The Healthcare Management Trust

St Hugh's Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Surgery	**Requires improvement**
Outpatients and diagnostic imaging	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

St Hugh's Hospital serves the population of North East Lincolnshire and surrounding areas. The hospital offers a range of outpatient services to NHS and other funded (insured and self-pay) patients including: cardiology, dermatology, general medicine, rheumatology, respiratory medicine, radiology and physiotherapy. Inpatient and outpatient services are also provided for cosmetic surgery, ear, nose and throat, general surgery, gynaecology, ophthalmology, oral and maxillofacial surgery, orthopaedics and urology.

The hospital does not provide emergency care services. St Hugh's Hospital contracts services for pathology, pharmacy, sterile services and MRI / CT scanning and these services do not form part of this inspection report. The registered manager is the Hospital Director who has been in post since October 2010.

This was the first comprehensive inspection of St Hugh's Hospital. CQC last inspected the hospital in December 2013 and reported compliance with all the standards inspected at that time.

We rated St Hugh's Hospital as requires improvement overall. We rated the service as inadequate for safe, requires improvement for effective and well-led and good for caring and responsive.

Are services safe at this hospital

Overall we rated safe as inadequate. There was a lack of robust systems and processes in place to manage patient safety. However there was evidence that a review of governance arrangements had started prior to inspection. We did not find evidence of thorough and robust incident investigations and there was a lack of assurance that learning from incidents was shared throughout the surgical service. There was a lack of evidence that action plans following the investigation of incidents were complete and evidence of root cause analysis was weak. Staff demonstrated an understanding of being open with patients when things went wrong but did not have a full understanding of the requirements of the statutory Duty of Candour. For example, incidents were not graded for level of harm which is critical to implementation of the regulation. Completion of risk assessment of venous thromboembolism was inconsistent. There was concern about medicines management including identification of medication errors and the recording of controlled drugs administration. There were no records of child safeguarding training and no Level 3 child safeguarding trained member of staff to lead an investigation if required. We found that records did not include individualised care plans and pre-operative assessment was not in line with national or best practice guidance; documented risk thresholds were not used to ensure patients were appropriately risk rated. We reviewed 19 World Health Organisation 5 Steps to Safer Surgery checklists. The 'sign in', 'time out', 'sign out' section were fully completed for 13 out of 19 forms (68%); however none of the forms indicated the procedure or date and therefore all forms were considered incomplete. Areas were visibly clean and tidy, equipment was visibly clean and available to staff. The rate of surgical site infections was good and lower than the national average.

Are services effective at this hospital

We rated effective as requires improvement as there was limited evidence that policies, care and treatment were evidence-based and that effective systems were in place to improve services. The lack of audit activity provided little assurance that the hospital monitored the quality of care effectively. Responsibility for local audit was centralised at a senior level and not delegated effectively. There was an ineffective response to audit findings and the management of action plans. The lack of robust audit systems was evident in the review of medication administration records, the 5 Steps to Safer Surgery checklists, fluid charts, consent forms and risk assessments. There was also a lack of formal monitoring and audit of outpatient clinic data to ensure that clinics were running effectively. Systems in place to approve and monitor practising privileges were under review and well supported by the Hospital Director and Medical

Summary of findings

Advisory Committee; however for 21% of NHS consultants, details of the latest appraisal were out of date at the time of the inspection. Whilst the appraisal may have taken place, consultants were not updating their records on a timely basis. Staff demonstrated good multidisciplinary team working; radiographers had regular clinical supervision and kept records; however the system used to record nursing supervision and appraisal was not as robust.

Are services caring at this hospital

We received 18 written feedback comments from patients at the time of inspection all of which provided positive feedback about the standard of care from all staff groups. The hospital incorporated the Friends and Family Test into their patient satisfaction survey. The survey response rate was 49% - 69% between April and July 2015 with 97% - 100% of patients likely or extremely likely to recommend the hospital. The hospital did not use the Friends and Family test for the outpatients department and had not performed an outpatient patient survey for approximately two years. This meant that the department did not have a formal way of measuring patient feedback. All the staff interacted with patients and their visitors in a polite and respectful manner and were helpful and friendly. Patients we spoke with said they felt involved in their care and treatment plans and family members praised the attitude of staff. They said nothing was too much trouble for them.

Are services responsive at this hospital

We rated responsive as good. The main volume of referrals was from the local NHS clinical commissioning groups. The hospital did not accept high-risk patients; however policy documents did not specify inclusion or exclusion criteria for accepting patients. The hospital reported 11 cases of unplanned transfer to an NHS hospital between April 2014 and March 2015 which CQC assessed to be worse than expected compared to the other independent acute hospitals we hold this type of data for during one quarter. Five transfers were to Level 1 care and four to Level 2 care for further assessment and investigations; of these, four were discharged from care within 24 hours. Two patients transferred to Level 3 care; one transfer related to an unpredicted condition and the other for post-operative complications. The hospital extended its services to meet local demand by adding cosmetic surgery services and by offering weekend MRI and CT scanning. Referral to treatment (RTT) data for April 2014 to July 2015 showed that the hospital met the target of 90% of admitted patients beginning treatment within 18 weeks of referral except for a dip in February, March and May 2015. The most common reason for this was reported to be lack of theatre capacity and a second laminar flow theatre had been added. All services at the hospital were on the ground floor; this allowed equal access for people with a physical disability. The hospital admitted patients living with a learning disability or dementia for day surgery supported by a carer or family member. There was a lack of evidence to show complaints and concerns were being used as an opportunity to make improvements or that learning was taking place.

Are services well led at this hospital

We rated well-led as requires improvement due to the lack of assurance that governance, quality improvement and risk management systems were working effectively. There was evidence of committee activity to monitor infection control, health and safety and clinical governance but limited evidence of the effective operation of the supporting risk management systems including learning from adverse incidents. The medical director for the parent organisation was appointed in April 2015 and was taking steps to develop a centralised governance framework led by the board of directors. The hospital director had a clear vision for the hospital and led the strategy to increase the volume of NHS referrals and add cosmetic surgery to the services offered at St Hugh's Hospital. Staff were less clear about the long term strategy for their departments and the hospital and there was no documented evidence of an overarching vision and set of values for staff. The hospital director was visible and accessible and the Medical Advisory Committee was actively involved in the process to monitor, agree and review practising privileges with the hospital director. There was no clear strategy for staff engagement but there was an open culture and staff reported good working relationships between departments and with the management team.

Our key findings were as follows:

Summary of findings

- Staff and patients told us the hospital was one of the cleanest they had experienced. All areas of the hospital were visibly clean and well-maintained. We saw evidence of cleaning programmes including deep cleaning and of environmental audits and their action plans, but no evidence of the completion of action plans.
- The hospital had a low infection rate and had had no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium Difficile infections at the hospital between April 2014 and July 2015. The hospital liaised with the infection prevention and control service at the local trust including links with two microbiologists and two infection prevention and control nurses.
- Nursing recruitment was a challenge but staffing levels had improved in the past year. Senior staff used their experience to determine the dependency of patients and staffing levels required. The hospital had an in-house bank and rarely used agency staff except in theatres where one agency nurse was on a short-term contract.
- There was limited documentary evidence that the hospital met the nutritional needs of inpatients. For example there was no evidence of nutritional screening in the clinical records and incomplete documentation on fluid balance charts. However patients spoke positively about the choice and quality of the food and drinks received.

There were areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that all staff receive the appropriate level of child and adult safeguarding training in relation to their role and responsibilities.
- Ensure that all staff receive the mandatory training identified as appropriate for their roles.
- Ensure that venous thromboembolism (VTE) risk assessment and interventions are consistently applied.
- Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
- Ensure that all staff have an understanding of Regulation 20: Duty of Candour and how this is applied. Additionally the hospital must have systems in place to comply with this regulation.
- Have effective systems in place which enable the hospital to assess, monitor and mitigate the risks relating to the health and safety and welfare of people who use the service.
- Ensure that staff document consent in line with national guidance from the General Medical Council and Royal College of Surgeons.
- Document and implement pre-operative assessment guidelines, including anaesthetic risk thresholds, in line with national guidance.
- Ensure that all care pathways, risk assessments and care planning documents are based on current evidence and national best practice guidance.
- Ensure staff follow policies and procedures about managing medicines, including prescribing and documentation of administration.
- Ensure that appropriate audit and data collection take place within the outpatient department to monitor service quality and ensure that this information is used to drive improvements.

In addition the provider should:

- Strengthen the recording and monitoring systems for mandatory training attendance and clinical supervision.
- Ensure that nutritional screening is implemented.

Summary of findings

- Ensure that written medical records are legible and in line with national guidance from the General Medical Council.
- Review the consent policy to include reference to guidelines for children.
- Ensure that a Did Not Attend (outpatient appointment) policy is in place.
- Consider ways to promote leadership and innovation from all staff.
- Develop and launch a vision and set of values for the hospital staff.
- Consider further participation in national audits to monitor and benchmark patient outcomes.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Requires improvement 	Overall we rated this service as requires improvement. There was a lack of robust systems and processes in place to manage patient safety. We did not find evidence of thorough and robust incident investigations and there was a lack of assurance that learning from incidents was shared throughout the surgical service. There was a lack of evidence that action plans following the investigation of incidents were complete and evidence of root cause analysis was weak. There was evidence of understanding the principle of being open with patients when things go wrong but no evidence of implementation of the Duty of Candour. For example, incidents were not graded for level of harm which is critical to implementation of the regulation. Completion of risk assessment of venous thromboembolism was inconsistent. There was concern about medicines management including identification of medication errors and the recording of controlled drugs administration. We found that records did not include individualised care plans and pre-operative assessment was not in line with national or best practice guidance. Pre-assessment staff did not use documented risk thresholds to ensure patients were appropriately risk rated. There was no evidence that care pathways were based on current evidence based guidance, standards and best practice. Staff had limited participation in external audits and did not consistently record the benchmarking of outcomes. There were instances of the record of consent not meeting relevant guidance and legislation. There was no clear vision or set of values for the service and there was limited evidence of the effective operation of governance and risk management. The risks reported on the risk register did not include clinical risks or correspond to the themes from incidents or issues described by staff.

Summary of findings

The patient satisfaction survey showed consistently high results. Staff treated patients with dignity, respect and kindness and supported them with decision-making. Managers were seen to be approachable with an open door policy.
The facilities and premises were appropriate for the services being delivered. Services were planned in line with the needs of the local population and were coordinated with other services and the local NHS hospital. People were listened to when they raised a concern and received a timely response to their complaint, but there was a lack of evidence to show complaints and concerns were being used as an opportunity to make improvements or that learning was taking place.

Outpatients and diagnostic imaging

Requires improvement

Staff escalated information about incidents and complaints to the management. There were also appropriate groups in place to discuss incidents. However, there was a lack of assurance that governance, quality improvement and risk management systems were working effectively. The system did not ensure that all staff had access to the outcomes of investigations, any lessons learnt, or information about what the department had done to make improvements to the service. We saw no information to confirm that a formal system was in place to ensure that complaints and concerns informed improvements in the service. There was also a lack of performance to ensure the quality of the service.
There were gaps in staff training, including higher level safeguarding. The hospital had not formally assessed or recorded nursing staff competencies. Staff told us that informal assessment and monitoring did take place. Within the departments, staff were not clear of the long term strategy for their department and for the hospital.
We found that there were areas of good practice and patients we spoke with were happy with the service. Staff told us that there was an inclusive culture and they were happy to work in the hospital. We also saw good examples of multidisciplinary team working, understanding and compassion to patients. There were issues concerning sharing information about the service between the management and the departmental staff. There were governance systems

Summary of findings

in place and these linked to hospital wide health and safety, and risk management committees. However, no system existed to provide feedback to staff in a formalised way. Staff were not involved in hospital wide strategies or encouraged to be leaders within the service.

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Services we looked at
Surgery; Outpatients and diagnostic imaging

Detailed findings

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Background to St Hugh's Hospital

The original St Hugh's Hospital building was founded in 1938. The Healthcare Management Trust assumed ownership of St Hugh's Hospital in 1985 and the current St. Hugh's Hospital site was opened to the public in March 1994.

St Hugh's Hospital serves the population of North East Lincolnshire and surrounding areas. The hospital offers a range of outpatient services to NHS and other funded (insured and self-pay) patients including: cardiology, dermatology, general medicine, rheumatology, respiratory medicine, radiology and physiotherapy. Inpatient and outpatient surgical services include cosmetic surgery, ear, nose and throat surgery, general surgery, gynaecology, ophthalmology, oral and maxillofacial surgery, orthopaedics and urology. The hospital also provides outpatient services for children and young people aged between three and 16 years.

The on-site facilities include an endoscopy suite, two operating theatres with laminar air-flow; consulting rooms supported by an imaging department offering X-ray and ultrasound, and inpatient and outpatient physiotherapy services. There are 24 patient bedrooms, all with a nurse-call system, en suite bathrooms, a television and a telephone.

The hospital was inspected as part of our planned inspection program. This was a comprehensive inspection and we looked at the two core services provided by the hospital: surgery and outpatients and diagnostic imaging.

The registered manager is the hospital director who has been in post since October 2010. The hospital director also acts as the accountable officer for controlled drugs.

Our inspection team

Our inspection team was led by:

Inspection Lead: Imogen Hall, Inspection Manager, Care Quality Commission

The team of nine included CQC inspectors and a variety of specialists: an independent healthcare hospital director, a plastic surgeon with independent healthcare surgical experience and a senior radiographer.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. We carried out an announced inspection visit on 25th and 26th August 2015 and an unannounced inspection on 10th September.

We also spoke with staff individually and in small groups. We talked with patients and staff from the ward, operating department, radiology, physiotherapy and outpatient services. We observed how people were being cared for, talked with patients and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at St Hugh's Hospital.

Facts and data about St Hugh's Hospital

Context

- St Hugh's Hospital serves the population of North East Lincolnshire and surrounding areas. The hospital offers a range of services to NHS and other funded (insured and self-pay) patients including: cardiology, cosmetic surgery, dermatology, ear, nose and throat, general medicine, general surgery, gynaecology, ophthalmology, oral and maxillofacial surgery, orthopaedics, rheumatology, respiratory medicine, urology, radiology and physiotherapy. The hospital does not admit emergency patients. St Hugh's Hospital contracts services for pathology, pharmacy, sterile services and MRI / CT scanning and these services do not form part of this inspection report.

Activity

- The hospital operates 24 inpatient beds and four day case beds and is registered for 31 beds.
- The hospital employed 90 WTE staff as of May 2015 and has 80 consultants with practicing privileges. Temporary bank are mainly used to cover staffing shortfalls with a low use of agency nursing in the operating theatres when required. One agency nurse was on a short-term contract in theatres at the time of inspection.
- There were no patient deaths at the hospital between April 2014 and March 2015. CQC received one statutory notification from the hospital of an unexpected death which occurred following an unplanned transfer from St Hugh's Hospital to a local NHS hospital. This was an appropriate action by the hospital.

In the year from April 2014 to March 2015 there were:

- 84% of day case surgery patients and 76% of overnight surgery patients were NHS patients.
- 1,218 overnight inpatients
- 3,825 day case inpatients
- 7,237 first outpatient appointments
- 11,121 follow-up outpatient appointments
- 4,046 visits to theatre including:
- 720 phacoemulsification of lens with implant procedures
- 409 diagnostic gastroscopy procedures
- 285 diagnostic colonoscopy procedures
- 237 arthroscopic meniscectomy procures
- 205 primary total hip replacement

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- 195 multiple arthroscopic operation on the knee
- 189 total prosthetic replacement of knee joint
- 155 primary repair to inguinal hernia
- 120 diagnostic endoscopic examination of the bladder
- 107 diagnostic flexible sigmoidoscopy
- Less than 100 cosmetic surgery procedures

In the year from April 2014 to March 2015, there were:

- 11 unplanned transfers (Average rate of 0.2% per 100 inpatient discharges 2014-15). This performance was regarded by CQC as 'worse than expected' compared to the other independent acute hospitals for which we hold this type of data. Five transfers were to Level 1 care and four to Level 2 care for further assessment and investigations; of these, four were discharged from care within 24 hours. Two patients transferred to Level 3 care; one transfer related to an unpredicted condition and the other for post-operative complications.
- We were informed there were 12 unplanned readmissions for 2014-15. After review of the incident reports we calculated there were 13 unplanned readmissions within 29 days of discharge (Average rate of 0.2% per 100 inpatient discharges 2014-15). This performance was regarded by CQC as 'tending towards worse than expected' during one quarter, July to September 2014. Of these 11 patients, seven stayed overnight, two stayed for 48 hrs and four for more than 48 hours. The majority of readmissions were related to wound management.
- Four cases of unplanned return to theatre (0.1% of theatre visits) for wound management.
- During the same period, the CQC received one statutory notification of a serious injury (fractured neck of femur).

For the period April to August 2015, there were:

- Two unplanned transfers, of which one was to Level 1 care and one to Level 3. The Level 3 care patient returned to St Hugh's within 24 hours.
- Three cases of unplanned readmission within 29 days of discharge.
- No cases of unplanned return to theatre.

Inspection history

This was the first comprehensive inspection of St Hugh's Hospital. CQC last inspected the hospital in December 2013 and reported compliance with all the standards inspected at that time.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and Diagnostic Imaging.

Surgery

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

Information about the service

St Hugh's Hospital provides day surgery and inpatient treatment for patients across a range of specialities, including ophthalmology, orthopaedics, gynaecology, cosmetic surgery and endoscopy. On-site facilities include a 28-bedded ward with 24 beds in use, four day care beds, an endoscopy unit and two laminar air flow operating theatres. In the 12 month period from April 2014 to March 2015 there were 4,046 visits to theatre. 1,218 were overnight inpatients and 3,825 were day case inpatients including:

- 720 phacoemulsification of lens with implant procedures
- 409 diagnostic gastroscopy procedures
- 285 diagnostic colonoscopy procedures
- 237 arthroscopic meniscectomy procures
- 205 primary total hip replacement
- 189 total prosthetic replacement of knee joint
- 155 primary repair to inguinal hernia
- 120 diagnostic endoscopic examination of the bladder
- 107 diagnostic flexible sigmoidoscopy

At the time of our inspection, surgery was provided for adults (18 years and over).

We visited the ward, two operating theatres, the theatre recovery area and the endoscopy unit. During our inspection, there were six overnight inpatients on the ward, two endoscopy sessions in the endoscopy unit and six operating sessions in the operating theatres.

We spoke with nine patients, two relatives and 21 members of staff. We observed the delivery of care, looked at 27 patient records and 13 medication charts. We observed a nursing handover. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the hospital.

The hospital was last inspected in December 2013 and found to meet all the standards inspected at that time.

Surgery

Summary of findings

Overall we rated this service as requires improvement.

We rated safe as inadequate, effective and well-led as requires improvement and caring and responsive as good. There was a lack of robust systems and processes in place to manage patient safety. We did not find evidence of thorough and robust incident investigations and there was a lack of assurance that learning from incidents was shared throughout the surgical service. There was a lack of evidence that action plans following the investigation of incidents were complete and evidence of root cause analysis was weak. Risk assessment of venous thromboembolism was inconsistent. We reviewed 19 World Health Organisation 5 Steps to Safer Surgery checklists. The 'sign in', 'time out', 'sign out' section were fully completed for 13 out of 19 forms (68%); however none of the forms indicated the procedure or date and therefore all forms were considered incomplete.

We found that records did not include individualised care plans and pre-operative assessment and discharge advice was not in line with national or best practice guidance. There was no evidence that care pathways were based on current evidence based guidance, standards and best practice. Staff had limited participation in external audits and did not consistently record the benchmarking of outcomes. There were instances of the record of consent not meeting relevant guidance and legislation.

There was no clear vision or set of values for the service and there was limited evidence of the effective operation of quality governance and risk management at ward level. The risks reported on the risk register did not include clinical risks or correspond to the themes from incidents or issues described by staff.

The patient satisfaction survey showed consistently high results. Staff treated patients with dignity, respect and kindness and supported them with decision-making. Managers were seen to be approachable with an open door policy. The facilities and premises were appropriate for the services being delivered. Services were planned in line with the needs of the local population and were coordinated with other services and the local NHS hospital. People were listened to when they raised a concern and received a timely response to complaints, but there was a lack of evidence to show complaints and concerns were being used as an opportunity to make improvements or that learning was taking place.

Surgery

Are surgery services safe?

Inadequate

We rated safe as inadequate. There was a lack of robust systems and processes in place to manage patient safety. We did not find evidence of thorough and robust incident investigations and there was a lack of assurance that learning from incidents was shared throughout the surgical service. There was a lack of evidence that action plans following the investigation of incidents were complete and evidence of root cause analysis was weak. There was evidence of understanding the principle of being open with patients when things go wrong but no evidence of implementation of the Duty of Candour. For example, incidents were not graded for level of harm which is critical to implementation of the regulation. Completion of risk assessment of venous thromboembolism was inconsistent. There was concern about medicines management including identification of medication errors and the recording of controlled drugs administration.

There were no records of child safeguarding training and no level 3 trained member of staff as required to lead an investigation. We found that records did not include individualised care plans and pre-operative assessment was not in line with national or best practice guidance, as documented risk thresholds were not used to ensure patients were appropriately risk rated. We reviewed 19 World Health Organisation surgical safety checklists. The 'sign in', 'time out', 'sign out' section were fully completed for 13 out of 19 forms (68%); however none of the forms indicated the procedure or date and therefore all forms were considered incomplete.

Areas were visibly clean and tidy, equipment was visibly clean and available to staff. The rate of surgical site infections was lower than the national average although the majority of readmissions and returns to theatre were related to wound management. Staffing levels were adequate but mandatory training levels required improvement.

Incidents

- There were no never events reported by the hospital between April 2014 and the date of inspection. Never Events are serious incidents that are wholly preventable.
- Between April 2014 and June 2015, the hospital reported 88 clinical incidents. The incident reporting system did not facilitate reporting by specialty or level of harm. Incidents were graded as accidents or untoward incidents; where relevant, these incidents were not graded in terms of severity of harm to the patient, such as no, low, moderate and severe harm. This grading is critical to measuring the quality of care and is critical to the implementation of the Duty of Candour.
- All staff we spoke to were aware of the policy for reporting incidents and were able to describe the process for reporting adverse events.
- The hospital notified CQC of one unexpected death between April 2014 and March 2015. This did not take place at the hospital but following unplanned transfer to a local NHS hospital; this was appropriately reported by St Hugh's Hospital. We reviewed the investigation of this incident and noted that recommendations were made with a review date. There was no evidence that a follow-up review had taken place or that practice had been audited to confirm learning was embedded. Theatre staff were aware of this incident, but were unable to describe the learning or changes to practice in response to the incident. This showed there were no effective systems in place to confirm staff learned patient safety incidents.
- The hospital reported one serious injury between April 2014 and March 2015. This was a fall that resulted in a hip fracture. Evidence that a thorough and robust review of this incident had taken place was weak and parts of the incident form were incomplete. During our inspection, we reviewed 19 records and observed three records of patients who were at risk of falls where this risk assessment was incomplete. The lack of investigation and incomplete risk assessments meant there was no evidence of learning from this incident. This was corroborated when observing handover. Night staff reported that a patient had been unsteady whilst mobilising during the night. No questions were asked by

the physiotherapist or nurses present at handover and when we reviewed the record, there was no documented evidence of falls risk being highlighted in the moving and handling risk assessment.

- Two incident reports in the previous 12 months related to patients readmitted after surgery due to severe constipation. We saw the clinical governance meeting minutes where these incidents were discussed. The committee concluded that the severe constipation could be linked to a specific analgesic and that this should not be routinely prescribed in future due to the side effect of constipation. During our inspection, we reviewed 13 medication charts and five prescribed this analgesic. We reviewed four discharge prescriptions; three of these prescribed this analgesic. The same analgesic was recommended in the patient information leaflet and staff confirmed this leaflet was given out to patients. This showed that staff had not learned from these incidents.
- The matron reviewed and investigated all incidents. Each incident report noted the time at which a senior manager received verbal notification of the incident. This was usually to the matron. The matron recorded immediate actions taken and comments on the outcome. The Hospital Director signed off all completed forms. Ward managers told us that in the absence of the senior staff, they would investigate incidents.
- There was no evidence of the mechanisms by which subsequent learning was shared with staff and no reference to learning in the incident reporting or risk management policies. We saw minutes of the monthly clinical governance meeting during which all incidents were discussed and were told that feedback was provided to staff; however we did not see any evidence of formal feedback systems at department level, for example: minutes of team meetings or team briefs.

Duty of Candour

- The Duty of Candour is a legal duty on healthcare providers that sets out specific requirements that providers must follow when things go wrong with care and treatment. Incidents were not graded for level of harm which is critical to implementing the Duty of Candour and there was no evidence that the requirements of the Duty of Candour were included in the relevant policies or added to the staff training programme.
- There was evidence of understanding of the principle of being open with patients when things go wrong but no evidence of implementation of the Duty of Candour. This meant that patients might not receive an apology and written information in line with the requirements of the regulation.

Safety thermometer or equivalent

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It looks at four harms; falls, pressure ulcers, venous thromboembolism (VTE) and catheter urinary tract infections. The safety thermometer used a ‘snap shot’ of data reported on one day each month.
- Safety thermometer data provided by the hospital showed 100% harm free care for the period August 2014 to July 2015. Safety thermometer data was not displayed on the ward and the two ward managers reported that they did not receive feedback on the results. .
- Data submitted by the hospital reported 100% compliance with VTE risk assessment screening between April 2014 and March 2015. A hospital audit of inpatient case notes showed VTE assessment compliance had reduced over the past three years; it was 90% in 2013, 80% in 2014, and 75% in 2015. The 2015 action plan identified that it was the responsibility of the pre-assessment ward nurses to complete VTE assessments on all relevant patients. There was no time scale for completion on the action plan or a record of progress made.
- However, during our inspection we reviewed 25 VTE risk assessments from January to August 2015 and found the assessment, action plan or the completion of interventions to reduce the risk of VTE was incomplete in 13 (52%) of cases.

Surgery

- We case-tracked a patient who had been assessed pre-operatively as high risk for VTE. Staff had not fully completed the expected actions to prevent VTE and there was no clear documentation from medical staff to support the deviation from the VTE risk assessment.
- There had been two cases of hospital acquired pulmonary embolism between September 2014 and July 2015. We reviewed the incident forms from these cases; VTE risk assessments and expected actions to prevent VTE had been completed for both patients but there was no formal root cause analysis documented and no evidence of potential learning as a result. The medical director was in the process of reviewing VTE prevention guidelines at the hospital and was drafting a policy to strengthen these.

Cleanliness, infection control and hygiene

- Ward and theatre areas were visibly clean and well maintained. Staff and patients told us the hospital was one of the cleanest they had experienced. We observed that all equipment in the theatre, endoscopy and ward areas was visibly clean. Equipment had stickers in place to evidence when they were clean. Environmental and mattress audits were completed. We saw evidence of environmental audits for the ward and operating theatres with action plans. We did not see evidence of completion of the action plans.
- The department did not carry out patient-led assessments of the care environment (PLACE). PLACE was introduced in April 2013. It is a system for assessing the quality of the patient environment. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care.
- The hospital had infection control policies and an infection control committee and had links with two microbiologists and two infection control nurses at the local NHS trust who provided expert advice. We saw minutes of the heads of departments meetings which showed that infection control issues were discussed and shared with the managers of the departments. There had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium difficile infections at the hospital between April 2014 and July 2015.
- Information provided by the hospital indicated that all patients admitted to the ward were screened for MRSA. We reviewed the documentation of four MRSA screens; one was incomplete.
- The hospital reported six surgical site infections (1.5%) occurring in 394 hip and knee replacement operations between April 2014 and March 2015. This was less than the national average of surgical site infection (2%). The quarterly clinical governance meeting reviewed and discussed surgical site infections. Due to low numbers, no specific trends were identified.
- Staff told us that they completed infection prevention and control training as part of their annual update training. Data submitted by the hospital showed that 81% of staff in the service had completed this training. Six percent of nursing and non-medical staff in the service had completed additional infection control training.
- Two hand hygiene audits completed in January and March 2015 showed 73% and 75% compliance in the service. An action plan was included in the audit, but there was no timescale for the actions or evidence of progress made. We observed staff using hand sanitizer from dispensers situated outside patient rooms.
- There were two designated clinical hand-washing sinks in the ward. Sinks were available in the en-suite bathrooms; these did not meet the recommendations of clinical hand wash basins in Health Building Note 00-09: Infection control in the built environment (March 2013). For example, the dimensions of the sinks were not large enough to contain most splashes or enable the correct hand washing technique to be performed. The ward was refurbished in 2013 and 2014 but national best practice guidance had not been followed.

Environment and equipment

- Patients had single rooms with an en-suite bathroom. Staff used the rooms that contained two beds for day surgery patients.
- Staff told us that items of equipment were readily available and the hospital replaced items or purchased new equipment in a timely manner.

Surgery

- Theatres had four anaesthetic machines, two of which were new. We saw that an ultrasound nerve-imaging device was now in place and both theatres had laminar airflow systems. Theatres were accessible via a keypad lock system.
- A Picture Archiving and Communications System (PACS) enables x-ray and scan images to be stored and viewed electronically. This was available in the theatre suite.
- We reviewed the servicing and PAT testing records of 19 pieces of equipment in the ward of which 84% did not have labelled evidence of service dates. We clarified with a member of staff that all this equipment was in use.
- Staff cleaned reusable endoscopes (which record images inside a body cavity or organ) in a dedicated decontamination room. We saw that that staff decontaminated endoscopes in accordance with best practice guidelines with a segregated clean and dirty area and the use of a coding system for traceability.
- Emergency resuscitation equipment was available on the ward and in theatre areas. Records indicated staff in theatre checked this equipment on a daily basis. On the ward, there were gaps in the daily checks; staff checked emergency equipment 70 out of 86 days. The hospital was open on these days. This meant that ward staff were not consistently assured the equipment was in date and in working order.
- The cleaning of sterile equipment for the hospital was outsourced to a regional hospitals sterile services unit. The unit returned equipment within 24 hours.
- We did not see any systems in place to ensure medical device safety alerts were cascaded to staff across the service. However, there was evidence these were discussed in the clinical governance meeting minutes.
- We found that temporary closures were not in use on sharps bins in the treatment room and the sluice. This meant that staff were at risk of injury when disposing of waste. There were two needle stick injuries reported in 2014.

Medicines

- There were no on-site pharmacy services at the hospital; the hospital had a contract with a national pharmacy services company to supply their pharmacy needs. The contract for this was reviewed in June 2015.
- There were no documented processes in place for medicines reconciliation, that is ensuring that patients continued to receive the same medicines and dosage in hospital as received at home
- The door to the medicines room on the ward was not locked, however, all internal cupboards containing medications were locked and only nursing staff on duty had access to the keys. This meant that medicines were stored securely.
- We saw four prescription forms for discharge medication pinned to a noticeboard in the unlocked medicines room. All the forms were complete and signed by a doctor; three out of four prescriptions contained a prescription-only analgesic drug. These were not stored securely and there was a risk that the completed prescriptions could be removed for personal use.
- Staff recorded fridge temperatures daily in theatres. There were gaps in the record and these were at the weekend when the theatres were not in use. On the ward, the temperatures were also recorded daily and were completed with four (6%) gaps in 62 days. Fridge temperatures are recorded to provide assurance that medicines are stored at the correct temperature.
- The contracted pharmacy conducted monthly medicines management audits on behalf of the hospital. The results of the audits between January and May 2015 showed 97% compliance with basic medicines safety requirements. An annual documentation audit including a review of medication administration records (MAR) was completed in June 2015 and found 100% compliance for completion of drug administration; however we found that there was a lack of assurance that staff recognised and investigated medication errors. We reviewed 13 inpatient MARs during the unannounced inspection and found five (38%) of these were incomplete with gaps in the recording of administration. It was unclear whether these were missed doses or that medicines were given but not signed for. Once-only medication prescriptions on two charts did not indicate the time and date to be

administered; nurses had signed that these had been administered. Staff had not recorded patient weights on any of the MARs. This meant that medication doses might not be accurate, as the prescriber did not have the patient's weight available to them.

- The hospital closed on a Sunday when there were no inpatients. We asked about the security of medicines during closure and were advised that one member of non-clinical staff was on site when the hospital was closed. This person would have access to all the keys in the hospital including to the controlled drugs. We discussed this issue with the hospital director who undertook an immediate review of arrangements to ensure medications were securely stored at all times, including when the hospital was closed.
- Daily and weekly controlled drug stock checks were in place on the ward. We reviewed these and found them to be complete.
- We checked the controlled drug register and found three entries in three months were incomplete. We found the controlled drug register was not kept in a locked cupboard during our unannounced inspection; this was not in line with NMC Standards for Medicines Management 2015 which states that CD stationery should be kept in a locked cupboard or drawer.
- The hospital's medicines policy review date was 2009. The references in the policy were over eight years old. This meant the policy was not based on up to date professional standards and guidance.
- We found evidence of correct administration and recording of controlled drugs was not robust. There were seven entries in the controlled drugs register by the same two staff members within a fifteen-minute period. There were two to five minute intervals documented between administrations and two entries where two patients received medication at the same time from the same two staff members. This meant that staff were not administering controlled drugs in line with NMC guidance. This was raised with the Hospital Director (Accountable Officer for Controlled Drugs) who was going to follow-up these findings with the nurses concerned.
- The hospital reported one medication error in the four months prior to our inspection. A consultant prescribed the wrong drug to a patient, realised their error and contacted the patient to apologise and amend the prescription. There was no evidence that this medication error was investigated by the hospital.
- The ward manager told us that most patients on the ward self-medicated their routine medications. The hospital medication policy stated that the consultant must confirm that a patient was suitable for self-medication and for the nursing staff to document this in the patient's record. We did not see any evidence of this confirmation in the 19 healthcare records we reviewed.
- During review of the medication administration records (MAR) charts, we found a potential medication error. Staff documented that a patient self-medicated at a time when the anaesthetic record showed they were still in theatre. We brought this to the attention of the ward manager who was going to discuss it with the nurse involved as nurses documented when patients self-medicated. An incident form was not completed.
- We saw empty medicine boxes and bottles stored in the clinical room. Staff told us that these were previously used to dispense medications for patients to take home. This practice had stopped following review of the pharmacy service contract in June 2015, but the empty boxes and bottles had not been destroyed.
- There was limited assurance that oxygen was administered in line with the British Thoracic Society guidance on emergency oxygen use in adult patients or the Pharmaceutical Journal oxygen therapy emergency use and long-term treatment guidance. There were three patients on oxygen during our inspection; "administration of oxygen as prescribed" was recorded in each nursing care plan; however only one patient had oxygen prescribed on their MAR chart.

Records

- The hospital used paper based clinical records. These were securely stored in each area we inspected.
- The admission policy stated that a clinical nursing documentation audit should be carried out every six months on five percent of patients using the hospital audit tool. Evidence provided to us during the

inspection showed that this was completed annually. However, the action plan from the June 2015 audit did not contain a timescale for actions or evidence of progress made.

- Entries in nursing and medical records were in line with Nursing and Midwifery Council and General Medical Council guidance.
- Records reviewed did not demonstrate individualised care planning. We did not see any additional patient specific care plans which would evidence patient centred care.
- The care pathway documents included pre-operative assessments so clinical information was available for staff on admission. This included details on known allergies.
- We reviewed six pre and post-operative patient handover checklists, three were not signed by the member of staff who was either handing over or receiving the patient. This meant there was no evidence of who was responsible for the patient during periods of their care. The June 2015 documentation audit identified this as an area for improvement and for reaudit in six months.

Safeguarding

- The hospital matron was the named adult safeguarding lead for the hospital. Staff we spoke to told us that they had completed adult safeguarding training. Training records indicated that 9 out of 41 nursing staff (22%) in the surgery core service including theatres, the ward and endoscopy had completed Safeguarding Adults and Mental Capacity Act training in 2015. Overall 34 out of 122 hospital staff (28%) from all staff groups had received this training. There was no record of equality and diversity training levels.
- The staff we spoke with were aware of how to identify potential abuse and report safeguarding concerns. The Protection of Vulnerable Adults policy was available that contained contact details for the local authority safeguarding team. Senior staff were able to give us an example of appropriate action they had taken in relation to a safeguarding concern.
- Data submitted by the hospital indicated that there had been no adult safeguarding incidents in the last 12 months.

Mandatory training

- The hospital's mandatory training target was 100%. Staff told us that they were up to date with mandatory training; however, records submitted by the hospital did not support this. We discussed this with the matron who agreed there was not a robust system in place for recording training levels.
- Managers told us that staff completed an annual update of mandatory training. Records submitted by the hospital showed that 34 out of 45 staff (75%) including administrative and cleaning staff in the service had completed this annual training in December 2014.
- According to the records provided by the hospital for the surgical service, 53% of all staff were up to date with manual handling training and 44% of nursing staff were up to date with resuscitation training. This included intermediate life support training and training for the use of specific resuscitation equipment. The resuscitation nurse lead had advanced life support training.

Assessing and responding to patient risk

- We were unable to identify documented admission criteria in policy documents. Patients were listed via Choose and Book in liaison with the consultants.
- All of the patients who had their surgery cancelled on the day of surgery in 2014-2015 had known medical conditions in addition to their existing surgical need. Staff felt the pre-operative assessment process was more robust than it had been in the past, however, the hospital did not have agreed documented criteria for an anaesthetic referral following a pre-operative assessment. Two nurses worked in the pre-operative assessment unit; we observed two patients' pre-operative checks carried out by the nurses. The checks included information on the patients past and present medical history, baseline observations and patients' preferences. We spoke to a pre-operative assessment nurse and reviewed the pre-operative assessment document and policy. There was no evidence that patients were risk stratified prior to surgery in accordance with national guidance. This meant that there was no clear guidance on when to

refer a patient to an anaesthetist for an opinion about suitability or further screening requirements. NICE CG3 recommends that departments should develop local guidelines for selected patient populations.

- The World Health Organisation (WHO) surgical safety checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. We reviewed 19 checklists. The National Patient Safety Agency template was used and requires patient details, including the procedure, to be recorded in a box at the foot of the document. A printed sticker with patient details was routinely applied to the form over this box but the procedure was not recorded. This meant that there was no way to identify which checklist related to which operation.
- The 'sign in', 'time out', 'sign out' section were fully completed for 13 out of 19 forms (68%); however none of the forms indicated the procedure and date and therefore all forms were considered incomplete.
- We saw two checklists for a patient who had returned to theatre during their admission and were unable to link the checklists to the relevant procedure as the procedure was not recorded on each form. The hospital did not audit completion of the WHO surgical safety checklist. This meant there was no assurance that there was a consistent approach to safety checks prior to surgery.
- We reviewed 64 risk assessments in 19 patient records; 15 (23%) of the risk assessments were either incomplete or there was inconsistent completion of action plans and interventions when patients had been identified as high risk.
- We observed a nursing handover on the ward where a patient was highlighted as at risk of falls. We checked the moving and handling risk assessment for this patient and it was incomplete. This showed that documentation was inconsistent with verbal handovers from staff. Staff told us if they were concerned, they could refer patients to physiotherapy and a falls clinic in the community.
- Staff told us that follow up telephone calls were made to eye surgery patients and the conversation was documented in the care pathway. Other day surgery patients did not receive next day follow up telephone calls including those who had undergone a general anaesthetic. This was not in line with best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011.
- We found that pressure ulcer risk assessments were complete in the records we reviewed.
- The hospital used a recognised national early warning tool called the National Early Warning Score (NEWS) to monitor patients for the need for escalation of treatment should their condition deteriorate. We reviewed 21 NEWS charts and found these to be appropriately completed. A patient deteriorated on the ward during our visit; there was prompt attention by the medical and nursing staff, and the Resident Medical Officer (RMO) gave a clear explanation of the assessment and management plan to a member of our inspection team.
- The hospital had two units of blood available for transfusion. These were kept on site in a dedicated fridge. The expiry dates were documented on a white board in the ward office to ensure that the blood supply remained within its expiry date. These arrangements were appropriate for the hospital.
- The hospital had a designated cardiac arrest team. Staff within the team carried a bleep in line with the hospital procedure statement on cardiopulmonary resuscitation.
- We observed a safety briefing in theatre where roles were clarified, the patients were discussed and the equipment and medications required were clarified.

Nursing staffing

- The ward employed two ward sisters, 9.3 WTE nurses and 1.9 WTE support workers. The endoscopy unit employed one sister, two nurses and a support worker and the operating theatres employed one ward sister, 3.1 WTE nurses, 4.7 WTE operating department assistants (ODA) and 3.2 WTE support workers.
- Inpatient departments' vacancy rates at 31 March 2015 were 6% for nursing staff. Theatre vacancy rates at 31 March 2015 were 36% for nursing staff, 40% for ODA and 30% for healthcare assistants. The average staff sickness rate between April 2014 and March 2015 was 9% for the inpatient departments and 6% for the theatre

department. Data submitted by the hospital showed that staff turnover between April 2014 and March 2015 was 27% in endoscopy, 21% in theatre and 15% on the ward.

- The hospital used NICE Guidelines July 2014 - Safe staffing for nursing in adult inpatient wards in acute hospitals to assess overall staffing needs. The number of inpatients on the ward fluctuated; senior nursing staff reassessed the staffing levels on a regular basis but they did not use an acuity tool to determine staffing levels. If no experienced nurses were available, there was no documented escalation plan available to manage staffing; however staffing levels were supported by use of bank and agency staff. During our inspection an agency worker was on duty in theatre on short-term contract. This was reported to be working well as the agency nurse was building familiarity with the hospital procedures. They had received an induction to their role and the hospital.
- The hospital had a staff bank through which staff worked additional shifts in addition to their substantive posts at St Hugh's Hospital. The rotas submitted by the hospital from May to July 2015 showed regular use of bank staff on the ward and regular use of both bank and agency staff in theatres. The full name of agency staff was not consistently recorded on the rota. This meant that there was not a complete record of who was on duty.
- Staff on the ward told us that staffing levels 'felt right' and that they were 'good'. We were told that the ward was staffed with two registered nurses for the inpatients, one for the day cases, one for the inpatient theatre list and one support worker. These levels were in place during our inspection. A member of staff expressed concern about the lack of sister cover on the ward; we were told that this was due to the hospital's self-rostering policy. We reviewed the duty rotas and saw that on 32 out of 104 days, (31%), there was no sister on duty on the ward and no deputy sister role to fill this gap including on night shifts.
- Staff in theatre reported working 'close to the bone.' The theatre manager told us that she planned staffing according to Association for Perioperative Practice standards; duty rotas were commonly produced a week in advance. Theatre activity had increased and there was an intention to reassess the staffing establishment but, at the time of our inspection, no date had yet been set to do this. Management recognised this as a risk but had not formally recorded this on the risk register.
- From the rosters provided by the hospital, on 14 (13%) out of 105 days there was recorded only one registered nurse on night duty. This meant that there was not a second nurse available to witness the preparation and administration of controlled drugs if required; however we were informed that the RMO would assist the nurse with controlled drugs management in the absence of a second nurse. Since the inspection, we were informed that the hospital was closed for four of these nights and for the remaining ten nights, two registered nurses were on duty but there had been omissions in transposing staffing information from the original duty rotas. The practice of transposing information from one rota to another has since ceased.
- No cover was available in the absence of the cosmetic liaison sister so access to this resource was limited; however an additional 10 hours of nurse time was agreed by the hospital to support this post.
- We saw evidence of a staff induction checklist and orientation programme dated July 2015. This indicated that nurses had a 12 week induction and six month review.
- We observed a morning handover on the ward. Nurses looking after the inpatients, a support worker and the physiotherapist attended the handover. This took place in the nurse's office with the door closed and a sign marked 'busy' displayed. However, other staff interrupted the handover by entering and leaving the office. Patients were arriving for theatre, a consultant was documenting in case notes and anaesthetists were arriving to assess patients. A comprehensive verbal handover of each patient's condition was given to the staff that were present. Staff receiving handover took notes on a handwritten sheet that had been prepared by the night staff. Staff discussed the theatre lists for that day; it appeared from the discussion among the staff that exact details of the consultants and timings of the theatre lists were not yet confirmed.
- The handover process did not ensure that patient information was communicated to all staff on duty in a timely manner. Two of the registered nurses on duty did

not attend the handover. The ward manager told us that these staff were admitting the patients for theatre and would receive a handover later in the shift. In the middle of the morning during our unannounced visit, we heard a nurse unable to answer a clinical question from another member of staff. They said this was because they had not had handover yet. Handover is an important process to communicate key information about each patient's plan of care and is necessary to prevent avoidable errors.

Surgical staffing

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were almost all employed by NHS organisations and had practising privileges (the right to practice in a hospital) at St Hugh's Hospital. There were three independent private consultant surgeons.
- Information provided by the hospital showed that there were 80 doctors and dentists with practising rights under rules or privileges. Between April 2014 and March 2015, 29 consultants carried out over 100 episodes of care, 18 consultants carried out between 10 and 99 episodes of care and 33 consultants, nine or less episodes
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay. Consultants would arrange a nominated individual to provide out of hours cover if they were unavailable. We viewed the telephone book that contained consultants contact details on the ward and saw the nurses documented in the ward diary and on the message board which consultant was covering when the patient's consultant was unavailable. There was no documented process for this arrangement.
- There were 14 consultant anaesthetists from the local NHS trust practising at the hospital. The main body of anaesthetists were in a consortia and with a lead anaesthetist who organised the rota and cover. There were two consultant anaesthetists who supported specific consultants in the more specialist areas of cosmetic and spinal surgery. The Hospital Director reported that the rota worked very well although the Medical Director was in dialogue with the anaesthetists regarding a more formal on-call setting than was currently in place. The rota did not cover out of hours. Where concerns arose out of hours, the relevant consultant and anaesthetist were contacted and the patient managed by the resident medical officers (RMO). When a patient required transfer to Level 3 care, the anaesthetist was noted to attend the patient at the time of transfer.
- The hospital employed two RMOs who were trained in advanced life support and responsible for providing medical cover on the ward. Each RMO was on site 24 hours a day for seven days and handover between the RMOs took place on a Monday. The RMOs were employed through an agency for a six-month period.
- We viewed a RMO resource folder that included an induction procedure and guidance on the completion of prescriptions. This was completed and signed by the RMO's.
- The RMO told us they had good support from consultants and they were easily accessible on the telephone out of hours.

Major incident awareness and training

- The hospital had a business continuity plan in place. Staff we spoke to were aware of the plan and that emergency generator tests were completed.
- The hospital played no part in local major incident planning or training; this was managed by the local NHS trust.

Are surgery services effective?

Requires improvement

The effectiveness of this service requires improvement. Evidence that care and treatment was based on current evidence based guidance, standards and best practice was limited. The limited participation in external audits and benchmarking provided no assurance that the quality of care improved as a result of monitoring. There was no evidence of nutritional screening of patients. Fluid balance charts were incomplete and a fasting audit was not completed. This did not provide assurance that the hospital met patients nutritional and hydration needs.

Although we were assured that appraisals had taken place for those consultants working in the NHS, the records held

by the hospital were not updated by 21% of medical staff and at least 45% of non-medical staff's appraisal records were out of date; the hospital's system used to record nursing staff supervision and appraisal was not robust. Staff did not always follow relevant guidance on recording consent. The hospital had not updated the deprivation of liberty policy following the changes to legislation in 2014.

There was good access to training at the local NHS trust and PROMS data for groin hernia surgery, hip and knee replacements was better than the national average in 2014.

Evidence-based care and treatment

- There were no specific care pathways in place for surgical procedures, for example, hip and knee replacements. Generic care pathways and risk assessments did not reference the National Institute for Health and Care Excellence (NICE) or other professional guidance. This meant there was no evidence that patients were receiving care in line with current evidence based guidance.
- The endoscopy care pathway had been revised in 2013 and referenced British Society of Gastroenterology and Royal College of Nursing guidance.
- The hospital did not undertake fasting audits. This meant that the length of time patients' fasted for was not monitored and there was no assurance that professional and best practice guidance from the Royal College of Nursing and The Association of Anaesthetists of Great Britain and Ireland was being followed.
- The process for cosmetic surgery was in line with the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Practice.
- The hospital recorded medical device implants on the prosthetic registers for orthopaedic joints, cosmetic surgery and ophthalmology. This was up to date, clear and fully completed.

Pain relief

- Staff used three different pain assessment scoring systems to assess pain levels. Staff scored pain between zero to three, zero to four and zero to 10 in the three different scoring systems. Staff asked patients to score their pain depending on which assessment the staff were using. There was a risk that this could cause confusion to patients leading to inaccurate pain reporting.
- Staff followed guidance on the frequency of pain assessment. We found the guidance gave three different frequencies of pain assessment. This meant there could be inconsistent assessment of pain by staff.
- We observed a patient continuous analgesia system (PCAS) document. This incorporated a prescription sheet, physiological observation chart and pain assessment score. Staff used this chart until the PCAS was discontinued. This provided documented evidence of timely and appropriate monitoring for patients who were receiving continuous, opiate pain relief.
- We reviewed eight pain charts. Staff had completed these fully.
- Patients were given a leaflet on how to manage pain symptoms following discharge from hospital.

Nutrition and hydration

- There was no evidence of nutritional screening in the clinical records. We reviewed 13 fluid balance charts during our inspection, all were incomplete. There was no assurance that the hospital met patients nutritional and hydration needs.
- Staff did not monitor the duration of time patients fasted.

Patient outcomes

- The hospital did not have a local system in place to monitor long-term outcomes.
- The management team told us the hospital compared itself with national figures for average length of stay and surgical site infections. Data submitted by the hospital in the annual quality account 2014/15 showed lower than the national average for surgical site infections. The average length of stay for all procedures was lower than the hospital's annual objective/target but it was unclear how the target had been set or whether this data was benchmarked against national NHS performance data.
- We saw the audit schedule for 2015. This was a rolling programme of local audits, for example, mattress,

pharmacy, quality dashboard and medical records. The ongoing national audits included were patient reported outcome measures (PROMs), commissioning for quality and innovation (CQUINs) and patient safety thermometer.

- PROMs data from April 2014 to December 2014 for groin hernia surgery, hip and knee replacements was better than the national average.
- The cosmetic surgery team had no audit or review process in place.
- The manager of the endoscopy unit had visited other units and completed informal benchmarking as part of working towards joint advisory group (JAG) on gastrointestinal endoscopy accreditation.
- The National Joint Registry summary data submitted by the hospital showed the consent rate was 93%, just below the national average of 94%.
- There were 13 unplanned readmissions within 29 days of discharge from April 2014 to March 2015. CQC assessed this to be tending towards being worse than expected during one quarter. The clinical governance committee discussed the unplanned readmissions but we were unable to identify discussion of cause or themes in the minutes.

Competent staff

- Staff we spoke to told us that they had had an appraisal. The hospital was not assured staff appraisal and supervision was undertaken, as there was not a robust system in place to record it. Records at the time of inspection indicated that non-medical staff appraisal rates ranged from 0% for some support workers and theatre staff to 67% of nursing staff in inpatient areas. Senior staff told us there were no competency assessments for nurses.
- There was support for most nursing staff to attend training courses. The hospital was building a relationship with the local NHS trust to access training courses. We saw evidence that some staff had attended a cannulation course, immediate life support and acute life threatening events – recognition and treatment (ALERT). One member of staff told us they had been unable to attend an annual specialist course that meant they did not have a professional update or access to a peer support network. The matron was unable to provide specific numbers of staff that had attended additional training or assurance that the training was recorded on the hospital database.
- Staff administered blood transfusions. Data submitted by the hospital did not include blood transfusion training records. During our inspection we were shown a blood transfusion folder. This contained policies from a local provider and training records relating to the competency framework for the administration of blood components and management of the transfused patients. Ten staff had received training or an update in August 2015. Dates on the previous training records were 2012 and 2011.
- Support workers had the opportunity to complete national vocational qualifications (NVQ).
- Staff underwent a disclosure and barring service (DBS) check on initial appointment. There was no policy on when an update review would be required. We reviewed two medical staff files, one a new appointment and one a longstanding member of staff. We found the application process to be comprehensive.
- There was no policy in place to ensure that the consultants working in the NHS provided documentary evidence of their most up to date appraisals and revalidation outcomes on a timely basis. There was a database in place to monitor the currency of indemnity insurance and appraisal details. We found details for one indemnity policy and 17 (21%) medical staff appraisal records to be out of date. The parent organisation, Healthcare Management Trust had appointed a consultant anaesthetist working at the hospital as medical director for the organisation two days a week from April 2015. He was in the process of reviewing the medical management systems and rewriting the practising privileges process and policy.
- The medical director stated that he had had good links and open dialogue with the medical director at the local NHS trust especially around fitness to practice issues. There were processes in place to contribute to the annual NHS appraisal for consultants undertaking surgical activity at St Hugh's Hospital. Outcome data was provided annually to each surgeon to support the appraisal and revalidation process. The hospital director took practice concerns to the chair of the Medical

Advisory Committee who would take it up with the trust. Fitness to practice concerns were addressed by the relevant NHS trust. Once deemed competent by the trust, the consultant was allowed back to St Hugh's Hospital to practice.

Multidisciplinary working

- Staff told us there was a good relationship between the multidisciplinary team (MDT).
- There was effective daily communication between the ward and theatres. We observed staff informing patients of their plan of care and being transferred to and from theatre efficiently.
- A physiotherapist attended the daily handover and received referrals from the nursing staff. There were no occupational therapists or pharmacists at the hospital. Staff could refer patients to community services on discharge if this was required.
- There was no formal MDT meeting on the ward.
- Patient records contained post-operative instructions and subsequent reviews from the consultant and entries from the RMO and multidisciplinary team.
- Nursing staff completed the discharge paperwork. The ward clerk typed the letter to the patients GP and made the follow up appointments.

Seven-day services

- The service carried out endoscopies and surgery Monday to Saturday. There was a physiotherapy service every day the hospital was open.
- The RMO provided 24-hour medical cover; staff told us they did not have any difficulties obtaining a medical review. The RMO told us they could easily contact consultants when needed.

Access to information

- The hospital did not have the patients' NHS records on site. The hospital created new paper records for each patient and received the clinical history including medication history from the referrer or GP, the pre-operative assessment and national joint registry information. We found letters in the record of one patient we case tracked that demonstrated good communication between the GP and consultant.
- The RMO told us there was good access to patient records from other hospitals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All the patients we spoke to told us staff explained their care and treatment to them and sought consent prior to delivering the care.
- The pre-operative assessment staff told us that they discussed with the patients the procedure they had agreed to, gave further explanation or information leaflets to patients to ensure patients fully understood their treatment and gave valid consent.
- We reviewed 15 consent forms. Staff had completed all the forms prior to the date of surgery. On two of the consent forms there had been a significant period (three months and five months) between completion and the date of the operation. There was no documented evidence in the record that medical staff had reviewed the consent on admission. This does not provide assurance that the hospital met national guidance from the Department of Health (Reference guide to consent for examination or treatment, second edition. 2009). This states that if consent has been obtained a significant time before undertaking the intervention, it is good practice to confirm that the person who has given consent (assuming that they retain capacity) still wishes the intervention to proceed.
- Handwriting on six of the 15 consent forms we reviewed was illegible. One of the consent forms for orthopaedic surgery did not contain information about the risks or complications of surgery or the date of consent. This meant there was no evidence that staff gave the patient the information required to allow them to give informed consent. This is not in line with professional guidance. The June 2015 documentation audit noted compliance to complete potential risks on consent forms was 75% and indicated this would be escalated to the Clinical Governance Group. This was not evident in the minutes of the group.
- We saw evidence of a pre-printed consent form in use in endoscopy for a specific procedure. The risks and benefits of the procedure were clear to read and allowed patients undergoing the procedure to give informed consent.

Surgery

- Evidence in a patient's record showed the consideration of relevant issues preoperatively in a cosmetic surgery case and included a two week cooling off period.
- Staff we spoke to showed limited understanding of the Mental Capacity Act. Nurses told us they would raise any concerns they had regarding a patient's capacity with the consultant. There was a dementia lead nurse and resources available at the local NHS trust for support if required.
- Staff we spoke to showed some understanding of deprivation of liberty safeguards (DoLs). There was no evidence of an update to the 2012 policy following the changes to legislation in 2014. This meant that the hospital might not have been following current national guidance. Policies were in place for the protection of vulnerable adults and deprivation of liberty including contact details for the safeguarding department at the local authority.
- There were no patients who lacked capacity or who were deprived of their liberty in the service during our inspection.

Are surgery services caring?

Good

We rated this service as good for caring.

Patients were supported, treated with dignity and respect, and were involved in their care. Feedback from patients, those close to them and stakeholders was positive about the way staff treated people. Patients were treated with kindness and were supported in decision-making. The patient satisfaction survey showed consistently high results and the percentage of patients that would recommend the hospital to family or friends was higher than the national average.

Compassionate care

- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The hospital incorporated the FFT into their patient satisfaction survey. The survey response rate was 48.6% - 68.5% between April and July 2015 with 96.6% - 99.7% of patients likely or extremely likely to recommend the hospital.
- Ward staff carried a bleep that made a sound and displayed the room number when a patient call buzzer was pressed. We observed staff responded to these promptly and patients told us they did not have to wait for a member of staff to attend the buzzer.
- Patients all gave positive feedback about all the staff. They told us they were always treated with dignity and respect and informed about every aspect of their care.
- Patients praised the compassionate care they received in the hospital. Two patients specifically mentioned the care they received from nurses in recovery was excellent.
- We observed staff treating patients as individuals and speaking in a polite and respectful manner in patients' rooms.
- We observed staff being sympathetic and addressing pain relief needs in a timely manner.
- We received written 18 feedback comments from patients at the time of inspection all of which provided positive feedback about the standard of care from all staff groups.

Understanding and involvement of patients and those close to them

- The pre-operative and admission assessments took into account individual preferences and any post-operative needs the patient may have. This meant that patients and their relatives/carers were involved in discharge planning and informed about their treatment.

Emotional support

- We witnessed staff interacting with patients in a supportive and reassuring manner, encouraging them to regain their independence in line with their post-operative progress.
- Relatives and carers told us they received support from staff and were able to visit or telephone at any time.
- The cosmetic surgery liaison sister was contactable via a pager to provide support to patients and staff when needed.

Surgery

Are surgery services responsive?

Good

We rated responsive as good.

Referral to treatment (RTT) data for April 2014 to July 2015 showed that the hospital met the target of 90% of admitted patients beginning treatment within 18 weeks of referral in February, March and May 2015. The most common reason why patients breached the 18 week treatment timescale was a lack of theatre capacity. The hospital reported 11 cases of unplanned transfer to another hospital between April 2014 and March 2015.

The facilities and premises were appropriate for the services being delivered. Patients and relatives/carers were listened to when they raised a concern and received a timely response. The service did not keep a log of informal complaints and there was no evidence of sharing learning from complaints with staff in the service.

Service planning and delivery to meet the needs of local people

- The hospital had an NHS contract under the Any Qualified Provider status and worked with the clinical commissioning group to provide this. The majority of primary referrals were directly commissioned through the NHS Choose and Book patient pathway.
- Demand for NHS services provided by the hospital was increasing and a second laminar flow theatre had been added to provide additional capacity.
- Future plans included the possibility of developing a purpose-built day case facility.

Access and flow

- There were 3,825 day case patients and 1,218 inpatients admitted to the hospital between April 2014 and March 2015.
- Eighty four per cent of day case surgery and 76% of overnight surgery were NHS patients.
- Referral to treatment (RTT) data for April 2014 to July 2015 showed that the hospital met the target of 90% of admitted patients beginning treatment within 18 weeks of referral with a dip in February, March and May 2015 to 88.3%, 88.1% and 85.2% respectively. The hospital director reported that these breaches were related to a lack of theatre capacity.
- The patients we spoke with did not have any concerns in relation to their waiting times, admission or discharge arrangements. One consultant raised a concern that there was a lack of capacity to take their admissions.
- The hospital provided a free walk-in clinic once a week for prospective cosmetic surgery patients.
- Data from July 2014 to July 2015 showed 19 patients were cancelled on admission. All of these were for clinical reasons.
- The hospital reported 11 cases of unplanned transfer to another hospital between April 2014 and March 2015. CQC assessed this to be worse than expected compared to the national average for one quarter. There was a hospital policy for unplanned transfer and staff were able to tell us the actions they would take in that situation.
- There were four unplanned returns to theatre between April 2014 and March 2015. Theatre staff participated in an on-call rota and clearly explained the process undertaken during an unplanned return to theatre. The explanations given were in line with the hospital policy we reviewed.

Meeting people's individual needs

- Staff told us they always tried to meet the needs of individual patients, for example in relation to their religious or cultural beliefs. Staff had a list of contact details to use when pastoral care was required for patients.
- The hospital had a limited number of patients whose first language was not English. Staff found that family members often wanted to act as an interpreter, but interpreters were available and staff told us how they would access them.
- As well as verbal information, patients received written leaflets about the hospital, their admission and their specific procedure or treatment. The hospital used EIDO Healthcare patient information leaflets. EIDO is an

electronic resource that provides up to date information leaflets for healthcare providers. Staff demonstrated how they could print these for patients on discharge and the hospital contact details were on the leaflet.

- British Association of Aesthetic Plastic Surgeons and British Association of Plastic, Reconstructive and Aesthetic Surgeons patient information was provided to cosmetic surgery patients. The leaflets provided up to date information from recognised professional groups.
- The hospital admitted patients living with a learning disability or dementia for day surgery; there was a dementia lead nurse on the ward and access to further specialist resources at the local NHS trust. Staff told us that a carer or family member would accompany the patient and we observed this was the case during our inspection. All services at the hospital were on the ground floor, this allowed equal access for people with a physical disability.
- The hospital arranged MRI and CT scanning (provided by an external contractor) for weekend sessions which were reported to be a popular option for patients
- Six out of the nine patients we spoke to told us staff offered a choice of food and regular drinks. The patients spoke positively about the quality of it.

Learning from complaints and concerns

- Information on how to make a complaint was contained in an information book in patients' rooms. It was not on display on the ward. One patient we spoke to did not know how to make a complaint but said they did not have any concerns.
- Ward managers told us they would listen to informal complaints to try and resolve them. The surgery service did not keep a log of informal complaints.
- Data submitted showed 21 formal complaints had been made to the hospital between January 2014 and June 2015. Ten of these complaints (48%) related to pre and post-operative care and post-operative complications. The matron and hospital director investigated complaints. Senior managers meetings and quarterly clinical governance meetings reviewed and discussed complaints.
- Mechanisms for cascading learning from complaints were unclear. Complaints were discussed at the Heads of Departments meeting and at the Clinical Governance Committee meeting but learning was not recorded. We found no evidence that senior staff shared the themes and lessons learnt from complaints.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement due to the lack of assurance that governance, quality improvement and risk management systems were working effectively. There was evidence of committee activity to monitor infection control, health and safety and clinical governance but limited evidence of identifying trends or opportunities to learn and change practice. Learning from adverse events was not referred to in the hospital risk management policies. There were no clinical risks related to surgery on the hospital risk register. The hospital provided data on cancelled operations for clinical reasons, unplanned returns to theatre and unplanned transfers to the local NHS trust. However, any risks identified through these events did not form part of the risk register.

There was no policy in place to ensure that the consultants working in the NHS provided documentary evidence of their most up to date appraisals and revalidation outcomes on a timely basis. The medical director was appointed in April 2015 and was taking steps to develop a centralised governance framework led by the board of directors.

There was no overarching vision and set of values for staff at ward level. There was little evidence of staff engagement; results from the 2013 staff survey were unknown although staff told us they felt morale had improved following a recent recruitment drive. Managers were seen to be approachable with an open door policy but there had been two ward team meetings for 2015. The hospital director had a clear vision for the hospital and led the strategy to increase the volume of NHS referrals and add cosmetic surgery to the services offered at St Hugh's Hospital.

Vision, strategy, innovation and sustainability for this core service

- There was not an overarching vision and set of values for the service; however, staff in theatre understood a day care unit or a dedicated ophthalmic unit formed part of the vision for future growth.

- The vision for endoscopy was a purpose built unit that would allow the service to grow and obtain joint advisory group on gastrointestinal endoscopy (JAG) accreditation.

Governance, risk management and quality measurement for this core service

- There was a governance structure in place with clinical governance, infection control and health and safety committees reporting to the medical advisory committee (MAC) and the senior management team.
- There was a clinical governance policy in place and terms of reference for the clinical governance committee. The terms of reference listed the clinical indicators that should be reported to the board. We examined a corporate governance scorecard that was submitted to the board of directors of the parent organisation. The scorecard covered activity data, clinical data, human resources data and serious complaints. The clinical data included infection control and unplanned transfers out, readmissions and returns to theatre, but the template did not include sections for "untoward occurrence reporting", length of stay data, patient satisfaction data, out of license use of medication, deaths or resuscitation data as per the terms of reference.
- The terms of reference required the clinical governance committee to review these data sets not less than quarterly. The committee met quarterly and a consultant surgeon (chair), the hospital director, matron and senior nurses from the ward, outpatients, endoscopy and theatres regularly attended these meetings. A consultant anaesthetist also attended but less regularly. The agendas covered medical device alerts, key performance indicator data, all adverse incidents (which included discussion of wound infections, unplanned transfers, readmissions and returns to theatre) and complaints.
- The outcome of the documentation audit of June 2015 was not discussed at the July clinical governance committee including the planned action to raise the concern around one consultant not recording risks on surgery consent forms. This practice was also noted during our inspection and reported to the hospital director.
- We reviewed minutes of the meetings and saw that there was no summary of trends or themes or identification of learning taken from the discussion of incident reports nor was there any discussion of Duty of Candour in the July 2015 meeting. There was also no discussion of clinical audit plans or activity. The medical director acknowledged there was a lack of coordinated speciality based audit. There was a plan to introduce this but the plan did not have a timescale. Two consultants we spoke to confirmed they did not collate or receive audit data of their outcomes at the hospital.
- We were not assured that information from the governance meeting was shared effectively, as staff were unable to tell us about the implementation of actions following a serious incident in January 2015. The consultant who was the chair of the clinical governance committee had recently left and plans were in development by the medical director and board of directors to develop a centralised governance framework.
- The chair of the medical advisory committee received the minutes of the clinical governance committee. The role of this committee in relation to clinical governance was to ensure compliance with clinical policies and procedures by consultant staff, advise the hospital director on the annual audit plan and on issues of non-compliance and inappropriate practice by the consultants. Between four and seven consultants attended the quarterly meeting from a variety of specialties. Clinical audit was not discussed in any of the meeting minutes reviewed and the review of clinical governance issues was limited but included anaesthetic cover, pre-operative assessment, cancellation of clinics and infection control. Consultant scope of practice was also discussed and it was planned to agree the procedures that could be undertaken at the hospital. The minutes did not refer to receipt of the clinical governance committee minutes.
- Incident reporting did not incorporate grading by level of harm and therefore there was no system in place for defining the impact of safety incidents and to enable learning. There was an action plan attached to the two 'serious incidents' (fall with harm and unexpected death) but no clear evidence of whether the identified actions were fully completed or followed up by the clinical governance committee or medical advisory committee.
- There were no clinical risks related to surgery on the hospital risk register. The hospital provided data on cancelled operations for clinical reasons, unplanned returns to theatre and unplanned transfers to critical

care. However, any risks identified through these events did not form part of the risk register. Senior staff we spoke to had limited understanding of the risk register. They explained that risk assessments were undertaken and reported at a quarterly risk meeting; however these were health and safety risk assessments.

- There was no policy in place to ensure that the consultants working in the NHS provided documentary evidence of their most up to date appraisals and revalidation outcomes on a timely basis. The parent organisation, Healthcare Management Trust had appointed a consultant anaesthetist working at the hospital as medical director for the organisation two days a week from April 2015. He was in the process of reviewing the medical management systems and rewriting the practising privileges process and policy.

Leadership of the service

- The hospital director had a clear vision for the hospital and led the strategy to increase the volume of NHS referrals and add cosmetic surgery to the services offered at St Hugh's Hospital. She worked closely with the matron and heads of service and met with them monthly for operational updates.
- The operational lead was the matron and managers of the ward, endoscopy unit and theatres reported to the matron. All the managers were experienced members of staff that had worked at the hospital for a number of years. One of the managers had formal leadership or managerial training.
- There was limited opportunity to develop leadership skills and competence through mentorship or benchmarking within the parent organisation as the other hospital owned by Healthcare Management Trust was located too far away for regular contact. Senior staff had connections with specialist staff in the local trust but there was a lack of emphasis on developing the skills to effectively manage quality and performance to meet the requirements of the NHS.

Culture of the service

- All staff told us the managers and hospital management team were visible, approachable and had an open door policy. Staff on the ward told us morale had improved over the last two to three months following a recruitment drive.
- Nurses that we spoke to felt comfortable to discuss any patient issues or concerns with the medical staff.

Public and staff engagement

- The patient satisfaction survey from January to July 2015 showed that feedback was positive. The monthly response rate varied between 37% and 69%. This was better than the England average response rate to the friends and family test (28%). The survey incorporated the friends and family test and asked for patient feedback in a wide range of areas including waiting times, communication, privacy and dignity, care and discharge processes. Results of the monthly patient satisfaction survey and thank you cards sent by patients and relatives were on display in the ward.
- A staff survey had been completed in 2013. Staff were unable to tell us the results from this, but staff told us they felt engaged and worked well as a team.
- The matron asked managers to set up team meetings; however there was no evidence of regular team meetings or future planned dates for team meetings on the ward or in the operating theatres. There had been two ward meetings in 2015.

Innovation, improvement and sustainability

- The cosmetic surgery service was set up to expand the range of services offered by the hospital and offered a free weekly walk-in consultation service.

Outpatients and diagnostic imaging

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

Information about the service

St Hugh's Hospital provided a range of outpatient and diagnostic imaging services. The services included audiology, cardiology, cosmetic surgery, dermatology, gastroenterology, general medicine, general surgery, gynaecology, oncology, ophthalmology, orthopaedics, pain management, rheumatology, urology, and ear, nose and throat. The hospital had an onsite X-ray department and used external services to provide CT and MRI scanning at the weekends via a portable scanner. An offsite contractor provided pathology services but this service did not form part of the inspection.

Patients attending St Hugh's Hospital were NHS patients who had been referred by their GP or who had booked through the 'choose and book' service, self-funding patients, or those patients covered by private medical insurance. The outpatient and diagnostic imaging department consisted of a reception desk, eight consulting rooms, two pre-operative assessment rooms, two waiting areas, a physiotherapy room, an X-ray waiting area, two changing rooms and two imaging rooms.

We carried out a planned inspection of St Hugh's Hospital outpatients and diagnostic imaging services over two days and revisited the service on an unannounced visit. During our inspection, we spoke with eleven patients, three family members, one consultant, three nurses, the departmental manager, the matron, one health care assistant, one radiographer, the maintenance officer, the business manager, three appointment clerks and two medical secretaries.

Summary of findings

We rated safe and well-led as requires improvement and caring and responsive as good. Staff escalated information about incidents and complaints to the management. There were also appropriate groups in place to discuss incidents. However, the system did not ensure that all staff had access to the outcomes of investigations, any lessons learnt, or information about what the department had done to make improvements to the service. We saw no information to confirm that a formal system was in place to ensure that complaints and concerns informed improvements in the service. There was also a lack of monitoring and audit of outpatient appointments to ensure the quality of the service.

There were gaps in staff training, including higher level child safeguarding and a lack of staff awareness of their role specific responsibilities in a business continuity incident. The hospital had not formally assessed or recorded nursing staff competencies. Staff told us that informal assessment and monitoring did take place. Within the departments, staff were not clear of the long term strategy for their department and for the hospital.

We found that there were areas of good practice, especially within the diagnostic imaging service, and patients we spoke with were happy with the service. Overall, staff told us that there was an inclusive culture and they were happy to work in the hospital. We also saw good examples of multidisciplinary team working, understanding and compassion to patients.

Outpatients and diagnostic imaging

There were governance systems in place and these linked to hospital wide health and safety, infection control and clinical governance committees. However, no system existed to provide feedback to staff in a formalised way. Staff were not involved in hospital wide strategies or encouraged to be leaders within the service.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement.

There was a lack of assurance that governance, quality improvement and risk management systems were operating effectively. However there was evidence that a review of governance arrangements had started prior to inspection. There was evidence of committee activity to monitor infection control, health and safety and clinical governance but limited evidence of identifying trends or opportunities to learn and change practice. Learning from adverse events was not referred to in the hospital risk management policies. Performance information was not reviewed and there were no quality or safety related risks for outpatients or the imaging department on the hospital risk register.

There were several gaps in staff training, including a lack of staff awareness of role specific responsibilities in a major incident. The outpatients and imaging department saw children but there was a lack of evidence of child safeguarding training within the department, with no member of staff having undergone Level 3 child safeguarding training. Managers reported that there had not been any safeguarding incidents within the departments in the past 12 months and staff confirmed this. However, there was a risk that the department would not appropriately address safeguarding issues due to the lack of higher level training for senior staff and the investigating officer/ safeguarding lead.

Incidents

- There were no never events reported by the hospital between April 2014 and the date of inspection. Never Events are serious incidents that are wholly preventable.
- Between April 2014 and June 2015, the hospital overall reported 88 clinical incidents. The incident reporting system did not facilitate reporting by specialty or level of harm. Incidents were graded as accidents or untoward incidents; where relevant, these incidents were not

graded in terms of severity of harm to the patient, such as no, low, moderate and severe harm. This grading is critical to measuring the quality of care and is critical to the implementation of the Duty of Candour.

- All staff we spoke to were aware of the policy for reporting incidents and were able to describe the process for reporting adverse events.
- There were no radiation related incidents in the past 12 months, such as incidents of exposure 'much greater than needed'. We saw that the department properly recorded all doses of radiation for each patient.
- Staff knew how to report incidents to matron using the incident reporting tool. The outpatient department manager and the staff on the units did not have a record of the incidents that occurred in their department. Staff informed us that they passed on the incident to matron once they had completed the incident form. Matron investigated the incident and passed the outcome through the departmental manager to staff on the units. Staff and the outpatient department manager told us that they shared such information verbally with staff during handover. There was no formal sharing of information or evidence to demonstrate that lessons learnt from incidents had been cascaded to all staff. Both the matron and the outpatient department manager agreed that their present methods did not provide evidence that sharing of information and the lessons learnt took place.
- We saw the last two sets of minutes of the Health and Safety and the Clinical Governance meetings. We noted that managers discussed incidents at the relevant meeting depending on the nature of the concern.

Duty of Candour

- The Duty of Candour is a legal duty on healthcare providers that sets out specific requirements that providers must follow when things go wrong with care and treatment. Incidents were not graded for level of harm which is critical to implementing the Duty of Candour and there was no evidence that the requirements of the Duty of Candour were included in the relevant policies or added to the staff training programme.
- The staff we spoke with had a good understanding of the broad principles behind the Duty of Candour. They described it as being open and honest, to admit to any mistakes and putting their efforts into making things right. However, there was no evidence of an understanding of the regulatory requirements behind the Duty of Candour and we saw no documented policy or process in place to ensure the hospital could comply with this requirement. This meant that patients might not receive an apology and information in line with the requirement of the regulation.

Cleanliness, infection control and hygiene

- The outpatient and imaging departments were visibly clean. We saw evidence of daily, weekly and deep cleaning programmes for the areas. The department completed monthly cleaning audits and we saw action points listed by the departmental manager. We noted the staff had completed actions in a timely manner. One of the actions was ensuring clinic trolleys were clean and free from dust; we saw this had been actioned during our visit.
- There were bottles of hand sanitizer in the outpatient reception area and X-ray waiting area. There were no posters or information displayed encouraging patients to sanitise their hands. The manager told us that the posters were removed when they had the department painted and had not been replaced.
- Staff working in the department were bare below their elbow as part of promoting infection control. The department performed monthly hand hygiene audits and the most recent audit in July 2015 showed 100% compliance. Hand sanitizer was also available to staff in all treatment and consultation rooms and was observed to be used.
- The hospital had an infection control committee. The hospital also had links with two local microbiologists and two infection control nurses; one from the community and one from an NHS trust hospital. Staff told us that this was to ensure they worked in partnership with other organisations and benchmarked their service. The hospital shared minutes of these meetings with us. This evidenced that issues were discussed and an action plan was developed and shared with the managers of the departments.
- The manager informed us that the outpatient department had a link nurse for infection control. They attended meetings and shared updates with other

members of the clinical team informally through handover and discussions. This meant there were no minutes or notes from the meetings available for us to look at. The staff on duty confirmed this.

- We saw evidence of infection prevention and control audits in the outpatient department. This occurred alongside a general environmental audit. The department completed the most recent audit on 6 May 2015. This showed an 85% compliance with the monitored infection control and environmental measures. The audit highlighted areas for improvement and we saw a written action plan in place to address these issues.
- The department did not carry out Patient-Led Assessments of the Care Environment (PLACE). PLACE was introduced in April 2013. It is a system for assessing the quality of the patient environment. The assessments apply to hospitals, hospices and day treatment centers providing NHS funded care.

Environment and equipment

- The hospital noted that the disabled toilet in the outpatient department was unsuitable for patients with disabilities. This was on the hospital risk register. We visited the disabled toilet and saw that this did now include appropriate handrails and support. The emergency call bell was in reach of patients on the toilet, but at a height that could have made it difficult for a patient to reach if they found themselves on the floor and wanted to call for attention.
- Storage of equipment in the outpatient department was on the hospital risk register. The matron and the manager of department told us that they have now made sufficient storage available by reorganising the storage and by using space elsewhere in the hospital. The department was free from clutter and was a safe working environment.
- We saw the local rules for the imaging department and they were located in the main X-ray room and on the mobile X-ray unit. These local rules were for the purposes of satisfying the requirement of Regulation 17(1) of the Ionising Radiations Regulations (HSE, IRR1999). This document describes the radiation protection arrangements for employees, patients, visitors and members of the public within the department. The department had protocols in place that complied with the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R.
- The diagnostic unit held a comprehensive list of all equipment currently in use. We saw that staff completed equipment performance reports annually. The last report was in August 2015. This report found that all equipment was fit for clinical use. Staff confirmed that equipment was in good working order.
- We saw that all diagnostic imaging equipment had routine quality assurance controls in place to ensure the equipment was safe to use.

Medicines

- St Hugh's Hospital did not have a dispensing pharmacy. Staff informed us that an external pharmacy service supplied and managed the medicines at the hospital under contract. Consultants prescribed medication and the patients used local pharmacies to purchase their medicines.
- FP10 prescription books were stored in the nurses' office in a locked cabinet. Nursing staff distributed these to clinic rooms on the morning of clinic and were collected when clinic was complete.
- The medicines fridge was locked and located in a locked treatment room. Staff monitored the fridge temperature on a daily basis and recorded this information. Fridge temperatures in August 2015 ranged from 3.5 - 4.2 degrees Celsius, which was within safe limits.
- The department manager told us that they stored medication in the fridge only on request from the doctors, for use by individual patients seen in the clinics. During our inspection, we saw disposable single dose units of eye drops, local anaesthetic and vaccines kept in the fridge. They were in date.
- We saw that each month there had been a visit from the external pharmacy representative to check the stock drugs and how they were stored. We did not see any audits on prescribing, ordering, managing and disposal of medication processes within the department. This meant management staff could not be assured that safe medicines management was taking place.

Records

Outpatients and diagnostic imaging

- Staff transferred patient medical records to the outpatient department on the day before their appointment. Staff checked records and stored them in a lockable cabinet in the nurses room. This room was also lockable. Staff transferred records to the nurse base room on the day of the appointment. Staff locked the room when they were not present so that patient information was safe and was only accessible to authorised people.
- Following each consultation, doctors completed dictations of their notes on tape in the outpatient department and passed the tapes and the patients' notes to the medical secretaries. We saw the medical records and the tapes stored safely in a locked room from where the medical secretaries worked.
- The hospital management team informed us that doctors saw all patients with appropriate medical records as the records were created at the hospital. They reported that the outpatient and radiology departments had not had any occasion in the last 12 months when there was delay in getting the full medical records from other NHS organisations prior to seeing patients. The medical, radiography and nursing staff we spoke with confirmed this; however we did not see evidence of audit activity to confirm this.
- We reviewed 10 sets of patient records. We found nursing records were legible and fully completed. The typed clinic letters clearly identified the doctor who had seen the patients and their personal identification. We found that handwritten clinic notes from consultants were hard to read and had not been appropriately signed and dated in line with General Medical Council (GMC) guidance. Depending on the nature of the referral, the patient may see more than one consultant and therefore it is essential to maintain an accurate audit trail.
- The hospital had recently installed an electronic system for storage of X-rays. The department had links to an image exchange portal. This meant that NHS providers were able to access and view the electronic records if they were part of the same system. Staff told us this was working well across the local health providers.
- Hard copies of the X-rays were stored securely and appropriately archived in the diagnostic imaging department. Reporting on x-rays was carried out by the external provider of scanning services.

Safeguarding

- The hospital had policies in place for the protection of vulnerable adults and children. These set out the actions staff should take in the event of them having concerns about the welfare of an adult or a child who may attend the hospital for consultation or treatment.
- The staff we spoke with were aware of the policies and explained the procedure to raise safeguarding concerns. They told us that they reported all concerns to the matron. They said the hospital director would investigate and they would receive feedback from the matron.
- Staff told us that they had all received adult safeguarding training and that the last date of training was 18 February 2015. The outpatient department manager and matron told us that all staff had attended training on this date. The records were not updated to reflect this.
- The outpatient and imaging departments saw children. Training records supplied did not refer to child safeguarding training. No staff in the hospital had undergone level two or level three child safeguarding training, including the hospital's nominated safeguarding lead. As an investigating officer, the nominated safeguarding lead should receive safeguarding training level three so that they are competent to investigate a safeguarding concern.
- The hospital did not have a policy for children not attending clinic appointments (DNA). Staff were not aware of potential safeguarding issues surrounding children not attending clinic appointments. Appointment booking staff explained that children who attended the department were routinely non-NHS patients who had their appointment booked by their parent. Given this, management staff told us that it was not felt that a DNA policy for children would be relevant. We did see that there were NHS patients under the age of 16 who had attended the outpatient department in

the past 12 months. We were informed and the records showed that there had not been any safeguarding referrals within the outpatient and the imaging departments in the past 12 months.

Mandatory training

- Matron and the manager told us that mandatory training modules were determined according to job roles and the frequency of the training depended on the hospital policy. For example, all staff received yearly fire safety training, staff handling food attended food safety training. The training programme was updated every two years.
- There was no designated lead for the training and development of all staff within the hospital. Therefore, there was no one responsible for carrying out training needs analysis of all staff and ensuring staff received appropriate training and development. Matron explained that she would be the training lead for nursing staff, with other relevant heads of department leading for their staff groups.
- The hospital maintained a staff training log. The log showed that not all staff had undergone all the required training. There was a category of training identified by the hospital as 'Update Training', which did not specify the topics covered. The manager informed us this was an annual training package that all staff at the hospital received. It included fire safety, customer services, health and safety and infection control. In addition, the clinical staff received resuscitation) and moving and handling training.
- In the outpatient and imaging departments there were ten staff employed. Six nurses, one health care support worker and three radiographers. We received data to show that all staff had completed fire training and nine out 10 of staff had completed resuscitation training and health and safety training. Eight out of ten staff had completed manual handling training and five out of ten staff had completed training in infection control and the Mental Capacity Act.
- We saw that all diagnostic imaging staff attended specific training for the legislative requirements for radiation protection. We also saw evidence that all diagnostic imaging staff completed a competency logbook before using the equipment.

Assessing and responding to patient risk

- Clinic consultation rooms had an emergency pull cord that allowed staff to alert colleagues to any concerns. Pulling a cord lit up a light outside the consultation room that other staff would see and could then attend. This also notified control boxes at reception and in the nurse base office.
- Emergency cardiac arrest bells were located in the two outpatient treatment rooms, with a further bell in the nurse base office. The hospital had a resuscitation policy that directed staff to go to either the treatment room or nurse base and push the emergency call bell to summon the arrest team. The arrest team consisted of a Resident Medical Officer (RMO), the nurse in charge and a registered nurse.
- Staff told us that the cardiac arrest team would bring resuscitation equipment from the hospital ward to the outpatient department.
- Staff informed us that if an emergency occurred in the outpatient department whilst a patient was waiting to see a consultant, in the absence of the consultant, they would contact the RMO to assess the situation.
- Staff were present in X-ray rooms and waiting areas and were ready to respond to patients who appeared unwell or who may need assistance.
- The diagnostic imaging department had an appointed Radiation Protection Advisor (RPA). Staff told us the RPA was supportive and they could ask for advice at any time. All relevant risk assessments were complete and up to date.

Nursing and other staffing

- The outpatient department employed a nurse manager, 4.5 WTE (whole time equivalent) nurses for clinics and pre-operative assessments, and a support worker.
- The outpatient department had low levels of staff sickness (less than 10%) between April 2014 and March 2015.
- The department did not have any vacancies, with the exception of an additional support worker who was due to start in post in October 2015.

Outpatients and diagnostic imaging

- The hospital had dedicated bank staff and the outpatient department reported no use of agency staff between April 2014 and March 2015.
- All professional staff within the outpatient and imaging department had their registration with their respective professional register checked as part of the hospital's recruitment process. We saw evidence of this when we checked staff files.
- The outpatient department did not utilise a specific safe staffing tool. Staff told us that the departmental manager decided safe staffing levels for clinics.
- Staff in the outpatient department routinely worked either an early shift (8.00am to 4.30pm) or a late shift (1.00pm to 9.00pm) during the week. Staff told us that additional 10.00am to 4.00pm shifts had been utilised in times of high demand and at the weekends.
- We saw evidence that staff recorded 'hours worked' to account for the time staff spent at work. They explained that on occasions when clinics finished early, they finished early and on occasions when a clinic ran over, they stayed on until all patients had left the department.
- The hospital had an induction training policy. This covered core training areas including; complaints, fire, adult and child protection, first aid, infection control and incident reporting.
- One staff member in the outpatient department who had been through the induction process in the past 18 months described this as being comprehensive. They felt it equipped them for their role.
- Staff within the diagnostic imaging department received a local induction and a hospital induction before starting work.
- There was 1WTE in the diagnostic imaging department staffed by part time radiographers. The department used bank staff on occasions to cover holiday, sickness and busy periods. Staff felt generally well supported but if the workload increased, there would be a need for more staff to cover theatres in particular.
- The outpatient department had low levels of staff turnover (less than 20%) for nurses and no staff turnover for health care assistants in 2014. A new support worker started in January 2015, but did not complete their probationary period and left the hospital in July 2015.

Medical staffing

- The hospital director informed us that all medical staff practicing within the outpatient department had their registration with the General Medical Council verified as part of the hospital's recruitment process. Most consultants employed at the hospital had their substantive posts in NHS hospitals, three undertook private work only.
- Information provided by the hospital showed that there were 80 doctors and dentists with practising rights under rules or privileges. Between April 2014 and March 2015, 29 consultants carried out over 100 episodes of care, 18 consultants carried out between 10 and 99 episodes of care and 33 consultants, nine or less episodes.

Major incident awareness and training

- The hospital had a business continuity plan in place. All staff we spoke with were aware of the plan. They also knew how to access this in the hospital intranet or in hard copy. All departmental staff with the exception of the manager told us that they would contact the bleep holder to confirm what they should do, but did not refer to interim actions in the event of a business continuity incident.
- The hospital played no part in local major incident planning or training; this was managed by the local NHS trust.

Are outpatient and diagnostic imaging services effective?

We inspected but did not rate effectiveness of the outpatients and diagnostic imaging services.

There was a lack of monitoring to ensure effectiveness of the service. There was no arrangement to audit patient files to ensure information recorded was accurate and that it was possible to track the staff who had contributed to the treatment. There was no policy in place to ensure that the consultants working in the NHS provided documentary evidence of their most up to date appraisals and revalidation outcomes on a timely basis and we found details for one indemnity policy and 17 (21%) medical staff appraisal records to be out of date at the time of inspection.

Outpatients and diagnostic imaging

Radiographers did have regular clinical supervisions and they kept records. However, managers did not formally assess nursing staff competencies in the outpatient department. Nurses did not have formal clinical supervision, although staff told us that informal supervision did take place but that this was not documented. Staff demonstrated good multidisciplinary team working. The service operated six days a week, Monday to Saturday to meet people's needs.

Evidence-based care and treatment

- During discussions with the manager and the matron, they provided examples of EIDO information sheets in use in clinic. EIDO Healthcare is a web-based resource that provides patient information leaflets and medico-legal e-learning resources for consent and clinical governance. Staff accessed this resource for procedure specific information in a number of languages. This was then printed and handed to patients in clinic.
- Staff told us that they referred to NICE guidance and updated themselves with new practices. They also told us that they received emails from matron on updates, which they shared amongst themselves during handover. They did not have examples of such updates to share with us during the inspection.
- Protocols were in place for all radiology examinations.
- Staff told us that they worked closely with their local NHS Trust to discuss any changes or updates required for X-ray procedures and protocols. This was a local arrangement rather than a formal system. Reporting was undertaken by the external provider of scanning services.

Patient outcomes

- The diagnostic imaging department collected all patient dose information and submitted them to the Radiation Protector Adviser Services for monitoring and benchmarking against national dose levels.
- Staff completed no further audits in the outpatients and imaging departments.

Pain relief

- Appointment staff told us that they asked patients to bring with them any medication they were taking, which included pain relief medicines. Therefore, patients were able to take their medication whilst waiting for consultation, as they needed it.
- If a patient became unwell due to a sudden onset of pain, staff explained that the RMO would be available to assess the patient and provide appropriate assistance.
- Staff told us if dressings or plaster casts caused any pain then nursing staff would assess the cause for the pain and take appropriate action. This would be in full consultation with the medical staff.
- The diagnostic imaging department held regular pain injection procedures under ultrasound guidance. Patients received a patient information leaflet the time of booking to explain the procedure, what to expect and any aftercare required.

Competent staff

- We were informed and saw evidence that all staff in the imaging department had regular clinical supervision and staff members held records. These records were used as evidence when staff applied for revalidation of their practice.
- All outpatient department staff had an up to date annual appraisal.
- Senior staff told us that clinical supervision did take place within the outpatient department. No records were kept to record this and staff told us that this was on an informal basis. The manager and nurses on duty spoke to us about them preparing for their professional revalidation and looking at formalising the supervisions.
- Patients said that they were confident about the staff capabilities and efficiency and had no worries.
- There was access to paediatric trained nurses at the local NHS trust if required.
- There were 80 doctors and dentists with practising rights under rules or privileges including three radiologists. The radiologists were employed by other NHS organisations. There was no policy in place to ensure that the consultants working in the NHS provided documentary evidence of their most up to date appraisals and revalidation outcomes on a timely basis. There was a database in place to monitor the

currency of indemnity insurance and appraisal details for all consultants. We found details for one indemnity policy and 17 (21%) medical staff appraisal records to be out of date at the time of inspection. The parent organisation, Healthcare Management Trust had appointed a consultant anaesthetist working at the hospital as medical director for the organisation two days a week from April 2015. He was in the process of reviewing the medical management systems and rewriting the practising privileges process and policy.

- The medical director stated that he had had good links and open dialogue with the medical director at the local NHS trust especially around fitness to practice issues. However there were no formal processes in place to contribute to the annual NHS appraisal process related to activity undertaken at St Hugh's Hospital. The hospital director took practice concerns to the chair of the Medical Advisory Committee who would take it up with the trust. Fitness to practice concerns were addressed by the relevant NHS trust. Once deemed competent by the trust, the consultant was allowed back to St Hugh's Hospital to practice.

Multidisciplinary working

- We saw medical staff, nursing staff, and radiology staff interacting within the department and discussing patient care. We noted a good team spirit amongst them.
- There was no formal MDT meeting or working group in place. Staff told us that owing to the small size of the department these interactions were more informal and occurred on an ad hoc basis.
- Patients told us that the departments ran very efficiently.
- Staff provided an example of MDT working. They explained that if a patient needed to have an x-ray, bloods taken and their wound re-dressed, once they arrive in the department, the nurses and the radiographers would work together so that the patient was seen promptly. They said if there was a delay in the X-ray department, they attended to wound dressing or would take blood to avoid unnecessary delays.

Seven-day services

- The outpatient and diagnostic imaging department was routinely open from 8.30am to 9.00pm, Monday to Friday. The department also offered Saturday appointments, from 8.30am. Management staff told us that any consultant could book a Saturday clinic if this was beneficial for their patients. The department closed on Sundays.
- An external contractor attended the hospital on Saturday and Sunday to provide MRI services and CT imaging services on alternate Fridays.

Access to information

- The hospital computer system contained access to all hospital policies electronically in a dedicated drive. All staff we spoke with said that these were easy to access.
- All staff we spoke with were aware that hard copy policies were also available on site and they could locate these.

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

- We saw evidence that people were supported by doctors and staff when making decisions about their treatment.
- Staff explained that during consultation the doctors explained: the procedure, why it was appropriate to undergo tests and any risks associated with the procedures to the patients before seeking consent.
- We looked at ten patient files and found patients had signed consent forms for procedures. However, in three files we found that the consent forms were signed by both patient and the doctor some months before the treatment took place, with no further evidence of reviewing the consent sought prior to treatment. This meant that there was a lack of evidence of any updates at the time of the procedure to ensure the agreed procedure was still appropriate. In these files, we also found examples of consent forms where the risk of the procedure had not been documented by the doctor to show that they had informed the patient, and it had been considered.
- We also noted that the doctors' hand written notes were difficult to read and signatures were not always supported by their GMC identification (ID) or a print of their name. This made it difficult to identify the advice given or treating doctor when reviewing the case files.

Outpatients and diagnostic imaging

- There was a consent policy in place but no reference to Fraser guidelines for consent for a child in the policy.
- Staff we spoke with had a good understanding of MCA. None of the staff we spoke with had experienced caring for someone who lacked mental capacity in the department. Management staff told us that 50% of staff working in the department had MCA training. Although staff understood the principles of lawful and unlawful restraint practices, they were not familiar with seeking authorisation for a deprivation of liberty.

Are outpatient and diagnostic imaging services caring?

Good

Caring in outpatients and diagnostic imaging service at St Hugh's Hospital was good.

All staff within the department demonstrated understanding and compassion. They interacted with patients and their visitors in a polite and respectful manner. They were helpful and friendly. Patients we spoke with said they felt involved in their care and treatment plans. Family members praised the attitude of staff. They said nothing was too much trouble for the staff.

We observed staff interaction and helpfulness. All grades of staff who spoke with us understood the impact a person's condition and ill health had on them and on those close to them. Staff appreciated that patients may be worried about their treatment and could find it difficult to understand what staff were explaining to them. To help with such situations staff were happy to spend extra time and explain treatments in detail and repeatedly until patients were satisfied.

Compassionate care

- The hospital did not use the Friends and Family Test for outpatients and had not performed an outpatient patient survey for approximately two years. This meant that the department did not have a formal way of measuring patient feedback.
- All patients we spoke with were happy with the care they received and felt well cared for by staff.
- We saw examples of good interactions between staff and patients in the outpatient and imaging department. Staff were polite, friendly and courteous.
- People were able to have staff to chaperone them in clinic if they wanted. We observed many patients attending with friends or family members; therefore, they did not require staff to chaperone them during our visit.
- Staff knocked before entering occupied clinic rooms showing respect for patient privacy and dignity.

Understanding and involvement of patients and those close to them

- All patients we spoke with felt involved in their care. Two patients we spoke with were accompanied by their partners. The partners reported being involved in the patients' care and being able to interact with staff.
- A patient told us that staff respected their wishes on whether or not they wanted their partner to accompany them into consultations.
- Patients having follow-up appointments told us that they received copies of letters sent between the hospital and their GP so that they understood the plan for their treatment. They also told us that they received details for the staff at the clinic if they needed any information.

Emotional and social support

- All grades of staff who spoke with understood the impact that a person's condition and ill health had on their wellbeing and on those close to them. Staff said that they gave people time to explain their worries and what they wanted to achieve by having the treatment. Staff appreciated that due to anxiety, people may find it difficult to understand what the doctor said. They told us that they were happy to repeat information without making the person feel awkward.
- Staff in explaining the processes also supported the family members and ensured doctors included them in the consultation if appropriate.
- Staff had access to support from different religious denominations and they were able to arrange contacts for patients and their families if required.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Good

Responsive in outpatients and diagnostic imaging service at St Hugh's Hospital was rated as good.

The hospital planned and delivered the service to meet the needs of local people. The main volume of referrals was from the local NHS trusts so people could choose to have treatment locally and the hospital met the target of 95% of non-admitted patients beginning treatment within 18 weeks. People's individual needs were considered when making appointments for the clinics and facilities and premises were appropriate for the services being delivered.

Lockers were available for patients to keep their valuables in when undergoing imaging and there was a loop system in the outpatient waiting area to help those with hearing difficulties; however we saw no facilities for children in the waiting areas such as toys or a dedicated waiting area. All staff we spoke with could explain how patients could raise a complaint.

Staff told us they made efforts to resolve concerns informally wherever possible. If this was not possible, patients could then receive a response under the formal complaint process. However, there was a lack of evidence to show complaints and concerns were used as an opportunity to make improvements in the service.

Service planning and delivery to meet the needs of local people

- We found the service used information about the needs of the local population to organise and plan the service. The staff informed us that they received referrals mainly through the local NHS hospitals and the clinical commissioning group (CCG) so that patients were seen and treated immediately.
- The hospital had adjusted the environment, such as the disabled toilet and suitable chairs for patents to sit safely and maintain comfort, as part of ensuring that the facilities and premises were appropriate for the services available.
- There was sufficient car parking available for people.
- We witnessed staff providing information about how to get to the hospital on the phone to a family member. Staff told us that with the appointment letter, they sent details of contact, the name of the consultant and directions to the clinic.

Access and flow

- The hospital met the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month between April 2014 and July 2015.
- The departments did not routinely record clinic appointment cancellations. This meant that the reasons for cancellations could not always be easily identified or monitored. The department held no records to show cancellations of clinics, but records were held of patients who had cancelled the appointments.
- The data supplied by the hospital showed that there were 1,155 patient cancellations, spread between 55 clinics, between 1 January 2015 and 28 August 2015. The hospital was unable to give us data on how many clinics were cancelled due to the unavailability of doctors.
- Staff told us that there were instructions displayed for patients to contact the staff at the reception desk if their appointment was overdue by 15 minutes. Staff had removed the notices during decoration and had not replaced them when we carried out the inspection. We observed staff informing patients that a clinic was running late and patients were happy to wait.
- Senior staff we spoke with did not believe that a Did Not Attend (outpatient appointment) policy was in place for outpatient clinics. Matron described that normal practice would be to provide two or three appointments before the treating consultant would contact the patient's GP.
- The department did not routinely monitor or audit Did Not Attend rates. On request, the hospital provided data to show that between 1 January 2015 and 28 August 2015 there had been 577 appointments where patients did not attend. The data had not been analysed to deduce the reason for non-attendance.
- We spoke with patients waiting for X-rays, they said that they had been before and staff were prompt and they did not encounter any delays.

Outpatients and diagnostic imaging

- We spoke to one patient who was unhappy that their appointment was rescheduled at short notice. They did not understand why this had been the case until they contacted the hospital and it was explained that this was due to a lack of theatre capacity.
- Two further patients said they were very happy with their experience in the outpatient department, but they did not always receive explanations around changes to appointments.

Meeting people's individual needs

- The department was clearly signposted and was easy to locate. Occupied clinic and treatment room doors had signs to show they were in use. We saw these in use by doctors during consultation to support patient privacy and dignity.
- The environment was welcoming, with complimentary hot drinks and water. Newspapers and magazines were available for patients to read in the waiting area and music played through built in speakers. Chairs in the waiting area were comfortable and in good repair. All chairs were of the same height. Most chairs had armrests, while some did not. This offered patients some choice of seating. Key lockable safe boxes were located in the two changing bays in the radiology department.
- The reception area was an open space, but patients did not discuss personal information except to confirm their name and the name of the consultant they had come to see.
- There were no leaflets or patient information available in the waiting areas for patients to pick up or take away from the department; however nursing staff told us that they printed patient information as required from the EIDO Healthcare website. This helped patients receive better understanding of the procedures and discuss with their family members, thereby reducing anxiety and maintaining consistency of information.
- The outpatient department had access to interpreter services. Staff told us that interpreters could be booked to attend in person if staff were aware of any language needs. Interpreter services were also available on the telephone if required. Health information leaflets were available in different languages to meet individual needs as required.
- The appointment booking staff highlighted that during booking they could find out if the person needed any additional facilities. This was a proactive process, as they had found patients did not always tell them if they had any disabilities or needed assistance. The outpatient department had a loop audio system to help people with hearing difficulties. Disabled toilet facilities were available and wheelchairs were available to assist in patient transportation.
- Senior staff explained that patients with learning difficulties, dementia, or patients in distress could wait in a separate waiting area or in a vacant consultation room. This would help to minimise any distress caused by waiting in the main outpatient area.
- There were no facilities for bariatric patients and staff explained that it was unlikely that they could be accommodated within the department.
- We saw no facilities for children in the waiting areas such as toys or a dedicated waiting area.
- People were able to gain contact through their GP with the community specialists such as the psychologists, continence advisor and pain control team.
- A system is in place to ensure self-funding patients were provided with a statement of the service being provided and the amount and method of payment of fees to avoid any misunderstandings.

Learning from complaints and concerns

- There were seven complaints received in the last 12 months about the outpatient and diagnostic imaging department. There were no trends or themes highlighted by these investigations.
- We looked at the outcomes of the investigations. We noted that there was a lack of evidence that complaints and concerns were managed as an opportunity to make improvements in the service. The complaint responses provided a response to their concern, but there was a lack of assurance in the complaint responses we saw that the matter was being addressed to prevent it happening again.

Outpatients and diagnostic imaging

- All staff we spoke with could explain how patients could raise a complaint. Staff told us they made efforts to resolve concerns informally wherever possible. If this was not possible, patients could then receive responses under the formal complaint process.
- A staff member told us that named staff were provided with feedback on complaints on a 1:1 basis.
- Complaints were discussed at the heads of departments meeting and at the clinical governance committee meeting but learning was not recorded.
- We did not see any formalised mechanisms in place to provide feedback from complaints to staff by means of regular agenda items on team meetings or staff communication. Staff passed complaints to the manager or matron. Unless implicated in the complaint, staff did not expect to have any further involvement or receive any feedback.
- A patient we spoke with who had concerns about changing their appointment was unaware of how to raise a complaint about the hospital. They said that they had spoken to staff and sorted it out.
- We saw no information about the complaint process on display within the outpatient department. However, there was information in the display box in the main reception area of the hospital and in the hardback hospital guide.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement due to the lack of assurance that governance, quality improvement and risk management systems were operating effectively. However there was evidence that a review of governance arrangements had started prior to inspection. There was evidence of committee activity to monitor infection control, health and safety and clinical governance but limited evidence of identifying trends or opportunities to learn and change practice. Learning from adverse events was not referred to in the hospital risk management policies. Performance information was not reviewed and there were no quality or safety related risks for outpatients or the imaging department on the hospital risk register.

The vision and values were not well developed and staff within the departments were not clear of the long term strategy for the department or the hospital. Staff understood their job role and were willing and committed to contributing to the future of the service; however staff were not encouraged to take ownership of actions to improve quality. The culture within each department was seen as inclusive by staff and they felt supported by senior managers. Management said that they did not have mechanisms for formal public engagement or staff engagement due to the small size of the departments. However, they said they were visible and sought public comments when they had the opportunity.

Vision and strategy for this service

- There was no formal long term strategy for the diagnostic imaging department. Staff told us there was a planned refurbishment programme in place; this had not yet begun in the imaging department.
- The outpatient department staff were not aware of the organisational vision, values or its strategy. They said that they were informed of changes in meetings with the director of the hospital. Staff said refurbishment had commenced in their department, but they were not aware of the expected progress or when it was to complete.
- Staff said that they understood their job roles and how they fitted into the quality and safety aspects of the hospital strategy. This was discussed at informal meetings between the staff and the manager.
- Whist speaking with staff we noted that staff were very willing and committed to their jobs. However, they were not clear about the vision and the values for the hospital, or what the top priorities were for their areas.

Governance, risk management and quality measurement

- There was a lack of assurance that governance, quality improvement and risk management systems were operating effectively. There was evidence that a review of governance arrangements had started prior to inspection but this was at an early stage.

Outpatients and diagnostic imaging

- There was evidence of committee activity to monitor infection control, health and safety and clinical governance but limited evidence of identifying trends or opportunities to learn and change practice. Learning from adverse events was not referred to in the hospital risk management policies and there were no service quality or safety related risks for outpatients or the imaging department on the hospital risk register. Incident reporting did not incorporate grading by level of harm and therefore there was no system in place for defining the impact of safety incidents.
- Performance information was not reviewed. For example, there were 1,155 cancellations by patient, spread between 55 clinics, between 1 January 2015 and 28 August 2015. However the hospital was unable to give us data on how many clinics were cancelled due to the unavailability of doctors.
- There was a full set of radiation protection policies and procedures in place and we spoke with the hospital Radiation Protection Supervisor (RPS) for the department. They had the relevant knowledge and skills to undertake this role appropriately and attended regular training. We saw evidence of their recent attendance certificate.
- We reviewed minutes of the clinical governance committee meetings and saw that there was no summary of trends or themes or identification of learning taken from the discussion of incident reports nor was there any discussion of Duty of Candour in the July 2015 meeting. There was also no discussion of clinical audit plans or activity. The medical director acknowledged there was a lack of coordinated speciality based audit. There was a plan to introduce this but the plan did not have a timescale. The consultant who was the chair of the clinical governance committee had recently left and plans were in development by the medical director and board of directors to develop a centralised governance framework.
- Clinical audit was not discussed in any of the medical advisory committee meeting minutes reviewed and the review of clinical governance issues was limited but included cancellation of clinics and infection control. Consultant scope of practice was also discussed and it was planned to agree the procedures that could be undertaken at the hospital.
- There was no policy in place to ensure that the consultants working in the NHS provided documentary evidence of their most up to date appraisals and revalidation outcomes on a timely basis. The parent organisation, Healthcare Management Trust had appointed a consultant anaesthetist working at the hospital as medical director for the organisation two days a week from April 2015. He was in the process of reviewing the medical management systems and rewriting the practising privileges process and policy.

Leadership of service

- The hospital director had a clear vision for the hospital and led the strategy to increase the volume of NHS referrals and add cosmetic surgery to the services offered at St Hugh's Hospital. She worked closely with the matron and heads of service and met with them monthly for operational updates. The operational lead was the matron and managers of outpatients and diagnostic imaging reported to the matron.
- The outpatient and the diagnostic imaging departments were represented at senior management level within the hospital. We saw minutes of meetings and staff from the departments attended the Health and Safety Committee and the Heads of Department meetings. There was a clear management structure and nursing staff were aware of their line managers. They felt supported and said that senior staff were always accessible.
- During our inspection, we noted that staff were not encouraged to take responsibility or develop leadership skills by their line managers. Staff told us that issues that would be reported to senior staff but we saw no evidence that staff were encouraged to find the solutions themselves.
- Diagnostic imaging staff told us they felt well supported by the senior management team. They said they always had an open door policy. They also said they had received excellent support during the recent change to PACS (Picture Archiving and Communications System). PACS enables X-ray and scan images to be stored electronically, and viewed on screens.

Culture within the service

- Staff within the diagnostic imaging department and the outpatient were welcoming, friendly and willing to speak with us about their jobs and the departments.
- Staff talked about their colleagues with great respect; they were very complimentary about all the staff within the hospital and said it was a great place to work. They said most staff had been working there for a number of years and they saw the culture as inclusive and supportive.

Public engagement and staff engagement

- Staff told us that they did not carry out any formal patient satisfaction surveys and therefore they did not have feedback comments from patients.
- Patients we spoke with said that they were satisfied with the treatment and care. Those referred by the NHS praised the atmosphere of the department and the friendliness and the timeliness of the care in the department.
- The matron and the departmental manager told us that the last survey they carried out was in 2013 and that they had no up to date information. They said that they engaged with patients and visitors by being visible in the department and listened to people' comments and answered questions.
- Staff told us that they were able to speak to the manager and the matron if they wanted to. They said that they could not remember the last time they had any formal satisfaction survey from the management of the hospital. Both the manager and the matron confirmed this.

Innovation, improvement and sustainability

- The appointment and admission staff informed us that they attended meetings with their departmental manager and the director of hospital. They had reviewed their performance and discussed changes to improve their efficiency. As part of this, they had developed the medical secretary pool. This had helped to divide the workload amongst staff, prioritise the work and type-up medical notes immediately.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that all staff receive the appropriate level of child and adult safeguarding training in relation to their role and responsibilities.
- Ensure that all staff receive the mandatory training identified as appropriate for their roles.
- Ensure that venous thromboembolism (VTE) risk assessment and interventions are consistently applied.
- Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
- Ensure that all staff have an understanding of Regulation 20: Duty of Candour and how this is applied. Additionally the hospital must have systems in place to comply with this regulation.
- Have effective systems in place which enable the hospital to assess, monitor and mitigate the risks relating to the health and safety and welfare of people who use the service.
- Ensure that staff document consent in line with national guidance from the General Medical Council and Royal College of Surgeons.
- Document and implement pre-operative assessment guidelines, including anaesthetic risk thresholds, in line with national guidance.
- Ensure that all care pathways, risk assessments and care planning documents are based on current evidence and national best practice guidance.
- Ensure staff follow policies and procedures about managing medicines, including prescribing and documentation of administration.
- Ensure that appropriate audit and data collection take place within the outpatient department to monitor service quality and ensure that this information is used to drive improvements.

Action the hospital SHOULD take to improve

- Strengthen the recording and monitoring systems for mandatory training attendance and clinical supervision.
- Ensure that nutritional screening is implemented.
- Ensure that written medical records are legible and in line with national guidance from the General Medical Council.
- Review the consent policy to include reference to guidelines for children.
- Ensure that a Did Not Attend (outpatient appointment) policy is in place.
- Consider ways to promote leadership and innovation from all staff.
- Develop and launch a vision and set of values for the hospital staff.
- Consider further participation in national audits to monitor and benchmark patient outcomes

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(1)(2)(c)(g)** • The hospital must ensure that all staff receive the appropriate level of child and adult safeguarding training in relation to their role and responsibilities. • The hospital must ensure that all staff receive mandatory training identified as appropriate for their role. • The hospital must ensure that there are effective systems in place for access to current appraisal and revalidation outcomes for practising medical staff. • The hospital must ensure staff follow policies and procedures about managing medicines, including prescribing and documentation of administration.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(a)(b)(c)** • The hospital must ensure that venous thromboembolism (VTE) risk assessment and interventions are consistently applied • Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.

This section is primarily information for the provider

Requirement notices

- The hospital must have effective systems in place which enable them to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.
- The hospital must ensure that staff document consent in line with national guidance from the General Medical Council and Royal College of Surgeons.
- The hospital must document and implement pre-operative assessment guidelines, including anaesthetic risk thresholds, in line with national guidance.
- The hospital must ensure that all care pathways, risk assessments and care planning documents are based on current evidence and national best practice guidance.
- The hospital must ensure that appropriate audit and data collection take place within the outpatient department to monitor quality and ensure that this information is used to drive improvements

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **Regulation 20** **The hospital must ensure that all staff have an understanding of Regulation 20: Duty of Candour and how this is applied. Additionally the hospital must have systems in place to comply with this regulation.**