.

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 received training specific for their role on how to recognise and report abuse. All incidents of suspected or potential abuse were logged in the services electronic monitoring system and were reviewed by managers to ensure appropriate action was taken. Safeguarding training was 93%.

Staff spoken with gave examples of how to protect patients from abuse, harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a flow chart available to assist staff displayed in clinical areas and available on the services website.

Staff followed safe procedures for children visiting and had received appropriate training specific to safeguarding children to level 2.

The hospital had a lead for adult safeguarding trained to level 3 in adult safeguarding and access to a member of staff trained to level 4. In addition, within the medical service, a senior member of staff told us that part of their responsibility was for safeguarding although they had not yet received the appropriate training for potential

Medical care (including older people's care)

investigations. The training had been arranged for later in the year. However, there was supporting policies and collaborative working with other safeguarding leads and external bodies that supported them until they commenced the training.

Cleanliness, infection control and hygiene

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

All areas we observed were clean and had suitable furnishings which were clean and well-maintained. We saw clean stickers on equipment and curtains. There was a rolling programme to replace all curtains every six months at a maximum.

The examination room used to visualise blood flow in the cath lab was visually clean. Staff adhered to a strict cleaning schedule, this was completed to demonstrate when each piece of equipment was appropriately cleaned.

For endoscopy the service had limited space as such all endoscopy scope equipment was sent of site for sterilisation.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Hand gel and sanitisers were readily available on entry to clinical areas and on entering the ward. Signage above sinks displayed the correct way for staff, patients and supporters to wash their hands.

Staff on the Richmond ward were aware of the hospital's cytotoxic spillage policy. Cytotoxic medicines are toxic drugs used to destroy cancer cells and need to be managed carefully to protect others. Staff we spoke with were aware of the service's policy. In discussion they were clear about what actions they would take if a cytotoxic drug split and where spillage kits were stored.

There were suitable safe arrangements for the handling, storage and disposal of clinical waste, including sharps boxes in all rooms. Clinical waste including chemotherapy waste and sharp objects were disposed of safely.

We saw three consultants and one employee during the inspection attended the clinical areas and wards including visiting patients without adhering to, "bare below the elbows" service policy. This policy in line with best practice

guidance ensures that any staff members do not wear long sleeves to reduce the potential spread of infection. The consultants were not consistently challenged by staff in order that they adhered to the policy.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. York ward was used for medical patients. Staff and managers told us that the ward layout did not meet patient's living with dementia needs. Staff had recently undergone training in dementia support and recognised that there was a need to adapt York ward to assist patients living with dementia or a learning disability. The service had recently requested assistance from an external source to assist with adaptations to the environment. An action plan had been developed and incorporated in the plans to refurbish the ward to meet these needs.

There was no lounge or quiet area that patients could spend time with visitors or where sensitive news could be delivered in a comfortable environment on the ward. There was a relatives' room located next to the progressive care ward. This was suitably decorated and furnished, had toilet facilities, a television and telephone that could be used. However, as detailed by staff, this was not always available and may not be of assistance for some patients.

In the catheterisation lab and endoscopy, staff carried out daily safety checks of specialist equipment. The endoscopy ward was not Joint Advisory Group accredited (JAG). However, endoscopy had separate rooms for dirty equipment and water checks were done by an external company. The service had ongoing plans to achieve accreditation with Joint Advisory Group but recognised that this would not be possible in the space they currently utilised for endoscopy. JAG accreditation is a formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against set criteria. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector.

Medical care (including older people's care)

Resuscitation equipment for use in an emergency was stored securely in a designated trolley. Records showed that checks were in place to make sure that the equipment was safe and ready.

Electrical equipment had been portable appliance tested (PAT) in line with health and safety legislation and the services policy.

All areas we looked at had the appropriate equipment, such as intravenous pumps and subcutaneous syringe drivers to meet patients' needs.

Assessing and responding to patient risk

Staff completed recognised risk assessments tools for each patient on admission or arrival for treatment and updated these as necessary.

Staff identified and quickly acted upon patients at risk of deterioration. A nationally recognised tool was used to identify deteriorating patients known as NEWS2 (National Early Warning Score) and staff escalated concerns appropriately. Of the records we reviewed, NEWS2 scores had been completed and calculated correctly. Records reflected that concerns had been appropriately escalated to the resident medical officer (RMO) who had attended to review the patients.

Staff knew about and dealt with any specific risks. A sepsis screening tool was available, and this was used in conjunction with a sepsis six care bundle when needed. Severe sepsis is a time-critical condition. The sepsis six is an initial resuscitation bundle designed to offer basic intervention within the first hour. We saw a record where staff had appropriately actioned a potential sepsis risk and escalated this correctly.

Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Managers made sure all bank and agency staff had a full induction and understood the service.

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. Staff were planned up to 4 weeks in advance to make sure there was enough staff on duty. For endoscopy and catheterisation lab patients could be booked in advance so staff planning could be managed around the patients booked in. For York ward there was unplanned patients that may have come from the urgent care centre and planned patients from other hospitals. York ward did not receive more than 48 hours' notice for patients that could be moved to the ward. For oncology patients the service managed over 200 patients', and these were booked in for the course of their treatment.

Staff spoken with said that there was enough staff available and if they need more staff they discussed this with managers and appropriate steps were taken.

The service had enough nursing staff of relevant grades to keep patients safe. The wards displayed required staffing versus actual staffing levels at the entrance so that patients and colleagues could see. At the time of the inspection all wards we visited met their establishment.

Managers could adjust staffing levels daily according to the needs of patients. We saw records where adjustments had been made to meet patients' needs.

Medical staffing

The service had enough medical staff to keep patients safe. Resident medical officers (RMO's) provided daily medical services and dealt with routine and emergency situations with the support from the named consultant.

All the patients were admitted under the care of a named consultant. Patients were reviewed by their consultant to make sure that the treatment in place met their needs. All consultants had been granted practising privileges by the hospital. Checks were carried out by the Medical Advisory Committee (MAC) before granting the consultants practising privileges.

Managers could access locums when they needed additional medical staff. Locums spoke with and records reflected that locums had an induction to the service

Medical care (including older people's care)

before they started work. We saw that the service made sure that appropriate medical support was available if medics left the organisation or where on leave. The service utilised locums who were familiar with the service.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Doctors were available for advice whilst on site and during out of hours were contactable via telephone. Consultants provided support either by telephone advice or attended in person out of hours.

All nursing staff we spoke with told us they were well supported by medical staff.

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.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team copies of their records were made available, to make sure there were no delays in staff accessing their records

Records on York Ward were not always stored securely. The cupboard used for storing records was not locked and we saw that staff were not consistently in the area to maintain the security of the documents.

All records except for oncology where paper based. The oncology service had an electronic record system that staff told us fully meet their needs. However, staff showed us that they were also expected to keep paper records as such they were making the same record both electronically and in paper records. Staff said as a busy ward repeating the same information into two different record formats was not convenient.

Medicines

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

Medicines records reviewed showed staff followed systems and processes when safely prescribing, administering, recording. Medicines were securely stored with room and fridge temperatures monitored.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. This included information when patients were discharged.

Staff stored and managed medicines and documents in line with the provider's policy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw that there was incident related to medicines.

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.

Records we reviewed confirmed that staff had received training and were confident with using the incident reporting system. Staff knew what incidents to report and how to report them. Incidents were recorded on the services electronic system and monitored by managers.

Incidents in the last 12 months were: for oncology 12, York Ward 47 with the largest group of incidents related to skin integrity, catheterisation Lab 12 largest group related to communication and endoscopy 35 for endoscopy the largest group related to communication. A notice board was available in each area for staff and managers to monitor incidents and any learning.

Documentation we reviewed confirmed that all incidents were rated as low or no harm and appropriate action had been taken at the time to prevent similar incidents happening again. None of the incidents reported, highlighted any concerns regarding overall patient safety.

No never events were reported by the service in the previous 12 months, Never Events are serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Medical care (including older people's care)

Staff spoken with understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

Managers debriefed and supported staff after any incident. Staff received feedback from investigation of incidents, both internal and external to the service.

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.

York Ward had an information board at the entrance displaying various information. This information included safety information such as the number of falls, pressure ulcers, staffing levels and any incidents.

Other areas such as oncology, Catheterisation lab and endoscopy kept information regarding safety and reviewed this as part of their safety monitoring measures.

Staff used the safety thermometer data and safety monitoring to further improve services.

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

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance and utilised this in the service to provide care and treatment that met patients' needs.

Policies and guidelines were developed in line with both National Institute for Health and Care Excellence (NICE) and Royal colleges. Policies, guidelines and protocols were available for staff to access on the services intranet.

Staff used a combination of guidelines based on nationally recognised best practice as a basis to determine the treatment they provided. Clinical pathways had been developed to guide practice in medical and chemotherapy services.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Patients spoken with told us that the food was of good quality and they had a good choice of what they wished to eat.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food.

We noted that a selection of hot and cold food was provided on the wards at meal times. Staff assisted patients who needed support with eating and drinking as needed.

Although staff made entries on patients' fluid and nutrition charts they did not consistently record the total of fluids given to the patients or tally the amount of fluid a patient received each day to monitor accurately the patient's fluid intake.

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.

Both medical and nursing staff actively sought advice from the pharmacy team if they needed support to manage a patient's pain.

Medical care (including older people's care)

Following endoscopic procedures, pain scores were recorded along with clinical observations. If patients had pain control issues, nursing staff escalated their concerns to medical staff, who reassessed the patient's medicine prescription as needed.

The ward sent discharge letters to the patient's GP, documenting medications given to patients on discharge. This was done to ensure that the GP was kept informed of the patient's care and treatment.

Patient outcomes

Staff undertook some monitoring of the effectiveness of care and treatment.

Managers and staff told us that they had some participation in relevant local and national audits, benchmarking, accreditation, peer review, research and trials. There was some comparison between other BMI services, but as many of the services provided by the service were not available in other BMI services there was limited opportunities for managers benchmark the services performance. The service did not have JAG accreditation for endoscopy, but did participate in the national endoscopy steering group an submitted and submitted data to the national endoscopy database. The oncology unit submitted data as part of the quality award from Macmillan Quality Environment Mark. The Macmillan Quality Environment Mark (MQEM) is a quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. The cardiac catheter lab submit data to the National PCI validation report and Dendrite where required. Patient-Led Assessments of the Care Environment were undertaken for BMI as an entire service and did not provide individual data per ward.

There were no arrangements to monitor outcomes of people's care and treatment as it was not routinely collected and monitored, which meant that we were unable to say if the intended outcomes for people were being achieved.

Competent staff

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff worked in areas that met their specific

competencies. 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 service encouraged staff to develop and undertake different training opportunities. Staff told us that they actively discussed with their line managers career development and progression opportunities.

All staff received a hospital induction when commencing employment, which included basic life support, health and safety and fire training. Staff were familiar with the BMI corporate and hospital induction programme.

Competency assessments were included as part of the induction system within the hospital. Staff were assessed for competency for specific parts of their job role such as medicines management and the use of equipment.

Managers supported staff to develop through yearly, constructive appraisals of their work. Records showed that staff received an appraisal on a yearly basis. All staff spoken with said that they received an appraisal from their line manager. The appraisal rates for all areas was 100%.

Consultants competency was determined through the Medical Advisory Committee (MAC).

The services resident medical officers were employed via an external agency, prior to commencing work at the hospital. Renewal of the mandatory training and competency was organised by the external agency, who updated the hospital with the required information.

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. The oncology service had recently commenced auditing multi-disciplinary working and had undertaken actions to make sure that the outcomes of the meetings and audits were followed to meet patients' needs. The service had a dedicated co-ordinator for multidisciplinary review of patients care that were co-ordinated within the NHS

Patients had their care pathways reviewed in accordance with the services policy, by the relevant consultants.

Medical care (including older people's care)

Staff worked across health care disciplines and with other agencies when required to care for patients. For patients on York ward whose condition deteriorated and meant that they may need palliative care and support the service had a service level agreement with a local NHS Trust. Representatives with expertise in palliative care attended the hospital weekly and were available for support to meet patients' needs. There was also a link with a local cancer care centre for oncology patients which patients could access to receive additional support as needed.

Seven-day services

For our detailed findings please see the effective section in the surgery report.

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

Medical staff had access to out of hour's services for radiology, pharmacy, and non-clinical support via an on-call system. Staff within oncology were on call to support patients. The oncology for chemotherapy services ran during the week Monday to Friday. Endoscopy services were available Monday to Saturday with occasional Sundays dependent on patient's needs.

Patients were reviewed by consultants depending on the care pathway.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on every ward.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle,

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

Records reviewed showed discussions with patients and verbal consent was documented.

Staff recorded confirmation that the patients was given appropriate information regarding the charges and treatment before they underwent the treatment they had been offered.

Records we reviewed confirmed that written consent was obtained prior to treatment and any charges were explained to them.

During the inspection no patients were subject to a deprivation of liberty application, but staff were able to discuss with us their responsibilities in relation to the Deprivation of Liberty Safeguards (DoLS) if needed

Staff we spoke to understood the relevant consent and decision-making requirements of legislation and guidance. However not all staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care under the Mental Capacity Act 2005. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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

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

Compassionate care

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

We observed good rapport and interactions between patients and all staff. Patients were complimentary about the care and support that they received directly from the staff.

Patients we spoke with told us that they had received care that met their needs and were supported with genuine kindness and consideration for them as individuals.

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.

Medical care (including older people's care)

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff demonstrated in discussion an awareness of how to meet patients' individual needs.

Endoscopy staff described ways in which they reassured patients who were anxious about the procedure and gave them support during the procedure.

Staff followed policy to keep patient care and treatment confidential.

Emotional support

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

The service had links with a cancer care centre that provided counselling services for oncology patients undertaking chemotherapy as needed. The oncology service had run an open day in conjunction with the cancer care centre this had provided additional support to patients such as aromatherapy, wig exhibition and access information to other services relevant to the patients.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking sensitive news and demonstrated empathy when having difficult conversations. They were supported in this aspect of patient care by a local NHS service with specialist staff available for palliative and end of life care. We spoke with representatives from the external service who were highly complementary regarding the commitment from the service and the staff in providing support to meet patients and their family's emotional needs.

All patients we spoke with said they were able to telephone the ward for further help and advice about any concerns or questions they had.

Visiting times were not restricted, family and friends were encouraged to visit their relative regularly for emotional support.

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. Although the service did not provide palliative and end of life care as a

speciality, they did make sure that when patients received difficult diagnosis, or their conditions deteriorated they provided suitable emotional support and had links with services outside the hospital to assist.

There was a quiet room for prayer or meditation booked through the hospital reception.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients and relatives, we spoke with told us how staff always gave them the information they needed and made sure that they were given opportunities to reflect and hold further discussions as needed.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback regarding the service was positive in nature. We saw compliment cards displayed within all the wards highlighting how supported patients were. The number of compliments regarding the quality of the service were: 19 for Oncology service, four for York ward, none for endoscopy and none for the catheterisation Lab. This was a total of 23 compliments in the previous 12 months.

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

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 the communities it served. It also worked with others in the wider system and local

Medical care (including older people's care)

organisations to plan and deliver care. The senior team were engaged with the local clinical commissioning group to support effective planning of the services.

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.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service had a draft dementia strategy they had been developed with the staff and with external experts. Senior managers were well informed and enthusiastic in putting into place a strategy to meet patients, their relatives and staff needs in supporting people living with dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff understood who to contact and when to do so.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

The service did not consistently have information leaflets available in different formats to meet patients' needs. However, staff spoken with explained how they could address these needs and obtain information in formats to meet patients' individual needs. The oncology service had developed a booklet diary and information for patients that they were developing into a smartphone app that would assist patients with their treatment and allowed them to access this information with ease. This kept patients well informed and provided the information they need if they wished to obtain support from the hospital and external agencies.

The service had questionnaires available to assist patients to give feedback.

Overall, facilities and premises were appropriate for the services being delivered. However, staff and managers within York ward reported that they wished to further

develop the facilities to meet the needs of patients living with dementia. Following the inspection, we received information from the service that outlined the plans they had in place to adapt the environment to meet patients' needs.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. For York ward the longest time before patients transfer from outside the hospital was 48 hours whilst a private ambulance and appropriate transfer arrangements were put into place. There was no referral to treatment times for oncology sent to us. However, staff told us that they were aware of the need for timely information and patients were assessed and commenced treatment within days of their referral. For endoscopy the referral to treatment times were within national guidelines of just over 11 weeks.

All patients we spoke with said that their admission or treatment was prompt and timely.

The service moved patients only when there was a clear medical reason or in their best interest. This included transfers to and from critical care.

Managers and staff worked to make sure that they started discharge planning as early as possible. This included liaison with pharmacy to make sure medicines were available in a timely manner.

Staff supported patients when they were referred or transferred between services.

There was access to translation services.

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.

In the last 12 months there had been 10 complaints representing a significantly low number in relation to the number of patients treated.

Medical care (including older people's care)

Learning from complaints and concerns were discussed in meetings and any learning shared. For example, following a complaint about incorrect information on a discharge letter, staff were reminded of the need for accuracy and to complete the information in a quiet area of the ward if possible.

Each ward had a noticeboard that outlined any complaints and what actions had been taken as a result.

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

Good 

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

Leadership

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

Staff told us they felt well supported by their managers and were complimentary about the support that they received from senior managers. They reported that managers were easy to contact, and they felt able to speak with them if needed.

There were regular safety huddles and briefings known as a CommCell in all areas to ensure that frontline staff received all relevant information.

Discussion with senior leaders and managers demonstrated a passion and keenness to place patients at the core of all the activities undertaken within the hospital. There were training opportunities for leaders to further develop skills and succession planning within the organisation to allow staff to progress to leadership posts should they wish too.

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 told us that they thought they delivered a valuable service to patients in line with the services vision and values. They were clear about the strategy and vision that the service had and were striving to meet it.

Throughout the service the vision was displayed. The vision and strategy of the service formed part of the staff appraisal system. Staff told us that they had objectives set in line with the services vision and these were reviewed yearly.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff told us of a good team working culture where staff helped each other. Staff told us they felt able to raise concerns without fear of retribution. They told us morale was positive and continued to improve

Staff told us that the majority had worked there for several years. They felt well supported and part of a good team who they worked well with. Staff told us they were supported by leaders and managers that they felt were open and honest. Staff told us they felt respected and valued by their immediate and service leaders

All staff spoken with were very proud of the work they did. At least one member of staff had returned to working in the service after leaving because of the support they received.

All staff told they were encouraged to put forward ideas to contribute to improving practice. Staff gave examples of when their ideas had been utilised and when they had been encouraged to undertake personal development opportunities.

Staff knew how to use the whistle-blowing process and about the role of the speak up guardian. Freedom to speak up guardians are staff who work within the service and are given additional training. Staff spoken with told us that they felt comfortable to approach the guardian.

Medical care (including older people's care)

There was an open culture where staff were encouraged to report concerns and incidents. This was demonstrated in the high rate of incident or low harm reporting within the service.

Staff appraisals included conversations about career development opportunities.

Governance

Service 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.

The service had dashboards in place that monitored areas such as patient satisfaction in order that strengths and areas of development could be recognised. Dashboards were discussed at team meetings and shared throughout the organisation by team leaders. Information regarding performance was readily available to staff on notice boards throughout the service.

Managers were familiar with risks in their department; they described the actions needed to address them and had showed evidence of processes in place to mitigate them. For example, the improvements planned for York ward in relation to the facilities and the draft dementia strategy.

Staff on wards and theatres were kept updated via several means, which included ward meetings, newsletters and via email.

Staff undertook or participated in local clinical audits. Leaders brought the information from the staff meetings and audits to the managers meetings, where governance, risks and serious incident reports were discussed. There were also departmental meetings, governance and business meetings. Information was fed into appropriate committees at board level.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Staff were aware of their responsibilities and who they reported to. There were processes at all staff levels to review performance and compliance against set targets.

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.

Risks were monitored by managers and reviewed to maintain quality of care to patients and were understood by staff.

Senior staff knew there was a local risk register, and managers could describe the key risks identified and their area of responsibility. They described how these risks were kept under review and updated. Senior managers had full oversight of the areas for development affecting front line staff and patient safety and experience.

Staff had access to information relating to risk management, information governance and how to raise concerns. Staff were knowledgeable about the service's incident reporting process.

Staff said the "CommCell" communication was effective. These took place took place at the start of each shift in clinical areas. Staff said that the direct communications with the executive team through this forum had made for constructive and meaningful team working.

The service conducted several internal audits to ensure that it was providing a quality service. It had a clear audit programme setting out the frequency of audits. There was a full audit plan for the year which highlighted those that had been completed and those that were pending. These audit plans were in line with the wider group requirements.

Key Performance Indicators (KPI's), were reported. Results were benchmarked nationally and performance against targets rated. Information was used to direct improvements. However, there were very few services for medical care within the group. Senior leaders and managers informed us that they did maintain close working with managers in other hospitals to share best practice and learning.

Managing information

Medical care (including older people's care)

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

There was a demonstrated commitment at all levels to sharing data and information proactively to enable prompt decision making and the delivery of care. Each area had their own individual meetings each morning to discuss patient needs and operational issues. Action plans were in place that were monitored and shared with staff.

Systems were in place to gather, analyse and share data and quality information with staff, key stakeholders and the public.

The service had a website where people could access information about the service and which would be useful when visiting the hospital.

Staff had access to the intranet to gain information relating to policies, procedures, professional guidance and training.

Engagement

The service was transparent, collaborative and open with all relevant stakeholders consulted about performance considering the needs of the population and patients they supported.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. This included through the intranet and displayed in clinical areas

The service provided details of support groups for patients and families, including information about early onset dementia, cancer support and local community services as needed.

The service had submitted a Commissioning for Quality and Innovation (CQUIN) plan. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. The service had a plan that included patient experience and equality and diversity.

There were meetings with the Clinical Commissioning Group who commissioned services to assist in understanding the changing patterns of care needed for the future direction of services required.

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. There were systems in place that supported improvement.

Maintenance and replacement schedules were in place for equipment and plans to improve services such as accreditation for endoscopy and continued accreditation for services such as the Macmillan Quality Environment Mark. The Macmillan Quality Environment Mark is a quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.

There were practices on wards and in theatres to review performance and identify how their services could be improved. Improvement plans were displayed along with action improvement plans.

All staff we spoke with reported that the service developed staff and supported their training needs

Incidents and good practice from other locations was shared as learning material for staff to prevent similar incidences happening at the service.

Surgery

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

Are surgery services safe?

Good 

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

Mandatory training

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

Data showed that at least 91% of the staff in the theatres and the wards had completed their mandatory training. Bank staff were expected to show evidence that they had completed training as part of their NHS work (or they could complete the training provided by the service).

Ward managers received weekly rates about training from the training manager.

Mandatory training included dementia awareness. There was no staff training for learning disabilities or autism, but a member of staff told us that there were plans to include these modules on the e-learning system.

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.

Data showed that over 90% of the staff in the theatres and most wards had completed their children and adult safeguarding training at the required levels. The exception

was Lancaster ward where 88% of staff had completed children's level three. All staff we spoke with could tell us how they would apply their knowledge to different situations.

Staff could access support from the safeguarding leads for children and adult services.

Each ward we visited had a safeguarding manual they clearly set out the referral pathway and contact details for the safeguarding leads. The manual included information about the different types of abuse, female genital mutilation, PREVENT and modern slavery.

A safeguarding 'helping hands' stamp had been introduced to identify a patient at risk by marking their records with a hands shape stamp.

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. However, we observed four members of medical staff who did not observe the bare below the elbow protocol, and there was no challenge by ward staff.

The service kept equipment and the premises visibly clean. Wards and theatres were visibly clean and tidy.

Equipment in the wards had green "I am clean" stickers with the date they had been cleaned.

There were enough hand gel dispensers in the wards and theatres, and we observed staff using these.

Personal protective equipment such as aprons and gloves were available for staff to use. Sharps bins containing used needles and syringes were secure and safely stored.

Surgery

The wards displayed waste segregation posters.

Patients that met certain criteria were screened for Meticillin-Resistant Staphylococcus Aureus during pre-assessment.

The service deep cleaned the theatres every six months.

The service managed surgical site infections well, and the staff had access to the corporate infection prevention control lead. In the 12 months to December 2018, there were 11 surgical site infections out of the 17,000 plus procedures that had been performed (a rate of 0.06%).

The service completed regular hand hygiene audits. Chester and Stafford Suite were over 97% compliant in the 12 months to July 2019. Lancaster Suite was 89% compliant.

Wards had weekly cleaning checklists. We saw that these had been completed appropriately apart from Chester suite. Checks were missing from 21 and 14 July, and 30, 16 and 9 June 2019.

The infection prevention control sub-committee highlighted non-compliance with the bare below the elbow protocol from medical staff as being an ongoing issue. Minutes from the sub-committee meeting in March 2019 confirmed that posters reminding staff would be displayed in the wards, and consultants would be reminded of their responsibilities

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 wards, whilst clean and tidy, were dated and had not been refurbished for some time (patients told us this as well). The hospital had a five year refurbishment plan. Some of the ward areas had scheduled start dates for the refurbishment, whilst others, including theatres, were still waiting for start dates.

We saw that the equipment used in wards and theatres, including anaesthetic equipment, had been safety checked and were regularly serviced – this included annual reviews of critical theatre ventilation systems. The service also had a comprehensive planned preventative maintenance programme.

There was no air conditioning in the wards or patient rooms and both staff told us that these areas could become hot in warm weather.

There was a clear pathway for reporting faulty medical equipment.

There were notice boards on the entrance to each ward. These displayed the number of nurses and healthcare assistants on duty that day, the name of the ward managers, the hospital's and department's vision, and patient satisfaction scores.

Call buzzers were in easy reach of the beds. The ensuite rooms had pull cords for emergencies.

Some of the showers had high steps that patients had to step over which could present falls risk. The service was aware of this and the refurbishment schedule included plans to reduce the height of the steps. There were posters in the shower rooms reminding patients to "Call, Don't Fall" and patients at risk of falls could be moved to areas with lower steps. The orthopaedic surgery ward had larger wet room style showers which had minimal steps.

The service had a 12 bay recovery area. These were open from 7.30am until the last patient left. They were staffed appropriately.

There were resuscitation trolleys in all surgical wards we visited and in theatres. The trolleys had been checked appropriately and contained up to date guidance from the Resuscitation Council (UK).

The theatre area included a difficult airways trolley. This was checked regularly and contained appropriate equipment.

The corporate team was looking to introduce more standardised theatre kits across all hospitals.

All theatres were laminar flow (a system that filters air coming into the theatre to try and reduce wound infections).

The service had previously had an issue in tracking medical equipment. Steps had been put in place to ensure that the asset register was up to date. This had allowed the service to better track which pieces of equipment needed to be serviced and when. Most of the equipment we saw in theatres (including anaesthetic equipment) and the ward areas had been appropriately checked and serviced.

Surgery

The service had enough equipment for bariatric patients including beds and mattresses, weighing scales and toilet seats.

The decontamination of surgical equipment had been outsourced to a third party contractor. Whilst there was a clear system for decontamination, staff told us the service level agreement had not always been monitored and equipment was not always returned on time. This had changed with the arrival of new management team in theatres (towards the end of 2018) and there was greater liaison with the contractor (we saw evidence of this in clinical governance meeting minutes).

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.

Patients underwent a pre-assessment before surgery. This detailed whether the patient had any disabilities and included information about patient's social circumstances – whether they lived alone or had any steps or stairs in their house.

Patients were asked about allergies, their current medication and any cardiac or respiratory issues. Patients were asked whether they had suffered from any mental ill health, such as depression or anxiety, and about any concerns about anaesthesia.

Pre-assessments could be carried out either by telephone or face to face, and the service had a matrix setting out which procedures supported which technique. Data sent to us by the service showed that, on average, 95% of eligible patients had a face-to-face pre-assessment.

The service carried out checks that venous thromboembolism assessments had been conducted on each patient. From August 2018 to July 2019, Chester Suite averaged over 95% compliance, Lancaster Suite 99%, and Stafford Suite 100%.

Bariatric patients were typically seen one to two weeks before surgery by a bariatric nurse and a physiotherapist. Patients were given advice regarding pre and post-operative care. A full past medical history was taken, as were baseline observations and an electrocardiogram.

Patients with suspected breathing difficulties underwent an assessment of their lung capacity to check that they were safe to have general anaesthetic.

The theatre team met daily at 7.30am to discuss that day's list. We observed one briefing. Staff checked that the right staff were in place, that equipment was available, and any risks and key messages.

The service used the latest version of the National Early Warning Score which was updated in December 2017. The system helped staff identify deteriorating patients (and those with sepsis) quickly and had been endorsed by NHS England and NHS Improvement. The same system was used to ensure that only medically fit patients were discharged.

National Early Warning Scores had been completed and actioned appropriately. Audit results between August 2018 and July 2019 showed that there was 91% compliance with completing the early warning scores.

We observed staff discussing a patient that had a sudden temperature increase. A doctor had reviewed them and ordered antibiotics to be given immediately.

The service operated a surgical safety checklist and we observed two being completed. These were carried out appropriately and the checks were recorded on a specific proforma ("BMI Safer Surgery booklet"). All staff were engaged in the process and discussions were held about, equipment, timings, prophylactic antibiotics and allergies. Post-operative pain relief was discussed and who would be taking the patient back to the ward.

The service carried out monthly audits of the surgical safety checklist. Data provided for April 2019 showed 100% compliance for the 20 procedures observed.

Recovery staff usually took patients back to the ward after surgery. This helped maintain an adequate number of nurses on the wards.

The hospital had a major haemorrhage policy that set out the steps staff should take (including out of hours) if a patient experienced major blood loss.

Safety huddles took place on the wards three times a day to coincide with shift changes. Staff discussed high risk patients, key performance measures, and team success.

Surgery

The service had introduced an initiative called 'Stop Before You Block', a campaign aimed at reducing the incidence of inadvertent wrong sided nerve blocks.

Certain staff within recovery and theatres had been trained in emergency paediatric life support.

Theatre staff checked that venous thromboembolism pathways had been followed prior to surgery and that plans were in place after surgery.

There was a full handover to recovery staff by the anaesthetic and scrub staff.

The service used the Sepsis Six pathway to manage patients with suspected sepsis. Each ward also had its own sepsis bundle – a pack with medical items (such as blood cultures) to help managed patients with sepsis.

There were clear processes to escalate deteriorating patients, including a dedicated emergency number for staff to call. There were regular practice emergency crash calls to ensure that staff knew what to do in an emergency.

We observed a radiographer checking that a patient was not pregnant before carrying out imaging.

Some anaesthetic staff were on-call after normal working hours to provide support.

All patients over 65 years of age underwent a dementia assessment. If there were any indications, staff would write to the patient's GP to request a referral for a full assessment.

Patients were called 48 hours after discharge to check they were recovering well, and to give any advice if they had concerns.

The bariatric link nurses had developed a traffic light system to help staff assess the needs of patients calling the department after being discharged. Dependent on the presenting symptoms, patients could be told to wait for their follow up appointment to discuss with a consultant, or if necessary, to attend A&E.

One to one care for patients could be provided if required. Any requirements for additional nursing care would be identified at the pre-assessment stage.

Patients at high risk of falls or that were infectious, had different coloured magnets placed on the door to their rooms to alert staff.

Nursing and support 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, agency and locum staff a full induction.

Theatre staffing rotas were typically decided four weeks in advance. Most staff would work one weekend every four weeks.

Staffing skill mix was constantly reviewed depending on patient acuity. The ward managers and senior staff nurses discussed requirements with the bed manager.

The service had a high rate of bank and agency staff use (approximately 20% in theatre nursing and 35% of operating department practitioners). There were also high turnover rates of nursing staff (38%). However, there were sufficient staff on the wards to provide patient care. Senior staff nurses were also supernumerary and could provide support when required.

The service blocked booked the same agency staff to ensure they had knowledge of the hospital, its processes and policies.

Theatre staff told us they had tried to retain several agency positions as this allowed some flexibility with allowing permanent staff to train. We were told that there were five staff training in additional competencies including cardiac, bariatric, neurological and ear nose and throat surgery.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Patients were admitted and treated under the direct care of a consultant and medical care was supported 24 hours a day seven days a week by onsite resident medical officers. Resident medical officers provided daily medical services and dealt with routine and emergency situations as when consultants were unavailable to attend within 30 minutes.

Surgery

The service's resident medical officers were provided via an external agency. The agency arranged for the resident medical officers to have up to date mandatory training, including advanced life support training. The agency provided the service with evidence of completed training modules.

Resident medical officers received a local induction when starting work at the service (and received an induction booklet). However, the induction booklet did not reference the service's safeguarding policy. We raised this with the service and were told that this would be addressed immediately.

Absences due to sickness or holiday were covered by an alternative resident medical officer from the agency.

The resident medical officers told us that they were well supported by consultants with on the job training.

Records

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

The service used paper records for surgical patients.

Records were stored securely, either behind the nurse's station in lockable cupboards, or in an office behind a locked (key coded) door.

The service had two systems to track records with a new scanning system replacing an older version (records were being migrated to the new system). A ward clerk told us that patient records were delivered from the medical records department the day before surgery on a covered trolley to protect any patient identifiable information.

We reviewed five patient records. All records were clear, fully completed, and legible. Allergies were listed where appropriate, as was information about the patient's home environment (for example, did they have anyone to support them for 24 hours after surgery), and any discharge arrangements.

The front file cover of each patient's records contained alert symbols to help staff easily identify whether a patient had dementia, an allergy or had a language difficulty. However, of the five records we checked, none had any symbols ticked. This was despite the written notes highlighting that

two of the patients had allergies. Therefore, whilst the records indicated this information, staff had to read through all the notes to find this detail rather than simply referring to the front cover sheet.

Medicines

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

The six prescription charts we saw evidenced that medicines were safely administered. Patients able to self-administer their medicines following a risk assessment had lockable storage facilities in their rooms.

The hospital's clinical pharmacists visited all in-patient wards daily (Monday to Friday) and reconciled patients' medicines within 24 hours. The pharmacy service met the standards of GPICS. (Guidelines for the Provision of Intensive Care Services)

Medicines storage arrangements were safe and well organised. Prescription stationery was kept safely, and an audit trail was kept. The temperature of medicine storage facilities was appropriately monitored, and medicines were kept at the correct temperature.

Patients' prescriptions were clinically checked by pharmacists. Good governance arrangements were in place for controlled drugs.

Medicines safety alerts were cascaded throughout the hospital. Staff were aware of the process for reporting incidents and examples of shared learning from incidents were seen.

Prescribers did not clearly state a total maximum daily dose when prescribing oxycodone regularly and 'when required' for pain.

Prescribers did not write separate prescriptions for medicines that could be given by either the oral or intravenous route. Making separate entries for each route is good practise to ensure clarity in the administration record.

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

Surgery

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 reported using an electronic system which automatically alerted the manager responsible for the investigation.

Incidents were routinely discussed at daily and monthly team meetings, and information about the most recent incidents were displayed on a notice board in staff rooms. This included details about the incident, which department it occurred in, what action was taken at the time, and what lessons had been learned. More systemic incidents were cascade throughout the hospital group via 48 hour flash reports.

Serious incidents were discussed as a monthly clinical governance meeting. Incident data was also collated and presented to the clinical governance committee.

Not all staff we spoke with were aware of the phrase, Duty of Candour, but all staff knew to apologise to patients if anything had gone wrong. Some staff could describe incidents where they had followed the Duty of Candour. There was also a “professional Duty of Candour” notice in Lancaster Suite.

There had been two never events (one that occurred after the organisation had sent us its pre-inspection information), both of which were wrong sided nerve blocks. The service introduced the Stop Before You Block initiative after the first incident, and the theatre team attended human factors training. However, there had been a subsequent wrong sided nerve block caused by an item of clothing being worn by a patient moving and blocking the site marker. A review concluded that these items of clothing must not be used.

We observed an incident whereby a patient’s records had gone missing on the day of surgery and could not be found. A member of staff told us that an incident would be raised. This was done the following day. The patient’s operation went ahead without delay. The service also confirmed that in the 12 months to July 2019, no procedures were cancelled due to missing records.

Safety Thermometer

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

Each ward had an information board at the entrance displaying various information. This information included the number of falls, pressure ulcers, medication errors, and Meticillin-Resistant Staphylococcus Aureus infections.

Between May and June 2019, Stafford Suite had had three falls, and zero pressure ulcers, medication errors, or instances of Meticillin-Resistant Staphylococcus Aureus infection. Chester Suite had one pressure ulcer and zero instances of the other indicators. Lancaster Suite had zero indicators.

Are surgery services effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient’s subject to the Mental Health Act 1983.

The service used the American Society of Anaesthesiologists (ASA) Physical Status Classification System to establish a patient’s fitness to be given an anaesthetic for a procedure.

Theatre staff followed guidelines produced by the Association of Anaesthetists of Great Britain and Ireland, including the Management of Severe Local Anaesthetic Toxicity.

The wards had up to date copies of the Nursing and Midwifery Council’s Professional standards of practice and behaviour for nurses, midwives and nursing associates available for staff.

The service took account of the Association for Peri-operative Practice guidelines on accountable items and ensured theatre equipment such as swabs were counted before and after surgery to check that no items had been retained.

Surgery

Theatre staffing was in line with the guidelines from the Association for Perioperative Practice.

Policies and guidelines could be accessed via the service's intranet.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

The service used a malnutrition screening tool to assess patients' nutritional requirements.

The service carried out health documentation audits which included a review of whether patients' fluid balances had been assessed. Data supplied by the trust showed compliance with these assessments of between 79% and 92%.

Patients could access bariatric nurses and dieticians for specialist advice, especially after bariatric surgery.

Surgical inpatients could choose their meals from a daily menu. Catering staff took account of dietary requirements, including gluten free and kosher foods, into account. However, staff told us that the halal option had recently been reduced to chicken only.

Patients were given sufficient food and drink. Water jugs were readily available in patient rooms.

Three of the four patients we spoke with told us that the food provided by the service was good. Another patient told us it was "awful", and they had to rely on their family to bring food in for them.

Inpatient care pathways contained several sections for staff to record whether patients were suffering from nausea following surgery.

Pain relief

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

The service conducted a quarterly pain management audit. The most recent results sent to us by the service related to December 2018 and showed that there were issues with compliance with certain actions. For example, of 20 patient

records reviewed, 67% had information documented about their pain on admission, 35% of patients had documented evidence of their pain score being recorded, and 38% had evidence about the effectiveness of the pain relief given.

The service had developed an action plan to improve compliance with pain management documentation including cascading the audit results to all staff. We saw evidence of discussions in staff meeting about access to a pain management link nurse to help improve the documentation of pain relief.

Whilst the service did not have a dedicated pain team, there were sufficient staff with the right skills to help manage patients' pain (this included a pain management link nurse). Nurses could refer patients to, and receive advice from, the resident medical officer, on-call pharmacist and the intensivist.

We spoke to patients about pain relief. All patients we spoke with told us that their pain had been managed appropriately. They told us that pain relief was given quickly, and nurses assessed the effectiveness of it.

The service used a pain score of zero to three to assess the amount of pain patients were in. Two of the patients we spoke with told us that staff had not asked them about their pain score. Staff also told us that they did not have access to alternative tools to assess the pain levels of patient who were non-verbal.

Patient outcomes

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

The hospital had produced several pathways for staff to follow including sepsis and bariatric surgery.

The service's 2018 Quality Accounts reported on a number of key patient outcomes. The data showed that substantially less patients were re-admitted to hospital within 28 days of discharge than the national average (0.4 patients per 1,000, compared to 11.45 per 1,000). The quality accounts also showed that in 2017, 98.5% of patients would have recommended the service (there was no sample size for this measure).

Surgery

The service provided data to a number of different external audits including Patient Reported Outcome Measures and the National Joint Registry. It also submitted data to the breast and cosmetic implant registry.

Key findings from the most recent National Joint Registry report from April 2019 showed that only 88% of eligible records were submitted to the registry which the registry reported as being “below the expected standard” (of 100%).

The service was not always meeting the Patient Reported Outcome Measures target (90%) for submitting data. The average submission rate from April 2018 to March 2019 was 86%, with some months falling to as low as 54.5% and 69.1%. Submissions had improved in February and March 2019 with rates of 94.4% and 100% respectively.

However, the data submitted showed that for a number of orthopaedic procedures, including total hip replacement, total knee replacement or hip or knee revision surgery, the hospital was either performing at the same level, or slightly better than (with regard to health gain) the England average.

The theatre managers acknowledged that the service had not always submitted timely data to external audits, and new procedures had been implemented to improve this. We saw that current processes for submitting data were clear and set out staff roles and responsibilities to ensure all eligible data was submitted in a timely manner. Minutes from the meeting of senior theatre staff in March 2019 showed that this issue had been discussed.

There were over 5,025 inpatient stays following surgery between January and December 2018. There were 25 unplanned returns to theatre, and 16 unplanned transfers of care to another hospital during this time.

The service was proud of its bariatric service. The second National Bariatric Surgery Register report (2014) highlighted that, on average, between 2011 and 2013, patients lost 58.4% of their excess weight (note – the third report which includes data collected from 2009 to 2018 would be published towards the end of 2019). The service told us that their patients lost 75% of their excess weight.

The hospital had recently introduced a robotic arm for joint replacement surgery but there was insufficient patient outcome data to assess its effectiveness.

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 undertook a variety of training, and the service provided opportunities for them to do so. For example, the service sent theatre staff on a “safer operating room” simulation day which staff told us they enjoyed. There were also various scenario training sessions including major haemorrhage and cardiac arrest.

Most staff had had their annual appraisal and told us that they found these useful. We heard examples of where development goals had been set for staff which they had been supported to achieve. There were also six monthly progress checks, although managers told us that they had not always had time to complete these.

Bank and agency staff underwent an induction. There was a checklist in their staff files demonstrating that they had completed health and safety and mandatory training, had reviewed corporate policies, and had had a site orientation.

New starters were supported by a mentor and were supernumerary until they were competent to provide care. New starters had a weekly review to check their progression.

The service encouraged staff to develop. We saw examples of healthcare assistants that had recently completed diplomas, and another than had progressed to become assistant nurse practitioners. Theatre staff also trained in other roles such as scrub nurses, and in certain cardiothoracic procedures (with support from consultants). One nurse had also been supported to obtain an MSc in diabetes care.

Ward managers told us that there was good support from the practice education facilitator.

Each ward manager and senior staff nurse kept staff competency files. Competencies included blood transfusion, intravenous therapy and medicines management. We saw that these files were up to date.

The wards had notice boards providing information for student nurses. Information included the NHS student placement charter and an information booklet with key contacts (including the emergency number).

Surgery

The bariatric link nurses underwent annual training at a large NHS hospital trust to ensure they were up to date with current practices.

Multidisciplinary working

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

There was good multidisciplinary working within the service. For example, bariatric patients received ongoing support from consultants, physiotherapists and bariatric link nurses.

There were clear discharge arrangements for patients having surgery.

There was an orthopaedic multidisciplinary team meeting every morning attended by ward staff, physiotherapists and occupational therapists.

Physiotherapists attended pre-assessments appointments of patients due to have major orthopaedic surgery. They talked to patients about what to expect from surgery, the recovery time and the exercises they would need to carry out to improve their outcomes. Physiotherapists would identify any equipment needs in advance of surgery such as walking sticks or Zimmer frames.

Physiotherapists had worked closely with the orthopaedic surgeons to develop set exercises for patients depending on the type of surgery they were having and the surgeon who was carrying out the procedure (each consultant had slightly different techniques and post-operative recovery requirements).

Physiotherapists were involved in the discharge of all orthopaedic patients.

Seven-day services

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

The surgical wards were staffed 24 hours a day, seven days a week.

Theatre staff were contracted to work 37 hours a week over six days (Monday to Saturday). Theatres could also be opened on a Sunday if staff volunteered.

Imaging services did not routinely work at weekends but there were on-calls arrangements if imaging was necessary (imaging requirements would be highlighted at the twice weekly scheduling meetings).

Resident medical officers were available 24 hours a day, seven days a week on a week on week off rota.

Physiotherapists mainly worked Monday to Friday during normal theatres times to ensure they could see patients post-operatively. There was also an on-call physiotherapy rota out of hours during the week, and bank and agency staff at the weekends.

Health promotion

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

Information booklets for different procedures included advice regarding exercise, weight loss and smoking before and after surgery to improve outcomes and recovery time.

The service ran a free weight loss support group.

We saw evidence of some patients having assessments for problem drinking and potential alcohol problems.

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. They used agreed personalised measures that limit patients' liberty.

Staff gave us an example where they identified, after pre-assessment, that a patient had symptoms of dementia. They re-consented the patient after checking capacity and making a best interest decision.

The service produced "Patient information leaflets for consent" for individual surgical procedures. The leaflets provided information about what the procedure involved, any alternatives to surgery, complications and recovery time. The leaflets also gave information about what patients should do with their own medication both before and after surgery. In addition to the pre-operative consultation, these leaflets helped provide patients with information to provide informed consent for surgery.

Surgery

Signed and dated consent forms were present in all records we checked. These forms detailed the risks and the benefits of the surgery. However, four out of five records contained consent forms signed on the day of surgery. There were no pre-operative consultation notes within the files to highlight whether any discussions about the risks or benefits had been discussed in sufficient time for patients to make informed decisions.

The service had identified that there was a long-standing issue relating to the consultant outpatient record not being part of the entire medical record for our patients. However, it was unclear what control measures were in place for this risk. However, the service conducted a twice yearly consent audit. Data for Chester Suite showed that of 20 sampled records, 100% of patients had been provided informed consent. We therefore had some assurance that consent was being obtained appropriately.

The patient satisfaction scores from March 2019 reported that 100% of (396) patients had had the proposed treatment explained to them by their consultant, and almost a 100% reported that they felt involved in the decision to treat.

Wards contained a safeguarding manual which included information about the Mental Capacity Act, flowcharts for assessing capacity, and information about how to make best interest decisions. There was also information about Deprivation of Liberty Safeguards, including contacting the adult safeguarding lead for more information about this matter.

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.

We observed staff maintaining patients' privacy and dignity. Patients were cared for in individual rooms. The patient information board was within each ward's office so patient identifiable information could not be seen by other patients or visitors.

We observed the start of two surgical procedures. Theatre staff were caring and compassionate to the patients and respected their dignity.

The pre-operative assessment ward was sited in a building away from the main hospital. The hospital provided a transport service to take patients to and from their assessment.

The service could provide chaperones for those patients that wished to have them.

Patients told us that staff introduced themselves by name. We heard one nurse using the "hello my name is" introduction, part of a national campaign to ensure that staff introduce themselves to patients.

The service had good friend and family test scores, although the response rates had been poor. From September 2018 to February 2019 the average score was over 96%. However, the response rates for the first three months were 3.1%, 7.1% and 19.8% respectively. Response rates had subsequently improved to over 44% in February 2019.

Emotional support

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

Each ward area had a staff guide to religious faiths and cultural needs. This helped staff understand the needs of patients and relatives from different backgrounds.

We spoke with a patient who described how staff kept them and their family involved with their care.

We saw numerous thank you cards from patients. Patients said they "felt like I was the only patient on the ward".

Theatre staff could describe making adjustments to help reduce anxiety in a patient with learning disabilities.

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.

Surgery

The pre-operative assessment clinic was open between 7.15am and 6.15pm which helped some patients attend before or after work. The service could also open on a Saturday when staffing allowed.

Confidential discussions could be easily had in the private patient rooms.

The hospital provided chaperones to patients if they required it.

Chester Suite had a family room that allowed for private discussions to take place with families and cares.

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.

The hospital's pre-assessment team identified those patients that required interpreter services and would pre-book support for appointments.

The hospital had a dementia lead who could support staff that had questions about caring for patients living with dementia.

The service provided weight loss support group meetings for those patients thinking about having surgery, and to support those that had undergone 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.

Information sheets had been produced for "international patients" and were available in several languages including Arabic, Polish, Urdu and Cantonese. They contained information about chaperones, and about informed consent.

Theatre staff told us that the pre-assessment team would flag in advance whether any patients had individual needs, such as a learning disability or were living with dementia, in advance of surgery. Such patients would usually be operated on during quieter theatre sessions.

Patients having bariatric surgery had a dedicated bariatric link nurse, as well as access to dieticians (dietetic support was provided by a third party provider). There were clear pathways for patients to follow. The pathways had been designed by the link nurses and had been rolled out across the entire hospital group.

Bariatric patients received follow-up support for two years after surgery. There was an initial multidisciplinary team meeting after six weeks, and then follow up appointments every three months with a consultant and the bariatric link nurses.

The service had produced a detailed A4 booklet for all patients considering weight loss surgery. The booklet provided information about obesity, the different types of weight loss surgery and their benefits. It also provided information about what patients could expect after surgery including recovery stages and a post-surgery diet.

Patients were given details of who to contact should they have any concerns or questions after being discharged. This included attending A&E in an emergency. Patients could also access the wound care clinic (part of the walk-in centre service) if they had any concerns about how their surgical wounds were healing.

Pre-operation assessments included information relating to discharge planning, including whether there was a responsible adult available to support the patients for at least 24 hours after they returned home.

We witnessed a nursing handover. All staff were engaged in the process. Information about the patient's current medical condition was discussed and any plans for ongoing care, including required pain relief and discharge arrangements.

Surgery

There were several other link nurses within the service to provided support for staff. These included safeguarding, diabetes, and infection prevent control.

Letters were sent to patient's GPs after discharge.

Any patients living with dementia, or who had a learning disability or autism, could be flagged on the patient information board so staff were aware and could ensure any individual needs were considered.

Theatre staff gave examples of where patients had toured the facilities to help manage their anxiety.

The hospital used a "This is me" form for patients living with dementia. This was a simple form that provided details about the person including their cultural and family background, events, people and places important in their lives, their routine and their personality. The form provided information to enable hospital staff to know more about the patient.

The service could book interpreters for patients who did not speak English sufficiently well enough to understand their care and treatment. The service could also arrange sign language interpreters.

The service had a strategy to improve its service to patients living with dementia. The strategy aimed to ensure that such patients were cared for in a holistic way. The strategy was developed in accordance with guidelines from Dementia UK and the National Institute of Health and Care Excellence.

The service's leading cosmetic surgeon was certified by the Royal College of Surgeons in 2017 and had been using psychological screening tools for several years. The surgeon referred all young patients under 21, all patients with a history of psychological issues, and any patient where a concern had been raised following psychological screening, to cognitive behaviour therapy clinics. This allowed further assessment of their psychological needs, especially regarding the presence of body dysmorphia or an eating disorder. This helped provide assurance that consent for cosmetic surgery had been appropriately obtained.

There was no dedicated mental health support on site or via an external provider. Staff told us that if they had concerns about a patient's mental health, they would escalate to a consultant or safeguarding leads.

Inpatients had private bedrooms with their own ensuite facilities. There was free Wi-Fi and a TV in each room.

Patients in wheelchairs could not easily access the ensuite showers due to their design (there was a step to get into the shower). These patients had to be taken to a different ward to have a shower.

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.

Data for the 12 months to July 2019 showed that most NHS patients referred for surgery were seen within 18 weeks. 94% of patients were seen within 18 weeks for incomplete pathways, and 85% of patients were seen within 18 weeks for admitted pathways. This was in line with the England average.

The service had cancelled 67 operations for non-clinical reasons in the previous 12 months (less than 1% of all visits to the operating theatre). 21 cancellations related to consultant availability on the day. 14 cancellations related to equipment issues – eight because of broken equipment or a failure of delivery, and six due to decontamination issues.

Thirteen cancelled procedures were not re-booked within 28 days. Six were due to staff absence, and four due to issues with consultant schedules. The other three were due to patient choice.

Two of the patients we spoke with had had their initial procedure cancelled. One patient told us that their operation had been cancelled on the day and they were given differing reasons by staff. They had also undergone preparation for surgery and it had been cancelled late in the afternoon.

We attended a theatre scheduling meeting (this occurred twice a week on a Monday and Wednesday) and reviewed the list for the following week. Theatre staff were present along with representatives from imaging, scheduling and medical equipment. The team discussed the length of

Surgery

procedures and the risk of any overruns. Equipment requirements were discussed. We saw examples of where lists had been altered to ensure that surgeons had sufficient time to operate on patients.

The service operated the golden patient initiative to help theatre lists run on time. The initiative identified the first patient due to be operated on the following day and ensured that all pre-operative checks and assessments had been conducted, equipment was ready, and any concerns addressed. “Golden patients” were clearly identified on the patient information board.

Theatre utilisation was approximately 60% (against a hospital target of 70%). The scheduling team constantly reviewed the capacity of theatres, and the availability of surgeons, to see whether additional patients could be added to lists. Every surgeon with “spare capacity” was emailed to see if they could take additional patients.

Urgent patients could be identified at a number of stages including their first consultation, pre-assessment clinic, or through multidisciplinary reviews. Complex patients were discussed at theatre briefings and morning huddles.

Theatre staff could prescribe take home medicines in theatre to help timely patient discharge.

The service had daily bed management meetings to review patients due to be admitted or discharged. This helped to manage patient flow from the wards to theatres, and to ensure that the wards had sufficient staff.

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.

Learning from complaints and concerns were discussed in monthly ward meetings and any learning shared. For example, following a complaint about incorrect information on a discharge letter, staff were reminded of the need for accuracy and to complete the information in a quiet area of the ward if possible.

There was a company complaints policy which the hospital followed. There were no complaints at the time of inspection which were overdue. Complaints were acknowledged in three days and responded to in 20 days.

Any delays were communicated to the complainant. The Executive Director met with patients and families to discuss concerns. The Executive Director saw and signed off all complaints.

Where complaints were classified as a stage 3 complaint review this was completed by an external independent adjudication service. For private patients in England, Scotland and Wales this was the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). For NHS patients, this was the relevant Ombudsman. Between March 2018 and February 2019 there were no complaints referred to the ombudsman or ISCAS.

Are surgery services well-led?

Good 

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

Leadership

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

The service’s senior leadership team had recently changed. Staff told us that they were visible and approachable and did regular walkarounds. One member of staff told us that the new executive team was on the same “wavelength” as frontline staff.

Staff told us that they were comfortable raising issues with managers.

The theatre clinical services manager visited the wards each day to let staff know that the recovery team could collect patients and bring them back to the wards if there were staffing pressures.

There were regular staff huddles and briefings in both wards and theatres to ensure that frontline staff received all relevant information about the hospital.

The hospital met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation

Surgery

ensures that directors are fit and proper to carry out this important role. We looked at the senior managers team employment files, which were completed in line with the FPPR regulations.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had a clear vision and strategy. This was displayed in the wards we visited. The hospital wanted to build a reputation as a leading provider of private healthcare in the region, and to deliver outstanding care and patient experience.

The hospital's strategy was centred on a five year development plan, and there was an acknowledgement from the leadership team that investment in the building was required. Staff had been engaged in the development plans for the site through several staff forums.

The wards we visited displayed their own "departmental vision". For example, Chester Suite's vision was to "use knowledge, skills, and compassion to provide outstanding experience to patients and families during their stay on Chester Suite." It also included providing a "positive working environment that support professional growth and development of staff".

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with told us that there had been a positive change in culture at the hospital over the last 12 months. One member of staff told us that they "absolutely loved" working at the hospital.

The theatre leadership team told us that there had been a number of managerial changes in theatres over the last year and that this had created some anxiety in the team. However, there had been stable leadership since the start of the year and the team were working well together.

Theatre staff told us that executives had helped clean the area following a leak.

All staff were expected to complete e-learning on equality and diversity. There was a Multi faith room and shift patterns were changed to accommodate fasting.

There was a BMI Healthcare Equality and Diversity Strategy and plan. The hospital submitted its workforce race equality standard data and compared favourably when benchmarked against other BMI hospitals.

All the ward and theatre staff we spoke with were proud of the team work and collaboration within the service.

The Freedom to Speak Guardian had recently been introduced. Information about the post was being rolled out through staff forums. The guardian was planning to hold a drop in clinic once a month. The guardian was linking into local networks with neighbouring NHS providers. There was a whistleblowing policy which staff could access.

Governance

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

There were clear governance systems in place at the hospital.

The hospital held a daily morning briefing (called "comm cells") attended by heads of all departments within the hospital. This provided an opportunity for all managers to share incidents, best practice or team success. 48 hour flash reports (typically produced after an incident to help share learning) were also discussed. Managers from the theatres and surgical wards attended.

48 hour flash reports were shared between all hospitals within the group.

Surgery

There was a regular theatre anaesthetic meeting. We reviewed the minutes from June 2019. There was good attendance. Staff discussed risks, incidents and training. There were also discussions about the major haemorrhage plan.

There was a monthly meeting of senior theatre staff. Standard agenda items included hospital performance, theatre utilisation rates, feedback from committees and regional meetings, staffing issues, risks and incidents, including a wrong sided nerve block. Actions were agreed at the end of each meeting with an owner and date due for completion.

There was a monthly heads of department meeting. This include leaders from the wards and theatres. There were standard agenda items regarding performance, staffing, training and incidents.

Notice boards in staff rooms in wards and theatres display various information including 48 hour flash reports, incidents, compliments and information cascade from the daily head of department team brief.

The service had a comprehensive system in place to monitor practising privileges. A team reviewed the database regularly to ensure that consultant information was up to date. This included General Medical Council registration, appraisals, indemnity insurance, and disclosure and barring service checks. We reviewed three consultant records and these all contained appropriate and up to date documentation.

There were close working relationships with medical directors of neighbouring trusts to share any concerns about a doctor's practice.

Monthly ward meetings were usually held in the early afternoon to include a many staff as possible (handover from the morning to the late shift). Minutes were also printed off and we saw these on the notice boards in the staff rooms. Agenda items included key messages, new policies, incidents, feedback on complaints and team success.

We reviewed minutes from three monthly clinical governance meetings and saw evidence that incidents were discussed in detail, with actions agreed and

documented. Complaints were discussed, as well as quality initiatives and patient satisfaction. There was a standing agenda item for mortality and any updates from the Coroner.

The clinical governance meeting also monitored training compliance and any shared learning or safety updates. Sub-committee groups reported to the meeting and updates from the medical advisory committee (MAC) or new clinical developments or services were fed back.

There was an organisation-wide monthly clinical governance and quality and risk bulletin, including lessons learned. This was distributed to and actioned through hospital governance committees and there was a hospital tracker in place to monitor this. The bulletin included safety alerts, audit updates and listed areas of non-compliance with actions required.

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.

The service had an audit plan for the year ahead which clearly set out what audits needed to be completed, when and in what frequency. Audits included, amongst others, venous thromboembolism, infection prevention, record keeping, surgical safety checklist, consent and controlled drugs.

The service had systems to manage unexpected events such as power cuts and floods.

The hospital had a clear risk management policy and risk register. The policy set out the process for the identification, assessment and control of risks at all levels across the organisation, including at divisional level. The policy set out how risk should be calculated depending on the impact and likelihood of a risk. Risks included the investment that was required in the "fabric of the building", recruitment in theatres and the accessibility of the outpatient records.

Heads of departments discussed ongoing risks during the daily morning briefings.

Surgery

Each ward, and the theatre department, had team boards where various information could be displayed, including information cascade by the executive team. Information included the departmental and the hospital risk registers.

The hospital had local safety standards for invasive procedures in place, including the five steps to safer surgery.

The service had a quarterly falls prevention committee to identify themes and lessons learnt. Outcomes from this committee included an information board (seen in Stafford Suite) that included information to help reduce falls. This included reminding staff to undertake mobility assessments within 24 hours of admission and taking lying and standing blood pressure measurements (a risk factor for falls).

There were monthly clinical governance meetings in which surgical risk issues were discussed. These meetings were well attended and included the theatre clinical services manager and other senior leads and executives from the hospital. Minutes from the April 2019 meeting demonstrated that the service was in discussions with the third party that provided surgical decontamination services regarding non-conformance to the service level agreement.

An improvement plan had been developed to drive improvements within theatres. Issues to resolve included the third party contractor for decontamination of theatre equipment – there was ongoing monitoring of the relationship through regular attendance at a regional theatre manager meeting.

The clinical governance committee and medical advisory committee reviewed and monitored mortality. The root cause analysis investigation for unexpected deaths was completed by the provider independently. The regional clinical board also sought assurance on the action taken.

The hospital had a system for reviewing potential new surgical procedures. Consultants wanting to introduce a new procedure had to follow a proforma. This included training, audit, evidence based research and competency. This was reviewed by the medical advisory committee before final sign off.

Managing information

The information systems were integrated and secure.

However, data or notifications were not consistently submitted to external organisations as required. The service was “below the expected standard” for submitting data to the National Joint Registry. It was also not always meeting the Patient Reported Outcome Measures target for submitting data.

The service submitted data to the Private Health Information Network. The network rated the service as having “good participation” in measuring health outcomes (the reporting period was July 2017 to June 2018).

Student notice boards included information about the service’s Caldicott guardian.

Staff told us that there were enough computer terminals to allow them to do their job safely.

There was a consultant app which allowed remote login to clinics and theatre lists. No data was stored on the device and a time-out was applied.

Engagement

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

The senior management team had reintroduced a hospital wide staff forum meeting that took place every couple of months. These sessions were usually held throughout the day so that as many staff as possible could attend and provide feedback on the service and their work.

Some wards used social media and messaging groups to keep up to date with training requirements and team meeting information.

The hospital operated a “You Said We Did” engagement initiative with patients, seeking their views on how to improve the service. This included better monitoring of pain relief.

The hospital completed monthly patient satisfaction surveys. This survey looked at a variety of measures including patients’ impressions prior to admission, nursing care, theatre staff, catering and an overall rating. The survey from March 2019 showed that most patients rated theatre staff as either “very good” or “excellent”. Almost 90% of patients rated their “overall impression of nursing care as very good or excellent.

Surgery

There were staff recognition programmes. For example, Chester Suite had a “Star of the Month” award.

Key learning and messages were shared at various committee meetings, including Heads of Department Committee, Clinical Governance Committee, Medical Advisory Committee and Executive Team Meetings. The Executive Director shared important messages on ‘Marge’s Messages’ on the main staff corridor. The board was used to cascade important information in a way the hospital team could engage including those staff who did not have routine access to emails.

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.

The service had a theatres managers group for all hospitals within the North-West region. The group met every two months to discuss incident, corporate plans and to share best practice.

The hospital had access to a robotic arm system to assist during knee replacement surgery. The system had only recently been introduced so there was insufficient information to demonstrate its effectiveness.

Critical care

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

Are critical care services safe?

Good 

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff.

The BMI The Alexandra mandatory training included, although was not limited to, modules on safeguarding vulnerable adults and safeguarding vulnerable children; consent; moving and handling; information governance; infection prevention and control; dementia awareness; and, care and communication of the deteriorating patient. The mandatory training modules were supported by a range of core critical care competencies.

Nursing staff received and kept up-to-date with their mandatory training.

At the time of the inspection in July 2019, 97.3% of all nursing staff in the critical care service had completed their mandatory training for the year. This figure included permanent and bank staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The corporate target for mandatory training was 100%, and the clinical services manager expected to achieve this. Current training figures were displayed within the staff room.

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.

Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding vulnerable adults and children level two was included in mandatory training. Although the ward did not usually treat children under the age of 18, the clinical services manager and all the registered sister and senior sister nurses had undertaken safeguarding vulnerable children level three training in order to support paediatric staff, or where a paediatric patient was accommodated on the ward until a ward room was available.

Safeguarding training was included in mandatory training; as such 97.3% of staff had completed safeguarding training. The training also included modules on female genital mutilation and the Prevent anti-radicalisation duty.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff were aware of, and could describe, the types of safeguarding incidents that should be reported. Staff were aware of how they could access further help and advice.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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.

Critical care

We observed all treatment areas and rooms in the ward, including the clean utility, sluice utility, store room and staff room. All areas were visibly clean, tidy and uncluttered.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeeping staff cleaned the environmental areas while nursing staff cleaned beds and equipment. We reviewed the cleaning rota, which was fully completed.

Disposable curtains were used around each bed bay to maintain privacy. These were all visibly clean and the last date of change had been clearly recorded.

There were sufficient antibacterial hand-gel dispensers throughout the ward, and within each bed bay. Hand wash basins were located in each bed bay. This was an improvement since the last inspection.

Hand hygiene audits were carried out every quarter. Between August 2018 and July 2019, the ward scored an average of 98% compliance in the audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff complying with the 'arms bare below the elbow' protocol, washing their hands between patients and using personal protective equipment including gloves and aprons. This was in line with the NICE QS61 statement three: "People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care".

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Green 'I am clean' stickers were used throughout the ward to identify equipment that had been cleaned and was ready for use. An infection prevention and control audit for patient equipment was carried out quarterly. Between August 2018 and July 2019, the ward scored an average of 99% compliance in the audit.

The critical care and progressive care wards were clean and had suitable furnishings which were clean.

In the period April 2018 to December 2018, there had been no cases of ward-acquired methicillin resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus, clostridium difficile, or vancomycin-resistant enterococci (VRE). All patients were screened for MRSA prior to admission to hospital for their planned procedure.

The service had a link nurse for infection prevention and control. At the time of the inspection, the hospital had advertised a vacancy for an infection prevention and control/microbiology post with a view to regular microbiology support for the antibiotic lead pharmacists at ward rounds.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The ward was located on the first floor of a modern building, co-located with the theatres and recovery area. Lifts were located close to the ward which meant it was accessible to people living with mobility difficulties. However, the entrance to the ward, at the front of Chester ward, was not easily identifiable.

Entrance doors to the critical care ward were secured by an electronic system, with visitors required to ring a bell to be admitted. This ensured that patients' safety was maintained.

The main critical care ward had five beds. Four of the beds were in bays and the remaining bed was in a side room. Although the side room could be used for patients with active infection, it did not have a negative pressure ventilation system. The side room was accessed through sliding doors, around which there were gaps between the door and the walls; as such, it did not provide infection control isolation. An observation window enabled staff to view the room from the nurses' station without having to enter it.

The ward had recently replaced all its beds. Beds were electronically adjustable, which enabled easier moving and handling of patients. Pressure relieving mattresses were available on the ward for any patient identified as being at risk.

The progressive care ward, which provided step-down care, prior to a patient moving to the relevant ward, had three individual rooms with en-suite facilities and was located opposite the entrance to the ward.

The service had suitable facilities to meet the needs of patients' families. A relatives' room was located next to the progressive care ward. This was suitably decorated and furnished, had toilet facilities, a television and telephone.

Critical care

The design and layout of the main critical care ward predated, and therefore did not meet, current guidance; the Department of Health's Health Building Note 04-02 (HBN 04-02) for critical care wards.

At the time of the inspection, there were no plans for full refurbishment of the ward to bring it into line with the guidance. However, the environment had improved since our last inspection, with the closure of one bed, installation of a sink in each bed space, replacement of flooring, creation of a storeroom and the general refurbishment of the entrance of the ward.

Although the bed spaces were smaller than current guidance, there was sufficient room around each bed for staff to provide safe care and to use equipment safely.

However, the ward was not served by an uninterruptable power supply. In the event of power failure staff implemented the hospital's business continuity policy. This included switching to an alternative generator or, as a last resort, by moving patients to the theatre recovery area which was served by an uninterruptable supply. The safety of patients on ventilators was maintained throughout as each ventilator ward had a two-hour battery back-up system.

The main critical care ward did not have an electronic patient call bell system. This was on the departments risk register and required additional funding to install a system. Manual bells were provided to each patient, and were kept within reach, for patients to alert staff if they required assistance. Electronic call bells were in place for the progressive care ward beds.

We found no concerns in our review of a sample of safety electrical testing throughout the ward. All equipment we reviewed had been tested and displayed the planned date for the next test. Equipment that was faulty was appropriately labelled as not for use.

Staff core competencies included training and appropriate use of equipment used within the service. We saw evidence of this in our review of four staff files.

Staff disposed of clinical waste safely. Waste was collected in foot operated bins through the ward. Clinical waste was appropriately segregated, bagged and stored awaiting disposal.

We reviewed a selection of consumable stock held within the store room, and on trolleys throughout the ward. All stock we viewed was within the manufacturer's recommended expiry dates.

At the time of the inspection, water was seen to be leaking through the roof of the ward. This was in a communal area of the ward and was due to problems associated with the building's flat roof. This was recorded on the ward's risk register, and the hospital was awaiting contract works to start to repair the roof. Although not affecting any patients, staff assured us they would temporarily close a bed if the leak spread.

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.

As most admissions to the ward were planned as part of elective surgery, assessment of each patient's risks, likely dependency, and acuity needs commenced at the pre-admission assessment stage. Staff worked with the admitting consultant, and pre-assessment nursing team, to understand individual patient needs.

The service ensured appropriately skilled staff were available to support each patient. Shift changes and handovers included all necessary key information to keep patients safe. A formal handover sheet was used to ensure staff were aware of patients' allergies, the procedure/reason for admission to the ward, details of patients' in-situ lines, pain control, medicines and oxygen.

Safety huddles were held at the start of each shift. A handover document ensured that key information about each patient was discussed during these meetings. Staff were informed of any key messages received from the daily hospital communication cell safety briefing, and information from relevant incidents or alerts was also shared.

All clinical staff on the ward had immediate life support training, which was reviewed annually. All sisters and senior sister nursing staff had received advance life support and paediatric life support training. Seventeen staff, including the speciality and associate specialist doctors had received cardiac advanced life support training.

Critical care

The ward held one resuscitation trolley, which was compliant with guidelines issued by the Association of Anaesthetists and the Resuscitation Council (UK). The trolley was secured with security tags; which meant that staff could be assured it had been checked and held appropriate supplies of equipment. In addition, the ward had trolleys for difficult airways and chest opening; both were secured by tags. The clinical services manager told us that lockable trolleys had been ordered to replace the current trolleys as it was recognised these could not be kept dust free. The new trolleys were expected to arrive imminently.

We checked a range of equipment and consumables held on the trolleys which were within their manufacturer's recommended expiry dates. We reviewed the trolley check logs, which were completed. Daily automated external defibrillator check traces were taped into a book held on the trolley, which ensured a robust audit trail of the daily checks.

Although the ward only transferred patients for clinical reasons to specialist providers, a transfer protocol was in place that had been agreed by the Greater Manchester, Cheshire and Mersey, and Lancashire and South Cumbria critical care operational delivery networks. The protocol enabled clear communication and information handover between critical care and ward staff. There had been no transfers out of the ward in the 12 months prior to the inspection.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. All four patient records we reviewed included risk assessment for the development of venous thromboembolism (blood clot), the development of pressure ulcers, and the risk of falls. We saw evidence that patients were reassessed as their conditions changed, and that blood clot prophylaxis medicines were prescribed and administered appropriately.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients' physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation were continually monitored and recorded to determine if escalation of care was needed. This enabled staff to calculate and, where necessary, escalate the patient's care accordingly, using the National Early Warning Score system (NEWS2).

All beds on the ward were connected by telemetry to the nurses' station, which meant that vital signs could be monitored remotely. A further twelve beds, used for cardiac patients, throughout the hospital were connected by telemetry to the ward, which enabled staff on the ward to monitor the patients remotely and to send the outreach nurses to provide advice and support to the ward staff as necessary.

We saw evidence in the records that nursing staff escalated care to the ward's medics appropriately if a patient showed signs of deteriorating.

Staff had received training in the recognition and identification of sepsis using the corporate sepsis screening and action tool. This incorporated the use of the Sepsis Six bundle, which consists of three diagnostic and three therapeutic steps all to be delivered within one hour of the initial diagnosis of sepsis. Staff had a clear understanding of sepsis and to monitor the signs for it and could access the hospital's sepsis guidelines. Algorithm flowcharts for identification and management of sepsis were displayed in the staff room.

Nurse and allied professional 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. The clinical services manager regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe. The ward was led by the clinical services manager and employed two senior sisters, six sisters, two charge nurses, seven registered nurses, one assistant practitioner, and two senior healthcare assistants.

The clinical services manager calculated and reviewed the number and grade of nurses, and healthcare assistants needed for each shift in accordance with national guidance. Staff duty rotas, which we reviewed during the inspection, were planned and agreed by the clinical services manager five days in advance to ensure enough staff were available for the planned admissions to the ward. This meant the service met the core standard recommendation to provide one nurse to one patient care

Critical care

for level three patients and one nurse to two patients care for level two patients. In addition, the planned staffing levels included one nurse to four patients on the progressive care ward.

The clinical services manager could adjust staffing levels daily according to the needs of patients. The clinical services manager reviewed the planned rota daily to ensure there were sufficient staff to safely meet the needs of all patients on the ward, including any unplanned admissions. The clinical services manager was supernumerary and, as such, was able to undertake clinical duties to meet any unexpected demands on the service.

We observed staff refusing to take a patient from the theatre recovery area when there was insufficient staff on the ward to provide safe care. The patient was subsequently cared for by recovery staff until such times as they could be safely transferred to the critical care ward.

Each shift had an allocated lead nurse. The lead nurse was not supernumerary but had a reduced clinical workload and was supported by at least one senior sister per shift or the supernumerary clinical services manager.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. During our inspection the ward was particularly busy, which meant there was little room for flexibility for unexpected occurrences. We observed at one point, a nurse providing care to a level three patient left the patient to assist a colleague with another patient; this was a potential risk although there was no negative impact on the patient.

The service did not have any vacancies at the time of the inspection. However, the clinical services manager had undertaken succession planning for a nurse that was due to leave; the post had been advertised.

The service had a 16.7% sickness rate in June 2019. However, this proportionately large rate was reflective of the small numbers of staff on the ward, and the use of the same cost code for staff on Chester ward (due to four staff being on a 50/50 split between the ward and Chester ward).

The clinical services manager limited their use of bank and agency staff and requested staff familiar with the service. Regular bank nursing staff were used as required to fill any gaps in the rota; this included bank staff who had previously been employed directly on the ward and were very familiar with the policies and procedures.

The clinical services manager made sure all bank and agency staff had a full induction and understood the service. Bank staff were expected to complete all relevant mandatory and clinical competency training, and the clinical services manager monitored this.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

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

The service was clinically led by two lead consultant intensivists supported by a further eight consultant intensivists. Consultant cover was scheduled for 24 hours a day, seven days a week. This meant, at full capacity there was one consultant for eight patients (five in the main ward and three in the progressive care ward). This maintained, and exceeded, the consultant to patient ratio recommendations of the core standards of one consultant for every eight to fifteen patients.

Eight speciality and associate specialist (SAS) medical staff provided on-site support to the service.

All consultants lived within an appropriate area to meet the core standards of attending within 30 minutes. There was sufficient consultant cover to ensure patients were reviewed by an on-call consultant intensivist 24 hours, seven days a week. However, although ward rounds were undertaken twice a day and all patients on the ward were reviewed by their admitting consultant and received a nurse-led multidisciplinary review, at the time of the inspection the service did not provide twice daily consultant intensivist ward rounds as per the core standards.

The service had enough medical staff to keep patients safe. We reviewed the consultant and associate specialist medical rota which confirmed there were sufficient medical

Critical care

staff scheduled for the usual demands of the service. However, staff told us the ward could be left unsupported if the associate specialist was called away to attend the wards as part of the outreach team.

AHP Staffing

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

The service had dedicated physiotherapy staff to support the needs of the patient. The ward was supported by the hospital's critical care physiotherapy team. This meant the service ensured assessment and provision of physiotherapy input for at least 45 minutes per session daily in line with the core standards.

Although the service did not have dedicated dietetic or speech and language therapy staff, nursing and medical staff were able to request referrals for patients to these specialities. Staff told us they received a timely response to referrals.

The service had a full-time dedicated pharmacist who was competent in delivering care to level two and level three patients. This met the core standards requirements.

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 critical care service predominantly used paper records with blood test results reported electronically.

We reviewed four sets of patient records. Each patient recorded included pre-printed care pathway booklets, which included clear guidelines within each document; for example, the cardiac surgery integrated care pathway.

We noted that records for patients with complex needs or those that had a number of care pathway booklets were not always easy to navigate, or to find information. We saw an example where it appeared there was no record of a doctor's interventions following a patient being extubated; however, it later became clear that the note had been entered but into another booklet within the patient's

records. This demonstrated a potential risk that important information could be overlooked or missed. This was a known risk that was included on the departmental risk register with controls and mitigation recorded.

All the records we reviewed included a summary of events requiring admission to the ward; risk assessments; pain assessments; screening for delirium; monitoring of observations, early warnings scores and escalation of care as necessary; nutrition and fluid balances; and, consent for treatment. However, we were unable to find any clear evidence in the records indicating discussions held by medical or nursing staff with the patient or their carers.

The ward had undertaken two health documentation audits (six records) in September 2018 and December 2018. This showed an improvement from 79% compliance to 93% compliance with the hospital's record keeping standards. A new audit was introduced in June 2019 to review documentation in line with the patient pathway; this showed a compliance rate of 86%.

Medicines

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

The critical care service had a dedicated critical care pharmacist; this was in line with the core standards. Absence cover for the critical care pharmacist was provided by the hospital's pharmacy team. The pharmacist proactively reviewed, and undertook medicines reconciliation, for all new patients. Patients already on the ward were reviewed twice a day by their admitting consultant.

We reviewed four sets of medicine prescription and administration charts.

Staff followed current national practice, and regional practice under the Greater Manchester Formulary, to check patients had the correct medicines. All the records indicated that medicines reconciliation (checking and listing the medicine patients are taking) had been carried out within 24 hours of admission, and any changes were recorded.

All medicines prescriptions were legible, signed, dated and documented any patient allergies to medicine. Venous thromboembolism (blood clot) prophylaxis and antibiotic

Critical care

medicines had been prescribed and administered appropriately in line with relevant guidelines for the patients who required them. Omission of medicines were recorded along with the reasons where applicable.

The critical care pharmacist had been instrumental in designing a new medicines chart. This was to ensure that prescriptions were only written for five days at a time, which prompted staff to regularly review medicines for long-term patients on the ward.

We observed two nurses checking and witnessing medicines, and undertaking positive patient identification, before administering the medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw evidence that medicines and antibiotics were subsequently reviewed, with clear instructions from the pharmacist recorded.

Although none of the records we reviewed demonstrated review by a microbiologist, this was likely related to the timing of our review of the records. Staff told us that the microbiologist attended the ward daily to review antibiotic usage, supported by the ward's pharmacist.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Stock levels were checked, and replenished, on a weekly basis by the pharmacy team. Stock was rotated to ensure the oldest medicines were used first.

Medicines and fluids were held securely in locked cabinets within temperature controlled rooms. We checked a range of medicines held; all were within the manufacturers' recommended expiry dates.

Controlled medicines were stored in locked cabinets. We reviewed a range of controlled medicines held and all were within the manufacturers' recommended expiry dates. A random sample of the associated log books showed double signatories and correct stock levels.

Temperature sensitive medicines were stored appropriately within locked fridges. A random selection of medicines in the fridges were within the manufacturers' expiry dates.

Staff manually recorded the maximum, minimum and actual temperature ranges within the ambient temperature of the rooms and in the fridge. We reviewed the temperature logs between March and July 2019 which had

been completed for all but seven days. A process for checking and sign-off by the clinical services manager was in place and any issues of concern were discussed with staff.

Anaphylaxis kits were available on the ward, and also held with the transfer trolley. These were sealed wards; all seals were intact and within the recommended expiry dates.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were cascaded centrally by the hospital, and the clinical services manager ensured staff were made aware of any alerts during the safety huddle.

The pharmacist introduced monthly seven-minute learning briefings. In July 2019, the briefing focused on medicines management and medicines reconciliation. It was expected the briefing in August would relate to the findings and learning from the hospital's controlled drugs audit.

Incidents

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

The clinical services manager 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. The clinical services manager ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report, including near misses.

Between August 2018 and July 2019, the critical care service reported 57 incidents. Of these, ten were classed as no harm incidents. The remaining 47 incidents were classed as low harm incidents, of which 13 were unplanned admissions and nine were related to pathology (including three where the results were not reported within the required timeframe). There were no other themes or trends identified within the incidents reported.

The critical care service had no never events. Never events are serious patient safety incidents that should not happen

Critical care

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 shared learning about incidents with their staff and across the hospital. These were shared in the daily communication cell and staff handover meetings, and in the monthly multidisciplinary meetings.

Staff received feedback from investigation of incidents, both internal and external to the critical care service. Feedback was shared individually to involved staff members, and more generally in the ward team meetings. Urgent information relating to incidents was shared at the daily safety huddles.

Safety Thermometer (or equivalent)

The service continually monitored safety performance. Staff collected safety information.

In the twelve months prior to the inspection, the clinical services manager told us of one patient fall where the patient slipped out of bed but came to no harm. Falls risks assessments were carried out for patients on admission and were reassessed throughout the patients stay on the ward. Patients at higher risks of falls or delirium were cared for in a bay opposite the nurses' station.

In the same period, the clinical services manager told us one patient developed a grade two to three pressure ulcer as a result of their underlying condition, which meant they could not initially be placed on an air mattress. Learning had been shared with staff.

There were no ward acquired catheter related urinary tract infections.

Are critical care services effective?

Good 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff in the critical care service used a wide range of evidence-based corporate and local policies, protocols and patient pathways based on national guidelines, such as the Intensive Care Society, National Institute for Health and Care Excellence (NICE), as well as guidance published by the relevant professional medical bodies such as the Royal Colleges and British Medical Association.

We reviewed several policies during the inspection, such as the BMI corporate care of the deteriorating patient policy (BMI NURpol33), the BMI corporate care of the deteriorating patient manual (BMI NURman04), and the hospital's local standard operating procedure on the deteriorating patient – escalation process, critical care outreach (BMI-ALX-NUR-SOP35).

All documents we reviewed referenced up-to-date relevant national guidance such as NICE clinic guideline CG50 - Acutely Ill Patients in Hospital. Recognition of and response to acute illness in adults in hospital. Centre for Clinical Practice at NICE (2007), and resuscitation guidelines published by the Resuscitation Council (UK). The documents also referenced the use of recognised national tools such as the SBAR (situation, background, assessment, recommendation) tool, which enables effective communication between members of the multidisciplinary team; and, the national early warning score (NEWS2) tool for monitoring and escalating deteriorations in a patient's condition.

The ward held a national safety standard for invasive procedures folder. This included safety checklists for chest drains, nasogastric tube insertion, tracheostomy and bronchoscopy procedures.

The critical care service was part of the Greater Manchester Critical Care and Major Trauma Network, which provides a whole system approach to the delivery of safe and effective services across the Greater Manchester region. Although the service had not needed to transfer any patients out to NHS hospitals, the ward supported and worked to the network's emergency critical care transfers from independent hospitals to NHS care protocol.

Critical care

The service had not been peer reviewed by the network, but it participated in, and submitted data and information to, the network's risk over network (RiCON) project. The RiCON project aims to improve patient safety within the regional critical care network by allowing different wards to share problems and best practice to improve the quality of care offered to all critical care patients in the network.

At handover meetings, staff routinely referred to any relevant psychological and emotional needs of patients, their relatives and carers.

Staff carried out assessment of delirium (acute confusion) in patients at risk of delirium using the 'Confusion Assessment Method for intensive care' (CAM-ICU) guidelines. This was supported by the use of a confusion assessment flowchart which was clearly displayed on the ward. Assessment was undertaken every 12 hours.

Processes were in place to undertake mortality and morbidity reviews with the aim of identifying any areas of improvement or learning for the service from deaths.

The critical care service had a standard operating procedure for organ donation and had trained staff on it. The service had close links with the specialist nurses for organ donation based at a local NHS trust.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had support with nutrition and hydration to meet their needs.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it. The critical care ward did not have a dedicated dietician; however, dietetic review and support was available to all patients that required it. Similarly, speech and language therapy support was available if required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff fully and accurately completed patients' fluid and nutrition charts where needed. Our record review indicated that none of the patients we reviewed required specialist dietetic input

or speech and language therapy assessment; however, all four records showed that nursing staff had appropriately and accurately recorded patients' fluid and nutritional balances.

During the inspection we observed the hospital's chef attending the ward to discuss with a patient the available food options to meet their individual health requirements.

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. There were processes in place to assess patient's pain. Individual care plans included pain assessments for all patients. This was reflected in all four records we reviewed.

Patients received pain relief soon after it was identified they needed it, or they requested it. Our records review showed that patients were provided with pain relief promptly when required.

Staff prescribed, administered and recorded pain relief accurately. Pain relief was routinely prescribed as part of individual patient management, and additional pain relief was available at patient request. A new pain nurse was expected to join the hospital the month after the inspection.

Patient outcomes

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

Staff in the ward delivered care and treatment in a highly effective way that achieved positive and consistent outcomes for people who used the service. The service was benchmarked nationally against similar wards and had achieved significant patient outcome results; no patients that had received care in the ward had subsequently died, no patients had acquired an infection on the ward, high-risk admissions and re-admissions were low.

Critical care

Between April and December 2018, the critical care ward provided care for 139 patients, of which 125 were planned admissions. Of the patients admitted, 93 patients were provided with level three intensive care and 46 were provided with level two high dependency care.

The critical care service participated in relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further. The service contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against other similar units and with all units in England.

Between April and December 2018, the service had a lower than expected risk of unplanned readmission than the England average. Although five patients were re-admitted to the ward within the same hospital stay, none of these were within 48 hours of discharge from the ward.

The service had a lower than expected risk of patients testing positive for ward-acquired infections in the blood than the England average. There were no ward-acquired infections for the same period.

The service had a lower than expected rate of high risk admissions from the ward. Between April 2018 and December 2018, there were no high risk admissions from the ward; this was better than similar wards (1.9%) and better than the national aggregate (6.2%)

Between April 2018 and December 2018 there were no deaths for patients that had been cared for in the critical care ward. This was better than similar wards, and lower than the expected risk of deaths.

Between April 2018 and December 2018 there were no deaths for low risk patients that had been cared for in the critical care ward, where the predicted risk of death was less than 20%. This was better than similar wards, and lower than the expected risk of deaths.

Managers carried out a comprehensive audit programme. The service's leaders worked closely with the Greater Manchester Critical Care and Major Trauma Network and submitted data to the RiCON project. This enabled the service to understand the role it played in critical care services in the region, and to share learning and improvements between regional critical care providers.

Staff had introduced the ICOUGH protocol to reduce the likelihood of chest related infections following a general anaesthetic.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The clinical services manager made sure staff received any specialist training for their role. Seventy per cent of registered nursing staff on the ward had completed a post-registration award in critical care nursing. This was better than the core standard requirement of 50% of staff to hold the award. All bank staff used on the ward had completed the award. One staff member had completed a coronary care course.

The service provided all new staff with a full induction tailored to their role before they started work. The service supported new staff through the step competency framework. The framework was designed to provide staff with the core skills required to care for critically ill patients safely, and to further develop the skills with enhanced knowledge as the staff member progresses through each competency step. Bank staff were expected to hold the same competencies as permanent staff members.

There were enough clinical educators to support staff learning and development. Staff knowledge, skills and development were supported by the service's practice based educator, who was supernumerary when carrying out the role. This was in line with the core standards.

The educator mentored and supported individual staff members on the ward as well as running mock training scenarios, such as transferring a patient to the radiology department with the transfer ventilator. The educator delivered a range of training courses and mini-sessions to staff on the wards. These courses included the use of chest drains, and cardiac pacing.

Staff on the ward had additional link nurse roles to support the ward with additional knowledge and expertise. These included, but were not limited to, resuscitation, blood transfusion, safeguarding, haemofiltration, airway management, medicines management, safe transfer and infection prevention and control.

Critical care

The clinical services manager supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their manager and were supported to develop their skills and knowledge. At the time of the inspection all but one nursing and healthcare assistant staff members in the critical care service had completed their six month, mid-year, appraisal. In the previous reporting year, 95% of staff in the service had received an appraisal.

Medical staff supporting the ward were appraised by their substantive NHS employers. However, a process was in place for sharing the appraisal documentation with the service's leaders.

Multidisciplinary working

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

Nursing and healthcare assistant staff attended safety huddles at the start of each shift. Information about each patient, their needs, and any notable events in their care during the previous shift were discussed. The huddle also shared information about safety alerts, incidents, or learning, and key messages from the hospital's daily communication cell briefings.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. A multidisciplinary meeting was held at 9.45am each day, led by the nurse in charge. Attendees included nurses, physiotherapists, pharmacists, anaesthetist and, if required, a cardiothoracic surgeon.

The meeting summarised each patient's condition, weight and allergies, and care plans, including any known patient risks for all patients on the critical care ward and the progressive care ward. The meeting also discussed any patients that were planned for admission later in the day.

Ward rounds were undertaken twice a day, although these were not always led by a consultant in intensive care medicine. However, due to the nature of service, it was not always possible to co-ordinate a full range of multidisciplinary representation at each ward round. This meant there was a risk that communication between multidisciplinary team members could be disjointed.

The service had set up an encrypted communications group application for the medical staff; this enabled staff to share relevant information quickly and securely, including when off-site.

Medicines, including antibiotics, prescription and usage was reviewed daily by the critical care pharmacist. This included review of antibiotic management by the hospital's microbiologist.

The critical care service had dedicated physiotherapy support, which meant that all patients received 45 minutes of physiotherapy per day, five days a week. This was in line with the core standards. In addition, the hospital had a physiotherapist specialising in bariatric patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was no dedicated dietetic or speech and language therapy support for the ward; however, staff made referrals to external dietitians and speech and language therapists as required. Staff told us there was a quick response to requests from the dietetics service, although this was only available Monday to Friday.

Staff could refer patients to a tissue viability nurse if required.

Seven-day services

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

The critical care service was available seven days a week. Most of admissions to the ward were planned admissions following surgery.

Staffing rotas showed that nurse staffing levels and consultant cover were sufficient to meet the core standards. The critical care service maintained on-call consultant and specialty and associate specialist (SAS) medical cover seven days a week, 24 hours a day.

The critical care service was supported by 24-hour pathology services and radiology services which were available within 30 minutes of request.

Consultants attended daily ward rounds on the ward, including weekends. Patients were reviewed by their admitting consultant twice daily in line with their care pathway.

Critical care

Dedicated critical care pharmacy support was provided by the critical care pharmacist. Out of hours and at weekends the ward was supported by the hospital's on-call pharmacy team.

Health promotion

There were limited opportunities for staff to undertake health promotion, due to the nature of the care provided by the ward. However, the service supported staff to promote healthy lifestyles to patients including smoking cessation at relevant opportunities.

The physiotherapy team took the opportunities to discuss rehabilitation needs with cardiac patients.

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. They used agreed personalised measures that limit patients' liberty appropriately.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards. All staff had completed training relating to the two Acts as part of their mandatory safeguarding training.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They understood that consent was decision-specific.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. They followed the service's policy and procedures when a patient could not give consent.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Written consent was obtained during the pre-admission assessment stage.

Staff were aware of the potential impact of delirium on patient's capacity to consent. Staff assessed this daily using the confusion assessment method for intensive care wards (CAM-ICU)

The clinical services manager monitored the use of Deprivation of Liberty Safeguards. The clinical services manager told us they were aware of only one occasion where a Deprivation of Liberty Safeguards application had been made to the local authority for a patient experiencing significant delirium. The patient's condition subsequently improved and they were transferred out of the ward before the local authority were able to assess the patient.

Are critical care 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.

During the inspection, we observed staff providing care and treatment and speaking with patients in a calm, compassionate and kind manner.

Staff were discreet and responsive when caring for patients and were conscious of maintaining privacy as best possible within the treatment bays. Staff took time to interact with patients in a respectful and considerate way. Staff were motivated to provide person centred care.

Patients said staff treated them well and with kindness. We spoke with four of the five patients that were receiving care on the critical care and progressive care wards. All four patients spoke positively about the staff and the care provided.

One compliment card displayed on the ward stated, "The staff were very attentive, and the service was excellent".

Critical care

The hospital monitored patient satisfaction through a patient survey and separate inpatient and outpatient friends and family postcard feedback systems. The data was not disaggregated into specific wards or ward type. As such it was not possible for us to determine results of the critical care ward.

However, in March 2019, 97.8% of all patients who participated said they were extremely likely or likely to recommend the service to the friends and family. This increased marginally to 97.9% for inpatient respondents only.

In the same period, 99.1% of all patients who participated said the quality of care was excellent, very good, or good. This increased marginally to 99.5% for inpatient respondents only.

Between October 2018 and March 2019 an average of 91.8% of patients who responded to the patient survey were satisfied with their overall impression of nursing care. This was in line with the National Institute of Health and Care Excellence's Patient experience in adult NHS services quality standard QS15 statement one. A range of thank you cards were displayed in the ward from patients and relatives who were appreciative of the care and service they were given.

Emotional support

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The ward held a spiritual need and contact details folder, which included relevant information for a range of religious and spiritual belief.

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. Although, between October 2018 and March 2019, an average of 45.6% of respondents to the patient satisfaction survey said there was someone at the hospital they could talk to about their worries and fears, 90% of these were satisfied with the helpfulness of the discussion.

Patients were treated with dignity by all staff involved in their care, treatment and support. This was reflected in the

patient survey which indicated that, between October 2018 and March 2019, an average of 99.8% of patients who responded (all hospital patients) were satisfied that they were given privacy when discussing the condition or treatment.

All patients were reviewed by the senior critical care team following discharge from the ward; patient diaries formed a useful tool in the support of patients, assisting them to understand the care and treatment provided during their admission to the critical care ward.

After discharge, a critical care nursing team member followed-up all the ward's long term patients (those admitted for longer than 48 hours). In addition, and voluntarily, the team member contacted each patient a year after their discharge.

The ward was embedding links with the critical care support group at a local NHS hospital; groups were held several times during a year and were open to patients who had received treatment in a critical care setting.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. In March 2019, the patient survey had a 9.3% response rate. This was a higher response rate than the first six months of 2018; however, it had dipped from a maximum response rate of approximately 24% in December 2018.

However, a high proportion of patients gave positive feedback about the service in the Friends and Family Test survey, with over 40% response rates in December 2018, February 2019 and March 2019.

Staff made sure patients and those close to them understood their care and treatment. In the hospital wide patient survey, between October 2018 and March 2019, an average of 98.5% of respondents said they were satisfied that they were given information by their consultant, while 99.7% of patients were satisfied that their proposed treatment had been explained to them by their consultant.

Staff supported patients to make informed decisions about their care. In the patient survey, for the same period, an

Critical care

average 99.8% of respondents were satisfied that they were involved in decisions about their care and treatment, while an average 90.4% said they were satisfied with the level of involvement in decisions about their care.

A compliment card displayed on the ward said, “Thank you for all the kind care and attention given to me on my stay with you during and after my operation.” A friends and family comment card stated, “from pre-op, operation, recovery, ICU and to the ward - all was excellent.”, while another said, “All staff were great, especially ICU and HDU.”

The ward supported, by agreement, open visiting for relatives and carers of patients. A comfortable relatives’ room, including en-suite facilities, was located across the corridor from the ward. Although the room did not include sleeping facilities, overnight stays could be accommodated for relatives, if required and available, on the wards.

Are critical care services responsive?

Good 

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population and were in line with the guidelines and standards of the Greater Manchester Critical Care and Major Trauma Network.

The service planned and provided their services in a way that were tailored to and met the individual needs and preferences of local people. The service had systems to help care for patients in need of additional support or specialist intervention. This meant the service was able to offer care and support to critically ill level three patients and meant that transfer of such patients to other local NHS organisations was rare and only for clinical reasons.

In addition, staff were trained in cardiac advanced life support, which meant patients requiring urgent cardiac intervention through the opening of the chest could be supported on the ward.

Facilities and premises were adequate for the services being delivered on the ward; although the ward’s leaders recognised that significant infrastructure investment was needed to fully adhere to the Guidelines for the Provision of Intensive Care Services.

The ward had a point of care blood gas analysis machine. This enabled staff to quickly obtain relevant results to assist in planning patients’ care. The machine had in-built protection systems to ensure that only staff who had current training on the machine could use it, and it automatically checked if the testing cartridges were within their manufacturer’s recommended expiry date.

The critical care service provided an outreach assessment service into the wider hospital. The outreach team were supernumerary to the ward staff establishment when in the outreach role, and included a senior nurse (the clinical services manager, associate director or resuscitation officer) and the on-site critical care doctors. The team provided assistance and advice to ward staff for patients that were at risk of deteriorating.

The service supported the hospital’s contract with regional NHS trusts in providing care for patients admitted for bariatric surgery and cardiac surgery. The service had twelve telemetry links to monitor the vital signs of cardiac patients throughout the hospital. This meant that staff on the ward, or the outreach staff could respond quickly to any alarms indicating the patient may be deteriorating.

The service had standard visiting hours between 10am and 10pm; however, by agreement with the lead nurse, open visiting could be supported on the ward. A relative’s room was available across the corridor from the ward; this included comfortable chairs, telephone and television. Overnight visitor accommodation could be supported within the wards if a room was available.

The ward worked with the regional specialist nurses for organ donation.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach; however, the facilities provided by the progressive

Critical care

care ward meant that staff were able to discharge a patient from the critical care ward to the progressive care ward while awaiting transfer to a ward. This meant the service had not breached the single sex accommodation standard.

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.

Most of the admissions to the ward were pre-planned to support patient recovery after elective surgery. This enabled the clinical services manager and consultant intensivist to plan nursing and medical staffing levels accordingly to meet the needs and the acuity of the patients.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Telephone and face-to-face translation services were available if required; this included access to British Sign Language interpreters.

The ward was designed to meet the needs of patients living with dementia. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The ward had been assessed by an admiral nurse (specialist dementia nurse). As a result of feedback provided, the ward had installed dementia-friendly clocks in each bay, and toilet seats had been replaced with high-contrast colour seats.

The hospital had been assessed under the Patient-led Assessment of the Care Environment (PLACE) framework in May 2018. The site was compliant with 17 out of the 18 elements of the assessment relating to dementia (for example, flooring, lighting and toilet fixtures); the outstanding element related to distinguishing door signage between public and staff only areas.

The ward supported the use of the 'This is me' hospital passport and patient diary. We reviewed a diary for a patient on the ward at the time; this included entries from staff and from the patient's relatives.

Beds on the ward had been recently replaced and were capable of supporting bariatric patients up to a weight of 250kg. Additional bariatric equipment and chairs was available in the hospital if required.

Patients were given a choice of food and drink to meet their requirements, cultural and religious preferences.

We did not see evidence that the service had information leaflets available in languages spoken by the patients and local communities, other than English. However, consent forms were available in a range of different languages.

The ward had a multi-faith information folder that staff could access. This included important information relevant to each of the main faith groups, including contact details for chaplains and clerics.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Most admissions to the ward were planned following elective surgery. This meant that bed occupancy was usually planned. However, the clinical services manager reviewed staffing levels on a daily basis to ensure there was sufficient permanent, or bank, staff available to meet the needs of any unexpected and unplanned admissions.

The time of admission to the ward was recorded on all four patient records we reviewed. However, the time of initial review by a consultant or doctor was not always clearly recorded within the records we reviewed. There was therefore insufficient evidence for us to determine if patients were initially reviewed by doctors within the recommended timescales set out in the core standards.

Between April 2018 and December 2018, data submitted to the Intensive Care National Audit and Resource Centre (ICNARC) showed the critical care ward provided care for 139 patients, of which 44 stayed on the ward for longer than 48 hours. Five of the admissions were unplanned admissions following elective surgery, and three were admissions following emergency surgery. The ward admitted six deteriorating patients from the ward areas.

The service monitored patients' length of stay on the ward. Between April 2018 and December 2018, on average,

Critical care

patients stayed 1.8 days on the critical care ward. This was slightly higher than the average length of stay at similar wards (1.1 days) but shorter than the national aggregate (2.1 days).

Between April 2018 and December 2018, 135 patients were discharged within four hours of being fully ready for discharge (lines out), 2 patients were discharged between four and 24 hours of being fully ready, and only one patient was discharged after 24 hours of being fully ready. However, we found no evidence to indicate that any breaches of the single-sex accommodation guidelines had occurred.

Delayed discharges

Managers and staff worked to make sure patients did not stay longer than they needed to.

Between April 2018 and December 2018, there were 2196 available bed days in the critical care ward. The average percentage of bed days occupied by patients with discharge delayed more than eight hours was zero per cent. The ward performed better than similar critical care wards (0.1%) and better than the national aggregate of 4.3%.

Non-delayed out of hours discharges to the ward

Staff did not move patients between the ward and wards at night unless they needed to, and with agreement of the onsite escalation managers.

Between April 2018 and December 2018, two patients were discharged to the wards between 10pm and 7am. The clinical services manager told us these were exceptional and due to a bed being needed urgently for patients of high acuity.

This equated to 0.7% of admissions that resulted in a non-delayed, out-of-hours discharge to the ward. This was within expected range and better than the national aggregate of all wards (1.8%); however, the ward performed slightly worse than similar wards (0.4).

Non-clinical transfers

The service moved patients only when there was a clear medical reason or in their best interest. Between April 2018 and December 2018, the critical care ward did not transfer any patients out to other NHS healthcare organisations. This was reflected in the ward's data submission to ICNARC, which also showed there were no transfers out from the

ward for non-clinical reasons. On this measure, the ward performed within the expected range and better than similar critical care wards (0.1%) and the national aggregate of all wards (0.3%).

Staff were trained in the transfer policy and process, and transfer equipment used was in line with the requirements of the Greater Manchester Critical Care and Trauma Network.

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.

Between October 2018 and the inspection, the critical care service did not receive any complaints.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with did not have any concerns at the time of the inspection.

The hospital clearly displayed information about how to raise a concern in patient areas. Information on how to provide feedback or complain was displayed in the hospital reception. Information on how to complain was included on the hospital's website, including details of the second-tier independent complaints adjudication service.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Complaints and associated documentation were managed through the hospital's incident reporting systems. Although the ward had not received any complaints, they would be investigated in line with the hospital's complaints policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. The clinical services manager shared any learning from complaints, including those highlighted in the wider hospital, at team meetings and at safety briefings as appropriate.

Critical care

Patient satisfaction feedback including patient survey data, patient forum feedback, complaints, and feedback on the NHS Choices Website were reviewed quarterly by the triangulation of patient feedback committee chaired by the hospital's executive director.

The ward displayed a range of compliment cards. One patient wrote "Thank you so much for treating me and being such a welcoming and kind team", while another wrote "Thanks for your fantastic care after my heart surgery. The care given was outstanding..."

Are critical care services well-led?

Good 

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

Leadership

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

The critical care ward delivered its services within the hospital's clinical services division led by the Director of Clinical Services supported by the associate Director of Clinical Services for nursing. Both senior staff members had joined the organisation within the previous six months.

The clinical services manager had been in post for two years, although had twenty years' experience at the hospital in a range of roles, including deputy manager for the critical care ward, tissue viability nurse, and staff nurse. The manager had been an advance life support trainer. The ward was medically led by two consultant anaesthetists, both of whom had significant experience within the NHS.

The clinical services manager was supported by a deputy manager and a team of eight senior sisters, sisters and charge nurses, two senior staff nurses, six registered nurses, an assistant practitioner and two senior health care assistants. Staff were aware of and could describe the managerial and escalation structures within the ward.

All staff we asked told us they felt supported by the clinical services manager and the senior leadership. Staff felt their leaders were visible on the ward, were supportive and approachable. During our inspection we observed the senior leaders visiting the ward daily.

The clinical services manager understood, and could describe the ambitions, priorities, the issues and challenges for delivering the critical care service. Environmental infrastructure and equipment were the main challenges for the ward but were dependent on the need for hospital and/or corporate funding.

Although the clinical services manager was able to describe plans for remedying a number of individual issues on the ward, such as a roof leak, it was unclear if or when more significant structural development would be undertaken to achieve the ward's ambition and to meet the environmental elements of the core standards.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had vision to be the "leading provider of private healthcare in the northwest of England [delivering] outstanding care and patient experience". This was supported by a five year developmental strategy to upgrade rooms and departments. The critical care ward's vision was "to provide high quality safe, evidence-based compassionate care to our critically ill patients and support those that care for them, both family and staff."

The clinical services manager described the development plans for the ward to underpin its vision. This included increasing the bed capacity from five critical care beds and three progressive care ward beds to five beds of each type. This was dependent on physical restructuring of the facilities, and the provision of additional ventilators. The clinical services manager also described the ambition to provide critical care to patients with neurological needs but recognised this would require significant investment in equipment and training.

Critical care

Development plans, new business leads, and ideas were discussed regularly by the senior hospital team in conjunction with the marketing team. Staff told us they were regularly told about any plans affecting the ward in staff forums.

Culture

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

We spoke with medical, nursing, pharmacy and allied health professional staff during the inspection. Staff we spoke with were proud of the critical care service and the hospital as a place to work, with the positive culture supported by the clinical services manager. The culture of the ward was focused on the needs of the patients.

Staff at all levels told us they were able to speak with their line or senior managers about any concerns and to request a temporary stop to procedures without any fear of repercussions if they had any safety concerns.

Staff on the ward had recently contributed towards a ward-specific survey. The data from the survey had not been collated or analysed by the time of the inspection; however, we were able to review the raw survey responses. These indicated primarily positive or neutral responses to most questions with only a few fewer positive responses relating to communication and the discussion of error themes. However, communication and incident/error investigations were not an area of concern for the staff we spoke with during the inspection.

We saw evidence of the service complying with the regulatory duty of candour in line with the joint Nursing and Midwifery Council and General Medical Council guidance, Openness and honesty when things go wrong: the professional duty of candour. The duty of candour requires a health service body, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, to notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

The hospital's incident reporting system included an automatic trigger for staff to consider the duty of candour

where appropriate. The clinical services manager understood the regulatory duty, and staff were able to describe the need to be open and honest with patients and carers.

Governance

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

Governance within the critical care service was led by the clinical services manager. Medical governance was shared by the two lead consultants; one was a member of the medical advisory committee, while the other chaired the hospital's blood transfusion committee.

Governance oversight of the critical care services was provided through the quarterly resuscitation and critical care committee. The meeting had oversight of performance across a range of measures include staff training, medicines management, risks, complaints, incidents and lessons learned.

Staff also attended or fed into the infection prevention and control committee; information governance committee; pain management committee; medicines management committee; dementia committee; and, the senior managers clinical service managers and heads of department meeting.

A systematic approach was taken to working with other organisations in the Greater Manchester Critical Care and Major Trauma Network to improve safety and care outcomes. The clinical services manager attended the network meetings. Although the ward was not yet fully compliant with the core standards, the close relationship with the critical care network promoted the safety and consistency of services, processes and equipment.

Processes and systems were in place to undertake mortality and morbidity reviews of any deaths on the critical care ward as part of governance meetings. However, as there had been not deaths by the time of the inspection, the effectiveness of such meetings had not yet been tested.

Critical care ward meetings were bi-monthly. We reviewed the minutes of the last meeting. The meetings included

Critical care

review of and sharing learning from incidents; concerns and complaints; patient safety, pharmacy and Medicine and Healthcare products Regulatory Agency alerts. The clinical services manager was able to describe one such alert relating to potential infection prevention and control risks associated with electrocardiogram leads; the ward had responded to this by obtaining disposable leads from the manufacturer.

The ward was represented at the hospital's daily communication cell ('Comm Cell) meeting at 8.45 each morning. The meeting had a standard agenda and looked at a range of service aspects such as an update from each service to include staffing, patient numbers and issues, general hospital wide updates such as health and safety, incidents and shared learning, and the clinician and manager on call for the day

Information from the comm cell meeting fed directly into the ward's safety huddles which were undertaken twice a day at shift handover. Safety huddles were structured and shared relevant clinical and social information about each patient, their condition and any areas of concern; for example, if the patient was living with dementia. The structured handover form also included confirmation that each bed area had been cleaned, and that controlled drugs had been appropriately checked.

Processes were in place to ensure that bank staff received any relevant procedural changes and learning.

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.

The clinical services manager and lead consultant could describe the main risks to the critical care service. These included risks associated with the environment, equipment, the use of paper records, staffing and adherence to the Guidelines for the Provision of Intensive Care Services.

These were reflected in the ward's risk register which, at the time of the inspection, included seven open risks. Each risk has been graded with three classified as medium risk, two classified as low risk and the remaining classified as very low risk.

Each risk had an action owner. Although the copy of the register we viewed did not detail the mitigations or control measures, the clinical services manager described the actions that had been identified to address the risks; for example, corporate agreement and funding was being sought for replacement of three main ventilators, all of which were approaching the end of usable life; and corporate investment was required to address environmental risks including the replacement of windows on the ward and repair of the roof.

A risk identified in the last inspection had recently been addressed; the transfer ventilator had been replaced and was compliant with the requirements of the Greater Manchester Critical Care Network.

The critical care service participated in a clear audit plan for 2018/19, which included audits of controlled drugs and medicines management; critical care discharge planning; health documentation and the patient pathway; infection prevention and control; and management of risk of venous-thromboembolism.

Staff from the ward participated in the Greater Manchester Critical Care and Major Trauma Network and Risk over Network (RiCON) project meetings. This enable the service to share and obtain information relating to critical care risks and performance. Similarly, the clinical services manager attended the Spire quarterly critical care nursing network meeting.

Managing information

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

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Critical care

The service subscribed to the Intensive Care National Audit and Research Centre (ICNARC). This meant the service was able to benchmark its performance against other similar wards and with all wards in England.

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Patient records were predominantly paper based. However, in conjunction with electronic reporting of test results, staff told us they had all the information needed to provide safe care and treatment.

Standard operating policies works instructions and procedures were available on the hospital's intranet. We reviewed a range of policy and procedure documents held and these were the latest versions; all had a clear review date in place.

Urgent updates, including patient safety and equipment alerts, were shared with staff during the handover safety huddles.

Engagement

Leaders and staff 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 hospital had a triangulation of patient feedback meeting, which reviewed a range of feedback methods from patients. These included review of patient complaints, patient satisfaction survey returns, NHS Choices on-line feedback, and the patient forum.

The hospital patient satisfaction survey for the three months ending March 2019, indicated that 95% of respondents were satisfied with the information pack provided before their admission, and 98% felt that the instructions provided were clear and easy to understand, although only 50% of respondents were asked if they had any communication needs.

The hospital also benchmarked patients' feedback against other BMI hospitals in the north region. In March 2019, 95% of those that responded indicated that the hospital compared favourably to their expectations. This was marginally lower than the average of all benchmarked hospitals of 95.7%.

The critical care service had undertaken a number of initiatives to engage with patients, families and carers and to improve the care provided. These included providing patient information boards for patient personal use, the introduction as patient passports and diaries, the provision of patient 'pamper packs' including eye masks and ear plugs.

The service told us they were currently looking at introducing other initiatives to improve patient engagement and experience on the ward, including pet therapy, music therapy, complimentary therapies and artwork in the side room.

Although the critical care service had only just implemented a ward-specific staff survey, staff we talked with spoke positively about the level of engagement on the ward from managers and leaders.

The clinical services manager attended the Greater Manchester North West Critical Care Network lead nurse meetings quarterly. Senior nursing staff from the ward attended airway management and safe transfer meetings, hosted by the network, which shared best practice and lessons learnt.

The Director of Clinical Services and associated Director of Clinical Services attended the independent sector matrons' quarterly network meeting, hosted by a regional NHS trust.

Learning, continuous improvement and innovation

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

The critical care service had an embedded relationship with the Greater Manchester Critical Care Network. This promoted safe working and improvements in all the network's wards.

The service supported students from the local universities to experience the provision of critical care services to patients, and to work through critical care competencies.

The service had supported a change to the use of citrate in haemofiltration for patients requiring dialysis while admitted to the ward. The change meant that patients could be transferred to theatre more quickly if necessary.

Critical care

The critical care pharmacist developed a range of new colour coded labels for infusion medicines in critical care to ensure staff were able to easily identify the different types of infusions and infusion rates for each patient's specific needs.

The critical care pharmacist developed delirium guidelines for the Greater Manchester Critical Care network.

A staff member had introduced the I-COUGH programme to the ward. The programme aimed to reduce the number of instances of hospital acquired pneumonia following surgery by providing patients with information, breathing and coughing exercises and advice on keeping their head raised in bed and mobilising.

Services for children & young people

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

Are services for children & young people safe?

Requires improvement 

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

Mandatory training

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

Staff we spoke with confirmed they had enough time to complete mandatory training.

Mandatory training completion was monitored by the ward manager, any staff who had not completed their training were reminded individually.

The service reported 100% of staff had completed mandatory training. The service reported 100% of staff were trained to level three safeguarding children at the time of inspection.

Safeguarding

Staff had training on how to recognise and report abuse.

However, during conversations with staff we found there was a lack of discussion between staff to ensure they fully understood safeguards and lessons learnt. Staff we spoke with said they did not have team briefs to discuss safeguarding, therefore, there was limited opportunity to support learning from safeguarding concerns across the wider team.

Although staff were aware of other concerns that may instigate a safeguarding referral, staff were unable to describe what they would do if a child was missing. Staff were unable to locate the missing child policy and were not familiar with this protocol.

Staff were unaware of child protection plans unless parents disclosed the information at preoperative assessment.

There was no information on display within the ward to inform patients and families about safeguarding concerns and who to contact. We also found no leaflets about female genital mutilation and child sexual exploitation.

Staff had access to an up to date corporate safeguarding children and young people policy, this could be found on the intranet.

All registered paediatric consultants working at the hospital were required to have level three training as part of their agreement when joining the hospital. Evidence of up to date training was kept on file.

Staff had access to a named designated professional for safeguarding, staff escalated any safeguarding concerns to the ward manager who was level four and level five trained.

Staff told us they had not come across any person at risk of female genital mutilation (FGM) or child sexual exploitation but if they had concerns they would discuss them with the safeguarding lead.

The service had introduced a paediatric safeguarding risk assessment at the pre-operative appointment to identify any children at risk. During the pre-operative appointments, we observed the nurse discussed the questions.

Services for children & young people

Staff, patients and visitors were unable to enter or leave the ward without the nurse letting them in or out.

In the patients notes we reviewed, we saw that the service used chaperones, this was always a paediatric member of staff.

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.

Appropriate personal protective equipment (PPE) such as aprons and gloves in small, medium and large sizes were available. All staff adhered to 'bare below the elbow' guidance and washed their hands after each patient contact.

Staff kept equipment and the premises visibly clean. For example, cleaning schedules were up to date and completed. 'I am clean stickers' were placed on equipment after it had been cleaned to indicate to staff it was clean.

Antibacterial rub dispensers were also located at intervals on the corridors and upon entry into the ward.

The paediatric ward reported no cases of hospital acquired infections including; clostridium difficile, MRSA, and methicillin susceptible staphylococcus aureus since it had been opened

We found no concerns with monthly hand hygiene audits; compliance rates were 100% across the last two months. The audit measured hand hygiene according to the '5 moments' approach which defines the key moments when healthcare workers should perform hand hygiene.

The service managed waste appropriately, waste was separated and disposed of in appropriate colour coded bins.

The service did not promote infection prevention control practices in a child friendly way, to children or parents.

Environment and equipment

The children and young people's ward was co-located with the adult medical ward. Authorised staff accessed the ward by a swipe card. However, this meant children walked through the medical ward to access the children's area.

There was no dedicated recovery area for children, children were placed in an area of recovery which was not

separated from the adult area but was screened off from the area used by adults. The environment was not child friendly, however staff we spoke with said they had very few paediatric surgical procedures.

Staff had access to specialist equipment for all age ranges. This included resuscitation equipment, which was available and fit for purpose. The resuscitation trolley was located on the ward, all equipment was checked daily by the paediatric nurse. This documentation was kept on the children's ward. At the time of inspection, we found no gaps on the daily check log.

Post inspection the management team provided information that informed us that staff had access to four paediatric crash trollies within the hospital. These were located on the Children's Ward, recovery, theatre and consulting suite and there were two grab bags, located within the MR Scanner and The Beeches.

Assessing and responding to patient risk

Staff were unable to identify and quickly act upon patients at risk of deterioration because they did not have an escalation process or policy for staff to follow if a child became seriously unwell on the ward.

Although there was no clear process or policy in place to escalate a deteriorating child, staff used the paediatric early warning scores (PEWS) system. This had recently been implemented but was not fully embedded. Staff completed the chart, but an audit showed that although scores were written these were not totalled and therefore it was not clear how staff could identify a child who's score could indicate a deterioration. As a recommendation from the audit extra training had been put into place and the PEWS charts were changed to become more user friendly.

Following our inspection, we raised this with the hospital management team and a review of the provisions for managing a deteriorating child was undertaken before we left the hospital. As a result, the service incorporated information about how to use the Paediatric Early Warning Score and information about the management of a deteriorating child within the Children's Resuscitation Policy.

The ward manager said staff followed the National Institute for Health and Care Excellence (NICE) guidelines for sepsis recognition, diagnosis and early management. However, the service did not have a sepsis policy and staff we spoke

Services for children & young people

with were unaware of where the sepsis pathway was kept or what sepsis six was. Sepsis is a life-threatening reaction to an infection that can lead to tissue damage organ failure or death. The sepsis six bundle is the name given to the bundle of medical interventions which are given to patients within the first hour to reduce mortality of sepsis. We were later told by the senior leadership team that the sepsis pathway was within the resuscitation booklet which was kept on the resuscitation trolley.

We found no evidence of staff having access to a sepsis care bundle for the management of patients with presumed/confirmed sepsis. We found there was no escalation policy for patients with resumed/confirmed sepsis. The service had not suspected or treated any children for sepsis and therefore we were unable to confirm if staff delivered treatment within the recommended sepsis pathway timelines. However, staff had access to information relating to sepsis. Information received post inspection confirmed sepsis scenarios would continue to be delivered as part of paediatric intermediate life support training.

When staff were asked about escalation and transferring seriously unwell children, they were unable to articulate what they would do and were unable to locate the policy or documentation to support them if a child became unwell on the ward. Senior managers after the inspection confirmed a transfer agreement with the local NHS Trust and North West and North Wales Retrieval and transfer team and a local agreed standard operating procedure (SOP) is in place and this information would be held by the senior nurse on duty, who would coordinate the transfer.

We found no evidence of how staff shared key information to keep children, young people and families safe when handing over their care to others. Staff told us, the ward was small, so it was not necessary to complete a formal handover sheet, all necessary key information to keep children and young people safe was verbalised.

Staff did not have access to 24/7 mental health liaison and/or other specialist mental health support if they were concerned about risks associated with a patient's mental health. Staff we spoke with said the consultant would refer patients to the child and adolescent mental health service, if issues were identified.

Recovery staff informed us that the theatre staff did not complete World Health Organisation (WHO) Surgical

Checklist. We were told by theatre staff that this was not applicable to children and young people's surgery. However, according to the standards for children surgery the WHO surgical check list should be completed for procedures.

We listened to pre-operative assessments carried out by a registered paediatric nurse, the risks associated with the surgery and the treatment plan was discussed with parents.

In accordance with the Resuscitation Council's Paediatric Emergency Treatment Chart (2015), staff recorded the height and weight of each child on admission to the ward and before surgery so that drug calculations could be safely worked out.

All young people aged between 16 and 18 years old, were risk assessed to see if they were suitable for treatment and care using adult care pathways under the care of a registered adult nurse. The risk tool captured previous comorbidities, weight, medications and the discussion with the patients and parents about what care in the adult services would look like.

Staff had access to the resident medical officer (RMO), who was present at the hospital 24 hours a day seven days a week. The RMO was trained in advanced paediatric life support.

The recovery area had child appropriate equipment including resuscitation equipment. The service ensured there were two registered nurses in recovery per child. These nurses were adult nurses who were trained in European paediatric advanced life support and had paediatric competencies. There were arrangements in place to provide parents and carers with support, once they left the hospital. Parents or carers were given an on call number to call if they had concerns when they went home, and staff also explained the emergency out of hours arrangement.

On inspection we saw that the service had one unplanned transfer to the local NHS trust in the last 12 months for children and young people, the transfer took place because staff immediately recognised the child required level three care. Staff had incident reported it and managed the transfer appropriately.

Nurse staffing

Services for children & young people

The service did not consistently deploy enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers did not regularly review and adjust staffing levels and skill mix to meet the needs of the service.

The children and young people's service did not have a minimum of two registered children's nurses at all times in all inpatient areas and day care areas at the time of the visit.

This was raised on inspection and senior managers immediately suspended the service so that they could review staffing provisions. The action plan provided by senior managers after their review showed, staffing would be reviewed on a two weekly basis so that it could always be aligned to admissions to the children's ward and the ward would be staffed with a minimum of two registered paediatric nurses.

There was not always one nurse per shift in each clinical area trained in APLS/EPLS (advanced or European paediatric life support) at the time of the inspection. This was raised with senior managers on inspection, who recognised this was not in line with the Royal College of Nursing guidance on defining staffing levels for children and young people's services. Senior managers reviewed the children and young people's EPLS provision and informed us staffing has been aligned to reflect the revised Policy and National Guidance and risk assessments and control measures had been put in place to ensure there was always access to a member of staff who was EPLS trained.

To ensure the ward was appropriately staffed, managers informed us, that a nurse from recovery would now escort the child to the ward post recovery so that staffing levels on the ward were maintained.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

All paediatric activity was consultant led, consultants caring for children and young people held approved paediatric practicing privileges, which were reviewed every two years by the Executive Director.

Staff had access to a named consultant paediatrician for advice and cover. Staff said they had no issues with reaching the named consultant.

The children and young people's service was represented by a consultant paediatrician on the Medical Advisory Committee.

There were two RMO's, who attended to children if it was required. The hospital policy stated that all RMO's covering children and young people services must have six months recent children's experience.

The RMOs were not employed directly by the hospital and were sourced through an agency. RMO's were APLS trained and completed level three safeguarding training.

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.

Records were stored securely behind the nurse's station in a locked cupboard.

We reviewed seven patient records, they all contained details of the patient and nursing notes were clearly documented.

In records where children were prescribed medication, we saw that staff had documented the clinical indication, dose and duration of treatment.

Paper based records followed the patient through the hospital, upon discharge a letter was sent to the GP electronically detailing the discharge summary, a copy of this was also given to parents.

All electronic imaging could be accessed electronically by consultants.

Medicines

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

Services for children & young people

Emergency drugs were available and sealed to ensure they could not be tampered with. We reviewed medicines and found no concerns.

All medicines were kept securely, and liquids were labelled with the dates they were opened.

Staff recorded the allergies, weight and height of the patient. We saw from the records we reviewed that medication was given to children according to their height and weight.

All medicines and medicines-related stationery was managed ordered, transported, stored and disposed of safely and securely by the pharmacist.

Medicines requiring storage in a fridge were kept on York suite, which was situated through the fire door. We saw that daily fridge temperature was checked and instructions of what to do if the fridge went out of range were displayed. Medicines was replenished by the pharmacist.

Incidents

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 children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns through the hospital electronic reporting system, but we were not given examples of any learning or improvements from incidents that had occurred.

The hospital had a policy for the reporting and investigation of incidents, near misses and adverse events.

We saw incidents were discussed at ward meetings and all staff received a copy of the hospital-wide newsletter which shared information nationally.

The service reported 21 incidents between February and July 2019, actions were taken to address all incidents.

The children's and young people service reported no never events over the past 12 months. 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.

In accordance with the Serious Incident Framework 2015, the service reported no serious incidents (SIs) in the children and young people service which met the reporting criteria set by NHS England from November 2017 to December 2018.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood the importance of being open and honest with patients.

Are services for children & young people effective?

Good 

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

Evidence-based care and treatment

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

Policies were based on national guidance and best practice such as that issued by National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics. All staff we spoke with could access available protocols and guidelines, using the hospital's intranet.

The service undertook local audits to indicate compliance with guidelines, these included infection prevention control audits, documentation audit, discharge planning and medicine management. We reviewed action plans to audits with low compliance outcomes, the service has put in place actions to address the areas of concern.

Staff we spoke with said they had never come across a child or young person which they thought to be at risk of suicide or displaying severe depression (but not suicidal). If

Services for children & young people

they thought a child was at risk, they would inform the doctor so that a referral to the children and adolescent mental health service could be made but they did not have access to a team to support them do this.

Nutrition and hydration

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

We found that the service had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of children and young people. For example, patient's nutrition and hydration status was assessed using the MUST (Malnutrition Universal Screening Tool). Completion of this document was monitored as part of the documentation audit.

Daily menus were offered to patients with a variety of dietary requirement options available. These were in a child friendly format.

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.

Child friendly pain charts were embedded into patient notes to assist children in expressing their pain.

All clinical staff were required to undertake pain assessment training as part of their mandatory training.

The service did not undertake pain audits; therefore, they were not assured that all patients in pain were effectively managed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. Where audits had been undertaken, findings were used to make improvements. For example, paediatric early warning score (PEWS) charts had been changed as a result of an audit that identified staff were signing the PEWS chart but did not total the scores and therefore were not able to identify a deteriorating patient.

The service did not take part in any national audits involving children and young people.

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.

Anaesthetists, theatre, recovery staff who may care for children and young people had up-to-date competencies.

There were arrangements for supporting and managing staff to deliver effective care and treatment, this included one-to-one meetings and appraisals. The service reported all staff had an appraisal.

Poor or variable staff performance was identified and managed by senior managers, at the time of the inspection, the service lead had no concerns.

We reviewed evidence of staff attending paediatric simulation learning scenarios to address either life threatening or an unfortunate event. During the two scenarios reviewed, we saw there was a wider team approach and a range of clinicians, porters, nurses and other staff who participated. Debriefs and learning was documented and shared amongst staff.

The resident medical officer had completed paediatric training and competencies, all assurances would be sought by an external agency and passed on to BMI.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. We heard of examples where multidisciplinary teams came together to assess a patient for surgery and it was concluded that the patient did not meet the admission criteria.

Staff on the children's and young people's ward had access to a pharmacist for advice 24 hours a day seven days a week.

When children and young people were discharged from the service there was a clear mechanism for sharing appropriate information with their GP and other relevant professionals. We saw discharge summaries in patient notes.

Staff and children did not have access to a qualified play specialist in areas that children were seen and treated.

Services for children & young people

During conversations with staff, it was clear the service had not established links with Child and Adolescent Mental Health Services (CAMHS) or Children's Social Services teams. This was recognised by staff, who advised the appointment of the new psychiatrist in September would help support these links.

Seven-day services

Key services were available seven days a week to support timely care for children, young people and their families, such as diagnostic services and pharmacy.

The hospital pharmacy was accessible seven days a week. An on-call service was also provided out of hours and any ward stock was provided weekly.

There was always a resident medical officer present on site 24 hours a day, seven days a week.

Health promotion

There was no evidence of staff supporting children and families to live healthier lives, including identifying those who require extra support, through a tailored approach to health promotion.

During the inspection we raised concerns regarding the service having no information available to promote healthier lifestyle through child friendly boards, activities and leaflets. Since the inspection the service have implemented a health promotion board that aims to focus on different areas of health promotion.

At the time of inspection, staff were not familiar with the national priorities to improve children's health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and other relevant national standards and guidance.

The service audited documentation to ensure staff consented children and young people in line with guidance, results showed 100% of the records recorded consent.

Staff had received training in consent, mental capacity and deprivation of liberty safeguards.

We saw that the hospital had an up to date policy dealing with consent and mental capacity. Staff were able to access this on the intranet.

Staff we spoke with said restraint had never been used on any child or young person at the service, staff said they would use other methods such as parents holding their child.

A specific consent form was used for children and young people. Staff we spoke with said they would assess each child during the pre-operative assessment and if they felt that the child or young person was Gillick competent to involve them in their care they asked patients if they would like to sign the consent form after their parent or carer.

Are services for children & young people caring?

Good 

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

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observe staff and patient interactions, they were jovial and child friendly. We did not see any bedside interactions as the service did not have any surgical patients during our visit but observed interactions during pre-operative assessments.

Staff took the time to interact with patients and parents in a caring and kind way. We saw staff support parents when their child was distressed. Staff considered the child's anxieties and tried different ways

We observed staff carrying out pre-operative assessments, children and parents were greeted immediately in a welcoming manner. Parents we spoke with said staff were friendly and were approachable.

Services for children & young people

The ward collected data on patient satisfaction, we saw that the ward reported 98% of patients and their families said that they would recommend the service to family and friends.

Staff we spoke with said they would always make sure that patient's privacy and dignity needs were understood and always respected, including during physical or intimate care and examinations. For example, all room doors were always closed when a patient was in bed. When examinations took place, if the child was older, staff said they asked the patient if they minded if "mum or dad" was present.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Children and their families were given appropriate and timely support and information to cope emotionally with coming into hospital. A coming into hospital leaflet was sent out with the appointment letter to support parents in getting their child ready for surgery.

One parent could accompany their child to the anaesthetic room when they went to reduce anxieties and emotional upset.

Children were given bravery certificates to award them for coming into hospital, staff we spoke to said by handing them out made children feel special.

We saw staff being empathetic towards parents who were worried about their child, we heard them reassure them and talk them through the day of surgery.

The service did not have a play specialist available on the children's ward to support any child that needed distraction.

Two parents we spoke to said, they would have welcomed some visual information to support the child during the patient journey and to help reduce anxieties.

We found no evidence of what support parents and others close to the child would receive if bad news was delivered, staff we spoke with said they had never come across this and were unsure what bereavement or counselling services were available.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff adapted the way they communicated with children so that they understood what they were asked. For example, we saw staff lower their tone, change their language and chose words that were child friendly when interacting with children.

All parents we spoke with said they felt involved in decisions about their child's treatment and care. Written communication was clear and received in a timely manner.

Parents were provided with the contact details to the ward and out of hours service on discharge, should they require additional advice once they left.

Are services for children & young people responsive?

Requires improvement 

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

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served.

We found no evidence of how the service engaged and involved children and young people to tailor their service. For example, there was no children's, and/or a parents/carers panel for the service. Staff recognised that this was a gap in their service and relied on the patient survey for feedback.

All outpatient, day case and surgical patients were seen on the children ward and those requiring diagnostics were seen in radiology. However, radiology did not have a separate waiting or play area for children whilst they waited for their appointment.

Evidence to demonstrate that staff had access to external networks to support children that may need further

Services for children & young people

support was limited. For example, the service did not have links with the mental health team, communities' leaders and organisations to support for example, concerns around healthy eating.

Staff relied on the doctor to refer a patient to the mental health team and all staff we spoke with recognised that this could hinder the patient's care. We found no evidence of processes or protocols in place to support staff in contacting those involved in the patient's care such as health visitors, school nurses and social care providers.

The hospital's pre-assessment team identified those patients and families that required interpreter services and would pre-book support prior to the appointments.

The ward had seven individual rooms with en-suite bathrooms, which meant children and adolescents were in separate areas. Young children had access to a playroom and adolescents had access to social media via WIFI.

Parents were encouraged to stay with their child on the ward, a fold up bed was available in all rooms when parents stayed overnight. Parents and children had access to their own TV and a selection of refreshments could be brought from the café.

Meeting people's individual needs

The service was not always inclusive and did not take account of patients' individual needs and preferences. Staff could not always make reasonable adjustments to help patients access services and did not always coordinate care with other services and providers.

For example, children who visited the hospital regularly did not have a system in place to inform staff of their preferences.

We found there was not always a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. This included patients with protected characteristics under the Equality Act or who had complex needs.

Children and young people on the ward had access to a playroom which encouraged them to play. The room has a selection of toys for children between 2 and 7 years of age but there were limited activities for children who were older.

Child friendly décor was limited to the corridor on the ward, bedrooms looked tired and were not child focused. This was raised with the manager on inspection, who accepted the ward would benefit from a child themed environment.

The play area on the ward was clean and tidy with a variety of toys for children between 1– 7 years old but did not have toys for older children. Staff advised board games were locked away, but we found no information informing parents or patients of this.

The children's services ward had seven single rooms with pull down beds for parents to stay along with integrated bathrooms. In addition, the ward also provided dedicated children's consulting rooms.

Staff and patients did not have access to a play specialist to support children through their hospital stay. For example, children with learning disabilities who would benefit from play input to help prepare them for surgery did not have this provision.

The service recognised that it did not meet the information and communication needs of children living with a disability or sensory loss. We saw limited provisions to support this group of patients, these included no communication cards or no sensory equipment. We noted that the service had recently contacted a charity to help shape the service for autistic children.

We found that staff did not have the provisions to support those using the services and those close to them to find further information, including community and advocacy services. For example, staff did not have any information on the ward, when asked about the services they could sign post to. They were unsure about what services were available in the community.

Verbal and written information in age appropriate formats was limited. Patients were sent an information booklet addressing their hospital stay but there was no other information such as information about infection prevention and control, post-surgery, different conditions or discharge.

If a child or young person started to display behaviour that was challenging there was no area, they could be directed to protect themselves and others and/or to maintain their privacy and dignity. Staff said if a room was not occupied, they could direct patients into that room but if they were all used, they wouldn't have a safe space.

Services for children & young people

Language interpretation services were available to patients and their families.

Access and flow

Children could access the service when they needed it and received the right care promptly.

The service reported six cancelled operations between August 2018 - July 2019. These were due to children being unwell prior to surgery and not having the right number of paediatric staff to care for children post operatively.

People could access the service when they needed it and received the right care promptly.

Children were admitted to the service via a referral made by their medical practitioner or self-referral. All children underwent an assessment to ensure they fitted a strict admission criterion on the paediatric pathways.

Children were admitted under the care of a named paediatric consultant with paediatric practising privileges.

Appointments could be scheduled during a time that suited the patient and their family. For example, operations were scheduled at the discretion of family and consultant, as to patient/family preference.

All paediatric cases were discussed with a minimum of one-week notice at theatre scheduling meetings (held twice a week) and children were prioritised as first on theatre lists.

The children and young people's dashboard measured the number of cancelled appointments, unplanned transfers and readmissions. The service reported one unplanned return to theatre between August 2018 - July 2019. This was reported as an incident and actions were put into place to address any gaps.

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.

There was a child friendly inpatient survey that was appropriate for children of different age ranges to easily access and use. This was used to inform staff of any concerns or compliments.

The service used the BMI group-wide complaints policy. The policy set out the process for complaints from NHS patients and self-paying patients.

Complaints from self-paying patients were managed in line with the Independent Sector Complaints Adjudication Service code.

Complaints were reviewed by the hospital management team; any emerging trends or themes and learning were discussed at various assurance committees. Any complaints relating to children were discussed at the CYP team meeting.

Complaints for children's services were low, the service had received one complaint over a 12-month period, this was responded to within timeframe (20 working days). The complaint was related to an unplanned admission.

Are services for children & young people well-led?

Inadequate 

Our rating of well-led went down. We rated it as **inadequate**.

Leadership

Leaders did not have the necessary experience, knowledge, capacity, capability to lead effectively. Leaders did not always understand and manage the priorities and issues the service faced. For example, the local leadership did not escalate any risks such as paediatric staffing, or lack of protocols to the senior leadership team.

Leaders were out of touch with what was happening on the front line, and they could not identify or understand the risks and issues to their service. For example, on inspection the executive team recognised they had not addressed any challenges because they were unaware of them. A review of the leadership team for children and young people was undertaken post inspection and the service was suspended until further action was taken to make the service safe.

Services for children & young people

We did not hear of any comprehensive and successful leadership strategies that were in place to ensure and sustain delivery of the service. For example, there was no plans in place for succession planning or how the strategy was going to be delivered at a local level.

However, leaders were visible and approachable in the service for patients and staff to speak with. The service was led by the ward manager who reported to the Director of Clinical Services.

Staff spoke highly of the new hospital executive team and told us they felt valued by senior managers.

Vision

The service had a vision for what it wanted to achieve and a strategy to turn it into action. However, there was no formal monitoring of the objectives set out and it was unclear how the local leadership was assured they were meeting the children and young people strategy.

Staff recognised their roles in delivering their departmental vision which was to deliver high quality care to children and young people in a child and family focused service and safe environment.

The hospital's five-year strategy incorporated the children's and young people development plans. The hospital leadership team recognised that there was a need for investment and a full-service review.

The values and the vision of the service were aligned to staff objectives, these were discussed at yearly reviews.

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.

Staff were proud of their service and spoke positively about the culture. All staff we spoke with felt there was a supportive 'no blame culture'.

Staff felt leaders valued their opinions and were approachable. We heard of and saw emails between management and staff celebrating positive achievements on the ward.

Staff were committed to work their best to provide patient focused care. Staff we spoke with said they enjoyed working across children and young people services. Staff survey results, in the July 2019 quality report showed 98% of staff recommended working at the hospital.

All staff undertook equality and diversity e-learning module.

Governance

Leaders did not operate effective governance processes, throughout the service. Although there were hospital governance frameworks in place which followed BMI processes, in the children and young people service there was a lack of clarity about how individuals were being held to account. For example, department managers attended the daily "comm cell" this was a meeting with the executive team and heads of departments. The comm cell was designed to discuss daily activity, highlight any issues, and discuss incidents or any complaints made to the service. Because of this discussion, any immediate actions were decided. However, we saw from communication briefs from the comm cells that the lead paediatric nurse had attended these meetings but did not raise any concerns or risks to the senior management team. In these briefings we saw no reference to the children and young people's service and therefore the senior management team did not resource or review the service to ensure it was safe for children.

Following the concerns raised at the inspection, we were informed by the senior leadership team that they had not focussed on activity in the service because no concerns had been discussed previously and risks had not been escalated.

The manager attended the corporate safeguarding meeting regularly, but we found no evidence of this information being disseminated to staff on the ward, visiting consultants and RMO's.

However, the service was represented at the Medical Advisory Committee (MAC). The MAC met quarterly to consider clinical information. Areas of discussion included risk, serious events, screening of new applications for practising privileges and complaints. We viewed the MAC meeting minutes for September 2018 and June 2019 and found it was attended by a paediatric representative.

Services for children & young people

There were processes to ensure those paediatric consultants expressing a wish to be granted privileges to practice at the hospital met the required criteria. Practising privileges were reviewed by the MAC chair and a recommendation was sent to the executive director prior to an application being granted.

Practising privileges were only granted to those procedures or techniques that were part of the medical practitioner's normal NHS practice or where the medical practitioner could provide evidence of adequate training, competency and experience. Practising privileges were reviewed annually by the executive director and the outcome was reported to the MAC.

We reviewed the June 2019 minutes of the children and young people's team meeting, staff discussed complaints, incidents and training. Monthly heads of department meetings discussed standard agenda items regarding performance, staffing, training and incidents, information from this meeting was cascaded to the team.

Ward meetings were monthly, agenda items included key messages, new policies, incidents, feedback on complaints and team success. Staff discussed action plans and those responsible for certain functions were asked to report at the meeting.

Managing risks, issues and performance

The service did not identify and escalate relevant risks and issues and identified actions to reduce their impact. Risk were not cascaded effectively to the senior management team, for example, the managers had not recognised the potential risk of not having the correct nurse staffing levels on the ward. During the inspection rotas showed that there was not the required number of two paediatric nurses on the ward or one nurse per shift trained in advanced or European paediatric life support. This did not meet the BMI policy for paediatric nurse staffing levels. The service had not added this on the local risk register. Post inspection, we were provided with an up to date risk register, this detailed the risks, actions and review dates.

The service had an annual audit plan which set out what audits needed to be completed, audits included, infection prevention, record keeping and consent. In addition, senior managers advised PEWS was going to be audited from September 2019 as the system had recently been implemented and was not yet fully embedded.

The service had implemented several health and safety risk assessments for the service. This included risk assessments covering manual handling. We found that risk assessments had been completed, scored and were in date.

The hospital had a business continuity plan which included actions to take in the event of a power cut or major incident.

Managing information

There was inadequate oversight of the information to challenge risk and performance by leaders. Leaders did not effectively receive information to enable them to challenge and improve performance. This was evident in the concerns we found during the inspection.

The information systems were integrated and secure.

The hospital ensured that all staff had a BMI email account and used an electronic encryption system to enable the sharing of secure information between healthcare professionals when required.

We found the ward had adequate numbers of computers for staff to work on. Doctors had remote access to images from scans so that interpretation was timely.

Engagement

There was minimal engagement with people who used the service, staff, the public or external partners. For example, we found no evidence where the service demonstrated learning from patient feedback. Staff were unable to give examples of how they had changed the service.

We found no evidence of the local leadership engaging with external stakeholders to deliver patient focused care. The manager was unaware of any discussions with local commissioning groups to explore ways in which the service could support children in the surrounding communities and local NHS hospitals.

Opportunities to engage with patients on the ward was limited, for example there was no child friendly ways of ascertaining feedback whilst on the ward, apart from the satisfaction survey.

Services for children & young people

The service did not invite children and their parent or carer to advisory groups to gain feedback to shape their service. During senior management feedback, we were informed the service had just started to work with parents and certain charities to improve the service.

We found no evidence of how the service involved any external organisations to help them improve or sustain the care provided to patients with mental health or emotional wellbeing issues.

The hospital wide staff survey results showed 98% of staff said they were happy at work.

A hospital newsletter was sent to staff monthly via email. This provided any local updates, with corporate information.

Learning, continuous improvement and innovation

There was little innovation or service development. We found limited evidence to show leaders of the service had a good understanding of quality improvement methods and the skills to use them.

For example, we found no innovative ways of improving practice towards recognised accreditation schemes.

There was a lack of children and young people forums, feedback or participation in national work streams to gain information on best practice to support staff to deliver care that was patient focused to this age group. This gap was recognised by senior management.

Outpatients

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are outpatients services safe?

Good 

We previously inspected and rated this service with diagnostic and 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 compliance rates as at 12 July 2019 for contracted staff in the outpatient's department was 96.2% and 76.2% for bank staff, which gave an overall compliance rate of 90% which was equal to the services target of 90%. In the outpatient's physiotherapy department, as of 29 July 2019, compliance rates for contracted staff was 94.9% and for bank staff 91.3% which gave an overall compliance rate of 93.1%.

There was a member of staff who had oversight of all mandatory training compliance for qualified and unqualified nurses for the hospital. We were shown an electronic spreadsheet where this was all recorded.

Data regarding outpatients mandatory training compliance was sent to the department managers who monitored staff training compliance.

Mandatory training was completed via a combination of 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 had an up to date safeguarding adult's policy which advised staff what actions to take and which staff member to contact in the event of a safeguarding adult concern.

Staff we spoke to were able to articulate to us what they would do in the event of a safeguarding concern. Safeguarding leads were always contactable within the hospital

There was a designated lead for female genital mutilation (FGM) in the department and all staff had to undertake this training as an e-learning module.

Mandatory training compliance for safeguarding training for all staff was 93.13%.

Staff in the hospital were trained to safeguarding level one or two dependent on their roles. The clinic leader was trained to level three and there were staff members trained to level four safeguarding on site or on call at all times as per intercollegiate guidance.

We observed in each of the staff office areas there was a comprehensive booklet that highlighted to staff what actions to take in the event of differing safeguarding concerns such as concerns regarding domestic abuse.

Cleanliness, infection control and hygiene

Outpatients

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

All areas of the outpatient's department appeared visibly clean and well presented.

All the equipment we saw during our inspection appeared clean and had labels on them stating that they had been cleaned.

During our inspection we observed staff and patients using hand sanitising gels and hand washing facilities. There were hand sanitiser gel dispensers and hand washing facilities throughout the clinical areas in the department at appropriate places.

We saw infection prevention and hand hygiene audits of the physiotherapy department from March 2019 to July 2019 which achieved an average of 94%, with compliance of 96% in July 2019. The hand hygiene audits for the outpatient's department for January and March 2019 showed 94% and 86% compliance respectively. Where improvement was required actions were identified and assigned to a lead to ensure implementation.

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). We were also shown evidence of leak testing being carried out appropriately between use on each patient which complied with HTM 01-06.

Dressing trolleys in the treatment rooms were clean and tidy.

There were 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 outpatient's department were visibly clean and were dated correctly.

Clinical areas in the outpatient's department had floor coverings that were wipeable, such as linoleum.

All 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.

We observed disposable coverings being utilised on the examination couches in the clinic and treatment rooms.

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 had an in date policy for screening and the management of meticillin-resistant *Staphylococcus aureus* (MRSA) which staff followed and which highlighted which patients were required to be screened for this bacterium prior to admission. These included all patients 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 outpatient's department screened patients in the preoperative period for Carbapenemase Producing Enterobacteriaceae (CPE).

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 outpatient's department consisted of 34 consultation rooms based across two floors of the hospital. The largest area, the consultation suite, consisted of consultation rooms plus one minor procedure room, one clinical treatment room, two ear nose and throat rooms, two ophthalmology rooms, one audiology room, one phlebotomy room and one gynaecological treatment room. There was one large waiting area and then two smaller ones for differing clinical areas within the department.

Outpatients

The Orchard clinic was where all orthopaedic patients were seen. This had its own entrance and waiting area with refreshments, six consulting rooms plus one treatment room.

A separate area had four GP consulting rooms and two neuroscience rooms and its own smaller waiting area.

The physiotherapy department included physiotherapy, occupational therapy and speech and language therapy. The department included eight treatment areas separated by floor length curtains, two private side rooms for treatment, one physiotherapy gymnasium and an offsite hydrotherapy service that we did not visit during this inspection.

Fire exits were clearly signposted and visible in appropriate places throughout the department.

All equipment had asset numbers affixed to them and dates that highlighted when they had been and were next due servicing. All the equipment we saw was in date for servicing and calibration.

There was a reception desk at the entrance to the hospital outpatients, with seating for patients and their relatives, which we noted was manned by as many as six staff and which we never observed left unattended during our inspection.

There were facilities for patients and their relatives to help themselves to hot and cold drinks in all areas of the outpatient's department.

We were shown a list of all the equipment located in the outpatient's departments which listed such information as the servicing dates. This facilitated the clinic manager to have oversight of all the equipment in her area and ensured that it remained in a serviceable condition for patients use at all times.

The resuscitation trolleys in all outpatient's areas were sealed and all had been checked correctly 100% throughout 2019. This was an improvement since our last inspection.

We observed the checklist that had to be completed daily for the safety huddle which included that all prescription safes were checked, machinery such as the urinalysis machine was checked, and the resuscitation trolleys had been checked, which worked as a failsafe to ensure compliance in these areas.

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 outpatient's department. These included inclusion and exclusion criteria for acceptance for consultation.

The staff that we spoke with were able to articulate what to do in the event of an emergency, such as due to a patient's health deteriorating and were able to highlight where the emergency equipment was and how they would summon assistance.

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 staff a full induction.

The outpatient's department employed 14.8 whole time equivalent nursing and assistant nursing staff.

As at 31 July 2019 there were 0.6 whole time equivalent qualified nurse vacancies and 1.6 whole time equivalent senior healthcare assistant vacancies in the outpatient's department.

In the period from August 2018 to July 2019 inclusive the department used 2785 hours of qualified nurse bank and 94 hours of unqualified nurse bank to staff the ward. Staff sickness was covered by either flexible staffing or bank staff.

In the year prior to our inspection the department had not used any agency nurses to staff the outpatient clinics.

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.

Outpatients

The service ensured that there was always at least one resident medical officer (RMO) to provide 24 hour, seven days per week to provide medical cover in the whole hospital.

Staff in the outpatient's department were able to request the attendance of the RMO to attend patients in the outpatient's department if required.

Records

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

During our last inspection we were made aware that consultants made their own records for each of their patients and removed them from the site to be stored elsewhere. At that time, patients only had a set of notes generated and stored on site if they received treatment or were admitted to the hospital as an inpatient.

At this inspection, we found, since the beginning of April 2019, the hospital had commenced a system whereby each patient that attended the outpatient department had a set of notes generated and that their consultation was documented contemporaneously. We reviewed 15 sets of outpatients notes, five from each month since the new system had been introduced and found that only 12 (80%) had their consultation documented within. The three sets of patient records that did not contain the records of the respective consultations were patients that had all seen the same consultant. We raised this issue to the senior team during our inspection and we were provided with assurance that the implementation of this new system was being monitored to ensure 100% compliance. This was an improvement from our last inspection.

All new consultants expressing an interest of working at the hospital would have to comply with this new system, existing consultants were reminded to ensure compliance with this via the consultant newsletter that all consultants receive. This highlighted that any consultant not complying with this new way of working would be managed individually by the MAC chair. We also saw evidence that all consultants working at the hospital had

been receiving emails prior to the start date informing them that this new system was being implemented and that they were required to comply, and further emails once implemented to reiterate the earlier message.

Prior to the commencement of any clinical consultation or treatment, patients were asked to read and sign a BMI Healthcare registration form. Part of the information contained within this form was how a patient's personal information may be used. However, whilst it highlighted, for example, that their personal information may be shared with other agencies, it did not inform patients that their consultant would take their personal information away from the hospital.

Patient records that were held onsite were stored in a locked storeroom, when required for clinics but not currently being used. We observed that patient records were never left unattended at all other times.

The outpatient's physiotherapy carried out regular note's audits on their staff and we observed that 82.5% achieved greater than 90% compliance. We observed action plans where further training or learning was identified.

We were told that the outpatients department carried out twice yearly as a standard and we saw the most recent audit results and the ongoing action plans to rectify any issues highlighted. The data that we were provided with was for all hospital staff and therefore we were unable to specify compliance for outpatient staff only.

The hospital had two policies named the "management of health records and clinical documentation" and "retention of records" that were in date. Both of which highlighted this new way of working.

The hospital had a standard operating procedure named "management of health records and clinical documentation" which was in date and highlighted to all staff which highlighted the expectation that all staff would comply and an audit tool that was to be completed monthly to ensure compliance.

We were shown evidence that the records issue was on the hospital's risk register at the time of our inspection and that it had been the subject of an in-depth comprehensive report into the risks posed, to ensure that it was closely and regularly monitored.

Outpatients

Medical records clerks prepared the patients records for the clinics that day.

Medicines

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

The hospital had a safe use of medicines policy which was in date and all staff worked within the parameters of the policy.

There was a pharmacy department within the hospital and the pharmacy staff monitored and replenished the stock levels of the medicine's cabinets in the outpatient's department.

Medicines were stored in lockable medicine cabinets, within locked rooms in the main outpatient's department. The ambient room temperature was checked daily in all of the rooms where these medicines cupboards were located.

Prescription charts were held securely in a locked safe in each consulting room in order that the visiting consultant could prescribe medication, when appropriate, for immediate use in clinic, as part of a clinical procedure or for the patients to take to the in-house pharmacy to take home.

There was oxygen available in the outpatient's area and stored appropriately, if required, for patients.

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.

In the period between August 2018 and July 2019 inclusive, the outpatient's department recorded a total of 42 incidents. There were 12 pathology incidents regarding insufficient samples. We observed on the staff notice boards that learning from incidents and actions were shared, such as improving communication with patients.

We observed minutes of meetings where it had been documented that incidents had been discussed along with learning and actions.

All the staff that we spoke with told us that they were made aware via email, as well as the noticeboards and staff meetings, of incidents and subsequent learning and actions.

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. Staff protected the rights of patient's subject to the Mental Health Act 1983.

There were a range of clinical care patient pathway 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 outpatient's 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.

During the pre-operative stage patients who were booked in for an implant, such as a hip replacement, were informed the hospital informs the National Joint Registry (an organisation which improves patient safety and monitors the result of joint replacement surgery) of each implant carried out by them. Patients were advised that they had to consent to their personal details being shared with this organisation which would be used for contact purposes if needed due to an issue with their implant.

Nutrition and hydration

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

Outpatients

Hot and cold drinks were always available in the outpatient areas for patients and their relatives.

We were told by staff that patients whom were in the outpatient's department for any length of time due, for example, waiting for transport, were invited to use the restaurant for food and other refreshments which was located adjacent to the main outpatients waiting area on the ground floor.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Patients attending the physiotherapy department were asked on discharge from the clinic if any pain associated with their condition had ceased following treatment. Between January 2018 and June 2019, 88.2% of patients reported that their pain had ceased which was slightly better than the northern regional average of 89.2%.

Patients were asked to complete a questionnaire prior to hip surgery which included 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.

Patients undergoing a certain gynaecological procedure were routinely offered paracetamol for pain relief as it was acknowledged that women were more likely to experience discomfort as a result.

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 had, 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 would enable them to identify areas of best practice and areas where service and professional development.

From the beginning of January 2019 up July 2019 patients with a gastric band, attending the specialised outpatients service, had an average of 62% weight loss compared with the expected figure of 50%.

The physiotherapy service had a pathway in place whereby if a patient with a serious spinal pathology was identified via a regional spinal service they received an immediate referral to the appropriate specialised service.

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.

In the outpatient's physiotherapy department, as at 30 July 2019, the appraisal compliance rate for contracted staff was 100% whilst bank staff was 92% giving an overall compliance rate of 96% which was above the hospitals target of 90%.

In the outpatient's area, as at the 9 August 2019, the appraisal rate was 91% for all staff.

The hospital had an induction policy which outlined that new starters in the department were given a 90 day induction booklet to work through and complete with targets including 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 had an agreed 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 could 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.

Outpatients

As at 12 July 2019, all nursing staff working in the outpatient's department had an up to date Disclosure and Barring Service check and 100% of staff that were required to maintain a professional registration had done so.

Multidisciplinary working

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

All the staff that we spoke with told us that there was good teamwork between all the staff to provide patient care.

We observed minutes from the multidisciplinary team meetings for specialities such as breast, plastics and gastrointestinal services. The meetings were attended by specialist medical staff from both the hospital and specialist nurses to review treatment options and progress for patients.

Breast care multi-disciplinary team meetings were held where patients had their care and treatment plans discussed.

Seven-day services

Key services, such as physiotherapy, were available seven days a week to support timely patient care.

The outpatient department was open 07.00 - 21.30 hours (last consultation finishes at 21.30 hours) Monday to Friday. Saturday opening times were 07.00 - 15.00 hours.

The physiotherapy outpatient's department was open from 8am until 8pm Monday to Thursday, 8am until 5pm Friday and 9am until 1pm on Saturday.

The service ensured that at least one resident medical officer was always on site to provide 24 hour cover, seven days per week.

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 described what patients should do to achieve optimum health following sports injuries and "treating

iron deficiency prior to surgery" which described how patients were able to optimise their health in preparation for surgical procedures and "breast health" advising women about breast health and screening.

In the outpatient areas we observed pull up banners highlighting the health benefits of giving up smoking and how this could be achieved.

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" 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. There was a two stage consent process.

All staff working at the outpatient's department were required to complete their mandatory training in Mental Capacity Act (MCA) (2005) 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 if they had a concern regarding a patient's capacity to consent to care or treatment which followed their policy.

All patients who were seen in the outpatient's department to consider cosmetic surgery were asked to complete a questionnaire pre operatively to assist the team in deciding whether surgery was the correct option for them. They were also asked to complete a post-operative questionnaire.

Are outpatients services caring?

Outpatients

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.

Patient feedback from the outpatient's department in June 2019 highlighted that of 68 responses, 16% would be likely to recommend this service to friends and family whilst 84% were extremely likely to recommend this service to friends and family.

Patient feedback from the outpatient's physiotherapy department in May 2019 highlighted that, of the 191 responses, 99.5% were either likely or extremely likely to recommend the service to friends and family.

We observed a notice board in the information room within the Richardson suite that was full of thank you cards and positive feedback from patients who had used the service.

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" or "excellent" and that they were "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 helpful" and have "all been amazing."

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.

On the Orchard suite we noted that the staff had created a room where patients could spend quiet time to decide whether to undergo such procedures as breast reconstruction and read all the relevant leaflets there.

The department held a pamper session for patients diagnosed with breast cancer in July 2019 where patients received prosecco, nibbles, different complimentary therapies and make up sessions. The event raised £500 for the local charity that provides counselling to patients diagnosed with breast cancer, whether being treated at the hospital or not.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We observed 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.

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

Outpatients

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.

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.

For certain pre-operative assessments, following a 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 outpatient's department ran specialised clinics such as the one stop breast clinic and a bariatric and gynaecology clinic. All these services were supported by dedicated specialised nurses in each area.

The service had in place a policy entitled "provision of chaperones during examination, treatment and care." We saw laminated signs in pertinent places throughout the outpatient's department highlighting to patients that they would be offered a chaperone if they wished.

At the reception desk we observed a booklet informing patients that chaperones were available for certain examinations, that was produced in nine different languages of those representing their service users.

The service referred certain patients to, and worked 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.

There were a variety of patient information leaflets in the reception area for patients to take away.

At the entrance to the hospital there was a concierge to assist and direct visitors to the hospital. There was also a complimentary transport system that was available for patients to use to be transported to and from their car to the hospital entrance.

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 chosen, had a chaperone present during their care.

The department used a translation service to provide care for patients for whom English was not their first language.

The department used an interpreter request form to arrange an interpreter for an outpatient's appointment.

The physiotherapy department had its own waiting area with accessible toilets and refreshments for patients on the first floor of the main hospital building. There was both lift and stairs access to this department.

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 The Alexandra hospital via their GP using 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.

Prior to being admitted to the hospital for a procedure patient were all given a pre admission checklist which informed them about avoiding smoking 48 hours prior to admission, arranging someone to drive them home after sedation or general anaesthetic and the average length of stay for the specific procedure.

A hearing loop was in place within the outpatient's department for those with a hearing impairment.

Highlighted within the "consulting suite departmental report" were details of the patient focussed work the

Outpatients

department had done, such as purchasing raised toilet seats for patients who had undergone a hip replacement and had to attend the outpatient's department for a consultation, dementia friendly toilet seats and the privacy room created for patients attending the department.

We were told that patients with a condition such as dementia, would be seen in clinic first to minimise any potential distress.

There were patient notice boards in several locations in the outpatient areas highlighting what clinics were running and if there were any delays.

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.

Patients that we spoke with told us they were offered an appointment at a time convenient to them.

We spoke with six patients and five 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. They said they were "seen very quickly".

We observed notice boards in the main outpatient's 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 respective 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 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 of the care that they received.

Between August 2018 and July 2019 inclusive, there were 63 complaints pertaining to outpatients. Themes identified were communication and finance/billing (where patients stated that they had not been informed of the costs to them of extra tests required as part of their treatment). Actions to address the communication complaints included message boards, safety huddles and information boards being placed in patient waiting areas informing patients of waiting time delays. Actions to address the finance/billing complaints included pop up banners in the outpatient waiting areas informing of added charges and patient information form advising of the costs of additional tests that may be required.

Are outpatients services well-led?

Good 

We rated well led as **good**.

Leadership

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

There were dedicated managers for both the main outpatients and physiotherapy departments. Both leaders told us that they were fully supported by the management board.

Outpatients

All the staff that we spoke with during our inspection were extremely positive about the leadership in the outpatient's department.

All the staff that we spoke with told us that the leaders in outpatients were 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 hospital's vision and strategy.

Copies of the hospital's vision and strategy, along with the new build plans, were displayed in several places upon the walls of the outpatient's 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 there was an open culture where all staff could discuss ideas and concerns.

All the staff that we spoke with during our inspection told us that the leaders were always visible and approachable and that they felt they could approach them and be listened to about suggested changes or a concern.

Governance

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

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 staff member. We were told by several staff members that doctors did not attend team meetings. We observed minutes of the monthly outpatient's team meetings at which all team members were invited to attend. Items discussed on the agenda were audits, incidents, training, medicines and risk and governance.

We observed minutes from the outpatient's physiotherapy department team meetings which were held every two weeks. Standard agenda items included such subjects as clinical and quality, recruitment, risk register and training compliance.

There were daily staff meetings, immediately following the hospital wide comms cell which was attended by the lead from each department, 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.

We observed staff noticeboards in all staff office areas highlighting to staff the current departmental risk register, minutes from the recent safety huddles and team successes such as a new swab check sheet to ensure that all swabs are accounted for following treatment.

The leads from the general and physiotherapy outpatients' departments attended the hospital wide comm cell meetings at 8.45am Monday to Friday and they each fed back to their respective departmental comm cell meetings which were held immediately following.

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 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.

Outpatients

The service had a departmental risk register that we reviewed. There were three risks listed on it which included the department only possessing one ear nose and throat microscope to cover two clinics and a camera used as part of gynaecological care being near the end of its serviceable life with no replacement parts. The latter had caused one procedure to be cancelled and re-scheduled due to breakdown. The third risk was due to storage capacity of patient records since the new system of producing a set of notes for each patient had begun in April 2019. All risks had review dates.

We observed workplace hazard identification tool which had been used to identify potential risks in the outpatient physiotherapy department. This included identifying appropriate lifting equipment and the availability of personal protective equipment for staff to use.

Managing information

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

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

There was a folder with information to be fed back to staff that contained information such as lessons learnt.

All the staff that we spoke with were aware of the departmental risk register and the risks that were documented upon it.

There were notice boards in the staff areas for staff to read which listed information such as training courses and compliance.

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.

Following suggestions from the hospital's employee engagement group that there was no counselling service for patients and their families who are given a poor

prognosis, the department held a raffle. In total they raised £13,481.68 for a local charity to provide this service. We were told that staff were also able to use this service.

The hospital facilitated a patient engagement group that met every other month for general feedback and engagement for the hospital. One of the suggestions from a service user in this group was that there was no breast cancer support group anywhere in their local geographical area for women to attend. Therefore, in February 2018 the department began a group specific for breast cancer support which patients and their relatives were able to attend once per month. Patients who were not treated at this hospital were also able to attend. The group recently held its first anniversary party to which over 50 participants attended.

The gynaecology outpatient's department recently held a "menopause event" which was attended by over 100 patients.

Consultants in the outpatient areas received the "consultant bulletin" which informed them of information pertinent to their area of work as required. We observed the 31 July 2019 version which included information such as Wi-Fi disruption and a memorandum about records.

Consultants also received the copies of the "consultant newsletter" from the hospital's executive director. We observed the version dated 31 July 2019 which contained information about the new outpatient's records system and medications updates.

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.

Following identifying that swabs and specimen results were not always being followed up, one staff member devised a form for all staff in the department to follow to ensure that none were missed. There had been no missed cases since this new initiative was commenced.

The outpatient's physiotherapy department facilitated a spinal service for a local NHS service. One of the aims of the service was to reduce the effect of patient's mobility issues. The service exceeded this target in all four domains.

Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are diagnostic imaging services safe?

Good 

We previously inspected and rated this service with outpatients, 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.

There was a mandatory training programme in place which included life support training and safeguarding training at the appropriate levels for different members of staff.

Mandatory training was recorded and monitored by the diagnostic imaging department manager. Information provided by the service after inspection showed overall compliance of between 95% and 100% for diagnostic imaging staff.

Training compliance for basic life support was 100% for all staff in the department. Training for immediate life support compliance was 100% for radiographers in x-ray, nuclear medicine and magnetic resonance imaging (MRI). For computed tomography (CT) radiographers there was 80% compliance.

Mandatory training was a standing agenda item at the team meeting and was recorded in the service improvement action plan. Staff were working towards 100% compliance and heads of department were monitoring this.

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.

Safeguarding training was included as part of the mandatory training programme. Information provided by the service following inspection showed that diagnostic imaging staff were 100% compliant with safeguarding vulnerable adults training and safeguarding children training at the required levels for their roles.

There was a safeguarding champion in the imaging department and a hospital safeguarding lead for children and for adults. Contact details and key responsibilities for safeguarding leads were set out in a chart displayed on noticeboards in staff areas.

A 'pause and check' system was in place as recommended by the Society and College of Radiographers. This included use of stickers with a checklist prompting staff to complete the different actions including checking the patient's identification and going through the necessary checks for exam justification, previous examinations and checking the diagnostic reference levels. There was also a checkbox prompting staff to explain the risk of radiation and to flag if the report was urgent. We observed this process being used.

All heads of department were invited to attend a monthly safeguarding meeting chaired by the Director of Clinical Services. Staff provided an example of a recent safeguarding referral they had made. This had been discussed within the team and documented in the team meeting minutes.

Diagnostic imaging

The service did not offer paediatric query non-accidental injury skeletal surveys as there was a local NHS pathway in place for this service.

Safeguarding was discussed as part of the standing agenda item for governance at the monthly team meetings.

Female genital mutilation (FGM) training was mandatory.

Posters were displayed in patient areas and bathrooms with information about who to contact with concerns about domestic violence.

Cleanliness, infection control and hygiene

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

Areas we visited were visibly clean and tidy. Cleaning checklists were completed daily and displayed on the communication (comm cell) boards in each area.

The ultrasound equipment which came into contact with patients was cleaned at the start of each session and between patients using a three-part decontamination system for medical devices. A pre-clean wipe was followed by high-level disinfecting with a sporicidal wipe and activator foam, before a rinsing wipe was used in the final stage.

A quality audit trail record book was completed and up to date. This recorded every clean at the start of a session and between each patient. Identification numbers from the wipes were recorded next to the patient number, with the time and date of cleaning.

The ultrasound machine casing was cleaned weekly and had a sticker showing it had been cleaned within the last week. It was wiped after every session.

Personal and protective equipment was available and in use when appropriate. We observed clinical staff washing hands and wearing gloves and aprons when dealing with patients.

If a patient attended with a known infection prevention and control risk, staff said they were taken straight through to the scanning room to avoid contact with other patients.

We observed a patient described as infectious waiting in the corridor near the changing cubicles, about to go into

the x-ray room. Staff said they knew the patient was infectious because the ward had informed them, however they did not have the patient's records and the scan request card did not have a section to alert diagnostic imaging staff that a patient was infectious.

Managers told us later they had changed their protocol so that patient records would be sent to the department with every patient and would be checked prior to scanning.

Disposable curtains were changed every six months. These had been checked in June 2019 and all were in date.

Waste was sorted into different coloured bins as appropriate. Yellow bins for infectious waste and sharps were locked and replaced every Monday. Black bins for paper, tiger (striped) bins for non-infectious clinical waste and orange bins for infectious waste were available when required.

There was a fabric chair in the magnetic resonance imaging (MRI) examination room. This had been identified as an issue by the department and was due to be replaced with a wipe clean alternative, however it was still in use at the time of our inspection.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The radiation protection advisor routinely carried out testing of x-ray equipment to supplement local quality control tests. Meeting minutes provided by the service following inspection showed the testing programme was up to date at the end of 2018. No equipment was found to be operating outside the tolerance for suspension in 2018.

There was a hospital asset register listing every piece of equipment by category, model and serial number, with the brand and location, and last and next service date. The asset register status was included in the departmental monthly report which highlighted if any equipment was coming up for a service. The equipment list was formatted to turn red if the service date expired.

The register identified who owned the equipment and which machines were on loan. The level of support required for equipment was recorded, for example

Diagnostic imaging

planned preventative maintenance (service) only for equipment that was replaced rather than repaired when faulty. Some equipment was serviced by an outsourced engineering team and large specialist equipment was serviced by the suppliers.

Management of the asset register had previously been identified as a concern and an action had been put in place to review every piece of clinical equipment in the department and bring the list up to date. The target date for completion was 30 September 2019 and following inspection the service provided information showing that in July 2019 this was 98% completed.

Specialised personal protective equipment was available and used by staff and carers when needed. Lead aprons were stored in sizes and identified by a numbered label. Each number had a corresponding assessment document in a file, showing it had been safety checked by x-ray screening. There was a central list showing all numbered aprons and their status which was rag-rated (red, amber, green).

Lead aprons rated green were undamaged and received an annual safety check. Those rated amber were showing signs of wear and were checked six-monthly. Those rated red were removed from use.

Rooms where ionizing radiation exposures occurred were clearly signposted with warning lights.

Emergency resuscitation trolleys and paediatric grab bags were situated in the main imaging department and in the magnetic resonance imaging (MRI) building. There were completed daily checklists to show that the tags were in place, the defibrillator battery had been checked and the trolleys had been wiped down.

For equipment inside the trolleys and grab bags there were lists detailing the expiry dates with the earliest showing first so that staff knew when to open the trolley and replace them. The paediatric grab bags had a contents list and included items such as suction catheters, face masks for the oxygen cylinder and paediatric airway equipment.

There was a wheelchair available which was compatible for use in the MRI building, and two trolleys, one in a scan room and one in the communal area. Equipment in the MRI department had stickers showing they were MRI safe.

Internal and national safety alerts were issued to the hospital in a monthly clinical governance and quality and risk bulletin, including lessons learned. This was distributed to and actioned through hospital governance committees and there was a hospital tracker in place to monitor this.

We saw evidence of this process in place, for example the bulletin in February 2019 alerted the hospital to an issue with a fire extinguisher provided to one of the organisation's MRI departments which had a ferrous nut (magnetic) attached to the horn of the extinguisher. The safety alert detailed what actions the MRI department needed to take.

Assessing and responding to patient risk

Staff completed exam justification information for each patient and safety questionnaires where appropriate, and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

There were four radiation protection supervisors in the department with plans in place to train more staff by the end of 2019. Staff turnover, staff sickness and staff shortages meant the number of radiation protection supervisors was not maintained at as high a level as planned but there were confirmed arrangements to improve this.

The imaging service ensured that women who were or may be pregnant informed a member of staff before they were exposed to any radiation in accordance with IR(ME)R. Documentation completed before the procedure included a standard statement confirming pregnancy status where applicable.

Information provided by the service, including the service improvement action plan and the risk register, indicated that the urgent report pathway was not clearly defined or understood, and that there was a lack of processes in place to review report completion. This was documented on the risk register in November 2018. This meant that processes to escalate unexpected or significant findings at examination and upon reporting were not clear to all staff. We spoke with staff about the timeliness of reports written by the radiologists and there were differing views.

Some staff said "most reports" were written on the same day at the end of the list, but others said reports took

Diagnostic imaging

three to four working days. Staff said the target was for reports to be generated within 48 hours of a procedure, but it took longer for some specialist scans. For example, in nuclear medicine one of the consultants was a specialist and their reports were usually completed within a week.

In the department's service improvement plan the timescale for imaging reports was recorded as the same day as examination for inpatients (either on picture archiving and communication system - PACS - or written in patient notes by radiologists with upload to PACS within 48 hours). A 48 hour timescale was documented for outpatients.

Following discussion at the medical advisory committee (MAC) a draft standard operating procedure (SOP) was presented at the June 2019 meeting. This said that imaging reports for inpatient procedures should be available within 24 hours for the referring clinician. It did not refer to a timescale for outpatients.

The draft SOP said radiologists, cardiologists, sonographers or dental referrers were responsible for issuing a report, ideally within 24 hours and the results provided to the referrer within two working days. However, it also said routine or non-urgent imaging should be reported within seven working days. A consistent specified timescale that could be audited would make the SOP clearer and minimise the risk to patients of important clinical findings not being reported in a timely manner.

All staff we spoke with said they could contact a radiologist for advice if they saw something of concern on a scan they felt could not wait for formal review. Radiologists could log into the electronic system remotely, to view the scan and assess the results. Staff could also bleep the resident medical officer (RMO) if they were concerned that a patient was becoming unwell or deteriorating.

The service had taken steps to strengthen their safety systems in relation to highlighting abnormal radiological findings (for example cancer, fractures, non-accidental injuries). A draft standard operating procedure (SOP) had been presented at the medical advisory committee (MAC) and governance committee and had been circulated for comment. The SOP was titled 'failsafe communication of findings from radiological examination' and was provided

guidance on escalation processes for radiologists when they identified unexpected or urgent or clinically significant findings and highlights who they need to escalate to.

There was a crash call alarm system in place which sounded throughout the hospital which meant that every clinical head of department was alerted and would attend to see if support was needed. A panel on the wall showed where the alarm was coming from. A pager also alerted the crash team, the RMO and clinical on-site manager (one of the heads of department).

In the MRI department there was a crash trolley bed with a pat slide in one room, to bring the patient out in an emergency. In the other room the table detached from the scanner so could be brought out and the patient transferred to a trolley outside the room. Resuscitation could not be performed on the MRI tables due to the magnetic coils in the MRI scanner.

At least one member of the crash team on duty was paediatric life support trained. All radiologists with practising privileges were consultants and were required to have up to date paediatric life support training. We saw evidence of this during the inspection.

Minutes from a meeting with the radiation protection adviser in October 2018 showed radioactive materials were stored appropriately and systems for use restricted exposure and limited the effects of contamination. Records of stock and waste were maintained. The annual return was sent to the Environment Agency's pollution inventory.

National and local diagnostic reference levels were displayed in all x-ray rooms, however there was some inconsistency in their interpretation. For some procedures, a cumulative rather than an individual radiation dose was being recorded. This meant that it may not always be obvious if an individual dose was out of range as when combined with another, the average of the two may be within range.

The diagnostic imaging managers consulted with the radiation protection advisor and took steps to implement individual dose recording with immediate effect.

Information and signage in the waiting room advised patients about areas and rooms where radiation took place.

Diagnostic imaging

Staffing

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

However, staffing levels were identified as an issue by the service, which was relying heavily on bank staff and staff overtime to fill shifts. There were regular bank radiographers who worked set days.

The service used an electronic staff management dashboard to calculate staffing needs, based on activity within the department. The workforce analysis element of the electronic programme showed the percentage of staff utilisation for every 15 minutes with a coloured bar chart indicating required staffing levels versus actual staffing levels.

We reviewed the dashboard for July 2019 which showed a staff utilisation rate of 91.4%. This meant that staff had been dealing with a patient for 91.4% of the time which exceeded the target rate of 75% to 80%. This optimum rate provided some flex to allow time for staff to be performing other duties, such as mandatory training. The utilisation rate in April 2019 was 95.9% and in June 2019 was 96.3%.

The imaging department manager submitted a monthly report to the executive director which included a staffing and controls section. A high staff utilisation rate was justified by controls in place to manage it, for example advertising to fill vacancies.

The governance report for July 2019 reported vacancies requiring recruitment as two whole time equivalent (WTE) in magnetic resonance imaging (MRI), three WTE and one bank in x-ray and one WTE in ultrasound. The report showed vacancy authorisation forms were to be raised for three radiographers and one nurse.

Recruitment and retention of staff in radiology was described as one of the big challenges when a new manager started earlier in the year. Since their arrival 13 staff had been recruited, some of whom had not yet started. Of these, three were new posts. Others were to replace leavers.

Staff we spoke with said the biggest issue in the department was staffing and it could cause problems but was mitigated by people staying late or coming in to work

on their days off. In the MRI department they re-arranged their breaks and changed the schedule between the two scanners to ensure both were in continuous use if they fell behind with the list.

There was a local 'work instruction' in place for lone workers. Work instruction documents were similar to standard operating procedures and set out guidance or directions for staff. The lone worker document advised staff on the protocol for lone workers to follow, which included informing reception staff of their whereabouts and identifying which staff carried radio handsets.

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.

Radiologists were not employed directly by the hospital but worked under practising privileges. Staff we spoke with said there was a radiology presence in the department every day and on call every day and night. If there was an emergency or staff needed a consultant opinion, they could get it.

Records

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

We reviewed eight sets of patient records on the electronic system. All had a scanned request card in their notes, seven of which were signed and dated by the clinician.

All notes had patients' clinical history detailed and all radiation doses were recorded where applicable. Magnetic resonance imaging (MRI) safety questionnaires were completed in full.

One request card was not fully completed. Incomplete referral documentation had been identified by the service as an issue and an audit to monitor standards had been agreed as an action following a serious incident. However, this was not included on the audit list submitted to us by the service following inspection.

Diagnostic imaging

Staff we spoke with were mindful of keeping patient information confidential and had taken steps to reduce the risk of patient information not being stored appropriately. Paper records containing information were stored behind the desk in the reception area which was not accessible to patients. Computers were logged off when not in use.

Medicines

The service prescribed, gave, recorded and stored medicines well.

For our detailed findings on medicines please see the Safe section in the Surgery report. Below are details related specifically to specialist medicines in diagnostic imaging.

The hospital held an employer's licence from Administration of Radioactive Substances Advisory Committee (ARSAC) for the administration of radioactive substances in line with Ionising Radiation (Medical Exposure) Regulations 2017. Individual practitioners in nuclear medicine also held their own licences.

The employer's licence defined the range of diagnosis, treatment or research services that could be delivered at the hospital. We also saw the licences held by individual consultants, with expiry dates, to clinically justify exposures involving the administration of radioactive substances for diagnosis, treatment or research. Research was not undertaken by the nuclear medicine team at the BMI Alexandra hospital.

The Medicines (Administration of Radioactive Substances) Amendment Regulations 2006 identified the operator under IR(ME)R (Ionising Radiation (Medical Exposure) Regulations) 2000 and allowed them to administer radioactive medicinal products under directions which are not patient specific. This meant there were no patient group directions (PGDs) in place in nuclear medicine. Radioactive medicinal products were not controlled drugs, but the operator was required to act in accordance with ARSAC guidelines.

There were work instructions in place to facilitate this. There was an imaging acquisition work instruction for each procedure which set out the dose administration and the diagnostic reference level equivalent parameters for nuclear medicine. For example, radiopharmaceutical

doses were listed for tests on different body regions such as bone marrow, brain perfusion and renogram. A work instruction for standard doses and waiting times set out the interval before the scan.

Patient group directions (PGDs) were in use in other areas. In the magnetic resonance imaging (MRI) department PGDs were in place for medicines including contrast agents. We reviewed the folder and saw PGDs were completed with the name of the health care professional, signed and dated by the staff member and the assessor. Training competencies were seen and in date.

Radioactive medicinal products were ordered and delivered the following day from a nearby NHS trust radio pharmacy under a service level agreement. All radiopharmaceuticals were tracked on the computerised radiology information system (CRIS). This included how much was ordered, what was delivered, scanned receipts, how much was given to the patient and how much was disposed of after a procedure.

The hospital pharmacy team were responsible for the procurement of radiopharmaceuticals and worked with the nuclear medicine team to ensure they were adequately trained in medicines management. The service level agreement included arrangements for checks and quality control.

All radiopharmaceuticals given to patients were authorised by a consultant and recorded and signed by two people.

Checklists were in place recording medicine expiry dates, audit and pharmacy meeting dates, risk assessments, clinical waste disposal and stock for consumable and pharmacy products. Pharmacy stock was audited by pharmacy. All medicines were stored in locked cupboards and only the registered professional staff held keys.

Contrast agents were locked in a temperature-controlled cupboard in the magnetic resonance imaging (MRI) department. Minimum and maximum temperatures were recorded on a chart with instructions for staff if the temperature went out of range.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and

Diagnostic imaging

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.

There were 61 incidents reported for diagnostic imaging from 1 August 2018 to 31 July 2019. Of these, 30 were low harm and 24 were no harm. One (a fall) had not been graded and the other six were non-clinical, for example related to the environment. One was a serious incident although the patient was not harmed.

Incidents were discussed at the daily comm cell meetings and in the monthly team meetings. We attended a comm cell meeting and reviewed the comm cell board. We saw learning and changes to practice being discussed at the meeting, with written details posted on the board.

All incidents involving equipment or radiation dose were reported to the radiation protection advisor who reviewed them and advised whether a notification to the Care Quality Commission was required, under the Ionising Radiation (Medical Exposure) Regulations requirements or to the Health and Safety Executive (HSE).

Managers were pro-active in disseminating learning, for example recently a note had been attached to the payslip for each member of staff to remind them about documentation standards.

We reviewed the root cause analysis for a recent serious incident and saw that an appropriate investigation was completed, with recommendations and an action plan in place. One of the actions was to amend a safety checklist, and we observed the appropriately amended checklist in use during our inspection.

Are diagnostic imaging services effective?

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The service had access to a wide range of guidance, policies and work instructions available on the electronic shared-drive. Some documents were available to all staff and others were department-specific. There was a document location direction on the comms cell board, which showed the location on the shared drive of all work instructions, standard operating procedures, policies and risk assessments.

Staff provided examples of national guidance they followed, for example before offering iodinated contrast agents to adults for non-emergency imaging, they investigated for chronic kidney disease by measuring eGFR (estimated glomerular filtration rate). This was in line with guidance Acute kidney injury: prevention, detection and management (National Institute for Health and Care Excellence, 2013).

Imaging department standards were displayed on the comm cell noticeboard and area specific local rules were posted on the walls in the corresponding clinical areas.

A monthly national clinical governance bulletin was issued by the Director of Clinical Services, detailing any new national guidance. This was reviewed locally and agreed actions were disseminated to the appropriate clinical leads using a baseline assessment document. This included details about the relevance of the new guidance, whether the service was compliant, and any changes required to practice.

An annual audit was undertaken by the radiation protection advisors who looked at equipment and processes and determined any actions that needed to be taken. These were logged and monitored in the service improvement plan.

Nutrition and hydration

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

Refreshments were available for patients at the hospital restaurant. Coffee and water were also available in the magnetic resonance imaging (MRI) department which was near the hospital and restaurant.

We observed staff explaining to patients when they could eat and drink, before and after their scans. Some patients

Diagnostic imaging

had to drink water before their computed tomography (CT) scans and others had a break in between one procedure and another, when eating and drinking instructions were clearly explained.

Pain relief

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

Staff checked that patients were comfortable, but no formal pain assessments were carried out. We observed staff asking patients whether they were experiencing any pain when preparing them for their scans.

Patient outcomes

The service completed some local audits to monitor the effectiveness of care and treatment and used the findings to improve them.

The service did not participate in national audits, however there was a local annual audit plan in place which included yearly regulatory audits for imaging (general and radiation) as well as for PACS (picture archive and communication system), RIS (radiology information system) and clinical practice. PACS is used for digital image management and RIS is an electronic resource to track and manage radiology patients.

Audits completed to date in 2019 for nuclear medicine included an inspection of radiopharmaceutical delivery conditions in nuclear medicine and an audit of reporting times. X-ray audits had been completed to check quality of images versus gold standard for knees and for x-ray justification criteria. A documentation audit had been completed in mammography and a pathway audit had been completed in computed tomography (CT).

Actions from audits were logged on the service improvement document, with a target completion date and rag-rated (red, amber, green) for evidence of completion.

Following inspection, the service sent us their current audit plan, however it did not include all the audits that staff had discussed with us, or that were documented in action plans. For example, it did not include monthly audits to monitor report turnaround or audits to monitor the completion of referral documentation as agreed in the action plan from a serious incident.

Weekly meetings had been set up between administrative and clinical staff to facilitate better understanding by clerical staff of the clinical services being provided. This was intended to improve relationships between staff and provide a better service for patients by more informed booking processes.

The Royal College of Radiologists report that early identification of failure to act on radiological imaging reports with critical, urgent or significant finding remains a problem in imaging departments (Standards for the communication of radiological reports and fail-safe alert notification, 2016).

There were entries on the risk register related to radiology reporting. In April 2019 a lack of compliance with national targets for auditing consultants imaging reports was noted, and in July 2019 it stated that 10% of radiology reports had not been audited by an external body for the last two years. The service improvement plan set a target date of 30 September 2019 for this to be addressed.

Monthly audits were agreed to monitor report turnaround. There was one audit listed, in May 2019, which needed closer scrutiny according to the service improvement plan. The deadline for completion was set for 15 September 2019.

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 monitor the effectiveness of the service.

Competency training was in place and was assessed annually. We reviewed a selection of competency records for nuclear medicine and for magnetic resonance imaging (MRI). These included training and annual assessment for equipment, image acquisition, patient identification protocols and CRIS (computerised radiology information system).

Following inspection, the service sent us information confirming the service was 100% compliant with modality specific competencies for computed tomography (CT), interventional procedures, mammography, MRI, ultrasound, BMI mobile image intensifier competencies, nuclear medicine, plain x-ray and mobile competency. Competencies were peer reviewed annually.

Diagnostic imaging

There was a continuing professional development calendar displayed on the comm cell noticeboard in the imaging department, which listed dates for future training.

All relevant staff held HCPC (Health and Care Professions Council) and RCT (Register of Clinical Technologist) registration. All staff registrations were current and active. Registration was monitored by the human resources assistant and flagged three months in advance of expiry, to prevent any lapses in registration.

Radiology consultants expressing a wish to be granted privileges to practice at the hospital were required to meet the criteria set out by the organisation. Please see the Surgery section of the report for full details.

The executive director completed a bi-annual review of the consultant radiologists register which held all their appraisal dates and competencies. They confirmed the practising privileges related to the same activity carried out by the consultant in the NHS and for retired consultants that they were completing sufficient activity to meet the royal college guidance.

Appraisals and mandatory training for consultants were required to be up to date. Where they were not, privileges were suspended until evidence was received that they had been completed.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Healthcare professionals supported each other to provide good care.

There was a daily heads of department communication meeting, called a 'comm cell' where the senior management team or their representatives came together with the executive director for 15 minutes to discuss the day ahead and any issues from the previous day.

Following this central comm cell, managers returned to their own areas and held individual departmental comm cell meetings with their teams, where any key messages from the heads of department were delivered. This was an opportunity for any concerns about the day to be discussed, for example staffing issues, and for any updates regarding any incidents or issues from the previous 24 hours to be raised.

Each area had a comm cell noticeboard displaying information for all staff including key messages and staff contacts, for example the safeguarding leads, fire wardens and health and safety leads.

There was a monthly multidisciplinary meeting where current practice was discussed. This was held on the first Tuesday of each month and was attended by different specialty clinicians, for example radiology, oncology, pathology and radiography.

Seven-day services

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

The magnetic resonance imaging (MRI) department was open 12 hours a day from 8am to 8pm, seven days a week, excluding some bank holidays. The computed tomography (CT) service was open from 10am to 6pm, five days per week, with 24 hours seven days a week on-call radiography provision for inpatients and clinical urgency, for example a patient requiring a CT scan or general x-ray following a procedure in theatre.

Ultrasound scanning, mammography and nuclear medicine were open when required between from 8am to 8pm, five days per week. General x-ray was also available during these hours, as well as until 6pm on Saturdays.

Health promotion

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

Diagnostic imaging staff provided health promotion advice and guidance as needed on an individual basis. This included areas such as smoking cessation and alcohol and drug use.

Leaflets and posters in the waiting room provided information for patients about x-ray safety.

Consent and Mental Capacity Act

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Diagnostic imaging

There was a BMI consent policy in place which outlined a two stage consent process with cooling off times for patients undergoing invasive procedures. As the fluoroscopy equipment was out of use, most diagnostic procedures being undertaken at the time of our inspection were non-invasive and were subject to a verbal consent process, with risks and benefits explained.

An audit of consent was included in the BMI national clinical assessment programme. There had been no recorded incidents related to consent for diagnostic imaging from April 2018 to April 2019.

We reviewed eight patient records and saw consent recorded appropriately where applicable.

Consent training was part of the mandatory training programme and mental capacity was included as part of the mandatory safeguarding training. Staff told us if they had any concerns they would contact the relevant safeguarding lead.

A poster on the wall in the waiting room advised patients that if they did not feel they had received adequate information they could refuse to go ahead with their x-ray.

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. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff treating patients kindly, showing care and respect. In the magnetic resonance imaging (MRI) department staff spoke with patients undergoing their scans to keep them updated with what was happening and check they were alright. A microphone was used so the patient could hear staff while in the scanner.

We saw staff providing extra support to a patient with a mobility impairment, helping them off the table and into a wheelchair and checking they were comfortable.

Emotional support

Staff provided emotional support to patients to minimise their distress.

We spoke with 11 patients and all felt well supported by the staff they saw. Staff we spoke with gave examples of occasions when they had needed to provide extra support to patients.

We observed staff interacting with patients in different clinical areas and saw them frequently checking the patients were alright and asking them if they were comfortable. While keeping the patients fully informed about what they were doing, they simultaneously distracted them from needles and cannulas by engaging them in conversation.

It had been noted at the patient focus group meetings that the concierge at the hospital was “brilliant”. During inspection we observed a consistently cheery and respectful greeting from the concierge to all who passed through the front door.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

From 1 July 2018 to 30 June 2019 the friends and family test results showed that the overall impression of diagnostic imaging was consistently rated by around 90% of respondents as either excellent or very good. The service had received five written compliments between 1 August 2018 and 31 July 2019.

Patients we spoke with said the doctor had explained the risks and benefits of the procedure they were undergoing. All were happy with their care and said they had been seen on time.

We observed clinicians explaining each step of the process to patients when being taken through for a scan. Their identification was checked, and information about eating and drinking was given. Staff explained exactly what was going to happen and gave the patient the opportunity to ask any questions.

The service was pro-active in making improvements following patient feedback, for example feedback from inpatients indicated that some did not feel the imaging

Diagnostic imaging

process was well communicated. In response to this, specific time windows were routinely allocated for inpatients requiring post-operative imaging so that a consistent process was followed.

Information provided by the service provided further examples of actions taken following patient feedback, and we saw examples displayed on the comm cell noticeboards.

There were notices in the hospital advertising how patients could sign up to the patient focus groups which were held approximately every two months. Constructive complainants were also invited to attend, during or after the complaints process.

The forums were minuted, with an action log showing the status of issues raised.

Are diagnostic imaging services responsive?

Good 

We rated responsive as **good**.

Service delivery to meet the needs of local people

The hospital planned and provided services in a way that met the needs of local people.

The diagnostic imaging department at BMI The Alexandra Hospital provided the following services; general x-ray imaging, dental imaging, interventional and diagnostic ultrasound and digital mammography. Within the main department they also provided computerised tomography (CT) and nuclear medicine. Magnetic resonance imaging (MRI) was provided in a separate building.

There were two general x-ray rooms, one with a digital workstation and the other with a cassette reader which patient information was scanned onto. A third room had a de-commissioned fluoroscopy machine which was not in use, however the table was used for ad-hoc ultrasound scanning when required. There had been some complaints from patients about the lack of a fluoroscopy service which was being outsourced to another provider.

There was a digital mammography room and two ultrasound scanning rooms, one of which was out of use at the time of our inspection due to engineers carrying out maintenance work. There were also rooms for CT and nuclear medicine.

There was a radiology reporting room with four reporting workstations where radiologists had access to the picture archiving and communication system (PACS) with headphones and Dictaphones for writing reports.

There were five cubicle changing areas. One set of three cubicles was used for mammography, ultrasound and CT, and a second set of two cubicles was available for general x-ray. The cubicles were near to the waiting area and although they had curtains they were not very private. Staff were mindful of patients' privacy and dignity and where appropriate, patients were invited to change in the clinic rooms rather than the cubicles.

There was a plan to upgrade the department within the next five years and a more appropriate changing area was one of the areas due to be addressed.

In the grounds of the hospital there was a separate building for the magnetic resonance imaging (MRI) department. There were two MRI rooms and two patient changing cubicles for each scanner. There were also patient lockers for use when needed. The MRI room building had back to back control rooms interlinked by an adjoining door, not accessible to patients.

The two MRI machines performed slightly different functions although there was some crossover. One had a bigger field of view and was better for long bones and large areas of the body. The other produced better images for small areas such as wrists or ankles.

There was a radiologist reporting room; although PACS mail could send images out to be reported on the neuroradiologists usually attended the hospital and wrote reports on site.

There were two portable x-ray machines in the department and four image intensifiers in other areas of the hospital.

Managers told us less than 25% of patients attending for diagnostic imaging were NHS patients. Most private

Diagnostic imaging

patients used the service, so they did not have to wait, for example the service had contracts with some sports organisations who wanted their athletes to get back into training as soon as possible.

Patient waiting areas near reception were small with limited opportunity for a private conversation. In the MRI department a television had been installed which meant a conversation between a patient and the receptionist was less easy to overhear. There were plans to do the same in the main diagnostic imaging department. In the meantime, a sign had been put up informing patients to let the receptionist know if they wished to speak privately.

Meeting people's individual needs

The service took account of patients' individual needs.

Services were provided for adults and children over the age of three years. Children staying on the paediatric inpatient ward were escorted by a member of the paediatric team when undergoing an invasive procedure in diagnostic imaging. Children who needed cannulating had the procedure on the children's ward, prior to arriving in the department for a scan.

Parents of younger children could stay with them in the scanning room. Chaperones were available for those who needed one. Toys for children to play with were available in the main diagnostic imaging reception area.

Staff we spoke with provided examples of accommodating individual patient's needs, for example offering patients the choice to get changed in the scanning room if they felt uncomfortable walking from the changing cubicles in a gown. Staff in the MRI department gave two good examples of how they had made specific adaptations to a booked procedure to enable it to go ahead after problems had arisen with the planned routine appointment.

When patients were anxious, staff took time to show them the equipment first and explain how it all worked. For many of the scans, for example nuclear medicine, ultrasound or magnetic resonance imaging (MRI), staff or parents could stay in the room with the patient if requested. There was an emergency buzzer for patients to press if necessary, when having an MRI scan.

There was a large hoist and a bariatric chair available on one of the inpatient wards which could be booked for use in the department if required. Walking frames and steps with different heights were available.

Some staff had watched an online video promoting awareness of additional needs for patients living with dementia. Posters were displayed in the department advertising a dementia friendly status.

Staff had access to an interpreter service if required. The chaperone booklet was available in 15 different languages and there was an international patient booklet available for staff access in x-ray reception.

Access and flow

People could access the service when they needed it.

From 1 July 2018 to 30 June 2019 there were 37,945 attendances for diagnostic imaging. The did not attend (DNA) rate was very low at approximately 0.18%.

During this same time period, monthly waiting times for key diagnostic tests and procedures were measured against a six week target as part of a national key performance indicator (KPI).

On average 80% of patients attended the imaging department within two weeks of requesting an appointment, and 99% of patients attended within six weeks. The remaining 1% of patients were seen after 6 weeks due to the consultant or patient requesting imaging on or after a certain date, to coincide with other treatment or to suit patient availability. Therefore, there was 100% compliance with the KPI.

Any clinician with a medical qualification working within the BMI Alexandra hospital or within the area of the BMI Alexandra Hospital could refer a patient for all examination types and interventional procedures. All GPs within the area served by the BMI Alexandra Hospital could refer a patient for any diagnostic examination excluding angiography.

Any qualified dental practitioner within the area served by the hospital could refer a patient for all plain film radiography of the head and jaw. Non-medically qualified referrers included radiographers, physiotherapists, dieticians, osteopaths and chiropractors who could refer under a fixed protocol basis only.

Diagnostic imaging

For nuclear medicine, all referrals had to be authorised by a consultant at BMI before being accepted.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

There had been 34 complaints about diagnostic imaging from 1 August 2018 to 31 July 2019. These had been reviewed and identified themes included delays in obtaining results, pricing information, contacting the imaging department and fluoroscopy equipment broken.

There had been some issues with the administrative processes which had caused some tension between administrative staff, clinical staff and patients. Some booking errors had occurred, and some patients had complained that their calls had not been returned.

The service was working together to resolve the issues. There were monthly meetings held with the administration team in the department with actions agreed to improve processes for patients, for example refining the booking system. Actions from the meetings were logged and tracked by managers.

Staff we spoke with were positive about the departmental management team and the senior management team and described them as “very visible”.

Vision and strategy

The service had a vision for what it wanted to achieve and was making plans to turn it into action developed with involvement from staff and patients.

There was a plan to refurbish the diagnostic imaging department within the next five years, but it was not yet underway. A notice on the wall in the department informed patients that the organisation had looked at the efficiency of the layout and recognised the hospital required significant investment to upgrade rooms and departments. This was signed by the senior management team.

The department vision was to provide an outstanding imaging service to patients and relatives.

There was a rag-rated (red, amber, green) service improvement plan in the form of recorded areas of concern with agreed actions, person responsible and target date identified and evidence of completion.

Are diagnostic imaging services well-led?

Good 

We rated well led as **good**.

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The manager of the diagnostic imaging department had only been in post for a few months but staff we spoke with said they were positive, supportive and accessible.

The manager and the deputy manager were knowledgeable about the department and were responsive to queries we raised during the inspection. It was clear that both were pro-active in a programme of continuous improvement.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There were monthly team meetings in the diagnostic imaging department and these had recently been held twice in the same week to facilitate the attendance of as many staff as possible. The intention was that staff who were unable to attend the first meeting would be available to attend a repeat meeting later in the week.

Minutes from the meetings were printed out and filed in an information folder for staff to read when they had been unable to attend. The folder also contained shared learning and other updates for staff to read which they signed to show they had seen it.

We saw the minutes for meetings held in May, June and July 2019. The standard agenda set by the BMI group included general updates, vacancies, governance, quality and complaints. There was a continuing professional development (CPD) item and a risk register update.

Diagnostic imaging

Incidents were detailed, and patient satisfaction feedback was discussed. Issues and incidents documented in the minutes corresponded with information relayed to us by staff during our inspection.

We observed staff supporting each other and working well together. Staff we spoke with were positive about the organisation, despite the issues sometimes caused by being short-staffed.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

A monthly departmental governance report had been introduced to replace an executive director's report. Managers told us the new report had better information and was discussed at the hospital-wide monthly clinical governance meetings, chaired by the executive director.

We reviewed minutes from three monthly clinical governance meetings and saw evidence that incidents were discussed in detail, with actions agreed and documented. Complaints were discussed, as well as quality initiatives and patient satisfaction. There was a standing agenda item for mortality and any updates from the Coroner.

The clinical governance meeting also monitored training compliance and any shared learning or safety updates. Sub-committee groups reported to the meeting and updates from the medical advisory committee (MAC) or new clinical developments or services were also fed back.

Policies, standard operating procedures (SOPs) and national guidance were on the agenda for the clinical governance meeting, including Care Quality Commission (CQC) information. For example, in the April 2019 minutes there was an update from an Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection carried out by CQC at a different BMI Hospital location.

Clinical audits and action plans were monitored through the clinical governance meeting.

There was an organisation-wide monthly clinical governance and quality and risk bulletin, including lessons learned. This was distributed to and actioned

through hospital governance committees and there was a hospital tracker in place to monitor this. The bulletin included safety alerts, audit updates and listed areas of non-compliance with actions required.

Managing risks, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a risk register in place for the imaging department which identified a risk level, description and date. The risk register was displayed on the comm cell boards and was included in a monthly governance scorecard. Actions were monitored through the service improvement plan, the monthly clinical governance meeting and departmental team meetings.

We looked at the scorecards for April, May and June 2019. Each was rag-rated (red, amber, green) against targets for a range of criteria including incidents, mandatory training compliance, appraisals and risk register within review dates.

Incident reporting was graded as green for no incidents and red for more than three incidents reported. This could discourage staff from reporting incidents when higher levels of incident reporting are generally regarded as a sign of an open reporting culture which facilitates learning.

Radiation protection advice was provided by a service level agreement with a local NHS trust. Medical physics and engineering at the trust was recognised by the Health and Safety Executive as a Radiation Protection Adviser Body under Regulation 13 of The Ionising Radiation Regulations.

A radiation protection committee meeting was held annually as a minimum, with meetings more frequently if required. We saw the minutes for an annual meeting held in October 2018, and for an interim meeting held in January 2019. Both meetings were attended by a senior radiographer in the role of lead for lead radiation protection supervisor, a radiation protection advisor, the Director of Operations and the associate Director of Clinical Services.

Minutes from the annual radiation protection committee meeting in October 2018 provided evidence of yearly reports and checks. New Ionising Radiation Regulations

Diagnostic imaging

(IRR17) came into effect from 1 January 2018 and the minutes showed the local rules in nuclear medicine were compliant, and that the work instruction had been updated.

There were some outstanding actions following the annual meeting, in terms of bringing the department's levels of Ionising Radiation (Medical Exposure) Regulations up to Care Quality Commission standards. The interim meeting in January 2019 was held to review the progress of these actions.

Completed actions included the screening of lead aprons and the updating of local rules and radiation risk assessments for all areas. Employers procedures were reviewed, and a new standard operating procedure had been created to reflect the updated regulations.

The comms cell noticeboards had a risk section where a document recorded 'concern, cause and countermeasure' for identified issues. Where these could not be easily resolved or mitigated, the issues were escalated to the risk register.

We saw audit records in nuclear medicine showing regular reports from the radiation protection advisor in relation to risk assessments for radiation, restriction of exposure, control of contamination and investigation of incidents. Local rules had been reviewed.

We saw evidence of changes to practice made following advice from the radiation protection advisor, for example consultants now had to declare where else they worked for dosimetry monitoring purposes. Doses were sent by other employers to BMI so that the combined dose could be monitored.

There was a generator in the hospital which provided power if the electricity supply was interrupted.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The electronic staff management dashboard used to calculate staffing needs was integrated with the patient booking system and the electronic staff rotas. The

computerised radiology information system (CRIS) recorded the beginning and end time for each procedure and reported how many patients had been seen and whether the radiographer had enough time.

These staffing tools were used in management one to ones to justify bank and overtime requests submitted to the executive director a week in advance. At the end of each month managers could review how many times the department had been over or under-staffed and make any necessary adjustments. They could compare their own staffing levels with other BMI hospitals or just look at the hours worked.

The electronic system was linked to the fingerprint login and logout electronic system used by staff and automatically reduced pay if a staff member was late. If overtime was worked, it was recorded by this system but needed to be approved before payment was authorised.

Engagement

The service engaged well with patients, staff and the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

There was a staff suggestions box near the staff entrance to the hospital and changes made because of staff suggestions were published in the monthly staff newsletter.

Each area had a comm cell noticeboard displaying information for staff including key messages, risks and 'quality improvement on a page' which showed issues and controls, appraisal rates and staffing.

The comm cell noticeboard displayed notes related to staff recognition, from colleagues and from patient feedback.

Patient forums were held approximately every two months and information provided by the hospital said monthly staff engagement meetings were held and minuted. The executive director held staff forums quarterly and all staff were invited.

There were annual awards to celebrate continuous service where staff received a pin as recognition for the number of years' service.

Learning, continuous improvement and innovation

Diagnostic imaging

The service was committed to improving services by learning from when things went well and from when they went wrong.

The service did not participate in research but was responsive to change when necessary.

Managers had created a rag-rated (red, amber, green) service improvement plan in the form of recorded areas of concern with agreed actions, person responsible and target date identified and evidence of completion.

The concerns were drawn from all the different areas where these might be raised, for example actions from audits, findings from complaints, actions from investigations or from walk rounds by senior staff. Feedback from staff and patient forums and from staff meetings was included.

Outstanding practice and areas for improvement

Outstanding practice

- The bariatric service had excellent outcomes for patients, with patients reporting 75% loss of excess weight two years after surgery (compared to 58.4% for the national average – based on the most recently reported data).
- Critical care nursing staff had received cardiac advanced life support training. This was better than the requirements of the national standards.

Areas for improvement

Action the provider **MUST** take to improve In Services for Children and Young People

- The provider must review its systems for managing a deteriorating child and ensure that there are the required number of trained emergency paediatric life support and advanced life support staff on the ward to meet staffing standards. **Regulation 12 Safe care and treatment.**
- The provider must review its governance processes to ensure there are systems and processes to assess, monitor and mitigate the risks to the health, safety and/or welfare of people who use the service.

Regulation 17 Good Governance

- The provider must review its systems and processes to assess, monitor and drive improvement in the quality and safety of the service. **Regulation 17 Good Governance**

Action the provider **SHOULD** take to improve In Urgent Care

- The provider should ensure it reviews and consolidates local safeguarding protocols with agency staff.
- The provider should ensure it reviews clinical and non-clinical information flow to include regular agency staff.
- The provider should ensure it reviews systems for calibrating equipment to ensure calibration takes place within manufacturer's timelines.

In Surgery

- The provider should ensure that all staff comply with the bare below the elbow protocol.

- The provider should consider ways to increase compliance with ward cleaning schedules.
- The provider should ensure it continues to review the arrangements for the decontamination of theatre equipment.
- The provider should ensure it continues to review its processes for recruiting and retaining staff and reducing the reliance on bank and agency staff.
- The provider should consider a review of compliance with the use of pain management scores and look at standardising tools to monitor pain in non-verbal patients.
- The provider should ensure it continues to improve its submission of data to external audits.
- The provider should consider including in its refurbishment plan the ability of wheelchair users to access shower facilities in their own room.

In Medicine

- The provider should ensure records reflect the total fluids given and record the actions taken if fluids need to be increased.
- The provider should consider the security of medical records to maintain confidentiality.
- The provider should consider reviewing its information to ensure that it is easily accessible to patients and their relatives in formats that meet their individual needs.
- The provider should continue with its development of a dementia strategy and refurbishment programme to assist in meeting the needs of patients living with dementia.
- The provider should continue with its plans to obtain JAG accreditation for the endoscopy ward.

Outstanding practice and areas for improvement

- The provider should ensure all staff understand how and when to assess whether a patient has the capacity to make decisions about their care under the Mental Capacity Act 2005.

In Critical Care

- The provider should consider the benefits of improving signage to more easily identify the entrance to the ward at the front of Chester ward.
- The provider should consider how it can meet the core standard for the provision of twice daily consultant intensivist lead ward rounds on the ward.
- The provider should consider how it can more clearly document and evidence of discussions between staff and the patient or their carers in the patient records.
- The provider should consider the benefits of undertaking an analysis of the main languages spoken by its clients and having electronic versions of important patient information leaflets in these languages available for staff to print off when necessary.
- The provider should consider recording details of existing control measures, gaps in controls, and descriptions of actions needed to mitigate risks identified on the department risk register.

In Services for Children and Young People

- The provider should review the application of the surgical safety checklist for paediatric surgery.
- The provider should ensure the location of the ward is reviewed as soon as possible.
- The provider should ensure that all staff are familiar with the abduction policy and their roles and responsibilities.
- The provider should ensure there is a safe space for children who have additional needs and need to be away from a busy ward environment.

- The provider should ensure they have arrangements in place to share details of attendance with school nurses, health visitors and other organisations involved in the child's care.
- The provider should ensure they have access to mental health liaison for those patients who have mental health concerns.
- The provider should ensure they implement a patient passport for patients with additional needs to ensure staff are aware of the patient's additional requirements.
- The provider should ensure they have information and access to services to support beavered families.
- The provider should ensure they make established links with external organisations to support patients who require support in the community.

In Outpatients

- The provider should continue working to ensure that a contemporaneous record of all patient contacts is always kept on site at the hospital.
- The provider should consider amending the registration form to inform patients that their consultant will be taking their personal information away from the hospital.

In Diagnostic Imaging

- The provider should continue to monitor staffing levels to ensure the department is adequately staffed at the optimum level of staff activity.
- The provider should ensure there is a clear and consistent set of standards for radiology reporting which are monitored by a robust auditing process.
- The provider should ensure there is an up to date audit calendar in place that reflects actions from incidents and national requirements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The provider did not have effective systems in children and young people services to provide care in a safe way.</p> <p>The provider did not have effective systems in place for managing a deteriorating child.</p> <p>The provider did not have effective systems in place to monitor staffing.</p> <p>The provider did not ensure there was an EPLS/ALS trained staff member on the ward in line with paediatric staffing standards</p> <p>Regulation 12 (1)</p>
Transport services, triage and medical advice provided remotely	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider did not have effective systems and processes to assess, monitor and mitigate the risks to the health, safety and/or welfare of children who use the service</p> <p>The provider did not have effective systems and processes to assess, monitor and drive improvement in the quality and safety of the service for children.</p> <p>Regulation 17 (1) (2) (a) (b)</p>