St Hugh's Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St Hugh's Hospital is operated by The Healthcare Management Trust and serves the population of North East Lincolnshire. The on-site facilities include one ward consisting of 24 single rooms and two double rooms, two laminar flow theatres and eight consulting rooms. The other clinical departments at the hospital include an endoscopy suite, a physiotherapy department and a radiology department with ultrasound and x-ray. The hospital provides surgery and outpatients with diagnostic imaging services.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 05 and 06 March 2019.

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

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

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

Services we rate

Our rating of this hospital stayed the same. We rated the hospital as requires improvement overall. This was because we rated well led as inadequate, we rated safe as requires improvement and we rated effective, caring and responsive as good.

We rated the surgical services as requires improvement. This was because we rated safe as requires improvement. We rated effective, caring and responsive as good. We rated well led as inadequate.

Although the hospital had made some improvements since our previous inspection, there was still work to do in terms of safety and leadership. This was because staff did not always recognise and report concerns, incidents or near-misses. We identified some discrepancies in medicines governance and were not assured there was a consistent approach to reporting medicines incidents and escalating patient risk. Mandatory training compliance remained low in some subjects, for example, safeguarding training. Not all consultants were completing care records in line with the hospitals record keeping policy.

There was no formalised and consistent system of clinical supervision in place. We had concerns formal complaints were not always managed in accordance with hospital policy. We had concerns that the senior leadership team were not proactively managing the concerns identified in some consultants practice, behaviour and record keeping. We also found some the concerns identified at our previous inspection were not fully addressed and some controls were not fully embedded, for example, issues relating to medicines governance, which breached hospital policy. We were concerned that there was not an equitable awareness of safety and risks across all services. Staff across all services raised concerns about low morale and the culture at the hospital since our previous inspection.

However, we found the surgical care areas, equipment and facilities were well maintained and safe. We found robust infection prevention and control processes were in place, audits took place and compliance rates were high. The hospital had reported two never events following our previous inspection. These were in October and November 2017, we found following these incidents the patients were fully informed and duty of candour (DoC) applied. Root cause analysis investigations were completed, learning identified and action plans put in to place to prevent recurrence.

Summary of findings

We saw patients were treated with care, compassion, and respect by all staff during their treatment and patients told us they were fully involved in their care.

The hospital worked with other care providers to improve services and to meet the needs of the local population. Patients could access treatment quickly. Referral to treatment performance was good with 90 to 95% of patients being treated within 18 weeks. On average patients completed their treatment within 10 weeks. There were low numbers of complaints. Staff told us the senior managers were visible and supportive. The hospital had a clear set of principles, goals and values. Despite the challenges of the previous year most staff said the hospital was a good place to work with good teamwork in their departments.

Overall, we rated the outpatient's department as good because we rated safe, caring, responsive and well led as good. We do not rate effective for outpatients.

This was because the department was clean and tidy. All equipment had been serviced in line with requirements. Records were stored securely. Staff were aware of their safeguarding responsibilities, how to assess patients for risks and respond appropriately if any were identified. When incidents occurred, staff knew their responsibilities to report incidents and near misses. There was adequate nursing and medical staffing available in the department to meet the needs of patients.

Patients received evidence-based care delivered by competent staff from a number of different disciplines who understood their responsibilities in relation to mental capacity and consent and focused on providing good quality care and treatment. Patients could access drinks and food if their clinical condition necessitated it however, pain relief was only accessible via a prescription from the consultants working in the department.

Outpatient clinics were offered during the day, evenings and some weekends depending upon demand. Patients we spoke with were happy with the care and treatment they received. Staff were kind, courteous, patient and understanding. Patients were offered support if they needed it and provided with information about their condition presented in terms that were understandable and avoided medical jargon. Services were delivered in a way that met the needs of local people by staff who understood patients had individual needs. The hospital provided support to patients who had sensory, language, physical disability and mental health support needs.

Patients could access appointments quickly. Complaints were few however all staff took complaints seriously and aimed to provide a good quality service for patients.

The department was managed by staff who were experienced in the management of an outpatient department. There was a strategy in place to develop the services delivered by the department in line with local needs and the requirements of local services the hospital engaged with such as the local NHS trust and Clinical Commissioning Group (CCG).

The department collected information about services and had governance processes in place to monitor the quality of services delivered. Risks faced by the department were assessed, recorded and managed. Staff mostly felt well led although some had concerns about their line managers occasionally being unsupportive.

Overall, we rated the diagnostic imaging department as requires improvement. We rated well led as inadequate and safe as requires improvement. We rated caring and responsive as good. We do not rate effective in diagnostic imaging.

This was because during our time on site, the management team were unable to provide us with assurance that equipment being used had been appropriately safety checked and calibrated. This posed a potential risk to both patients and staff. Staff were not wearing appropriate safety equipment and there was no evidence of safety equipment having mandatory safety checks.

Summary of findings

Although the hospital had received a safety assessment from their local radiation protection advisor (RPA) in November 2018 highlighting many breaches of IR(ME)R (ionising radiation medication exposure regulations), we found no evidence whilst we were on site and managers could not provide us with any evidence of how these breaches had been addressed other than with an out of date action plan showing no prioritisation and only one action completed.

Whilst on site, we were unable to find, and the hospital was unable to provide us with up to date information about safety and quality checks carried out in the department to ensure ionising radiation procedures were performed in line with national guidance and local procedures. When we arrived at the department, local rules were out of date however these were updated and replaced during the inspection.

The department did not have an established safety checklist for carrying out interventional radiology as highlighted at the hospital's previous CQC inspection.

We were concerned about the safety of patients and staff visiting the department because the hospital could not provide us with immediate assurance that the department was safe.

The hospital was unable to provide us with evidence of how they were assured they provided evidence-based treatment. Documentation relating to evidence-based care was out of date and had not been updated to reflect the latest IR(ME)R regulations issued in 2018.

The process for quality checking the work of individuals was unclear and there was no evidence that quality assurance of images took place. We found no evidence of discrepancy meetings taking place.

We identified concerns about the senior management of the diagnostic imaging department. They were unclear about the quality assurance and safety processes involved in managing a service that uses ionising radiation. There were no robust embedded systems of governance in place and the department was reliant on one person to oversee governance and quality assurance. Staff were unclear about the governance processes in place to safeguard both them and patients.

Management and leadership was remote. Staff were unaware of any strategies or future plans for the department.

We wrote to the hospital director immediately after our inspection and told him the Care Quality Commission was considering action under section 31 of the Health and Social Care Act 2008. We told the hospital they must provide us with information which showed that patients and staff working in the diagnostic imaging department were safe from harm. The hospital voluntarily suspended diagnostic imaging services until this information was provided. CQC received this information within the required timescales and therefore the hospital was able to resume diagnostic imaging services.

However, we also found the following good practice in the diagnostic imaging department. Staff were aware of their responsibilities relating to consent and mental capacity of patients requiring x-rays or ultrasound.

Patients received care from staff who were kind and compassionate. They were given information in terms they understood and were given emotional support if it was needed. Patient feedback was positive and we were assured the hospital had carried out due diligence to ensure radiology and radiography staff were suitable qualified.

The service was planned to meet the needs of people attending the hospital and x-ray imaging was available whilst clinics were running as well as when required by inpatients. Patients did not have long waits for appointments and could be seen quickly if needed.

Services were designed to meet the needs of individuals and support was available for people living with sensory impairment, physical and learning disabilities, mental health problems and dementia.

The department had received no complaints however complaints received across the hospital were discussed with staff and lessons learned shared to improve services and prevent future complaints.

Summary of findings

Following this inspection, we told the provider it must take some actions to comply with the regulations and it should make other improvements, even though a regulation had not been breached, to help the service improve. We issued the provider with two requirement notices. These were related to regulation 12, safe care and treatment and regulation 17, good governance that affected surgery and the diagnostic imaging departments. Details are at the end of the report.

Name of signatory

Ellen Armistead

Deputy Chief Inspector of Hospitals North Region

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated the surgical services as requires improvement. This was because we rated well led as inadequate and safe as requires improvement. However, it was effective, caring and responsive.
Outpatients	Good 	We rated the outpatient department as good because it was safe, caring, responsive and well led. We do not rate the effectiveness of outpatient departments.
Diagnostic imaging	Requires improvement 	We rated the diagnostic imaging department as requires improvement. This was because we rated the leadership as inadequate and we rated safe as requires improvement. However, the department was caring and responsive. We do not rate the effectiveness of diagnostic imaging departments.

Summary of findings

Contents

Requires improvement

St Hugh's Hospital

Services we looked at

Surgery; Outpatients and Diagnostic imaging.

Summary of this inspection

Background to St Hugh's Hospital

St Hugh's Hospital is operated by The Healthcare Management Trust. The hospital opened in 1994. It is a private hospital in Grimsby, Lincolnshire. The hospital primarily serves the communities of North East Lincolnshire. It also accepts patient referrals from outside this area.

The hospital has had a nominated individual in post since October 2010.

The hospital has had a registered manager in post since 2010. At the time of the inspection, the registered manager had been in post since November 2016 and registered with CQC since June 2017.

The hospital offers a range of inpatient and outpatient services to NHS and other funded (insured and self-pay) patients including orthopaedic, general surgery, urology, ophthalmology, ear nose and throat, gynaecology and cosmetic surgery. The hospital does not provide any services for children and young people.

Our inspection team

The team that inspected the service comprised of Kerri Davies CQC lead inspector, two other CQC inspectors, an assistant inspector and four specialist advisors with expertise in governance, diagnostic imaging and surgery – both nursing and medical. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about St Hugh's Hospital

St Hugh's Hospital has one ward consisting of 24 single rooms and two double rooms, two laminar flow operating theatres and eight consulting rooms. The other clinical departments at the hospital include an endoscopy suite, a physiotherapy department and a radiology department with ultrasound and x-ray. The hospital provides surgery, outpatients and diagnostic imaging services. We inspected all services.

The hospital is registered to provide the following regulated activities:

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

Before our inspection we held five focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. During the inspection, we visited all areas of the hospital including the ward, theatres, endoscopy suite, outpatients and the diagnostic imaging departments.

During our inspection we spoke with 19 patients and 33 staff members including all grades of medical and nursing staff, administrative staff and therapists. We also met the senior management team for the hospital and the services. We observed practice, staff interactions with patients and viewed 16 sets of care records.

Before and after our inspection, we reviewed performance information about the service and information provided to us by the hospital.

The hospital had been inspected four times from 2015 to 2019. Following a focused inspection in 2017, we served the provider with a warning notice under section 29 of the Health and Social Care Act 2008 and issued three requirement notices. These were related to regulation 12 safe care and treatment, regulation 17 good governance and regulation 18 staffing.

The warning notice related to Regulation 12, (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment. It required the

Summary of this inspection

provider to take action to ensure systems and processes were established to ensure the proper and safe management of medicines. We gave the provider three months to make the necessary improvements.

We carried out an unannounced focused inspection in February 2018 and although we found there had been improvements made in the proper and safe management of medicines we found there was still more work to do.

We served a further warning notice on 28 February 2018 under section 29 of the Health and Social Care Act 2008. The warning notice related to Regulation 17, (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance. The warning notice required the provider to take action to ensure systems and processes are established to ensure effective governance arrangements were in place in relation to the proper and safe management of medicines. We gave the provider three months to make the necessary improvements.

We carried out a desk top review in July 2018 and were assured the provider had made the necessary improvement to their governance arrangements.

Activity (August 2017 to July 2018)

- In the reporting period August 2017 to July 2018 there were 1167 inpatient and 4806 day case episodes of care recorded at the hospital; of these 84% were NHS-funded and 16% were non-NHS funded.
- 18% of all NHS-funded patients and 25% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 10886 outpatient total attendances in the reporting period; of these 22% were other funded and 78% were NHS-funded. The hospital provided information prior to our inspection indicating the activity levels within the outpatient's department were as follows:
  - Orthopaedics - 40%
  - Ophthalmology - 10%
  - Gynaecology - 5%
  - General surgery - 13%.
  - ENT - 3%.
  - Cosmetic surgery - 3%.
  - Cardiology - 2%.
  - General medicine -1%.
  - Rheumatology - 1%.
  - Urology - 7%.
  - Pain management - 7%.
  - Dermatology - 2%.
  - Gastroenterology - 6%.

From December 2017 to November 2018 there were 69 consultants working at the hospital under practising privileges. Information provided by the hospital showed 19 consultants had carried out more than 100 procedures, 19 had carried out between ten and 99 procedures, three carried out between one and nine procedures and 28 had not carried out any procedures.

The hospital had two regular resident medical officers (RMO) who worked on a seven-day on seven- day off rota. The hospital employed 24.9 whole time equivalent (wte) registered nurses and 19.5 wte health care assistants and operating department practitioners. The accountable officer for controlled medicines was the peri-operative care manager.

Track record on safety

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Following our inspection in 2017 the hospital reported two never events in October and November 2017. There were no recorded never events in 2018. The hospital has reported one never event in 2019.
- The hospital reported 322 clinical incidents from October 2017 to September 2018. Of these 301 were reported as no harm, seven were low harm, 11 were moderate harm and two were severe harm. There were no deaths reported during the same period.
- There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),

Summary of this inspection

Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or Escherichia coli (E-Coli) reported by the hospital from October 2017 to September 2018.

- The hospital received 16 complaints from December 2017 and November 2018.

Services accredited by a national body:

- Operating theatres - the association for perioperative practice

Services provided at the hospital under service level agreement:

- Pathology
- Pharmacy
- Instrument decontamination
- RMO provision
- Facilities management
- Occupational health
- Laundry services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- Mandatory training compliance was low in some subjects, for example, safeguarding training was low in endoscopy, theatres and the ward.
- In surgery staff did not always recognise and report concerns, incidents or near-misses. Therefore, we were not assured safety and risk concerns were consistently identified or addressed quickly enough.
- We identified some discrepancies in medicines governance and were not assured there was a consistent approach to reporting medicines incidents and escalating patient risk.
- Consultants did not always keep contemporaneous records which breached the hospital's record keeping policy.
- We were concerned about the safety of patients and staff visiting the diagnostic imaging department because the hospital could not provide us with immediate assurance that the department was safe.
- We were not assured that equipment being used for diagnostic imaging had been appropriately safety checked and calibrated. This posed a potential risk to both patients and staff.
- Staff in the diagnostic imaging department were not wearing appropriate safety equipment and there was no evidence of safety equipment, such as lead aprons, having mandatory safety checks or that they were stored in a way that maintained their efficacy to keep patients and staff safe.
- The diagnostic imaging department did not have an established process for completion of a safety checklist for carrying out interventional radiology as highlighted at the hospital's previous CQC inspection.
- When we arrived at the diagnostic imaging department, local rules were out of date however these were updated and replaced during the inspection.

However, we also found:

- The surgical and outpatient department equipment and facilities were visibly clean and safe.
- We found robust infection prevention and control processes were in place, audits took place and compliance rates were high.

Summary of this inspection

- Staff were aware of their safeguarding responsibilities, how to assess patients for risks and respond appropriately if any were identified.
- In the outpatient department staff knew their responsibilities to report incidents and near misses.
- There was adequate nursing and medical staffing available in the departments to meet the needs of patients.

Are services effective?

Good

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

- In the surgical services patients received care in line with evidence-based best practice.
- At this inspection we saw improvement in provision of up to date policies and guidance.
- The services carried out local audits, participated in national audits and collated patient outcomes. They used the data to improve services for patients.
- Surgical site infection rates were low at less than 0.1%.
- Care was delivered by competent staff from a number of different disciplines.
- Patients on the ward were assessed for their nutritional needs and supported if they were at risk of malnutrition.
- Patients pain relief was managed well. Staff assessed patients and provided pain relief in a timely manner.
- Staff across all services understood their responsibilities in relation to mental capacity and consent and focused on providing good quality care and treatment.

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

- We had concerns there was no formalised and consistent system of clinical supervision in place.
- We had some concerns, that some consultants were not practicing in accordance with national institute for health and care excellence (NICE) guidance.
- Although the hospital had received a safety assessment from their local radiation protection advisor (RPA) in November 2018 highlighting many breaches of IR(ME)R (ionising radiation medication exposure regulations), we found no evidence of how these breaches had been addressed other than an out of date action plan showing no prioritisation and only one action completed.
- The hospital director was unable to provide us with evidence of how they were assured they provided evidence-based

Summary of this inspection

treatment in the diagnostic imaging department. Documentation relating to evidence-based care was out of date and had not been updated to reflect the latest IR(ME)R regulations issued in 2018.
- The hospital's consent policy indicated a two-stage process. However, this was not reflected in the consent forms we reviewed as these were only signed and dated on the day of surgery.

Are services caring?

Good

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

- We saw patients being treated with care, compassion, and respect by all staff during their treatment and patients told us they were fully involved in their care. Staff were kind, courteous, patient and understanding.
- Patients we spoke with were happy with the care and treatment they received.
- Patients were offered support if they needed it and provided with information about their condition.
- Patients were given information in terms they understood and were given emotional support if it was needed.
- Patient feedback was positive across all of the services provided by the hospital.

Are services responsive?

Good

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

- Services were delivered in a way that met the needs of local people by staff who understood patients had individual needs.
- The director was also establishing close working relationships with other health providers in the area to improve services for the local population.
- The hospital provided support to patients who had sensory, language, physical disability and mental health support needs.
- Patients could access treatment quickly. Referral to treatment performance was good with 90-95% of patient being treated within 18 weeks. On average patients completed their treatment within 10 weeks.

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

- We had concerns formal complaints were not always managed in accordance with hospital policy.

Summary of this inspection

Are services well-led?

Inadequate

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

- Following our inspection in 2017, we told the provider it should ensure leadership is embedded in all clinical areas to drive quality improvements.
- At this inspection we were concerned managers did not have an equitable awareness of safety and risks for their services.
- We were not assured there was a consistent approach to governance across all services. We did not find all current risks documented on the risk register.
- We had concerns that the senior leadership team was not proactively managing the concerns identified in some consultants practice, behaviour and record keeping.
- Staff across all services talked about low morale and the culture at the hospital since our last inspection. They said they felt different staff groups had not been treated equitably.
- Staff we spoke with at focus groups told us the low morale had not affected patient experience. However, 75% of complaints relating to surgery were about staff attitude and behaviours.
- We identified concerns about the senior management of the diagnostic imaging department. Management and leadership was remote.
- The managers and senior leadership team were unclear about the quality assurance and safety processes involved in managing a service that uses ionising radiation.
- There were no robust embedded systems of governance in place in the diagnostic imaging department. The department was reliant on one person to oversee governance and quality assurance. Staff were unclear about the governance processes in place to safeguard both them and patients.
- The diagnostic imaging staff were unaware of any strategies or future plans for the diagnostic department. The leadership team was unable to provide us with evidence of how they were assured they provided evidence-based treatment.

However, we also found the following:

- Most staff told us their immediate line managers were visible and supportive.
- The hospital had a clear set of principles, goals and values. The goals were to improve patient and user experience, improve outcomes for patients and to support the community.
- The hospital's 2019 business plan included a comprehensive action plan to achieve the five-year strategic objectives. However, we noted there were no timescales for completion of the identified actions.

Summary of this inspection

- Despite the challenges of the previous year most staff said the hospital was a good place to work with good teamwork in their departments.
- There was a strategy in place to develop the services delivered by the outpatient department in line with local needs and the requirements of local services the hospital engaged with such as the local NHS trust and Clinical Commissioning Group (CCG).
- The outpatient department collected information about services and had governance processes in place to monitor the quality of services delivered. Risks faced by the outpatient department were assessed, recorded and managed.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

Mandatory training

- During our inspection in August 2017 we found some mandatory training compliance for ward staff was low.
- Since our last inspection the hospital had changed the mandatory training system. Details of the new process were provided before our inspection. This included information about which training modules each staff group attended as follows:
  - Every three years all hospital-based staff completed consent, dementia awareness, safeguarding adults - level two, being open and the duty of candour, equality, diversity & human rights, moving and handling - level one, safeguarding children - level two and communicating with professionalism and etiquette.
  - All hospital-based staff completed information governance and infection prevention and control - level two, every two years.
  - Annually all staff completed the control of substances hazardous to health (COSHH) safety awareness, fire safety - level one and health, safety & welfare - level one. Clinical staff completed medicines management training yearly.
  - Catering and ward staff completed food hygiene in health and social care – level two every two years.
  - All clinical staff completed mental capacity act and mental health awareness training every two years and national early warning score two (NEWS2) training every three years. Facilities and catering staff completed legionella training every three years.
  - Customer service staff 'completed customer service over the phone' training every two years.
- At this inspection information provided by the hospital showed overall mandatory training compliance across the hospital was 75%. We were told this was below the aspirational level of 80% but the senior team hoped the introduction of the new system would support with an improved picture by the end of 2019.
- Compliance at the time of our inspection was:
  - Basic life support 71%
  - Moving and handling 86%
  - Equality, diversity, & human rights 66%
  - Health, safety, & welfare - level one 78%
  - Infection prevention and control - level two 77%
  - Safeguarding children - level two 76%
  - Consent 87%
  - Dementia awareness 79%
  - Mental capacity act 70%
  - Customer service over the phone 72%
  - Communicating with professionalism and etiquette 80%
  - Safeguarding adults - level two 57%

- Mental health awareness 78%
- Control of substances hazardous to health (COSHH) Safety Awareness 85%
- Food hygiene in health and social care – level two 55%
- Being open and the duty of candour 88%
- National early warning score two (NEWS2)- updates in sepsis detection 78%
- Information governance 79%
- Fire safety - level one 85%

Safeguarding

- At our inspection in August 2017, staff were not up to date with current safeguarding training. At this inspection compliance with safeguarding training remained low in endoscopy, theatres and the ward. For example, in endoscopy children's safeguarding training compliance was 33%, in theatres adults safeguarding training compliance was 20% and, on the ward, it was 50%.
- The company had a corporate lead for safeguarding who completed level four children's and adult safeguarding training. This was the clinical services manager at the hospital, who was also the lead for adults and children's safeguarding.
- All staff were required to complete level one safeguarding training for both adults and children. All clinical staff were required to complete level two adult and children's safeguarding training.
- The hospital had safeguarding policies in place to support staff to safely care for patients and to ensure patients were safeguarded against abuse. This included policies to safeguard children and adults and a chaperone policy. These policies were in date and contained references to appropriate legislation and best practice guidance. The policies contained specific advice on female genital mutilation (FGM) and child sexual exploitation (CSE). Telephone numbers to report safeguarding concerns were displayed on the ward for quick reference.
- Safeguarding concerns were discussed at the clinical governance meeting.
- Staff we spoke with provided examples of recent safeguarding referrals they had made and were aware of the outcomes of referrals.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and premises clean and used control measures to prevent the spread of infection. For example, we saw staff complied with arms 'bare below the elbows' policy, there were posters showing correct hand washing technique, domestic staff used colour-coded mop heads for specific tasks and all cleaned equipment had an 'I am clean' sticker on it. The exception was an oscillating fan stored in a wardrobe in bedroom five, which had very dusty fan blades.
- Hand washing facilities were available in all clinical areas and patient en-suite bathrooms. Clinical wash hand basins had elbow taps and adequate supplies of liquid soap and paper towels. We saw staff washing their hands and using hand sanitising gel between patient interactions.
- Personal protective equipment (PPE) including disposable plastic aprons, non-latex glovesand hand sanitising gel were available at the entrance to the departments, at point of care on the ward and in theatre. We observed staff wore PPE and complied appropriately with the principles of infection control.
- In theatres, we observed improved surgical scrub techniques, these were now performed in accordance with the Association for Perioperative Practice (AFPP) recommendations for safe practice.
- There was a new endoscope disinfector washer installed in endoscopy suite and the department had an infection prevention and control link nurse responsible for audit activity.
- Central sterile services department (CSSD) equipment such as surgical instruments, was out-sourced and processed off site. Collections were scheduled twice daily and sterile supplies were delivered daily.
- Surgical patients were screened for healthcare acquired infections and the assessments of patients who were at risk of developing a healthcare infection were incorporated into nursing assessment documentation as part of the nursing record.

- There were no reported cases of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile infections from October 2017 to September 2018.
- The hospital had infection prevention and control policies in place to support staff, for example we looked at the hospitals standard precautions relating to infection prevention and control, the MRSA policy and the hand hygiene policy. These policies were in date and had references to current best practice guidance.
- We looked at the hand hygiene and environmental cleanliness audits for the theatres and the ward area and found that compliance was consistently 95% or above from April to December 2018.

Environment and equipment

- The fabric of the wards and theatre was generally in good order. The exception was damage to the floor covering behind the ward reception desk, which had been repaired temporarily with hazard warning tape.
- We saw general improvement in equipment storage. The exception was in the dirty utility room on the ward, where cleaned and labelled pneumatic compressors and drip stands were stored next to open sharps waste disposal bins and equipment still to be cleaned.
- Some equipment safety- check records on the ward were incomplete, for example, there were gaps in the blood glucose meter daily checks and the test calibration fluid was not dated when opened. This was brought to the attention of staff at the time and the fluid was replaced.
- There were eleven gaps in the daily hoist-battery checks between January to March 2019 and six gaps in the checks for the emergency resuscitation equipment trolley between November 2018 and January 2019. The records did not always indicate if the department was closed.
- All fire extinguisher appliances inspected had been serviced within an appropriate timescale. Exits and corridors were clear of obstructions.
- Both operating theatres had laminar airflow. Laminar airflow is used to separate volumes of air or prevent airborne contaminants from entering an area.
- We inspected two patient ready-bedrooms and found them to be welcoming, bright, clean and fit for purpose.
- Cleaning products were stored in cupboards in the dirty utility rooms and domestic cleaning trolleys containing products subject to control of substances hazardous to health regulations (COSHH), were not left unattended.
- We observed all the emergency equipment was now stored in clean environments.
- During our inspection in August 2017 we found a number of items which had no evidence of servicing. At this inspection we saw significant improvement. For example, the hospital had systems in place for recording the service and maintenance of equipment identified through compliance stickers, which indicated the dates tests were due. We inspected several pieces of equipment, including intravenous pumps, monitors, suction machines, anaesthetic machines, a bladder scanner and pneumatic compression units. All were clean, had been serviced and were maintained appropriately.
- There was improved recording and review of the cleaning of equipment and we saw comprehensive cleaning schedules and records now in place.
- The patient hoist on the ward was serviced in accordance with the lifting operations and lifting equipment regulations 1998 (LOLER) and patient weigh scales were labelled as calibrated.
- We saw improved management of equipment on the emergency resuscitation trolleys. For example, laryngoscopes were stored in sealed, transparent packaging which enabled them to be tracked and traced.There were daily and weekly checks in place. We found the trolley checklists now reflected the contents although the drawers on the ward trolley were not labelled and the check list was not document controlled or reference to UK resuscitation council guidance, which is best practice.
- We inspected the difficult intubation trolley in theatre and this now had laryngoscopes in sealed, transparent packaging. There was a check list and all checks were dated and signed.
- The microwave oven in the ward pantry was rusty inside and around the door. This meant it could not be cleaned effectively.

- Linen was stored appropriately on shelving in linen cupboards.

Assessing and responding to patient risk

- The service had a health and safety policy and procedure statement which outlined the requirements for health and safety. They also had a health and safety policy with reference to national guidelines and health and safety framework.
- Previously only clinical and portering staff undertook basic life support training however, the hospital had recently introduced this for all staff at the hospital. Compliance at the time of our inspection was 71%
- An external training provider had been appointed to deliver United Kingdom Resuscitation Council intermediate life support (ILS) training to all qualified staff which was due to commence in April 2019.
- There was a requirement for the hospital to have one advanced life support (ALS) provider. The RMO was the recognised ALS certified staff member. However, the hospital had recognised that best practice would be an ALS qualified member of staff within theatre and plans were in place for additional ALS training to be undertaken.
- There was also a named resuscitation officer at the hospital, who was ALS trained. They provided practical training every six months and had over-view of mandatory training compliance and management of emergency resuscitation equipment. Unannounced emergency scenarios were not conducted routinely but this was being considered for the future.
- There was a formal service level agreement in place with the local NHS trust for emergency transfer of patients. Staff showed us a paper version in the department which was dated 2003, but when asked, most staff we spoke with could state the correct procedure to follow. The exception was a member of medical staff who was unclear about the procedure.
- The hospital did not have formal mortality and morbidity meetings however, this was a standard agenda item at the clinical governance meeting. No deaths were reported by the hospital between October 2017 and September 2018.
- We attended a daily '10 at 10' meeting, where senior staff, such as the leadership team and heads of departments, discussed operational issues of the day, such as incidents, training, equipment availability, clinical workload, staffing and operational risks. The content was informed by a comprehensive list of prompts and was led by the hospital director. The meeting was not attended by the resident medical officer (RMO).
- Patients attended preoperative assessment to ensure they were fit and appropriate for surgery at the hospital. Staff we spoke with explained how they used the national confidential enquiry into patient outcome and death (NCEPOD) surgical preoperative risk prediction tool (SORT) to do this.
- The hours of work for most of the ward nursing day-staff was from 7.30am to 8pm. They gave a verbal hand-over to night staff and received a full verbal hand- over at the start of their shift from the night team. Staff who came to work mid- shift to cover specific busy periods, received a pre-printed hand-over tool and verbal update from the staff on shift.
- We reviewed clinical risk assessments including pressure damage acquisition, malnutrition, falls, moving and handling and infection. We found these were completed appropriately. Where risk assessments identified patients at high-risk, staff had referred them to further services such as therapy services, to provide additional support, equipment or assistance.
- Staff used the national early warning score (NEWS2) to assess the health and wellbeing of patients. Information provided prior to this inspection showed more than 75% of staff working in surgery had completed NEWS2 training. These assessment tools enabled staff to identify if the clinical condition of a patient was deteriorating and required early intervention and or escalation to keep the patient safe.
- Nursing staff we spoke with could describe signs and symptoms of a deteriorating patient and gave examples of when and how they would escalate a concern. They had a clear understanding of the signs and symptoms of sepsis and used the sepsis-six screening tool.
- Staff we spoke with explained how practice had changed to reduce the risk of post- operative delirium in

elderly patients. For example, safer alternatives to opiate analgesic (pain killing) medicines were used and where appropriate, patients had surgery under spinal or regional anaesthetic block.

- We observed patients had access to a consultant anaesthesiologist review for general anaesthetic cases, to determine ASA grade. ASA is the American society of anaesthesiologist's physical status classification system, for assessing the fitness of patients before surgery.
- We observed a robust process in place to manage and communicate changes to operating theatre lists, between theatre and the ward.
- Prior to this inspection the hospital provided their observational and documentation audits of the world health organisation (WHO) checklist for general surgery and ophthalmology. The results for surgery showed compliance with all aspects of the checklist at 97% and above every month from March 2018 to December 2018. We saw 100% compliance was achieved in October, November and December 2018. For ophthalmology the results were 100% every month during the same period except for May 2018 when they were 99%.
- After gaining patients' consent, we observed two ophthalmology cases and two orthopaedic surgery cases, which were conducted in accordance with national and local safety standards for invasive procedures (NatSSIPs and LocSSIPs). We saw that since our last inspection, compliance with the WHO safer surgery checks had improved and witnessed improved practice in the cases we observed, for example we saw swab and instrument counts were now performed robustly.
- However, whilst observing a procedure, we witnessed a significant near-miss. Following this, we were not assured the immediate risks were sufficiently controlled. Staff subsequently reported the near miss on the electronic incident reporting system and assured us it would be investigated.
- Information provided by the hospital prior to our inspection showed 100% of patients had a venous thromboembolism (VTE) risk assessment recorded from October 2017 and September 2018. The hospital reported three cases of patients who developed a VTE (blood clot) during the same period.
- All care records we inspected, showed patients had been prescribed prophylaxis (treatment given, or action taken to prevent blood clots) for VTE where this was indicated. On the day prior to inspection, there were no anti-embolism stockings available for patients who had them prescribed. Pneumatic pump devices were therefore used for some patients as an alternative, until they were mobile.
- We raised concerns with the ward manager about a specific incident relating to VTE prophylaxis because we were not assured patient risk was always managed promptly and escalated appropriately when required.

Nursing and support staffing

- The service had enough nursing and support 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 reported their qualified nursing staff numbers in surgery in terms of whole-time equivalents (wte). The wte for each person was based on their hours worked as a proportion of the contracted hours normally worked by a full-time employee in the post. The ward registered nurse (RN) establishment was 15.8 wte. At the time of our inspection there were 14.55 wte staff in post. employed on the ward and 1.28 wte vacancies. The health care assistant (HCA) establishment was 5.13 wte. There were no HCA vacancies. Staff turnover between December 2017 and November 2018 was 2.9% for RN's and zero for HCA's.
- The ward did not use a safer staffing or patient acuity tool. Managers explained duty rotas were planned in advance and staffing was reviewed daily by the ward manager, based on activity and acuity. There was a minimum of two registered nurses per shift. The ward manager was rostered to work 'clinical days' where required which also ensured their clinical skills were kept up to date.
- Bank and agency use had reduced since our last inspection. From December 2017 to November 2018 bank and agency use for the ward was between:
  - 2.5% and 12% for RN shifts.
  - 0.8% and 4% for HCA shifts.

- Sickness levels on the ward between December 2017 and November 2018 were between:
  - Nil and 5.5% for RN's.
  - 1.8% or less for HCA's.
- The theatre RN establishment was 6.75 wte, at the time of our inspection there were 5.08 wte staff in post, leaving a 1.67 vacancy. The HCA and operating department practitioners (ODP) establishment was 14.52 wte, there were 10.52 wte in post, leaving four wte vacancies. Staff turnover in theatres was zero for RN's and 1.2% for HCA and OPD's.
- From December 2017 to November 2018 bank and agency use for theatres was as follows:
  - 1.9% and 5.5% for registered nurse shifts
  - 4% and 12% for HCA and OPD's.
- Sickness levels in theatres for the same period were three percent or less for RN's and between zero and 6.4% for HCA's and ODP's.

Medical staffing

- There was an up to date policy in place for management of consultant practising privileges, which were reviewed every two years as a minimum. Thirty nine of the seventy-seven consultants had gone through this process, which was ongoing at the time of the inspection.
- The surgery service was consultant- led. Consultant ward rounds were conducted daily and consultant were contactable by telephone for advice in between ward rounds. There was always appropriate anaesthesiologist cover. Surgical and anaesthetic consultants remained responsible for their patients throughout their stay in hospital and were required to be available within 30 minutes or to arrange cross cover with another consultant if they were unable to provide the required level of availability. Nursing staff did not raise any concerns about the availability of medical staff.
- The hospital used an agency for their RMO cover. There were two RMO's covering the hospital. Each RMO covered the hospital 24 hours a day for seven days. They then had seven days off, to ensure appropriate rest periods were maintained. The hospital used a proforma to monitor any out of hours calls out to ensure safe working hours. The RMO we spoke with confirmed they had adequate rest and sleep.
- Consultants provided support for the RMOs remotely and on site, as required. The RMO we spoke with said they felt supported by the nursing staff.

Records

- At this inspection we looked at the hospital health records management policy. The policy was in date and supported staff to ensure best practice in relation to record keeping. This had been updated to include the most recent national legislation in the General Data Protection Regulations (2018). Information provided by the hospital showed 79% of staff had completed information governance training.
- Paper records were available for each patient on the ward and held in a single file, except for nursing observation charts and medicine administration record (MAR) charts, which were held in numbered ring binders.
- Health records were stored in a lockable trolley in the ward office, which had magnetic card access to reduce the risk of unauthorised access.
- The hospital completed audits on 20 sets of care records each month. We looked at the data provided for March to December 2018 and saw that other than June 2018 when the compliance rate was 83%, all results were above 90%.
- At this inspection, we looked at six sets of clinical records and found there was significant improvement in nursing documentation. For example, records were filed chronologically, all nursing entries were now dated, timed, signed and designation was recorded. However, in four of the six records we inspected consultant's operation notes were illegible and one consent form was illegible.
- Only one of the six records we inspected had consultant daily progress notes written. Staff we spoke with told us it was usual practice for most consultants to provide verbal orders which the nurses wrote in the record. This meant there was a risk consultant orders could be misconstrued and recorded inaccurately. This practice breached section 7.2 of the hospital health records management policy, which stated staff and consultants

must keep clear, accurate and legible records. In addition, one consultant we spoke with confirmed separate consultant records were not permitted and all consultant notes had to be written in the hospital record, by the consultant.

- Within the clinical lead minutes December 2018, it was documented that one consultant was not recording any post-operative notes and one consultant was documenting surgery notes pre-operatively.
- 'Staff not completing documentation in relation to local and national standards', was recorded on the risk register. The description of the risk was in relation to nursing compliance and did not identify controls in respect of consultant non-compliance.
- The hospital provided data to be included in the national breast and cosmetic implant register.

Medicines

- We reviewed the medicines management policy which had been amended following our inspection in 2017. The policy had been updated to ensure all the required actions were documented clearly to support staff to manage medicines safely. However, we noted the policy contained out of date references to Care Quality Commission outcomes in the introduction and the reference section of the policy.
- Information provided prior to our inspection showed 100% of staff had completed medicines management training.
- The hospital was supported by a dedicated pharmacist, three days a week. The pharmacist or RMO checked (reconciled) patients' medicines on admission to hospital.
- We observed improvements made since our last inspection. For example, we saw staff now consistently recorded the temperature of the medicine fridge in accordance with national guidance.
- Medicines, including intravenous fluids, were stored securely and access was restricted to authorised staff.
- However, there was a significant amount out of date stock in the controlled medicines cupboard on the ward. We saw this had been escalated for resolution in June 2018. Managers explained this was due to delays in receiving destruction witness documentation back from the Home Office. This was not recorded as a risk on the local risk register. We observed the out of date items were stored together at the bottom of the cabinet and clearly marked as out of date, to reduce the risk of administration to patients.
- Data provided by the hospital before our inspection showed from September to December 2018 there had been 69 incidents involving medicines. One incident resulted in moderate harm, 68 were reported as no harm. We reviewed the incident which resulted in moderate harm and found suitable and sufficient controls were now in place.
- We saw from the data the numbers of incidents were decreasing month on month, from twenty-six in September 2018, to three in December 2018. The majority of the incidents (fifty-nine) were prescribing errors. Actions had been implemented to address the concerns which included weekly audit communications, individual conversations and letters to the consultants involved, discussion at the consultant forums, meetings to review prescription charts (with the potential introduction of a day case chart being formatted) and increased challenge from all clinical staff.
- Prior to our inspection we looked at the controlled medicines audits completed by the hospital during September 2018, for the ward and theatres and saw 100% compliance against all the audit components. Audits were also completed by the external pharmacy, in conjunction with hospital staff. These audits also showed no concerns in relation to safe storage of medicines, room and fridge temperature recordings for the endoscopy unit, the ward, theatres and the outpatients department.
- The hospital provided audits of medicine administration records before this inspection. We looked at this data and found overall compliance with completion of all aspects of the care records, was consistently above 90%, from August to December 2018. During our inspection, we looked at six prescription records and all were completed legibly and correctly.
- Although the hospital had made improvements, we still had some concerns about medicines governance. For example, controlled medicines register for the ward was

not always completed correctly. We saw several written errors including amended administration times, which were crossed out and not recorded in accordance with the hospital medicines management policy.

- We saw completion of the controlled medicines register was audited periodically and results were communicated by the pharmacist, to managers by email. However, we were not assured the results of the audits were always actioned appropriately. This was brought to the attention of managers during our inspection and an action plan to address the concerns we raised was submitted by the end of the inspection.
- Although the ward clean utility room had a magnetic lock to restrict access, we observed medicines such as codeine tables left out on the work surface when the room was unattended.
- The ward had introduced tabards as an action following our last inspection, to be worn by nurses while conducting medicines rounds. However, interruptions were still happening, therefore staff tended not to use the tabards. This contradicted the hospital management of medicines policy, which stated staff should take steps to ensure medicine administration, for any patient, can be completed without interruption.
- Staff we spoke with and information provided by the hospital showed there were now fewer errors. An external report, provided by the hospital prior to our inspection, indicated staff did not always recognise errors. We were told some errors were 'overlooked under pressures of the medicines round'. A reminder about not interrupting staff was emailed out to all consultants but we heard this was 'largely ignored'. This indicated staff might not always recognise incidents and controls to reduce risk of errors were not effective. Therefore, we were not assured there was a consistent approach to reporting all medicine errors.
- In theatre, we saw four intravenous medicine infusions, not for immediate use, had been drawn up in advance of the theatre list. Staff we spoke with agreed this was not in accordance with best practice guidance or the hospital management of medicines policy (section 19.2) and acknowledged potential medicines safety risks. When we returned the following day, we asked if this incident had been reported. The theatre manager stated the medication issue had not been reported and said this was common practice by anaesthetists. The manager appeared to be unclear as to why this should be reported. Following discussion, it was agreed that this was not in accordance with best practice guidelines. We requested incident data after our inspection and saw this specific incident had been reported.
- We found some expired injectable medicines in the theatre medicine cupboard. This meant were not assured there was a robust system in place to manage medicines stock.

Incidents

- Regulation 20, 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 and other 'relevant persons' of certain 'notifiable safety incidents' and provide reasonable support, truthful information and a written apology. All staff we spoke with were aware of the duty of candour and provided examples of when they had used this.Overall training figures showed 88% of staff had completed duty of candour training.
- The hospital had a reporting and management of incidents policy and a duty of candour policy to support staff when dealing with incidents. We looked at both policies and found they were in date and contained appropriate references to legislation and to relevant national best practice guidance.
- We looked at minutes of the clinical leads meetings and found all reported clinical incidents were discussed for shared learning across all departments.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level and should have been implemented by all healthcare providers.
- There were no reported never events from December 2017 to December 2018. The hospital had reported two never events since our last inspection, in October and November 2017. These related to ophthalmology and orthopaedic surgery. We observed four cases in theatre and staff we spoke with were aware of the never event incidents. We witnessed staff adhering to the new processes put in place to help prevent the incidents happening again.

- However, during our inspection, we observed examples of incidents that were not reported and were not assured there was a consistent approach to reporting all incidents and near- misses on the electronic incident reporting system.

Safety Thermometer (or equivalent)

- The hospital produced a monthly clinical quality dashboard which was shared with hospital staff members, the Healthcare Management Trust (HMT) board and clinical commissioning groups (CCG).
- The dashboard showed specific information for each area from February 2018 to January 2019 such as inpatient ward, theatres or outpatients and identified if the hospital target had been achieved. These included audits, national quality indicators and incident reports.
- There were no hospital acquired catheter urinary tract infections or pressure ulcers reported from February 2018 to January 2019. Surgical site infections were also reported on the dashboard.
- The hospital reported three cases of patients who developed a VTE (blood clot) during the above period.
- There had been 19 patient falls on the ward between from February 2018 to January 2019.

Are surgery services effective?

Good

Evidence-based care and treatment

- At this inspection we saw improvement in provision of up to date policies and guidance. For example, the clinical supervision policy had been updated and was referenced to national best practice guidance.
- The resuscitation policy had also been updated with the most recent national guidance from the Resuscitation Council (UK) and in theatre, we saw up to date Association of Anaesthetists of Great Britain and Ireland (AAGBI) anaphylaxis guidelines.
- We saw how the surgery service conducted pre-operative assessments using a surgical preoperative risk prediction tool (SORT), in accordance with national confidential enquiry into patient outcome and death (NCEPOD) best practice guidance.
- The endoscopy department had continued to take positive steps toward achieving joint advisory group (JAG) accreditation. This is the formal recognition that an endoscopy service has demonstrated it has the competence to deliver against the criteria set out in the JAG standards. For example, the hospital had replaced old equipment and dedicated endoscopy staff had received training to manage automated decontamination of endoscopes. An electronic track and trace system for endoscopes had been implemented. There had been investment in new information technology systems to facilitate electronic reporting and completion of audits required for JAG.
- We had some concerns consultant practice was not always in accordance with national institute for health and care excellence (NICE) guidance. For example, prescribing anti-embolism stockings in conjunction with pneumatic pumps. NICE Clinical Guideline (CG92), published January 2010 and last updated June 2015 and superseded by NICE Guideline NG 89, March 2018 states 'select one of the following'. It does not actually state contemporaneous use of both is contraindicated but implies it is not best practice.
- Consultant preference information sheets, relating to anti-embolism prophylaxis, which nurses referred to on the ward, were not document controlled and not signed, dated or referenced to best practice guidance.

Nutrition and hydration

- There was a ward pantry and dedicated hostess staff to serve meals and drinks for patients.
- Each patient had a comprehensive menu to choose from. We saw regular morning and afternoon hot drinks rounds and drinking- water jugs were replenished by hostess staff.
- Special dietary needs were catered for, for example, diabetic, gluten free and texture modified menus were available for patients who required these. There was a white board in the ward pantry indicating room

numbers and patient's special dietary needs (no patient names displayed). However, pantry staff also had printed patient lists which detailed unnecessary data, including operative procedures.

- Patients we spoke with told us the food was 'excellent'.
- Patients we spoke with confirmed pre-operative fasting information was discussed with them at pre-assessment and they were sent written information by post in advance of admission. Patients were advised to have no food orally for six hours prior to admission and could have water up to two hours prior to admission. Fasting audit results from February 2018 to January 2019 provided by the hospital indicated 97% to 100% of patients were fasted in accordance with best practice guidance.
- Post- operative patients and those experiencing nausea and vomiting were routinely prescribed antiemetic (anti-sickness) medicine.
- We looked at the hospital record keeping audit and saw improvements in the completion of nutritional assessments. The records audit showed 100% compliance in 20 sets of care records audited in from October to December 2018. We saw six malnutrition universal screening tool (MUST) charts completed correctly. Staff could explain the process for referral to an on-call dietician for advice and support. We looked at two fluid balance charts and both were completed fully.
- Foods and juices in the ward food fridge were not always dated when opened and did not indicate a use by date.

Pain relief

- Patients we spoke with who identified they had experienced pain, said this had been managed well during their stay and nursing staff had responded promptly when pain relief had been requested.
- On the ward, endoscopy and in theatre recovery, we saw pain scores were monitored as part of the NEWS records, using a zero to three assessment.
- One nurse we spoke with explained how they used their clinical judgement to assess pain in patients unable to communicate. For example, vocalised sounds, facial expression, raised pulse and blood pressure, changes in behaviour and body movements.However, a formal tool was not in use.
- Prior to this inspection the hospital provided details of pain audits, the results were as follows:
  - October 2018 - 94% of patients had pain scores fully documented and 92% of records showed patients pain was well controlled or if not, appropriate pain relief was provided.
  - November 2018 – 67% of patients had pain scores fully documented and 100% of records showed patients pain was well controlled or if not, appropriate pain relief was provided.
- December 2018 - 95% of patients had pain scores fully documented and 100% of records showed patients pain was well controlled or if not, appropriate pain relief was provided.

Patient outcomes

- The hospital collated local audit data to monitor patient outcomes and these were reported through the quality dashboard.
- The hospital submitted data for national audit including:
  - The Private Healthcare Information Network (PHIN).
  - The national joint registry (NJR).
  - The cosmetic and breast implant register.
  - Patient reported outcome measures (PROMS).
- The hospital indicated they were also implementing a system to enable them to collate data for QPROMS. QPROMs have been developed by the Royal College of Surgeons' Cosmetic Surgery Inter-Specialty Committee for cosmetic surgery service providers to routinely collect data for all patients undergoing augmentation mammoplasty.
- Information was provided to the Private Healthcare Information Network (PHIN). This included information on length of stay, patient satisfaction and the number of

patients seen. PHIN ensures robust information is received about private healthcare to improve quality data and transparency. Details of cosmetic surgery were uploaded to the appropriate database.

- During our inspection in 2017 we found the hospital did not use PROMS data to improve services.
- The PROMS were reported in the hospital's governance report. The scores were better than the England average for hip and knee replacements as follows:
  - For total knee replacement: 148 (96.1%) patients said their condition had improved, no patients said they felt the same and six said their symptoms had worsened.
  - For total hip replacements: 100% of patients said they had improved.
- The governance report indicated they would be investigating those cases where patients reported worsened symptoms to enable them to make changes to practice.
- The hospital was still working towards JAG accreditation although the endoscopy action plan anticipated this would be complete by December 2019.
- The hospital reported 4080 visits to theatres from October 2017 to September 2018. During the same period three (less than 0.1%) surgical site infections occurred, these were following orthopaedic surgery.
- Minutes of the clinical governance meetings showed patient outcomes were shared across departments, through this meeting.

Competent staff

- At our previous inspection we had concerns staff working in the surgical first assistant role did not have the skills and competence to do so.
- At this inspection, we saw the service now had three qualified first- assistant staff and two newly appointed staff, who were completing a programme of competency based first- assistant training.
- Information provided by the hospital showed 97% of RN's and 100% of HCA's on the ward had an appraisal during 2018. The appraisal period was from January to December each year. At the time of our inspection 29% had an up to date appraisal or their appraisal booked. This meant the hospital was meeting its trajectory of 25% of staff each quarter having an appraisal.
- Consultant appraisal summary documents were linked to their NHS practice appraisals. These were reviewed at the same time as practising privileges. Practising privileges were renewed by the hospital every two years. This meant the hospital had ways to monitor each consultant and ensure procedures were in place to monitor performance. However, we were concerned that poor performance and behaviours were not always addressed.
- The hospital worked closely with the local NHS trust, where the majority of consultants held a substantive contract. The medical director (MD) explained the practising privileges applications now request additional details. For example, orthopaedic surgeons were asked to declare any sub speciality and any sub speciality training they have had. All applications were reviewed by the MD and where necessary advice would be sought from the relevant clinical advisor.
- The hospital was a member of the Independent Healthcare Providers Network (IHPN). The MD advised that the hospital would be submitting consultant data to be included within the oversight framework led by the IHPN.
- RMO's received mandatory training from their employing agency, which included for example, sepsis, advanced life support and infection prevention and control. In addition, they completed on-line continuous professional development modules.
- The hospital had a clinical supervision policy to support nursing staff. We saw this was in date and contained appropriate references to best practice guidance.
- Staff we spoke with said clinical supervision was available when they asked for it. Managers we spoke with explained there was no formalised programme of supervision in place and ad-hoc supervision was not documented. This was recorded as a risk on the local risk register.

Multidisciplinary (MDT) working

- Staff described the process for contacting key MDT colleagues such as dieticians, social workers, district nurses and speech and language therapists when required.
- Communication with MDT colleagues was recorded in the nursing pathway documentation.

Seven-day services

- There was a pharmacist on-site three days a week. Out of hours advice and assistance was available until 10pm Monday to Saturday and Sunday until 4pm. If medicines were required out of hours, the resident medical officer generated a prescription.
- Physiotherapy services were available on the ward seven days a week and all clinical staff could make referrals when required. In addition, nursing staff had received certified practical training to enable them to make mobility assessments and issue walking aids out of hours.
- Surgical and anaesthetic consultants remained responsible for their patients throughout their stay in hospital. They were required to be available within 30 minutes or to arrange cross cover with another consultant of the same speciality, if they were unable to provide the required level of availability. Nursing staff did not raise any concerns about the availability of medical staff.
- Patients also had seven- day a week access to diagnostic services, provided through on-call services out of hours.
- Staff explained they had access to interpreter services via language line.
- Staff could access advice from an on-call dietician.

Health promotion

- The service held weekly pre-operative education sessions for patients undergoing joint replacement. This was to facilitate informed consent and enhance patient recovery by providing better understanding of what to expect and their role in their own recovery.
- Patients received written health promotion information in the post prior to admission and written advice on discharge, as appropriate.
- The hospital had a health promotion lead and proactively promoted a range of health promotion initiatives through its website. For example, the website included a frequently asked questions section for breast augmentation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS)

- The hospital had a mental capacity act (MCA) policy and patient consent policy, these were in date and included references to appropriate legislation and guidance.
- Information provided prior to our inspection showed 70% of staff across the hospital were compliant with MCA and DOLS training.
- Staff we spoke with were aware of duties regarding MCA and DOLS. Any concerns or issues relating the MCA and DOLS were discussed at the clinical governance meetings. We saw evidence of this in the minutes we reviewed.
- The hospital patient consent policy described a two-stage process but staff we spoke with on the ward explained patients routinely signed consent forms on the day of surgery. We noted the process for obtaining informed consent was initiated in pre-assessment, through provision of information. However, this was not always documented and dated on the consent forms we saw in patient records. This was confirmed by the patients we spoke with.
- Staff at the hospital were 87% compliant with consent training.

Are surgery services caring?

Good

Compassionate care

- The hospital gathered patient feedback through the friends and family test (FFT). From June 2018 to November 2018, data showed positive feedback at 91% to 97% with response rates varying from 31% to 55%.
- We saw many thank- you cards from patients, expressing their positive comments about the care they had received, displayed on the ward.

Requires improvement

Surgery

- We saw patients received compassionate care. For example, in theatres and ward, staff were seen to observe patient privacy and dignity by ensuring curtains were closed around them and bedroom doors were closed in accordance with their wishes.
- We observed staff providing reassurance to patients undergoing local anaesthetic procedures in theatre.
- Patients we spoke with confirmed staff were attentive, treated them well and with kindness.One patient said, 'it is just like a five-star hotel'.
- Call bells on the ward activated a bleep, held by the patient's allocated nurse and response times were recorded on the electronic monitor located in the ward office. We observed prompt response to calls.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Staff on the ward explained patient relatives could be accommodated overnight if required.

Understanding and involvement of patients and those close to them

- Patient education groups were available for those undergoing some elective orthopaedic procedures. This provided the patients and those close to them the opportunity to learn about the treatment they were going to receive and provided the opportunity to ask questions.
- The ward had unrestricted visiting times that allowed greater time for friends and relatives to be part of a patient's care.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients we spoke with told us they felt fully informed about their treatment plans and arrangements for discharge.

Are surgery services responsive?

Good

Service delivery to meet the needs of local people

- The hospital had an NHS contract under the 'any qualified provider' status. Patients were referred to the surgeon of their choice where possible and seen by the same consultant throughout their treatment ensuring continuity.
- The hospital offered surgery and outpatient appointments Monday to Saturday and in the evenings where possible. Where possible; appointment and treatment times were undertaken at a time suitable to the patient.
- A range of services were available for NHS patients where commissioners had identified capacity shortfalls or for patients who wished to exercise their rights of flexibility and choice.
- The facilities and premises were accessible to all patients. The hospital car park provided 120 free parking spaces.
- Pre-admission assessment appointments were provided to ensure effective planning of admissions.
- The hospital provided care and treatment including diagnostic procedures at the same location.
- Patients had a consultation and examination in their first visit. A subsequent pre-operative assessment appointment was provided to patients prior to their admission, with the exception of patients undergoing cataract surgery, who were pre-operatively assessed at their first appointment.
- The hospital director had worked hard to promote a positive working relationship with other health providers in the area. This included taking patients who were long waiters in the local NHS trust for elective surgery.
- The hospital director was also establishing close working relationships with other health providers in the area. We heard plans were being considered to develop a 'step-up, step-down' dementia facility which would further support the local health economy by creating a purpose-built unit. This could be utilised to support patients living with dementia and prevent unnecessary admissions to the local NHS acute hospital.

Meeting people's individual needs

- The hospital had a privacy and dignity policy. This was in date and contained guidance for staff to ensure all

patients received equitable treatment regardless of their race, religion, gender, marital status, sexual orientation, disability, offending past, caring responsibilities, social class or age.

- Equality, diversity and inclusion was a mandatory e-learning training course, which all staff completed on induction and every three years thereafter. At the time of our inspection training compliance across all staff was 66%. The hospital had also produced an equality and diversity strategy document to ensure equitable treatment for patients and staff regardless of their characteristics.
- Patients were provided with information leaflets regarding risks and benefits of surgery and could review these before their procedure.
- Designated car parking spaces for patients, carers and relatives with limited mobility were available. Beverage bays and toilet facilities were available throughout the hospital for patients, carers and relatives including those living with a disability.
- The hospital offered access to translation services for patients where English was not their first language.
- We saw staff cared for patients as individuals and strived to meet their individual needs. We saw patients being treated with dignity and respect by addressing them as they wished to be addressed and closing curtains and bedroom doors as necessary.
- We saw open visiting times were promoted and carers were able to stay overnight where required.
- Staff completed dementia and mental health awareness training as part of their mandatory training programme. At the time of our inspection compliance levels were 79% for dementia training and 78% for mental health awareness training.
- We saw a 'you said, we did' display on the ward which demonstrated learning from feedback and complaints with the changes made in response. Feedback had been used to provide positive feedback for staff and to improve services.

Access and flow

- Patients were referred to the hospital by their GP, self-referral or NHS referral.
- In the reporting period August 2017 to July 2018 there were 1167 inpatient (admitted) and 4806 day case (non-admitted) episodes of care recorded at the Hospital; of these 84% were NHS-funded and 16% were non-NHS funded.
- 18% of all NHS-funded patients and 25% of all other funded patients stayed overnight at the hospital during the same reporting period.
- The hospital provided referral to treatment information which showed 90% of patients on an admitted pathway and 95.5% of patients on a non-admitted pathway were seen within 18 weeks. On average admitted patients completed their treatment within 10 weeks and non-admitted patients completed their treatment in 9.8 weeks.
- Staff we spoke with told us non-clinical cancellations at ward level were rare and were mostly due to equipment issues in theatre.
- On the day non-clinical cancellations were reported on the quality dashboard. We saw these had improved since our last inspection. In the six months from January to July 2017, 53 surgeries were cancelled. In the twelve-month period from February 2018 to January 2019, 39 patients had their surgery cancelled on the day.
- The dashboard provided narrative of the rationale for the non-clinical cancellations for the current month (January2019). These included issues around patient consent, a clinical emergency and a theatre list overrunning.
- Clinical cancellations were also reported on the quality dashboard. These had also reduced since our last inspection. Previously there were 33 cancellations in the six-month period from January to July 2017. In the twelve-month period from February 2018 to January 2019, there were 49 on the day clinical cancellations.
- The quality dashboard showed the reasons for the cancellations in January 2019 as being due to two patients not being medically fit, one requesting alternative surgery and one with an insufficient fasting time
- All cancelled patients were reappointed and their surgery performed within twenty-eight days.

Requires improvement

Surgery

- From October 2017 to September 2018 there were six unplanned returns to theatre, nine unplanned transfers out of the hospital and one unplanned readmission. All of these were reported monthly through the quality dashboard. We saw the details of these and any shared learning was discussed at the clinical governance meetings and consultant forums.

Learning from complaints and concerns

- The hospital director was the service lead for complaints handling.
- The hospital had a concerns, complaints, comments and compliments policy. This was in date and contained references to appropriate legislation and best practice guidance to support staff when dealing with concerns, comments and complaints.
- Patients could raise complaints through the hospital's website, through patient feedback forms, patient forums, social media, verbally to any member of staff as well as in writing and by email.
- Complaints were discussed daily by the senior management team and shared more widely at the '10 at 10' daily huddle meeting and team meetings.
- We saw that complaints were discussed at the clinical leads and clinical governance meeting to ensure shared learning across the hospital.
- The hospital policy stated all complaints would be resolved within twenty days. If this was not achievable the complainant would be advised in writing of the reason for the delay.
- We looked at the complaints received from 16 July 2018 to 20 December 2018 for surgery and found there were four complaints. The hospital did not resolve three of these complaints (75%) within the twenty-day target. We saw that three of the four complaints related to staff attitudes and behaviours.

Are surgery services well-led?

Inadequate

Leadership

- At this inspection the hospital was led by a hospital director and clinical services manager. Each service area had a head of department and associate deputies or team leaders. An organisational chart was displayed in the ward office which showed roles but not the names of the management team.
- Heads of departments told us the senior leadership team at the hospital and the corporate team were visible, supportive and approachable.
- Staff we spoke with mostly told us the senior managers were visible and very supportive; particularly the hospital director. We saw a weekly 'drop in' sessions advertised on the hospital intranet and ward staff said the hospital director and the clinical services manager visited the ward and spoke with staff every day.
- Following our inspection in 2017, we told the provider it should ensure leadership is embedded in all clinical areas to drive quality improvements.
- Some heads of department had changed since our previous inspection in 2017. Ward and theatre staff spoke positively about their immediate line management. We saw some improvements had been made to address concerns identified in our previous inspection, in both the theatres and ward. However, we were still not assured there was an equitable awareness of safety and risks across all services. Team leaders had been identified and formally appointed to support the ward manager.
- Some members of staff described 'slotting in' to their role or their promotion being part of a 'natural progression', rather than an externally advertised robust competitive recruitment process. The lead for human resources at the hospital was relatively new in post and was not aware of any internal selection processes.
- We spoke with the finance lead who told us they were part of the senior leadership team with overall responsibility at this hospital for accounting and financial reporting. Monthly reports were prepared for the hospital director for scrutiny before being presented at the corporate board meeting.

Vision and strategy

- The hospital provided details of their principles, goals and values. These were displayed clearly in a public area on the ward. The principles were:

- Internal redesign - Doing everything they can to design their services to provide the best quality care and best value for money.
- Charitable Impact - To ensure their charitable surplus creates a positive impact in the areas of dementia care and health promotion.
- People development - Enabling the continued growth and development of our employees, the most valuable resource.

- The goals were to improve patient and user experience, improve outcomes for patients and to support the community.
- The values were:
  - Person and Patient Centred - Everything they do was driven by what patients and service users need.
  - Valuing Achievement - Success was celebrated. Making people feel valued and proud to work for St Hugh's Hospital.
  - Driving Innovation – Using their imagination to provide better care. Finding solutions quickly and without getting bogged down.
  - Delivering Value - Providing value for money. Freeing people from unnecessary red tape, allowing focus on the things that matter. Making sure that time and money are spent wisely.
  - Forging Relationships - Providing the best by breaking down barriers and working in partnership with other organisations.
  - Releasing Ambition - Insisting on the highest standards; OK is not good enough. Constantly challenge what they do, and setting ambitious, yet realistic goals. Problems are never ignored and people are given freedom to do what they need to do.
- The chief executive told us the hospitals five-year strategy was to achieve good. It was felt the local strategy and annual business plan would shape the strategy to assist the hospital to move towards operating like an NHS trust.
- We looked at the Hospital Management Trust (HMT) five-year strategy document. We found this included:
  - The management teams desire to become Lincolnshire's preferred healthcare employer and provider.
  - Plans to embed the HMT dementia strategy.
  - To improve governance and gain a good or outstanding CQC rating.
  - To develop the service to add value to the local healthcare system by increasing capacity by 50%.
  - To work with partners to positively impact on health inequalities and outcomes around North East Lincolnshire.
- The hospitals 2019 business plan included a comprehensive action plan to achieve the strategic objectives however we noted there were no timescales for completion of the identified actions.
- Staff we spoke with were aware of future plans for a new day-case unit and possible refurbishment to facilitate an additional operating theatre.

Culture

- Some staff we spoke with told us that following our inspection in 2017, morale at the hospital was low. They told us they experienced a 'horrendous year' and described what they perceived to be a 'punitive' response by the corporate team.
- The disciplinary processes adopted to manage non-compliance with policy, for example in relation to medicines safety, were referred to as being 'heavy handed'. We heard that staff were 'escorted to clear their lockers and marched off the premises'. However, at the focus groups we held before our visit and from speaking with staff during our inspection it was apparent mood and morale was improving.
- Members of the senior leadership team also referred to this and told us they had felt they had listened to and communicated with staff before undertaking any performance management procedures.
- Despite the challenges of the previous year most staff said the hospital was a good place to work with good teamwork. They told us there was a more open culture and staff supported each other in their departments.

Requires improvement

Surgery

- Staff we spoke with at focus groups told us the low morale had not affected patient experience, however, 75% of complaints relating to surgery were about staff attitude and behaviours.
- Staff were familiar with the hospital whistleblowing policy and said there were no issues with bullying in the workplace. Bullying was discussed at senior leadership meetings and minutes we reviewed indicated there had been no new incidents reported.
- However, some staff said they did not feel nursing and medical staff were treated equitably. They said that although they felt empowered to challenge medical colleagues, they felt managers did not always support them with this because consultant practice and behaviour issues had not improved. Staff described some consultant colleagues as 'difficult' and resistant to challenge and change. Staff also reported they were unaware of outcomes of incidents, for example, when they had reported prescribing errors.
- Heads of department spoke positively about the culture of the hospital. They described inclusive communication, an ability to raise concerns and challenge without fear of retribution. However, this was not the view of some staff we spoke with.
- Newly recruited staff told us everyone was friendly and they enjoyed working at the hospital. All staff we spoke, with at all levels, spoke about care being patient centred.

Governance

- Following our inspection is 2017, we were not assured the hospitals governance processes enabled the senior team to be fully sighted the hospitals' risks.
- At this inspection, we found some of the concerns identified at our previous inspection were not fully addressed and some controls were not fully embedded. For example, issues relating to medicines governance, which breached hospital policy.
- The hospital had introduced a pharmacist intervention process. This was to ensure compliance and improve the governance and oversight of safe management of medicines. This meant any discrepancies identified by the hospital pharmacist would be actioned immediately and reported through the electronic reporting system.
- Although errors we saw in the controlled medicines register were noted in audits the results were not always actioned by managers and the errors continued to persist. However, at our request we were provided with a plan to address the non-compliances we found.
- We were not assured there was a consistent approach to reporting incidents and near misses.
- An external report we reviewed found staff did not always recognise incidents and needed prompting to report them. We found similar concerns.
- We also found that controls put in place to reduce the risk of medicine errors were not monitored for effectiveness.
- We were not assured consultants were working to NICE guidance or hospital policy regarding VTE prophylaxis and that this was being monitored and managed appropriately by the management team.
- In addition, the external report received from the hospital prior to inspection, identified there were nine different post-operative regimes for orthopaedic patients. The report stated the senior team was working to progress an agreement with the consultants. This position was not on the local risk register and there was no evidence of discussion in meeting minutes we received from the hospital. This meant we were not assured consultants always practised in accordance with best practice guidance or that the senior team were working to address this.
- Meeting minutes did not show evidence of an effective or consistent approach to sharing and learning from incidents. The content and quality of the minutes varied and did not reflect good practice in relation to sharing governance information. For example, in September 2018 the hospital reported 81 incidents. However, the theatre minutes of 25 October 2018 indicated 'no feedback to report this month'. Staff in theatre told us they did not have team meetings, they said governance information was communicated via a memo and emails. These were displayed with audit results and a quarterly bulletin, on a governance notice board. Staff were required to read and sign to confirm they had read the information. Therefore, we were not assured there was a consistent approach to governance.

- We spoke with the chief executive of the Hospital Management Trust who explained the overarching governance processes for the company. The board of trustees for the charity met six times each year. Governance oversight was part of those meetings. All trustees for the charity had equal responsibility and the trustees have a range of skills to enable oversight, for example, the charity had a trustee who is a medical director within an NHS acute hospital and had recently employed a G.P.
- The board of trustees received a copy of the quality dashboard and notifications of a range of metrics including all serious incidents, never events, infection prevention and control concerns, patients who need to return to theatre and any patient deaths.

Managing risks, issues and performance

- The hospital had a Health and Safety Framework. This document linked to other resources for example the major incident plan. We looked at the major incident plan, which was in date and had references to appropriate legislation, for example The Management of Health and Safety Regulations 1999.
- We looked at the hospitals risk management policy, this was in date and contained guidance for staff to ensure any service risks were identified and escalated appropriately.
- The chief executive told us the key risks for the hospital were equipment, policy implementation failure and availability of staff.
- The hospital had recently introduced a ten-minute safety huddle which took place at ten o'clock each morning and was called '10 at 10'. We observed this and saw senior staff, such as the leadership team and heads of departments, discussed operational issues of the day, such as incidents, training, equipment availability, clinical workload, staffing and operational risks. The content was informed by a comprehensive list of prompts and was led by the hospital director.
- The corporate quality improvement manager managed performance data and was responsible for the oversight of the quality dashboard. Heads of departments completed local audits and inputted data in to dashboard, where necessary an action plan was collated and also able to be viewed within the dashboard.
- The HMT medical director (MD) told us the hospital worked closely with the local NHS trust, where the majority of consultants held a substantive contract. The MD explained the practising privileges applications now request additional details, for example orthopaedic surgeons would be asked to declare sub speciality and any sub speciality training they have had. All applications were reviewed by the MD and where necessary advice would be sought from the relevant clinical advisor.
- However, we were concerned risks, issues and performance were not effectively managed by the senior team or the heads of departments.
- We reviewed minutes of consultant forum meetings and clinical lead meetings dated August, November and December 2018. These highlighted persistent, poor compliance with record keeping by consultants. This was not recorded as a risk on the local risk register and despite consultants being reminded of policy, in writing and verbally, compliance remained poor at this inspection.
- Staff we spoke with told us it was routine for most consultants to not write in the notes to record their assessments and orders, during daily ward rounds. This was confirmed on the notes we reviewed. We were therefore concerned the risks associated with consultant behaviour and practice were not always managed. Staff we spoke with also said they did not routinely report poor record keeping by consultants on the electronic reporting system.
- We looked at the local risk register. This had been added to the electronic reporting system. We saw this contained the dates the risks were added, was reviewed regularly and had actions taken to mitigate the risks.
- We spoke with the facilities manager at the hospital who told us risk assessments and maintenance, for example for water and fire safety systems were outsourced to an external company. We asked about the oversight of this and were not assured that a robust process was in place. The facilities manager was unaware if there was

an associated programme of works and explained this would go to the head porter. However, we were told any required works were always agreed and funding had never been questioned.

- We found risks which were fully mitigated, for example the lack of a director of infection prevention and control (DIPC) and the failure of the hot water boilers were still active risks and had future review dates despite the hospital now having a DIPC and the hospital boilers being replaced.
- The hospital had a consultant forum in place of the traditional medical advisory committee (MAC). We reviewed a set of minutes from the consultant forum and found practice privileges, scope of practice, hospital development and quality issues were discussed. However, minutes of the meetings showed limited attendance by consultants. The senior team advised this had been recognised and there was a proposal for attendance to be mandatory twice a year.
- The hospital had five consultant clinical advisors who represented the main services offered by the hospital. The minutes of these meetings also indicated a lack of attendance by the relevant personnel with only two of the five advisors attending in September and December 2018.

Managing information

- Important information such as policies and minutes of meetings were held electronically on the hospital shared drive and all staff we spoke with could access the system.
- Staff were able to view pathology results electronically.
- Health records and nursing pathway records were on paper and amalgamated into a single record.
- We observed good adherence to the principles of information governance. For example, computer screens were closed when unattended and records were kept in lockable trolley, away from public areas. Staff compliance with information governance training was 79%.

Engagement

- Managers were visible on the ward, which provided patients and visitors with opportunity to express their views and opinions.
- Discussions with patients regarding decision making was recorded in patient notes. We saw thank you cards and letters displayed on the ward.
- We were told by staff that management engaged with them well and we saw senior managers also communicated with staff through the intranet; for example, e-bulletins, team briefs and safety '10 at 10' huddles. Staff we spoke with told us they were encouraged to voice their opinions and speak with the managers but said they did not always receive feedback after raising concerns.
- The ward held staff meetings monthly when possible where issues, such as service configuration, governance and staffing, were discussed. Staff explained all departments would be using new templates by the end of March 2019.
- Staff we spoke with said they felt appreciated by their clinical colleagues and hospital managers.
- The hospital strategy indicated they wished to further develop programmes such as friendship at home, the musical choir and the sporting memories initiative to enable them to support elderly people in the local community.
- The hospital's website provided a wide range of information about the clinical services available. Details about the collaborative initiatives the hospital was involved in were also included. For example, bringing the 'Cycling Without Age' scheme to the area, to help mitigate loneliness and social isolation in the community. The hospital and an independent mental health provider in the area had collectively invested over £11,000 in two trio bikes to support the scheme.

Learning, continuous improvement and innovation

- The hospital director had worked hard to promote a positive working relationship with other health providers in the area. This included taking patients who were long waiters in the local NHS trust for elective surgery.
- The hospital director was also establishing close working relationships with other health providers in the area. We heard plans were being considered to develop a 'step-up, step-down' dementia facility which would

further support the local health economy by creating a purpose-built unit. This could be utilised to support patients living with dementia and prevent unnecessary admissions to the local NHS acute hospital.

- Staff we spoke with said they were supported to attend external training provided by a local trust, to develop their career. For example, management courses, and ALERT (patients at risk).
- The hospital had an agreement with the local university to take second and third-year student nurses on clinical placement. We saw positive written feedback from the students.
- Information received prior to inspection described a patient pathway co-ordinator role implemented in theatre. Managers reported improvements in the way lists were run, effective management of theatres and the staff, better communication, less frequent extended late hours of work, improved patient and staff experience and reduced patient delays as a result.
- The hospitals strategy included establishing a training academy to train and develop the workforce.
- Other developments included improving already established programmes supported by the hospital such as friendship at home, the musical choir and sporting memories to add to the support of elderly in the community.
- The hospital was a member of the Independent Healthcare Providers Network (IHPN). The medical director for HMT advised that the hospital would be submitting consultant data to be included within the oversight framework led by the IHPN.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

Mandatory training

- For our detailed findings on mandatory training please see the safe section in the surgery report.

Safeguarding

- For our detailed findings on safeguarding please see the safe section in the surgery report.
- Staff we spoke with told us they understood the principles of safeguarding both vulnerable adults and children.
- Staff in the outpatient department told us that although the hospital did not see anyone under the age of 18, sometimes children arrived with family members. They explained how they would take action if they were concerned about visiting children.
- Staff were aware the hospital had a safeguarding policy and knew how to access it. They were also aware that they could seek advice from their line manager and more experienced or senior staff.

Cleanliness, infection control and hygiene

- For our detailed findings on cleanliness, infection control and hygiene please see the safe section in the surgery report.
- We saw from the infection prevention and control (IPC) meeting minutes in September 2018 that IPC audits of the department were completed. These were not evident on the clinical dashboard however we found the treatment and waiting rooms clean and well kept.

Environment and equipment

- For our detailed findings on environment and equipment please see the safe section in the surgery report.
- All the equipment we checked was clean.
- We found two pieces of equipment that were a week out of date. These were removed and replaced by staff immediately after being brought to their attention. Patients would not have come to harm had the equipment been used after its use by date.

Assessing and responding to patient risk

- For our detailed findings on assessing and responding to patient risk please see the safe section in the surgery report.
- We spoke with nursing staff who carried out preoperative assessment of patients. We found this process to be robust and comprehensive. Preoperative assessment ensured only suitable patients underwent surgery at the hospital. Patients who were identified as being of a higher risk were referred back to the local NHS trust for their surgery.
- The hospital operated on patients with a body mass index (BMI) of less than 35 and an anaesthetic risk score of three or less.
- We looked at the hospitals observational and documentation audits of compliance with the World

Health Organisation (WHO) safer surgery checklist in the pain clinic and found that compliance in completion of the checklist was predominantly 100% from March 2018 to December 2018 except for June, July and August 2018 when it was 99%.

- Resuscitation equipment was in place with all staff trained to basic life support level and some to immediate and advanced life support level.

Nurse staffing

- For our detailed findings on nurse staffing please see the safe section in the surgery report.
- The registered nurse (RN) establishment for the department was 5.3 whole time equivalent (wte), there were no RN vacancies at the time of the inspection. The health care assistant (HCA) establishment was 4.43 wte, there were 3.89 wte staff in post at the time of our inspection, leaving a 0.54 wte vacancy. This was covered by staff working additional shifts and did not cause any problems with shifts not being covered.
- The hospital reported that there were no shifts left unfilled during the reporting period.
- From December 2017 to November 2018 bank and agency use for the outpatient department was between:
  - 1% and7% for registered nurse shifts.
  - 0.8% and 5% for health care assistants.
- Sickness levels for the same period were between zero and 5.4% for RN's and zero and 4.5% for HCA's. During the same reporting period there was no sickness for seven of the 12 months for both RN's and HCA's.
- Staff turnover was 1.2% for RN's and zero for HCA's.

Medical staffing

- For our detailed findings on medical staffing please see the safe section in the surgery report.
- Consultants with practicing privileges from a number of different specialties saw patients in the outpatient department.

Records

- For our detailed findings on records please see the safe section in the surgery report.
- We looked at the records of six patients and found these to contain sufficient information to ensure patients were cared for and treated safely.
- Records were stored securely to protect patients' personal information.

Medicines

- For our detailed findings on medicines please see the safe section in the surgery report.
- The outpatient department did not hold any medicines. If patients required any medicines, consultants were required to write a prescription, which patients could take to a pharmacy.

Incidents

- For detailed findings on incidents, please see the safe section in the surgery report.
- Staff in the outpatient department were aware of the type of things they should report as incidents and told us they would be confident to report an incident if they needed to.

Are outpatients services effective?

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- For further information about evidence-based care and treatment please see the effective section of the surgery report.

Nutrition and hydration

- Patients could access cooled water if required. If a patient required something to eat due to a medical condition staff could provide this.
- For further information about nutrition and hydration, please refer to the effective section of the surgery report.

Pain relief

Good

Outpatients

- The outpatient department did not provide patients with pain relief. If patients required pain medication whilst visiting the department, a consultant could write them a prescription to be dispensed at a pharmacy.

Patient outcomes

- For information about patient outcomes, please see the effective section of the surgery report.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Information provided by the hospital prior to our inspection showed all staff had an up to date appraisal during 2018. The hospital appraisal period was from January to December each year.
- Staff we spoke with in the outpatients' department told us they found their appraisals useful for planning their training and development needs for the coming year.

Multidisciplinary working

- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The department employed a team of physiotherapists who supported patients pre and post-surgery to improve their surgical outcomes.
- For further information about multidisciplinary working, please see the effective section of the surgery report.

Seven-day services

- The department offered clinics, during the day, evening and limited times over the weekend to meet patient demand.

Health promotion

- Staff discussed patient health and wellbeing as part of their preoperative assessment.
- There was some information available to patients about self-care, weight management and smoking cessation.

Consent and Mental Capacity

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. The outpatient department had specific documentation in place to support patients who may have fluctuating capacity.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff told us most patients who attended with a learning disability or living with dementia were supported by family members.
- For further information about consent and mental capacity, please see the effective section of the surgery report.

Are outpatients services caring?

Good

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Patients we spoke with told us staff were friendly and professional. None of the six patients we spoke with had ever had cause to complain about staff.
- The hospital reported friends and family test results on the quality dashboard. These were collated across all services and were consistently above 95% between April and December 2018.

Emotional support

- Staff provided emotional support to patients if it was required to minimise their distress however, staff told us this was rarely needed.

Good

Outpatients

- Consultants could refer patients to support services such as counselling if this was appropriate.
- The six patients we spoke with told us they had not needed emotional support however believed staff would provide this if it was needed.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- We observed staff discussing care and treatment with patients in language patients and their family and carers could understand. They also made sure patients had the opportunity to ask questions.

Are outpatients services responsive?

Good

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people.
- The department provided outpatient services to private patients and patients funded by the NHS.
- Clinics provided by the hospital helped to manage the demands placed on the NHS to provide services in busy specialties such as orthopaedics.
- Private patients were usually seen in the outpatients' department within one week. NHS patients had slightly longer waits however patients were seen quickly and did not experience long waits for appointments.
- For further information about service delivery to meet the needs of patients, please refer to the responsive section on the surgery report.

Meeting people's individual needs

- The service took account of patients' individual needs.
- People with sensory impairment such as sight or hearing loss were supported within the department. Staff could access sign language interpreters if patients needed to access these services.
- Staff could access interpreters for patients who spoke English as a second language if they were required.
- Patients living with a learning disability or dementia could be accommodated in the department and staff treated patients according to their individual needs.
- The waiting room, toilets, treatment and consulting rooms could all accommodate wheelchairs and mobility aids.
- For further information about meeting individual needs please see the responsive section of the surgery report.

Access and flow

- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- In the reporting period August 2017 to July 2018, there were 10886 outpatient total attendances in the reporting period; of these 22% were other funded and 78% were NHS-funded.
- The department did not see patients who needed to be seen within the two-week urgent time frame. However, patients did not have long waits to be seen by consultants in the outpatient department. We had no concerns about the referral to treatment rates which we discussed with staff in the waiting list and appointment booking office.
- For further information about access and flow, including referral to treatment performance, please see the responsive section on the surgery report.

Learning from complaints and concerns

- We looked at the complaints received from 16 July 2018 to 20 December 2018 for this core service and found there were three complaints. The hospital did not resolve any of these complaints within the hospitals twenty-day target. The complaints related to waiting times for appointments (two) and administration processes (one).
- The service investigated complaints and learned lessons from the results and shared these with all staff.

Good

Outpatients

- We discussed complaints with staff in the department. They told us formal written complaints were uncommon. When patients had complaints, staff told us they would try to resolve them at the time and would involve someone more senior if necessary.
- Staff told us any complaints were discussed specifically with individuals involved and generally with the entire team as a way of learning lessons and preventing similar occurrences.
- For further information about learning from complaints and concerns please see the responsive section of the surgery report.

Are outpatients services well-led?

Good

Leadership

- The managers in outpatients were able to demonstrate to us that they understood the workings of the department and provided good leadership to staff.
- Staff thought managers in the outpatients' department were knowledgeable and understood how the department ran.
- Staff told us their line managers were visible.

Vision and strategy

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.
- During the inspection, work was underway to refurbish one of the treatment rooms and change its use to a minor surgery room. The management team had identified the need for such a room as part of their vision for the future.
- Staff were aware of the vision for the future of the outpatient department including the changes to the treatment room and were positive about the future of the department.
- For further information about vision and strategy, please refer to the well led section of the surgery report.

Culture

- After our previous inspection, staff told us the culture within the hospital had been difficult with staff being disciplined and leaving the organisation. Staff told us this had led to a culture of fear and had made staff nervous of making mistakes. They told us sometimes the atmosphere was difficult. However, staff also told us this was becoming less of an issue now and they felt more confident in their roles again. Some staff expressed a worry about the severe repercussions if the CQC report identified any problems, no matter how small.
- Staff told us the culture was better than previously most of the time. However, some staff told us their line managers could sometimes be unsupportive or unsympathetic to personal circumstances.
- Most staff we spoke with thought line managers were approachable and would listen to any concerns brought to their attention and when possible, take action.
- Staff in the department had a common purpose, to provide a good service for patients. Staff worked together across disciplines to ensure patients received the best service they could.

Governance

- The service monitored standards of care by creating an environment for learning and sharing best practice.
- Quality of care was discussed with staff and any causes for concern, complaints or drops in standards were addressed quickly to ensure patients received a good quality service from the outpatient department.
- The department had worked with an independent provider to assess the safety of the resuscitation processes throughout the hospital, including the outpatient department.

Managing risks, issues and performance

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The management team had systems in place to monitor performance, identify areas of challenge and address them quickly.
- The department had business continuity plans in place to manage challenges such as IT system failure.
- Staff attended regular department meetings where risks and performance were discussed.

Managing information

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Staff were aware of their responsibilities in relation to data protection and during the inspection we saw all records were stored securely and individuals' private information was protected.
- For further information about managing information, please refer to the well led section of the surgery report.

Engagement

- The service engaged and collaborated with partner organisations such as the local NHS service provider effectively to plan services.
- For further information about engagement, please refer to the well led section of the surgery report.

Learning, continuous improvement and innovation

- The service improved services by learning from when things went well or wrong and promoting training.
- For further information about learning, continuous improvement and innovation, please refer to the well led section of the surgery report.

Requires improvement

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

Mandatory training

- For further information about mandatory training, please refer to the surgery section of the report.
- Compliance with mandatory training was low however staff we spoke with were new to the organisation and were in the process of completing their mandatory training.

Safeguarding

- Please refer to information about safeguarding vulnerable adults and children within the surgery report.

Cleanliness, infection control and hygiene

- Following our inspection in 2017 we told the provider it should ensure that the radiology department was clean and dust free.
- At the inspection in March 2019 we found the department to be clean and dust free.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- We observed staff cleaning equipment after each patient. Covers on couches and x-ray tables were changed between each patient.
- Hand gel was available for patients and staff.
- We saw from the infection prevention and control (IPC) meeting minutes in September 2018 that IPC audits of the department were due to be completed. We did not see these reported on the clinical dashboard. The department had hand washing facilities for staff. Toilet facilities for staff and patients were located nearby in the reception and outpatient's area. These were clean and in good order.
- Staff and patient changing rooms were clean and spacious. Curtains were infection control compliant.
- Throughout the hospital we saw patient chairs that were not infection control compliant.

Environment and equipment

- We checked x-ray equipment to ensure it had been serviced and maintained in line with manufacturer and safety guidelines. At the time of the inspection we could not find, and the department and hospital management team were not able to provide us with evidence that equipment had undergone safety checks such as calibration. We had concerns about this because we could not be assured that patients were receiving the correct dose of radiation.
- Additionally, we were concerned that patients could be receiving a higher dose of radiation than the x-ray machine displayed. We asked the hospital management team to take urgent action to ensure all x-ray machines were calibrated and tested. This was to ensure the safety of patients. Within six days, the hospital provided us with evidence of equipment tests being carried out. In the meantime, the hospital voluntarily suspended use of such equipment to ensure patients remained safe.

Requires improvement

Diagnostic imaging

- Dosimeters must be worn by all radiographers to measure how much radiation they are exposed to. Each radiographer should have a dosimeter assigned to them only. During our inspection, we found radiographers wearing dosimeters however, the dosimeters were not allocated to the radiographers wearing them and were in the names of former staff. Therefore, we were not confident the hospital was fulfilling its responsibility in ensuring staff were appropriately protected from harm by their exposure being monitored correctly. We brought this to the attention of the departmental management immediately. On the second day of the inspection, this had been rectified.
- The department had lead aprons to protect staff. During the inspection we were unable to find, and the management team were unable to provide us with assurance that these had been subject to the mandatory checks they should undergo every year to ensure their efficacy.
- We found the aprons were stored on a rail that was too low which had caused them to bend. We therefore had concerns that they may have been damaged and would not provide staff with the protection they should. We brought these concerns to the attention to the hospital director on the first day of our inspection. The hospital director provided us with assurance that personal protective equipment (PPE) met the appropriate standards within six days of our inspection.

Assessing and responding to patient risk

- When we arrived at the department, local rules were out of date however these were updated and replaced during the inspection.
- We were unable to locate, and the management team were unable to provide us with evidence of radiation protection information available to all staff, signed to confirm they had read it.
- During the inspection, we observed staff adhering to pause/check criteria to make sure they were examining the correct patient and carrying out the correct x-ray. However, we did note there were no posters promoting pause/check.
- Staff questioned females of child bearing age to ensure there was no risk of pregnancy as x-ray is contraindicated in pregnancy unless urgently necessary. There was provision to protect unborn babies using lead aprons when x-rays were required.
- There were processes in place to manage patients who may deteriorate however on the first day of our inspection, neither of the staff on duty were able to locate the resuscitation trolley. This had not been covered in their local induction and they had not sought out the trollies.
- Staff completed and updated risk assessments for each patient and they kept clear records.
- There was a process in place for escalating unexpected or serious findings and staff could contact the reporting radiologist and the referring consultant to highlight the findings.

Allied health professional staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- There were two part time radiography staff who only worked at the hospital. Other radiography staff worked part time at the hospital and also worked at other organisations.

Medical staffing

- The department had identified a lead clinician in 2013, however they had not formally signed the appropriate paperwork to formalise their position until the second day of our inspection.
- Consultant radiologists worked within the department to report on x-rays taken. They also performed interventional radiology such as ultrasonic guided injections to relieve pain.

Records

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

Requires improvement

Diagnostic imaging

- We looked at four sets of records and found these contained sufficient information to keep patients safe.

Medicines

- The diagnostics department held limited medicines such as contrast media. The contrast media were used by an external provider who carried our MRI and CT scans. Contrast media were stored safely and appropriately in line with medicine storage guidelines.
- The department did not hold medicines such as pain relief and if these were required the patient was referred back to the consultant for them to be prescribed,
- For our detailed findings on medicines please see the safe section in the surgery report

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The department reported no incidents classified as never events for diagnostics. (Source: Strategic Executive Information System (STEIS))
- We spoke with staff about incidents. They could describe to us the process for reporting incidents electronically.They understood the type of occurrences they must report, relating to radioactive materials, public and patient safety and staff safety.
- Staff told us that if they reported an incident, they received an acknowledgement and sometimes feedback depending on the severity of the incident.
- Staff understood the principles of duty of candour, being open and honest and told us that if they made a mistake, such as an incorrect x-ray, they would inform the patient and then report it as an incident.

Are diagnostic imaging services effective?

Evidence-based care and treatment

- Employer's Procedures were in place however these were out of date and referred to IR(ME)R regulations from 2000 which were superseded by updated regulations in 2018.
- The department had referral criteria, standard operating procedures and exposure authorisation protocols however these were based upon IR(ME)R 2000 which had been superseded by IR(ME)R 2018.
- The department had radiology department referral guidelines. These were based on IR(ME)R 2000 which had been superseded by IR(ME)R 2018.
- During the inspection, none of the staff we spoke with could show us the above information which should be readily available for staff to refer to.
- We could find no evidence and the hospital could not provide us with evidence at the time of the inspection, of discrepancy meetings taking place to discuss the quality of x-rays. Therefore, we were not assured that x-rays carried out followed evidence-based care guidance.

Nutrition and hydration

- The department had water fountains available for patients to access drinking water.
- If staff had concerns about a patient who had not eaten and had a health condition such as diabetes, they could provide a light snack, however staff told us this almost never happened as patients came prepared and waits in the department were usually short.

Pain relief

- The department held few medicines and generally did not administer pain relief for patients.
- Staff asked patients about their pain levels and tried to ensure any scanning was carried out in the least painful way.

Patient outcomes

- We discussed discrepancy meetings with staff. Staff were unable to tell us whether discrepancy meetings took place. We asked the management team of the department and the hospital leadership team for

evidence that discrepancy meetings took place. They were unable to provide us with evidence at the time of the inspection however did supply us with assurance within six days of the inspection ending.

- We asked for evidence of ongoing clinical audit within diagnostic services. There was no clinical audit related to radiology scheduled for 2018/2019.

Competent staff

- Evidence provided by the hospital showed less than 30% of all staff employed had undergone an appraisal within the last 12 months. This information was not broken down by core service.
- Evidence provided by the hospital showed 64% of staff who needed to have an appraisal, did not have one booked.
- St Hugh's carried out appropriate employment checks to ensure staff were registered appropriately and did not have any concerns about fitness to practice. The hospital carried out due diligence in relation to radiographers working in the department.
- Staff who worked in the diagnostic imaging department at St Hugh's also worked with other organisations such as large NHS hospitals.
- Staff received an induction when they joined the department. We had some concerns about the robustness of induction of new staff because the people we spoke with had not been oriented properly or shown where emergency resuscitation equipment was.
- The department had employed a radiation protection supervisor (RPS) who had overall responsibility for ensure staff were working within their competencies.
- The department had appointed a radiation protection supervisor (RPS) to oversee the safety and quality checks of the department and ensure ionising radiation procedures were performed in line with national guidance and local procedures. During the inspection we were unable to find, and the department was unable to provide us with evidence of this however the hospital management team provided us with evidence within six days of the end of our inspection.
- The management team confirmed the department had arrangements in place to seek advice from an external radiation protection advisor (RPA) and we saw evidence of the latest report provided by the RPA from November 2018. The RPA worked for a neighbouring acute hospital trust and there was a service level agreement (SLA) in place for their services.

Multidisciplinary working

- The department worked with the outpatients' department to provide x-rays for patients.
- Radiologists worked shifts on site however there were no reporting radiographers employed.

Seven-day services

- The radiology department was open from 8am until 6pm Monday to Friday with some availability over the weekend depending upon which clinical services were running in the outpatient department and the needs of inpatients on the ward.

Health promotion

- The department had posters and leaflets to promote patient good health, such as about stopping smoking, healthy diet, child and adult safeguarding.
- We asked staff if they spoke with patients about promoting good health. They told us they would only intervene if the patient asked for advice or if they thought the patient was in immediate danger or harm.

Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)

- During our inspection we spoke with staff about how they obtained consent form patients who had learning difficulties or were living with dementia. They told us if the patient was unable to identify themselves they would not perform the examination however they also added that the hospital rarely saw patients with such an advanced condition.
- Following our inspection, the provider told us that if a patient was unable to identify themselves, a best interest meeting would be held with the patient, their family and the multidisciplinary team to agree what was in the patient's best interests. This was not

detailed by the staff we spoke with therefore we were not assured that staff understood or followed this process. The provider confirmed that whilst they did see patients who lacked capacity, the numbers of these patients were low.

- The service used plain film x-rays only and therefore patients were not required to complete a consent form. However, verbal consent was obtained from patients. The process included staff informing patients of the risks of having an x-ray and the contraindication of x-raying when patients had some conditions or were pregnant.
- When a patient was pregnant or suspected they were, staff discussed the risk of an x-ray on the unborn child and supported patients to decide. Staff also offered patients the option of lead apron protection of the abdomen in cases when an x-ray was necessary.
- Inpatients who required an x-ray had their identity checked from their wrist band and against the x-ray referral. The staff did not formally document consent but used implied consent.

Are diagnostic imaging services caring?

Good

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- We spoke with five patients during our inspection of the radiology and diagnostics department.
- All the patients we spoke with told us they had been treated with courtesy and respect. Patients told us they had their dignity preserved as they were treated and staff made sure they were covered and not left exposed.
- We observed staff interact with patients of different ages and with different health conditions. Staff were kind, patient and caring with patients as they supported them on and off beds, out of wheelchairs and on to x-ray apparatus.

Emotional support

- Staff provided emotional support to patients to minimise their concerns.
- Anxious patients were not rushed and were given time to get used to the environment.

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.
- The patients we spoke with told us staff explained to them why they were there and what would happen during the x-ray or procedure they were having.
- Patients and relatives were given time to ask questions such as any side effects or complications they might experience.
- Staff made sure relatives and carers could be with the patient if this was what the patient requested, if it was safe to do so, such as vulnerable patients undergoing x-rays.
- Patients told us staff explained information in a way that was easy to understand and did not contain lots of medical jargon or terminology. This made sure that when patients were being asked to give consent, they fully understood what they were consenting to and the associated risks.

Are diagnostic imaging services responsive?

Good

Service delivery to meet the needs of local people

- The department was on the ground floor of the hospital on a single storey with wide doors therefore it was easy for patients and relatives to access. It was signposted and easy to find.
- There was sufficient car parking on site to meet the demands of the hospital.
- The department had fixed opening hours which coincided with the clinics running in the outpatient department. The department was open at the times when demand was at its highest.

Requires improvement

Diagnostic imaging

- We asked staff about long waits in the department. They told us that it was rare for patients to have long waits however if there were delays, they would inform patients of the delay and the reason.
- There was no electronic screen informing patients of delays however radiographers and health care assistants were frequently in and out of treatment rooms and updated patients as they needed to.

Meeting people's individual needs

- The service took account of patients' individual needs. Staff understood the needs of patients who were living with a learning disability or dementia. Staff told us patients' needs were supported whilst undergoing x-ray, including having a chaperone or relative with them for reassurance.
- There was no specific quiet area for patients with sensory needs or who did not like to be in busy areas due to health conditions however, we asked staff how they would support such patients and they told us patients would be supported to be seen quickly.
- The department provided information for patients about treatments offered by the radiology department. There was some online information for patients to access. We checked all the leaflets and found they were in date. There was information about how to access the leaflets in other formats such as large print, Braille, easy read or other languages.
- Staff told us they could access interpreters either in person or by telephone if needed however they also told us that this was rarely needed in the department.
- The department could accommodate bariatric patients for x-rays if required and the waiting area had suitable seating however, bariatric patients were uncommon at the hospital because of strict admission criteria which meant patients with a BMI of over 35 were considered as unsuitable for surgery at the hospital.

Access and flow

- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. The hospital did not see patients referred under urgent referral criteria, for example two week waits.
- Staff within the waiting list office told us patients were seen quickly regardless of whether they were private patients or NHS patients.
- The department did not manage patients who fell within the two week wait criteria.
- Staff told us x-rays were reported quickly by consultants who worked part time for the hospital. They said there were minimal delays for plain film x-ray reports to be produced and staff could prioritise and escalate any x-rays they had concerns about. However, we did not see any key performance indicators reported on the hospital's quality dashboard

Learning from complaints and concerns

- We looked at the complaints received from 16 July 2018 to 20 December 2018. There were no complaints about diagnostic imaging.
- However, staff told us the service investigated complaints and learned lessons from the results and shared these with all staff.
- The hospital director was the service lead for complaints handling.
- The hospital had a concerns, complaints, comments and compliments policy. This was in date and contained references to appropriate legislation and best practice guidance to support staff when dealing with concerns, comments and complaints.
- Patients could raise complaints through the hospital's website, through patient feedback forms, patient forums, social media, verbally to any member of staff as well as in writing and by email.
- Complaints were discussed daily by the senior management team and shared more widely at the '10 at 10' daily huddle meeting and team meetings.
- We saw that complaints were discussed at the clinical leads and clinical governance meeting to ensure shared learning across the hospital.

- The hospital policy stated that all complaints would be resolved within twenty days. If this was not achievable the complainant would be advised in writing of the reason for the delay.

Are diagnostic imaging services well-led?

Inadequate

Leadership

- Managers in the service did not have the right skills and abilities to run a service providing safe, effective, high-quality sustainable care. We found evidence of this when we spoke with the management team.
- The management team were heavily reliant on one person in the department to provide them with assurance. This person was absent from the hospital during our inspection and as a result, the management team were unable to provide us with any evidence of quality assurance or safety assurance. We had serious concerns about this.
- The management team presented us with an action plan created as a response to a recent radiation protection advisor (RPA) assessment. The report identified how the department was not meeting IR(ME)R regulations. The management team were unable to prioritise the actions required.
- In relation to day to day management and human resources processes, staff felt supported and could raise any concerns they had.
- We were concerned that the head of the diagnostic imaging department did not fully understand the risks associated with carrying out diagnostic imaging processes or managing a service using ionising radiation. This member of staff was unable to verbalise or demonstrate their understanding of the risks identified during the inspection.
- Following our inspection, we were told by the senior leadership team that this member of staff had completed IRMER training and had an understanding of the regulations. However, this was not apparent at the time of our inspection.

Vision and strategy

- The department supported outpatients and the ward. This was their primary role. The department had plans to develop in line with the needs of these services.
- Some consultants had developed additional services for patients such as for pain management and interventions carried out using ultrasound.

Culture

- From the evidence we looked at and what we were told, the management team managed the department at arm's length and had little involvement in the day to day running of the department. This was evident when we asked them to provide us with evidence as part of the inspection and they were unable to do so.
- Staff told us they felt supported by their colleagues and that staff within the whole hospital were friendly and professional.
- Staff told us patients were always at the centre of people's focus.

Governance

- During the inspection we were unable to find evidence of quality assurance systems and processes. When we looked for information about monitoring of standards of care, safety and quality we were unable to find any evidence.
- We asked staff if they could provide us with any evidence or direct us the files and folders that contained evidence. They were unable to do so.
- We spoke with the department manager. We asked them to provide us with evidence of how the department monitored quality, safety and standards of care. They were unable to provide us with this evidence immediately, so we asked them to provide it to us before the end of the inspection the following day. Neither they, nor other senior managers at the hospital were able to do so. We therefore had serious concerns about the safety and quality of the services provided by the diagnostic imaging department.
- The senior team told us that they outsourced professional support from an external radiation protection advisor (RPA) for specialist advice and that audit processes were overseen by the head of department and the RPA. However, during our inspection, the head of department was unable to

provide any evidence of audits undertaken or any assurance of the progress made against an action plan which was created following the RPA report in November 2018. In addition, the action plan had not been created using a risk-based approach.

- We were concerned the department may not have processes in place at all and we had concerns that if there were processes in place, the staff and management were not fully aware of them. After the inspection we found processes were in place however, they were reliant on one person. This demonstrated to us that governance processes were neither robust nor embedded in the department because not all staff were aware of them.
- We spoke with the management team about sharing information with local NHS providers about the levels of radiation staff were exposed to. Arrangements for sharing information should have been in place to ensure staff were not over exposed. The management team were unable to describe to us how the process worked however we found evidence of a memorandum of understanding dated 2 January 2018 which detailed how information about staff working at St Hugh's and their exposure levels should be sent to the local trust. Due to the lack of awareness of the management team, we had no confidence this was happening.

Managing risks, issues and performance

- The risk register did not identify all the risks within the department. For example, the risk register did not mention the RPA report received in November 2018 which highlighted a number of breaches of IR(ME)R regulations.
- The department had one risk identified on the hospital risk register. This was in relation to the use of the world health organisation (WHO) checklist in interventional radiology. The WHO checklist, a safety list used for invasive procedures had been implemented the day before our inspection. This was despite us raising this as a 'must do' at our last inspection in August 2017.
- We were therefore concerned neither staff nor the management team fully understood the risks associated with a diagnostic imaging department where radioactive substance were used.
- If there were particular concerns about the performance of individual staff, these were addressed by the manager with the individual however staff were unable to describe to us the process used to identify concerns. This information was sent to us after the inspection.
- We had some concerns about the robustness of induction of new staff because the people we spoke with had not been oriented properly or shown where emergency resuscitation equipment was.

Managing information

- The department did not have robust systems in place to collect information about performance and share it with staff who worked in the department. For example, we did not see any information relating to reporting times.
- The department used several IT systems to collect and share information such as x-ray results.
- Staff could access patient information such as previous x-rays and scans.
- Some information such as x-ray reports were shared with GPs however this was done with the agreement of patients.
- The trust had information governance policies and procedures in place to ensure that information was stored securely and protected patients' privacy and security.
- Staff were aware of their responsibilities in relation to data protection and making sure that information was accurate and managed securely. Data protection principles were followed within the department at St Hugh's.

Engagement

- We saw evidence of team meetings as engagement with staff.
- The staff we spoke with were relatively new to the department and were not able to comment on how well engagement with staff worked.
- We were unable to find any evidence of engagement with patients and the public assessing the quality of services provided.

Requires improvement

Diagnostic imaging

Learning, continuous improvement and innovation

- We did not find evidence of a dynamic, forward looking department.
- Within the diagnostic imaging department there appeared to be little motivation from the management team to change, develop, improve or promote innovation.
- From discussions we had with staff, the department was seen as a necessary support to both outpatient and inpatient services but not a service that needed to be developed so long as it delivered what the other departments needed. This was evident for example by the fact that the WHO checklist had not been implemented for interventional radiology until the day before our inspection, on a trial basis by a new member of staff.

Outstanding practice and areas for improvement

Outstanding practice

The hospital had brought the 'Cycling Without Age' scheme to the local area, to help mitigate loneliness and social isolation in the community, the hospital and an independent mental health provider in the area had collectively invested over £11,000 in two trio bikes to support the scheme.

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure consultants keep legible, accurate, contemporaneous records in accordance with hospital policy. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure there is a consistent approach to reporting and investigating all incidents and near-miss events. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure patient risks are managed and escalated appropriately. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure all staff are compliant with all aspects of mandatory training. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure regulatory breaches including IR(ME)R are identified and be able to evidence the action taken. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.
- The provider MUST ensure there are robust governance processes in place that provide evidence of assurance to senior leaders in the organisation. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.
- The provider MUST ensure staff have their own personally allocated dosimeters and are not using a dosimeter assigned to another person. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure all personal protective equipment is regularly serviced and hold readily available evidence of this. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure evidence that all equipment has been safety checked and calibrated is readily available, provided to the senior leadership and appropriately recorded. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure robust safety processes and procedures are in place to protect patients and staff from harm from ionising radiation. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure all guidance, standard operating procedures and local rules are up to date and reflect national guidance and regulations and that staff can readily locate and refer to them. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- The provider MUST ensure it has documented evidence recorded and readily accessible to show discrepancy meetings take place to identify and act on poor practice. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

Outstanding practice and areas for improvement

- The provider MUST ensure all formal complaints are managed in accordance with hospital policy. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.
- The provider MUST ensure department managers fully understand the workings of a diagnostic imaging department including the risks to patients and staff from ionising radiation. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.
- The provider MUST improve the robustness of the induction process to ensure as a priority staff are aware of emergency lifesaving equipment. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.
- The provider MUST produce a risk register that clearly identifies all risks associated with the diagnostic imaging department. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.
- The provider MUST ensure there are robust processes for collecting diagnostic imaging data that all staff are aware of and can contribute to. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.
- The provider MUST ensure information is shared with the employers of staff who also work in the diagnostic imaging department at St Hugh's Hospital as per the memorandum of understanding in place. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

Action the provider SHOULD take to improve

- The provider SHOULD ensure consultant behaviour and practice, are managed appropriately.
- The provider SHOULD ensure there is a formalised system of clinical supervision in place, which is documented.
- The provider SHOULD ensure consultants practice is in accordance with published best practice guidance.
- The provider SHOULD proactively engage with the radiation protection advisor for advice and guidance.
- The provider SHOULD support the radiation protection supervisor to ensure they are able to fulfil their responsibilities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Consultants did not always keep legible, accurate, contemporaneous records in accordance with hospital policy. There was an inconsistent approach to reporting and investigating all incidents and near-miss events. Patient risks were not always managed and escalated appropriately. Staff were not compliant with mandatory training including safeguarding vulnerable adults and children's safeguarding training. During the inspection there were no records available to show that all equipment in the diagnostic imaging department had been safety checked and calibrated. During the inspection there were no records available to show that personal protective equipment was regularly serviced. Staff did not have their own personally allocated dosimeters and were using a dosimeter assigned to another person. Therefore, robust safety processes were not in place to protect patients and staff from ionising radiation. Induction processes were not robust for all staff.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

Senior staff did not always have the right skills and knowledge to manage their areas of responsibility.

The hospitals governance systems and processes to provide oversight and assurance in terms of risks, to senior leaders were not always in place.

Some of the concerns identified at our previous inspection were not fully addressed and some controls were not fully embedded, for example, we found issues relating to medicines governance, which breached hospital policy.

Risks, issues and performance were not effectively managed by the senior team or the heads of departments.

Complaints were not managed and resolved in a timely manner or in line with the hospitals policy.

The hospital risk register did not identify all current risks, for example regulatory breaches including IR(ME)R were not identified and therefore the hospital was not able to evidence any action taken. In addition, some risks were out of date.

Managers did not fully understand the workings of a diagnostic imaging department including the risks to patients and staff from ionising radiation.

The hospital was unable to provide evidence that personal protective equipment was regularly serviced.

Guidance, standard operating procedures and local rules were not up to date and did not reflect national guidance and regulations and staff were not able to readily locate and refer to these.

There was no documented evidence to show discrepancy meetings took place in the diagnostic imaging department to identify and manage poor practice.

Processes for collecting diagnostic imaging data that all staff are aware of and can contribute to were not in place.

The hospital did not share information with the employers of staff who also work in the diagnostic imaging department at St Hugh's Hospital as per the memorandum of understanding that was in place.