St Hugh's Hospital

Quality Report

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

Ratings

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

Overall summary

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

CQC carried out a comprehensive inspection of St Hugh's Hospital in August 2015 where it rated the hospital as requires improvement overall and issued requirement notices in regard to compliance with Regulation 12: safe care and treatment, Regulation 17: good governance and Regulation 20: duty of candour. CQC also carried out a focussed inspection in response to information received about the endoscopy service in November 2016. This was also rated as requires improvement overall and further requirement notices were issued in regard to compliance with Regulation 17: good governance and Regulation 18: staffing. The provider put action plans in place, which had been implemented by the hospital and monitored by CQC.

We carried out an inspection on 22 and 23 August 2017 using our focused inspection methodology. A focused inspection differs to a comprehensive inspection, as it is more targeted looking at specific concerns rather than gathering a holistic view across a service or provider.

Summary of findings

In our comprehensive inspections, to get to the heart of patients' experiences of care and treatment we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well led?

Focused inspections do not usually look at all five key questions; they focus on the areas indicated by the information that triggers the focused inspection. Although they are smaller in scale, focused inspections broadly follow the same process as a comprehensive inspection.

We carried out this focussed follow up inspection in order to ensure the provider had taken action to comply with the regulations. At this visit, we inspected the safe, effective and well-led domains in surgery and the safe and well led domains in out patients and diagnostic imaging services. We found there had been some improvements made; however, there was still more work to do.

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

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

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

We rated the hospital as requires improvement overall. with surgery rated as requires improvement and outpatients and diagnostic imaging rated as good.

We rated the hospital as requires improvement because:

- Although there had been improvements there had been a period of time since the last inspection where change had not been implemented and some of the issues raised at the 2015 and 2016 inspections remained a concern. For example, we found medicines management and record keeping was not in line with required standards, some staff did not have evidence of required competencies, there was limited evidence of nutritional screening in the clinical records, staff continued to use different pain assessment scoring systems to assess pain levels and some care pathways did not reference national or professional guidance.
- We had significant concerns about the management of medicines. Prior to the inspection the hospital provided copies of reports completed by the external pharmacy company and the hospital's own medicines audit. These did not provide assurance that robust checks were being performed.
- Some staff in theatre were performing a surgical first assistant role (SFA) which was outside their competency level and job description. This meant the hospital was not meeting the requirements of the Perioperative Care Collaborative (PCC) position statement on surgical first assistants (2012).
- There was limited evidence that the hospital's practice met the World Health Organisation (WHO) surgical safety standards.
- Senior staff and the leadership team did not appear familiar with the national safety standards for invasive procedures (NatSSIPs) and the local safety standards for invasive procedures (LocSSIPs) and practice in relation to safety standards differed across departments. Providers of NHS funded care must be compliant with these safety standards.
- The medical and nursing care records we reviewed in surgery and inpatients were not completed in line with professional standards or the hospital's policy.
- The hospital had introduced a new process to review policies to ensure that they contained the most relevant guidelines and current legislation. The senior management team could not confirm how many policies were left to review and update and identified that they had chosen the policies to complete first on a risk basis.
- In theatre some of the protocols and policies stored in a folder were out of date for example the Association of Anaesthetists of Great Britain and Ireland (AAGBI) anaphylaxis guidelines. We were not assured the folder was updated with the latest policies and guidance.

Summary of findings

- Work needed to be embedded for local leaders to take ownership of department audits and for clinical staff to be accountable when audits were consistently not met.
- Staff in theatre showed an awareness of safety and risk; however, this was not mirrored or evident on the ward.
- Some staff we spoke with were not aware of the principles of the duty of candour.
- The mandatory training performance for some departments was worse than the hospital target.
- Information up to August 2017 showed that 65% of ward staff had completed Deprivation of Liberty Safeguards (DoLS) training.
- At the time of the inspection there was no formal competency framework for staff on the ward to follow, some specific competencies were due to be introduced.
- Cleaning products, such as chlorine tablets and cream cleanser were not stored securely.

However;

- The hospital had taken action on some of the issues that were raised in the 2015 and 2016 inspections. For example, an electronic reporting system had been implemented, patient-led assessments of the care environment (PLACE) were carried out and clinical hand wash sinks had been fitted, the hospital had introduced a quality dashboard, a system was in place to record when staff had completed training, the hospital had a vision and set of values, risk registers and department team meetings were in place.
- The senior management team at the hospital had been restructured and strengthened to include two new posts. We saw that this team's leadership had developed and changed practice within the hospital in a short period of time, implementing systems and processes to support governance in the hospital.
- Staff felt valued, enjoyed coming to work at the hospital and held the senior leadership team in high regard.
- The hospital had a freedom to speak up guardian in post and the culture of the service encouraged candour, openness and honesty to promote the delivery of quality treatment and to challenge poor practice.
- Staff within the theatre team had changed and a theatre and deputy manager had been appointed. All staff we spoke with in theatre were positive about the culture and new leadership in the department.
- The hospital reported no never events and one serious incident between January and December 2016.
- The hospital had no hospital acquired infections and a low surgical site infection rate.
- Staffing needs were based on acuity of patients and reviewed daily to ensure safe staffing.
- The pre-assessment of patients had much improved. The hospital produced a guideline for the pre-assessment of patients prior to surgical intervention. This document was based on national evidence based best practice to ensure that all patients were appropriately risk assessed as being suitable for surgery at the hospital. This had resulted in a lower cancellation rate when patients were admitted for an operation.
- The hospital had a dedicated care pathway for endoscopy procedures, that contained appropriate references to national guidance and evidence based best practice.
- All staff in theatres, ward and endoscopy had completed an appraisal.
- All consultants had to meet the criteria set out in The Healthcare Management Trust (HMT) hospitals practising privileges policy to be granted authorisation by the medical director to undertake the care and treatment of patients in the HMT hospitals. Processes had been put into place for medical staff to follow such as a consultants cancellation policy.
- The hospital had worked to improve the engagement with patients and other stakeholders.

Following this inspection, we told the provider that it must take some actions to comply with the regulations

Summary of findings

and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices. Details are at the end of the report.

On 15 September 2017 we served a warning notice under section 29 of the Health and Social Care Act 2008. The warning notice related to Regulation 12, (1)(2)(g) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The warning notice requires the provider to take action to ensure systems and processes are established to ensure the proper and safe management of medicines. We have given the provider three months to make the necessary improvements.

Ellen Armistead.

Deputy Chief Inspector of Hospitals (North Region).

Summary of findings

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Services we looked at
Surgery, outpatients and diagnostic imaging

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Background to St Hugh's Hospital

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

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

The hospital has had a registered manager in post since October 2010. A new manager was appointed in November 2016 and registered with the CQC in June 2017.

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

Our inspection team

The team that inspected the service comprised a CQC manager, Tracy Church, three CQC inspectors, and specialist advisors with expertise in governance, outpatient services, surgical and operating theatre nursing and clinical surgery. The inspection team was overseen by Lorraine Bolam, CQC Head of Hospital Inspection.

Information about St Hugh's Hospital

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

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures (17 December 2010)
- Surgical procedures (17 December 2010)
- Treatment of disease, disorder or injury (17 December 2010).

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (June 2016 to June 2017)

There were 5,918 inpatient and day case episodes of care recorded at the hospital in the reporting period; of these 84% were NHS funded and 16% were other funded (insured and self-pay).

The five most common procedures performed which accounted for visits to theatre were phacoemulsification of cataract, knee replacement, hip replacement, arthroscopic operation on the knee and primary inguinal hernia repair.

There were 19,339 outpatient total attendances (including follow up appointments) in the reporting period; of these 64% were NHS funded and 36% were other funded (insured and self-pay).

At the 1 January 2017 there were 77 consultants including surgeons, anaesthetists, physicians, and radiologists who worked at the hospital under practising privileges. Two resident medical officers (RMO) worked on an alternate weekly rota. The hospital employed 27.4 whole time

Summary of this inspection

equivalent (wte) registered nurses, 15.6 wte health care assistants and operating department practitioners and 63.6 wte other staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (January to December 2016):

- No never events.
- One serious incident.
- There were 102 clinical incidents of which 82% (84 incidents) occurred in surgery or inpatients and 18% (18 incidents) occurred in outpatient and diagnostic imaging services. Out of the 102 incidents 8% were categorised as no harm, 64% as low harm and 28% as moderate.
- There were five non-clinical incidents of which none occurred in surgery or inpatients and outpatients and diagnostic imaging services. They all occurred in other services.
- No incidents of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile (C.diff) or E-coli.
- Ten unplanned returns to the operating theatre.
- Nineteen unplanned readmissions.
- Fourteen unplanned transfers to an NHS hospital.

Services accredited by a national body:

- Operating theatres - the association for perioperative practice.

Services provided at the hospital under service level agreement:

- Instrument decontamination.
- MRI and CT scanning.
- RMO provision.

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records, and results of surveys and audits. We requested information from the local clinical commissioning groups. We placed comment boxes at the hospital before our inspection, which enabled patients to provide us with their views. We received 26 completed comments cards from patients.

We held four focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team, medical director and the chair of the clinical governance committee. We spoke with a wide range of staff, including nurses, the resident medical officer, radiographers and administrative and support staff. We observed care in the outpatient and imaging departments, in operating theatres and on the ward, and we reviewed 17 patient records and 14 medicines charts. We visited all the clinical areas at the hospital.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We had concerns about the management of medicines. Prior to the inspection the hospital provided copies of reports completed by the external pharmacy company and the hospital's own medicines audit. These did not provide assurance that robust checks were being performed.
- Cleaning products, such as chlorine tablets and cream cleanser were not stored securely.
- Some staff we spoke with were not aware of the principles of the duty of candour.
- The mandatory training performance for some departments was worse than the hospital target.
- The medical and nursing care records we reviewed in surgery and inpatients were not completed in line with professional standards or the hospital's policy.
- There was no evidence that the hospital's practice met the World Health Organisation (WHO) surgical safety standards.There was no evidence that the radiology department was cleaned regularly.

However,

- The hospital reported no never events and one serious incident between January and December 2016.
- Staff knew how to report incidents.
- The hospital had no hospital acquired infections and a low surgical site infection rate.
- Staffing needs were based on acuity of patients and reviewed daily to ensure safe staffing.
- The pre-assessment of patients had much improved and this had resulted in a lower cancellation rate when patients were admitted for an operation.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Some staff in theatre were performing a surgical first assistant role (SFA) which was outside their competency level and job description. This meant the hospital was not meeting the requirements of the Perioperative Care Collaborative (PCC) position statement on surgical first assistants (2012).

Summary of this inspection

- At the time of the inspection there was no formal competency framework for staff on the ward to follow, some specific competencies were due to be introduced.
- The care pathways for minor procedures and day case or short stay patients contained all the relevant paperwork required for the patient however; there was no references to national guidance.
- The hospital had introduced a new process to review policies to ensure that they contained the most relevant guidelines and current legislation. The senior management team could not confirm how many policies were left to review and update and identified that they had chosen the policies to complete first on a risk basis.
- In theatre some of the protocols and policies stored in a folder were out of date for example, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) anaphylaxis guidelines. We were not assured the folder had been updated with the latest policies and guidance.
- Record keeping audits showed that compliance with staff ensuring that a pain score was in place, utilised and evidence that patients' pain was well controlled was variable with the overall compliance being 66% between January 2017 and June 2017.
- Record keeping audits for the ward area showed 56% of patients had a nutritional risk assessment completed. From February to June 2017, the section on the audit was marked as not applicable for all patients.
- Information up to August 2017 showed that 65% of ward staff had completed Deprivation of Liberty Safeguards (DoLS) training.

However,

- The hospital produced a monthly clinical quality dashboard which was shared with staff, the Healthcare Management Trust (HMT) board and stakeholders.
- All staff in theatres, ward and endoscopy had completed an appraisal.
- The hospital produced a guideline for the pre-assessment of patients prior to surgical intervention. This document was based on national evidence based best practice to ensure that all patients were appropriately risk assessed as being suitable for surgery at the hospital.
- The hospital had a dedicated care pathway for endoscopy procedures, that contained appropriate references to national guidance and evidence based best practice.

Summary of this inspection

Are services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- There had been a period of time since the last inspection where change had not been implemented and some of the issues raised at the 2015 and 2016 inspections remained a concern.
- Work needed to be embedded for local leaders to take ownership of department audits and for clinical staff to be accountable when audits were consistently not met.
- The audit systems and processes in place did not identify all the shortfalls in the completion of records, the WHO safer surgery checklist and medicines management.
- Senior staff and the leadership team did not appear familiar with the national safety standards for invasive procedures (NatSSIPs) and the local safety standards for invasive procedures (LocSSIPs) and practice in relation to safety standards differed across departments. Providers of NHS funded care must be compliant with these safety standards.
- The medical director had introduced a new process to manage practising privileges at the hospital. At the time of the inspection not all staff working under practising privileges had been reviewed using the new process.
- Staff in theatre showed an awareness of safety and risk; however, this was not mirrored or evident on the ward.

However;

- The senior management team at the hospital had been restructured and strengthened to include two new posts. We saw that this team's leadership had developed and changed practice within the hospital in a short period of time, implementing systems and processes to support governance in the hospital.
- Staff felt valued, enjoyed coming to work at the hospital and held the senior leadership team in high regard.
- The hospital had a vision and a set of values. We saw these were clear in the staff survey and quality accounts. Staff we spoke with were aware of the hospital values.
- Risk registers were in place and discussed at the heads of department meetings.The management team had had appointed five clinical advisors, consultants to represent the main specialities delivered at the hospital. A bimonthly clinical governance meeting was chaired by one of the clinical advisors.
- The hospital had worked to improve the engagement with patients and other stakeholders.

Requires improvement

Surgery

Safe	Requires improvement
Effective	Requires improvement
Well-led	Requires improvement

Summary of findings

Surgery was the main activity of the hospital.

Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated this service as requires improvement overall. We rated safe, effective and well led as requires improvement.

There had been a period of time since the last inspection where change had not been implemented and some of the issues raised at the 2015 and 2016 inspections remained a concern.

Some staff we spoke with were not aware of the principles of the duty of candour.

The mandatory training performance for the service showed compliance was predominantly worse than the hospital target.

The medical and nursing care records we reviewed were not completed in line with professional standards or the hospital's policy.

All the medicine charts we reviewed on the ward had some anomalies. Prior to the inspection the hospital provided copies of summaries completed by the external pharmacy company and the hospital's own medicines audit. These did not provide assurance that robust checks were being performed.

We reviewed World Health Organisation (WHO) surgical safety checklists and observed the process in theatre during our inspection. We found not all actions were completed appropriately in all three sections of the WHO checklist.

The hospital was not meeting the requirements of the Perioperative Care Collaborative (PCC) position statement on surgical first assistants (2012).

The hospital had introduced a new process to review policies to ensure that they contained the most relevant guidelines and current legislation. Some policies we reviewed had not been through new process and did not contain current information. The senior management team could not confirm how many policies were left to review and update and identified that they had chosen the policies to complete first on a risk basis.

Senior staff and the leadership team did not appear familiar with the national safety standards for invasive procedures (NatSSIPs) and the local safety standards for invasive procedures (LocSSIPs) and practice in relation to safety standards differed across departments. Providers of NHS funded care must be compliant with these safety standards.

The medical director had introduced a new process to manage practising privileges at the hospital. At the time of the inspection not all staff working under practising privileges had been reviewed using the new process.

However;

The service had reported no never events and one serious incident between January and December 2016.

The hospital produced a monthly clinical quality dashboard which was shared with staff, the Healthcare Management Trust (HMT) board and stakeholders.

The service had no hospital acquired infections and a low surgical site infection rate.

Staffing needs were based on acuity of patients and reviewed daily to ensure safe staffing.

Requires improvement

Surgery

All staff in theatres, the ward and endoscopy had completed an appraisal.

The hospital had produced a guideline for the pre-assessment of patients prior to surgical intervention. This document was based on national evidence based best practice to ensure that all patients were appropriately risk assessed as being suitable for surgery at the hospital.

The senior management team at the hospital had been restructured and strengthened to include two new posts. We saw that this team's leadership had developed and changed practice within the hospital in a short period of time, implementing systems and processes to support governance in the hospital.

Staff felt valued, enjoyed coming to work at the hospital and held the senior leadership team in high regard.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement**.**

Incidents

- At our inspection in August 2015, we found that incidents were not graded in terms of severity. There were no effective systems in place to confirm staff learned from patient safety incidents or that information was shared. We did not find evidence of thorough and robust incident investigations and there was a lack of evidence that action plans were completed.
- At this inspection, we saw that the hospital had implemented an electronic reporting system that allowed staff to record the severity of the incident. We spoke with staff who told us they were confident in using the system and they were encouraged to report incidents.
- Information provided by the hospital showed that 263 incidents were reported from January to September 2017. The majority of the incidents were classed as no harm with 4% classed as moderate harm. There were no incidents classed as a severe incident.
- We looked at seven incident reporting forms and saw they had been completed within 24 hours of the incident. The forms documented any recommendations and action taken, this included any lessons learned and if the incident needed to be shared. The form identified if any further investigation was required.
- We were told that the details of incidents reported in theatres were stored in a folder in the office so that all staff were able to see what had been reported. We saw evidence that incidents and near misses were discussed in the endoscopy team meeting minutes.
- Staff were provided with flow charts to support them to complete the incident form. The hospital created an incident reporting 'lessons learnt sheet' every two months which provided staff with generic themes of incidents rather than patient specific. We saw these on display around the hospital and staff we spoke with told us they found them useful.

- The hospital would complete a root cause analysis (RCA) investigation report for incidents that were reported as moderate harm or above where further investigation was required. RCA reports would always be completed for patients that had been transferred out of the hospital to another provider. The report provided a timeline of events, recommendations, action plan and arrangements for sharing learning. We reviewed seven RCAs and found the action plans to be complete, with a rating system.
- The Healthcare Management Trust had a policy about the duty of candour, which detailed the action staff should take. The duty of candour (DOC) is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Within the incident report it allowed for information to be documented in relation to DOC.
- The majority of staff we spoke to had an understanding of duty of candour; however more junior staff we spoke with were not aware of the principles of duty of candour. This was across both ward and theatre staff.
- There had been no never events reported between January and September 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital produced a monthly clinical quality dashboard which was shared with hospital staff members, Healthcare Management Trust (HMT) board and clinical commissioning groups (CCG). We saw evidence during our inspection of the latest clinical quality dashboard on display. Staff could tell us about the clinical quality dashboard and the findings within the report.
- The dashboard showed specific information for each area from March 2017 such as the inpatient ward, theatres or outpatients and identified if the hospital target had been achieved. These included audits, national quality indicators and incident reports.
- There were no catheter urinary tract infections, pressure ulcers and surgical site infections reported from January 2017 to July 2017.
- No hospital acquired venous thromboembolisms (VTE) were reported from January to July 2017.
- There had been 17 patient falls on the ward between January and July 2017. There had been one patient fall in January, March and June 2017. Two falls in April and May 2017, three falls in July and seven falls (one patient had four falls) in February 2017. Within monthly clinical quality dashboards a brief overview of the falls was given.

Cleanliness, infection control and hygiene

- At our inspection in August 2015, we found that the hospital did not carry out patient-led assessments of the care environment (PLACE). There were insufficient clinical hand wash sinks and sinks within the en-suite facilities did not meet the required national building standards (health building note 00-09). Hand hygiene audits identified 75% compliance, but did not contain timescales for improvement or evidence of progress.
- During this inspection clinical hand wash sinks had been installed in all patient rooms that met the required standards.
- The hospital had undertaken PLACE audits in May 2016 and August 2017. Details about the May 2016 audit were provided by the hospital, only two recommendations were required and these had been implemented.
- Information provided by the hospital showed that an infection control frontline ownership (FLO) audit was completed for the ward and endoscopy unit in February 2017 and March 2017. The results for the ward showed that six indicators were classed as inadequate, these included hand hygiene facilities at 75% and patient equipment at 72%. Two of the outcomes were at 100%. The results for the endoscopy unit showed that eight indicators were 100%, five indicators were classed as

moderate with the lowest at 85%. We saw hand hygiene audit tools completed for eight staff in April 2017, in five of these the correct hand washing techniques were not adhered to.

- Hand hygiene audits had improved over recent months. On the ward in June 2017 compliance was 95%; this had improved from February 2017 when compliance was 75%. Compliance had improved in theatre one; compliance in June 2017 was 89% compared to 76% in November 2016.
- Infection control audits for theatres identified that standards were not being met in June and July 2017. We saw that surgical scrub rates were at 75% and 88% for different practitioners. The actions taken identified that a new audit process, which was more in-depth, would commence in June 2017. However these results would not be published until the August 2017 clinical quality dashboard. Another action was a poster highlighting the scrub technique for visual prompts.
- We saw it had been highlighted, that consultants were not adhering to the correct scrub method, in the infection control committee minutes in June 2017.
- During our inspection, we observed six occasions where the staffs' surgical scrub technique was not performed in line with the Association for Perioperative Practice (AFPP) recommendations for safe practice.
- We saw that all staff wore appropriate personal protective equipment (PPE) whilst in theatre and on the ward. This included facemasks and hats that covered their hair whilst in theatre. We saw that hand sanitising gel was used by staff at appropriate times, after cleaning equipment and disposing of waste. Patients had their own individual equipment such as blood pressure cuffs to be used during their stay on the ward.
- Disposable cubicle curtains were in use in the recovery bays in theatre. It is recommended that disposable curtains are changed every six months or when visibly soiled. The curtains were dated August 2017 however; staff were unaware of when the curtains should be changed as this was deemed to be the responsibility of the porters.
- In theatre two, we found that the anaesthetic room was visibly clean and tidy. However; in the theatre room, the patient transfer slide was stored on the floor, this is not recommended as it means that patients are not protected from infection. We also found that some equipment was dusty including the diathermy machine, waste bag holder and trolley bowl stand. The suction machine was visibly contaminated with blood; these concerns were raised with a member of staff who addressed them immediately.
- The decontamination of surgical equipment was completed through a contract with an outside service. There was a decontamination lead within the hospital who was responsible for completing the verification checks.
- Surgical site infection rates for the hospital in 2016 were low (0.4%). We spoke with staff who reviewed patients post operatively and were assured that the hospitals processes for detecting and reporting post-operative infections were robust.
- There were no cases of hospital acquired methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA), clostridium difficile or escherichia-coli (E Coli) reported by the hospital between January 2017 and July 2017.
- An external company carried out testing of water on site for legionella bacteria to avoid cross infection to patients and the risk of developing legionnaires disease, a potentially life threatening pneumonia.
- We saw that infection prevention and control issues were discussed in the endoscopy team meeting minutes.

Environment and equipment

- At our inspection in August 2015, we found that 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. Servicing and safety testing records of 19 pieces of equipment in the ward identified that 84% did not have labelled evidence of service dates.
- During this inspection, the resuscitation equipment on the ward had been checked every day between 1 April 2017 and 21 August 2017, except for one day in July 2017.

- Information provided by the hospital identified that resuscitation trolley checks were audited each month. These showed that compliance from January to June 2017 was 90% or above, increasing to 100% in June 2017.
- Maintenance contracts and service level agreements were in place with external providers to service, maintain and repair equipment. The hospital had recently changed the external provider of the contract.
- We checked equipment on the ward and found that some items had stickers to indicate when it had last been serviced. However, we saw a number of items which had no evidence of servicing, for example in the ward store cupboard, there were 11 flotron machines, two had an out of date service sticker (December 2016 and July 2017), seven had no stickers to indicate the date of last service and three had stickers which indicated they were in date. We saw a further machine in a patient's room which also had no service sticker attached. We discussed this with the ward manager who advised that they were unsure about the servicing process.
- On the ward, we found that the door to the dirty utility room on the ward was not lockable. This room was used to store cleaning products, such as chlorine tablets and cream cleanser, which could be harmful if ingested. These items were in unlocked cupboards.
- Each patient room had oxygen and suction units at the bedside; we checked these and found that they were in date for routine servicing.
- We looked at the emergency equipment in theatres and found that the defibrillator was in date for servicing in line with manufacturers guidelines. The trolley was clean and had a label indicating that it had been cleaned the day before our inspection. We saw that the contents of the trolley were in date, for example, the emergency drugs had an expiry date of October 2017. However, we saw that laryngoscope blades were not in packaging therefore it would not be possible to track or trace these items; in addition, it was not clear if these items had been decontaminated. We also found that the trolley checklist did not reflect the contents and some items were in different drawers to the checklist. There was also additional items on the trolley which were not detailed on the checklist. We discussed this with a member of staff who advised that they would address these concerns.
- In theatres, there was a separate difficult intubation trolley, difficult airway society guidelines were attached to this trolley. The trolley was visibly clean and had a label to indicate when it was last cleaned. However, this trolley also held unpackaged laryngoscope blades; this was raised with a member of staff who advised they would address this concern immediately. There was no checklist for this trolley, we discussed this with a member if staff who advised that they were currently revising the contents of the trolley in line with national guidance and that a checklist would be implemented once this was completed.
- We checked the anaesthetic machine log book from June 2017 to the time of our inspection. There were some omissions, however, on checking we identified that the theatre was not used on those days.
- We found that theatres had a prosthesis recording log that was used to attach labels and record the prosthesis, implants, cements and screws. This log appeared to be complete and up to date.
- We saw that laminated copies of the resuscitation council guidelines 2015 were displayed. We also saw that the anaphylaxis and failed intubation guidelines were also displayed. We saw that Association of Anaesthetists for Great Britain and Ireland (AAGBI) guideline checklists were available for anaesthetic equipment.
- In theatre, we saw that substances that could be harmful to health were stored in a locked metal cupboard with a warning sign; this meant that staff were adhering to Control of Substances Hazardous to Health (COSHH) Regulations 2002.
- In theatre, we observed that staff labelled clinical waste with case number, date and theatre. This is in line with best practice guidance.
- We looked at equipment in the endoscopy unit and found equipment had been sterilised and stored correctly. The scopes were stored and validated within the appropriate timeframe.

- Disposal bins for needles and other sharps instruments were appropriately labelled in line with policy, in all areas we visited.
- Most items of equipment had labels attached indicating when it had last been cleaned. Regularly used equipment, such as patient observation machines were labelled as being cleaned on the day of our inspection. However, we saw that other equipment, such as a hoist, portable oxygen, patient warming device, bladder scanner and equipment stored in the storeroom (crutches, nebulisers and flotron machines) had labels which indicated that they had not been recently cleaned; some labels were dated 4 August 2017, which meant that the equipment had not been cleaned for 18 days. We found that the electrocardiogram machine, which had a clean label dated 4 August 2017, was visibly dusty. We spoke with the ward manager about cleaning schedules and were told that weekly schedules were being introduced.

Medicines

- At our inspection in August 2015, we found that the door to the medicine rooms on the ward was not locked. Prescription charts were pinned to the noticeboard in the unlocked medicines room. There was lack of assurance that staff recognised and investigated medication errors. Oxygen was not always prescribed on medication charts.
- During this inspection we looked at 14 medicine charts on the ward and all had some anomalies.
- We found three medicine charts written in blue pen, three charts did not have the date and time that the medicines were prescribed and three charts had medicines discontinued but these were not signed or dated to identify when this was completed.
- We found five charts where signatures for administration were missing or an 'X' had been completed instead of completing the approved code for non-administration. We found one chart where medicine had been administered on 23 August 2017, but was signed by the nurse on the wrong date.
- Oxygen was pre-printed on the medicine chart and there was evidence that this was prescribed by the doctors. However target oxygen saturation rates were not detailed. We found on nine charts oxygen was not signed by the nurses to identify that the patient had been given oxygen. The nurses had recorded on the patient observation chart and within the documentation when the patient was receiving oxygen. We discussed this with the ward manager. We only found one prescription chart where oxygen had been signed by a registered nurse; this was after it had been raised by the inspection team.
- Medicines which were written up as 'once only' were not always given on three medicine charts. When we asked about this we were told that these medicines were only given if needed, therefore they should have been written on the 'as required' part of the chart.
- We found two medicine charts where paracetamol had been prescribed orally, however in the nursing notes and other documentation it had been administered intravenously (IV). We discussed this with the ward manager at the time of inspection who assured us this would be looked into. We observed that IV had been added in different colour pen to medicine charts after this discussion, although no time and date had been recorded to identify when this had been completed. The ward manager identified that these would be documented as medicine errors, however, information provided by the hospital identified no medicine errors in August 2017.
- We looked at the controlled medicines register on the ward and found thirteen entries, between November 2016 and August 2017, where a number of patients had been administered controlled medicines by the same two members of staff in a short space of time. For example, we saw entries for seven patients, who had been administered controlled medicines by the same two staff members within 17 minutes in February 2017 and an entry in August 2017 where five patients had been administered controlled medicines in 18 minutes by the same two staff members. This would indicate that staff were not adhering to the HMT hospitals medicines management policy.
- We looked at the controlled drugs registers in theatre and found that staff completed daily checks of the controlled medicines stocks. We saw that all entries within the register were fully completed in line with policy.

- We checked the medicines storage cupboard outside recovery and found that stock was rotated within the cupboard. All medicines we checked were in date.
- We looked at the medicine fridge on the ward and found that temperature checks were not always recorded daily. For example, we saw seven gaps in April 2017, six gaps in May 2017, three gaps in June 2017 and one gap in July 2017. The checklist was fully completed for August.
- We looked at the medicine fridge in theatres and found that temperature checks were recorded daily. Staff members we spoke with were not aware of the safe temperature parameters for medicine storage however, they advised that they would raise any concerns with their manager.
- We saw in meeting minutes that medicine cupboards and areas had been left unlocked over the weekend. However we saw that access had recently been restricted to the room where medicines were stored on the ward, with a key card system. During our inspection cupboards containing medicines within the storeroom were locked.
- Information provided by the trust identified that 38% of staff had completed the medicine management training up to August 2017. We spoke with the senior management team who identified that they were implementing a medicines management competency booklet that all registered nurses would need to complete. This was due to be implemented and completed by December 2017.
- Prior to this inspection the hospital provided copies of summaries completed by the external pharmacy. These did not show evidence of checks against set criteria for a specific time period or the number of records checked but gave a summary for example 'the room temperature is well recorded' for endoscopy and 'controlled drug registers are always well organised' for the ward area. These documents were dated 'time period 2016/17'. These did not provide assurance that robust medicine checks were being performed.
- The hospital completed a medicine audit completed in 2017, which had included a review of 45 medicine charts. It did not identify if a set criteria of checks were completed for each chart. The report identified that the majority of the cards were legible, written correctly and legally completed. It did identify some anomalies with the charts such as not documenting maximum doses, strengths or directions; however it did not identify how many this affected. The action plan identified that the finding would be discussed with the registered medical officers (RMO). It was unclear if this had been discussed with all doctors that worked at the hospital.

Records

- At our inspection in August 2015, we found that records did not include individualised care plans and pre-operative assessments were not in line with national or best practice guidance.
- During this inspection we looked at 11 sets of nursing records and 10 sets of medical records and found these were not completed in line with professional standards. We found that documentation was not fully completed in nine sets of nursing records. In four records blank spaces were not scored through where staff had not written to the end of the line or page. In two records the documentation was not written in chronological order. This identified that information was written retrospectively. Some records did not always have the date and time recorded next to the entry. In one record the times spanned overnight into another day and the date was not recorded. We saw correction fluid used on one diabetic chart.
- We looked at four patient records used within endoscopy; an endoscopy care pathway had been completed. Information was recorded to identify the scopes that had been used and tracking and traceability was evident.
- Information provided by the hospital identified that records were audited monthly in each department. It identified that the compliance on the ward was at 72% in March 2017 and 70% in April 2017. The results had improved in May and June 2017 to 89% and 93%, but reduced to 86% in July 2017. The hospital had requested the Royal College of Nursing to provide documentation training and this was arranged to be completed in the next few months. In theatres, the monthly compliance rates between March and June 2017 varied from 59% in April 2017 and 98% in July 2017. June and July's percentages were between 95 and 100%.

- In endoscopy compliance with all aspects of the audit between December 2016 and July 2017 varied from 88% - 99%. With the exception of June 2017 the results improved each month.
- All staff were required to complete Information Governance training. The figure was not provided as separate departments; however overall compliance for clinical staff was 52% and non-clinical 88%.

Safeguarding

- All staff were required to complete safeguarding adult training. Training information up to August 2017 was provided showing that all clinical staff within the endoscopy team and 92% of theatre staff had completed the training. Only 55% of ward staff had completed the training, this meant that staff were not up to date with current safeguarding training.
- Most non clinical teams had completed safeguarding training with several teams reaching 100% compliance. The lowest compliance was 83% in the catering department.
- One staff member was required to be trained to level three for safeguarding adults and children; this staff member was up to date with the training.
- Staff we spoke with told us that they also completed level one child protection training. The hospital did not treat children; however, this meant that staff were trained to identify safeguarding concerns relating to children, if children were brought into the hospital.
- One staff member discussed they had safeguarding concerns and these were raised correctly. The appropriate meetings were held to support the individual with the safeguarding concern.
- We saw that the senior management team liaised with safeguarding services in relation to safeguarding matters. Safeguarding concerns were discussed in the endoscopy team meeting minutes.

Mandatory training

- The hospital had a system in place to record when staff had completed training; this was not in place at the inspection in 2015. A leaflet had been devised for all staff outlining their requirements and frequency of training.
- Resident medical officers (RMO) were not directly employed by the hospital. It was a requirement of the hospital that all RMO's completed mandatory training on employment and attended yearly refresher training. We saw that the current RMO's had received up to date mandatory training.
- Consultants with practicing privileges received mandatory training via their local NHS trusts. We reviewed seven staff files which showed that these were up to date or had been provided by the hospital for those consultants who were not employed by the NHS.
- Staff completed training such as fire, basic life support, manual handling, equality and diversity and health and safety.
- Information provided at the time of inspection showed that health, safety and welfare training overall for non-clinical staff was 93% and clinical was 80%. Clinical staff was broken down into areas which identified that endoscopy 100%, theatre staff 92% and ward staff 61%.
- Equality, diversity and human rights training rate overall for non-clinical staff was 83% and clinical staff was 76%. Percentages were 100% for endoscopy, 85% for theatre staff and 65% for ward staff.
- Manual handling training figures for non-clinical staff were 29% and 65% for clinical staff. Basic life support information was not provided for clinical staff but non clinical staff was 100%.
- Staff we spoke with told us that four staff in theatre were trained in advanced life support (ALS) and a further member of staff was due to complete the training. Staff said that there was always an ALS trained member of staff on duty.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- We reviewed 12 World Health Organisation (WHO) surgical safety checklists, eight were completed fully and four were not, this included the 'sign in', 'time out' or 'sign out' parts not being fully completed. Examples of these included: no signature under the 'sign out' part of the checklist and no indication if the anaesthetist could provide cover over the next 24 hours.

Requires improvement

Surgery

- Observation of the process in theatre during our inspection indicated that not all actions were completed appropriately in all three sections of the WHO checklist.
- We observed that staff used the WHO safety checklist for all patients. However in theatre we saw that three of the WHO checklists were completed in the reception area and the 'sign in' part was not read out as indicated on the form. This is not in line with national guidance. We observed that one consultant surgeon asked the staff member if the WHO checklist 'sign in' had been completed, which they replied it had been.
- We observed four 'time out's' of the WHO checklist; this was commenced before the start of the surgical procedure. This was verbalised appropriately and the steps followed accordingly.
- In two of the 'time out' parts of the checklist staff were busy organising equipment and not observing the silent focus. One staff member was not present during one of the 'time out' parts of the WHO checklist.
- On three occasions whilst observing the 'sign out' the team did not observe a silent focus. We saw that members of the team were performing duties such as skin preparation and connecting equipment whilst the checklist was being verbalised.
- However, we observed a two 'sign out' where the lead member of staff articulated all elements.
- We looked at four modified 'WHO' safety checklists for patients that attended endoscopy. These included a 'sign in' part that was to be completed before the patient was sedated and 'sign out' prior to any member leaving the room. All four checklists were completed fully.
- We observed comprehensive briefing sessions prior to surgery; this involved an introduction of team members including recovery staff. There was discussion regarding the order of the surgical list and a change in order to accommodate a patient that was diabetic. Staff fully interacted with the briefing and appropriate communication was observed.
- Information provided by the hospital identified that WHO surgical safety checklists were audited monthly. Compliance between January and July 2017 varied between 82% and 97% with no trend. For example compliance improved from 92% in January 2017 to 97% in February, this then reduced and improved again in April 2017 and reduced to 82% in June 2017. Latest figures for July 2017 showed an improvement in compliance to 97%. For endoscopy, overall compliance was 98% for data collated between January and July 2017 with 100% for four months.
- In endoscopy a debrief form was completed which included the consultant and anyone else in the room. We observed some of the forms and reviewed the information. Audits of the team brief identified compliance was between 99% and 100% from January to July 2017.
- Compliance for the debrief within theatres was between 96% and 99% between March and July 2017. We observed an instrument check in theatre. We saw that not all instruments were visualised by the members of staff performing the check. This meant that staff were not following national guidance which states that there should be visual and verbal confirmation of the instruments being checked.
- We saw that theatre staff used a white board in the theatre to record the use of instruments and swabs. In addition, staff also recorded tourniquet application times on the white board. We saw that a swab and instrument count took place at the end of a theatre case; this included a visual and verbal check.
- We saw that skin preparation solution was not always checked in line with best practice recommendations, as two members of staff did not check this visually.
- The hospital completed a VTE audit each month. This included between 10 and 20 records per month. Each month from January to June 2017, 100% of patients had a VTE risk assessment form in place. During our inspection VTE risk assessments were in place in the records we observed.
- We found that the hospital was auditing the completion of national early warning score (NEWS) in the ward area. Between October 2016 and June 2017 overall compliance with completion of the NEWS was 87%. The trend in compliance had varied being 94% in October and 96% in November 2017, this reduced to 73% in March and 64% in April 2017. However improvements had been seen in May and June 2017 with compliance at 96% and 99%.

Requires improvement

Surgery

- Information provided by the hospital identified that only 38% of staff had completed the NEWS training up to August 2017.
- The hospital had a revised policy in place for transferring patients who were critically ill. This had been sent to all consultant surgeons and anaesthetists. The hospital had highlighted that they had learnt lessons from reviewing a number of transfers and identified they did not always comply with Association of Independent Healthcare Organisations (AIHO) or AAGBI guidance. During our inspection we saw a patient being transferred to the local NHS trust, communication had taken place and the patient was accompanied by an anaesthetist.
- The hospital had a patients admission policy in place. Staff had access to 24 hour follow up post-surgery. Day surgery patients were provided with contact details.
- The hospital had a policy for administering blood and blood components and clinical guidelines for the management of transfusion reactions. However blood transfusion training figures for clinical staff was low at 34%.
- The guideline for the pre-assessment of patients prior to surgical intervention included reference to ensuring that two units of type specific blood was ordered for any patients who had a rare blood type.

Nursing and support staffing

- The hospital did not use an acuity tool to plan nurse staffing levels on the ward or in theatre. Staffing levels were based on forecasted activity levels, with senior staff considering the number of patients due to come in for surgery and the type of surgery they were having. Staffing was then flexed to meet these needs. We saw sufficient numbers of staff on duty. The ward manager had set days each week where they would be part of the nursing establishment.
- Information provided by the hospital showed that between January and December 2016, 11% of registered nurse (RN) shifts were covered by bank or agency staff on the ward.
- The average number of health care assistant (HCA) shifts covered by bank or agency staff on the ward during 2016 was 58%.
- For theatres the average bank and agency use to cover RN shifts was 52%.
- Theatre staffing was reviewed by the theatre manager and was in line with safe staffing as per the Association for Perioperative Practice (AfPP) guidelines 2014.
- We spoke with several agency nurses during our inspection and all had worked at the hospital for long periods of time on a continuous basis.
- The hospital had recently recruited new staff members and were currently advertising vacancies through NHS jobs which had generated more interest in the positions. The hospital was also working with local universities to recruit newly qualified nurses and apprenticeship schemes.
- At the time of inspection there were two scrub nurse and an endoscopy nurse vacancy. The hospital identified that the services covered shifts through bank and agency and no shifts had been left unfilled across the hospital.
- Handovers on the ward took place twice a day at shift changes, the ward manager told us that an extra handover would take place for staff that start at alternative times. We observed a nursing handover where night staff provided an update of the patients who had been on the ward overnight. This consisted of one registered nurse, RMO and healthcare assistant. Other staff on the ward did not participate in the handover as their focus was to provide support to patients arriving onto the ward for planned day and overnight surgery.

Medical staffing

- There were 77 consultants with practising privileges at St. Hugh's Hospital. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have been approved to practise there. New consultants would meet with the hospital director where a practising privilege agreement would be completed.
- Any practitioner applying for practicing privileges had to be licensed with and on the specialist register of the General Medical Council (GMC) and were required to demonstrate relevant clinical experience appropriate to practice in an independent clinic.

Requires improvement

Surgery

- We saw that since 2015, a process had been put in place to manage practicing privileges at the hospital. Thirty nine of the 77 consultants had gone through this process which was on-going at the time of our inspection.
- Staff we spoke with described the procedure for on-call arrangements for anaesthetists or surgeons out of hours. Surgeons were expected to provide 24 hour cover for their patients during their admission. Consultants were expected to be no more than 30 minutes away according to the terms of their practising privileges.
- Anaesthetists were required to be available to provide cover for the first 24 hours following the patient's surgery. In May 2017, a letter was sent to all consultant anaesthetists outlining a change of practice and the procedure they must follow if they were unable to provide cover for their patients for the 24 hour post-operative period. This was documented within the WHO checklist to identify alternative cover if the anaesthetist was unavailable.
- There was one Resident Medical Officers (RMO) onsite 24 hours a day, seven days a week. RMOs alternated one week on and one week off to cover the hospital. The RMO would predominately cover the surgical ward and provide a patient handover to the incoming RMO.
- An RMO 'call out' proforma was in place to monitor the number, type and duration of any RMO contact during the out of hours period and weekends. There was also a non-urgent communication book which the RMO reviewed twice a day.
- When the RMO and nursing staff needed to seek advice or support out of hours, they contacted the patient's consultant in the first instance. No concerns were raised about the support they received from consultants or their availability out of hours. During our inspection we saw that nursing staff had contacted the patient's consultant who attended the hospital to review their needs. They reported effective relationships and good communication about patient care and treatment plans.

Emergency awareness and training

- The hospital had recently updated the business continuity plan, we saw that an external company had undertaken a review in May 2017 and identified that further work was required. An action plan was created where actions were on-going.
- We saw that the annual fire risk assessment had been completed in May 2017 and an action plan created as a result of this. The hospital had recently completed a fire evacuation drill in partnership with the local fire brigade, which allowed staff to rehearse their response in the event of a fire. All staff received fire safety awareness training. About half the staff were compliant in fire safety with 52% of both non clinical and clinical staff trained.
- Some staff we spoke with told us they had been involved in fire evacuation training.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement.

Evidence-based care and treatment

- At our inspection in August 2015, we found there were no specific care pathways in place for surgical procedures. Generic care pathways and risk assessments did not reference the National Institute for Health and Care Excellence (NICE) or other professional guidance. The hospital did not undertake fasting audits; therefore this meant that the length of time patients' fasted for was not monitored.
- During this inspection the hospital had commenced fasting audits in July 2017 where 10 patients records were reviewed. This figure had increased to 20 records from August 2017 onwards. Compliance in July 2017 was 83%; this was due to not recording when the patient last had anything to drink. In August 2017 compliance was 97% due to the same issue and also because consideration was not given to a non-insulin dependent diabetic patient.
- A new process was in place to review policies, this was introduced in March 2017 where polices were to be reviewed through the quality group. All policies were changing the format to include specific sections which

included the approval process. This identified who had been consulted in the development of the policy and the lead clinician. There was also a section for amendments which identified the date and amendment that was required. The quality group ensured that the policies contained the most relevant guidelines and current legislation. The number of policies that had been through the process was 27, however the hospital could not confirm how many policies were left to complete. The senior management team identified that they had chosen the policies to complete first on a risk basis.

- Some policies we reviewed had not been through the quality group process and did not contain current information. These included the resuscitation policy which included references from the Resuscitation Council (UK) 2010 guidelines instead of the most current adapted 2015 guidance. The review for the policy was not until July 2018, however the hospital identified they would have changed all the policies into the new format before that date.
- The clinical supervision policy contained various references from 1989 to 1993 where more current guidelines were available to be used. The policy referenced The Midwives' Code of Practice when the hospital did not employ any midwives. The policy had been in place since December 2014 and due for review in December 2017.
- The hospital had a dedicated care pathway for endoscopy procedures, we reviewed this pathway and found that it contained appropriate references to national guidance and evidence based best practice.
- We saw care pathways for minor procedures and day case or short stay patients. The pathways contained all the relevant paperwork required for the patient however there was no references to national guidance.
- Within the monthly quality dashboard data NICE guidance relevant to the service was listed. This identified current compliance and on-going updates in relation to the guidance.
- At this inspection, we saw a file in theatres that contained emergency protocols. Some of the protocols and policies within the folder were out of date for example the Association of Anaesthetists of Great Britain and Ireland AAGBI anaphylaxis guidelines. Within the folder we saw an emergency transfer policy with a review date of November 2013 however the hospital provided a copy of an inter hospital transfer of critically ill patients policy which had been approved in May 2017. In addition, we saw a major haemorrhage protocol which did not have a review date and contained out of date guidance. This meant that the file was not being updated with the latest policies and guidance.
- All patients who attended an appointment with a cosmetic surgeon had to be given a two-week 'cooling off' period. This was strictly enforced at the hospital in line with guidance from the General Medical Council (GMC).
- Information was provided to the Private Healthcare Information Network (PHIN), this included information on length of stay, patient satisfaction and the number of patients seen. The PHIN ensures that robust information is received about private healthcare to improve quality data and transparency. Details of cosmetic surgery were uploaded to the appropriate database.
- Prior to this inspection, the hospital provided a copy of 'The guideline for the pre-assessment of patients prior to surgical intervention'. Within this document there was guidance relating to the referral, where necessary, for a pre-operative anaesthetist assessment. This document was based on national evidence based best practice which would ensure that all patients were appropriately risk assessed as being suitable for surgery at the hospital.

Pain relief

- At our inspection in August 2015, we found that staff used three different pain assessment scoring systems to assess pain levels.
- During this inspection we saw that staff asked about patient's pain and this was recorded, however records did not always identify the pain score after receiving pain relief. We saw that the ward had two different pain assessments with different scores.
- A pain clinic was held at the hospital on a weekly basis by one of the consultant anaesthetists.
- Patients we spoke with told us that staff asked them about their pain control.

- Information provided by the hospital identified that pain relief was audited as part of the monthly record keeping audit. Compliance with staff ensuring that a pain score was in place, utilised and evidence that patients' pain was well controlled was variable at between 44% and 80% (overall compliance was 66%) between January 2017 and June 2017.

Nutrition and hydration

- At our inspection in August 2015, we found that there was no evidence of nutritional screening in the clinical records. We also found that staff did not monitor how long patients had fasted before their surgery.
- During this inspection we saw that the hospital had introduced a policy for the nutritional care of inpatients in May 2017. This document stated that all patients were to be assessed for risk of malnutrition prior to admission. We looked at the record keeping audit for the ward area and found that in January 2017, 56% of patients had a nutritional risk assessment completed. From February to June 2017, this area of the audit was marked as not applicable for all patients.
- The ward record keeping audit showed that overall 92% of patients had fully completed fluid balance charts. Compliance with the completion of fluid balance charts was 100% in January, February, March and May 2017. Compliance fell to 79% in April 2017 and 75% in June 2017.
- The hospitals pre-operative assessment guidelines provided staff with advice about how long patients should starve for prior to surgery.
- During our inspection we saw that a nurse requested IV fluids for a patient when there was a delay in them going for their surgery.

Patient outcomes

- At our inspection in August 2015, we found that there was no local system in place to monitor long-term outcomes. The cosmetic surgery team did not have an audit or review process in place.
- During this inspection we saw the hospital had introduced a quality dashboard. Results from this dashboard were benchmarked with the other hospital in the group. Each department conducted clinical audits on a monthly basis.
- Information from patient's surgery was recorded onto the National Breast and Implant Register.
- At our previous inspection, the hospital submitted patient reported outcome measures (PROMS) as better than the national average for knee, hip and groin surgery. We spoke to staff at this inspection who indicated that PROMS were introduced at the hospital at the start of 2017. To date the results that had been received from the national PROMS centre had not enabled the hospital to make any changes to practice. However, it was hoped that this would be possible by the end of 2017.
- The hospital submitted data to national clinical audits for shoulder replacements and elective surgery.
- There had been three unplanned re-admissions, to the ward between January and July 2017, one of these was in February 2017 and two were in March 2017.
- There had been no unplanned returns to theatre between January and July 2017.
- There had been seven unplanned transfers out of the hospital between January and July 2017, two in February 2017, two in March 2017 and one in May, June and July 2017. Within the quality dashboard a review of the reason for the transfer was given and a root case analysis was completed. During our inspection we saw that one patient was transferred to the local hospital for further medical care. The anaesthetist accompanied the patient in line with the hospital's policy.
- A system was in place to record both clinical and non-clinical reasons for inpatient cancellations on the day. Between January and July 2017, 33 surgeries were cancelled due to clinical reasons. There were 53 non-clinical cancellations for the same period, these included 20 patients cancelled in March 2017 and 11 patients cancelled in July 2017 due to the hospital not being able to accommodate the pain management clinic.
- The endoscopy unit was working towards Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation. JAG accreditation ensures that set standards are met. It was highlighted at our inspection in August 2015 that the hospital was working towards

JAG accreditation. However we did see that on the endoscopy action plan it identified the hospital were working towards this being completed by December 2017.

Competent staff

- CQC undertook an unannounced responsive inspection in November 2016, this identified that staff in the endoscopy unit did not have evidence of the required competencies. An action plan was devised and completed. Competencies were completed using the Gastrointestinal Endoscopy for Nurses (GIN) competency framework. This provided staff with a self-assessment pathway which was then reviewed with the manager. We reviewed some of the competency files and found them to be updated with competency information.
- We were told that staff on the ward were observed and given feedback in performing clinical skills. There was no formal competency framework that was followed. A competency booklet for medicines management was to be introduced to all registered staff and completed by the end of December 2017.
- An assessment of competency had been introduced for registered nurses administering intravenous injections and fluids. At present staff were working through the competencies and working alongside other nurses and doctors to achieve competency. This involved the completion of a document that provided evidence and assurances that nurses were assessed in that skill.
- The theatre manager had set up regular one to one meetings with staff, introduced training and competencies and ensured appraisals contained measurable objectives appropriate to staffs individual development needs.
- We found that some staff in theatre were performing a surgical first assistant role (SFA) which was outside their competency level and job description. The hospital did not have any qualified SFA's in post at the time of our inspection. We raised this concern with the senior leadership team who advised that they would be unable to operate without staff undertaking this role. We were provided with the hospitals mitigating evidence in relation to this. This included the risk being logged on the risk register and also being part of their Association for Perioperative Practice (AfPP) action plan. Staff had been offered training and the management team were trying to identify staff to complete the training. Staff working in the SFA role were supervised by the consultant at all times and were completing local competencies that had been developed in house and complied with the AfPP SFA competencies.
- The Perioperative Care Collaborative (PCC) position statement on SFA (2012) recommends that the role of the SFA must be undertaken by someone who has successfully achieved a programme of study that has been benchmarked against nationally recognised competencies underpinning the knowledge and skills required for the role. This meant that the hospital was not meeting the requirements.
- Staff we spoke with identified that they had completed an appraisal which they had found effective. The appraisal system at the hospital had changed. The new system allowed staff members to complete how they felt they were performing. Information provided by the hospital identified that all areas: theatres, ward and endoscopy were at 100% compliance.
- Consultants were required to provide evidence of satisfactory annual appraisal from their NHS practice, as well as undergo the HMT practicing privileges processes.
- The hospital employed a cosmetic surgery specialist nurse, who offered support, advice and counselling to patients considering cosmetic surgical procedures. This member of staff had no formal qualifications for counselling.
- Patients could self-refer in to an open access clinic, for advice about cosmetic surgery. Literature about cosmetic procedures was available for patients, to review prior to making a formal appointment with a consultant.
- The RMO's were employed through a national agency, which provided continuing professional education sessions throughout the year. The RMO was supported by consultants, nursing and management staff.
- The hospital had a practising privileges policy. There were systems in place to withdraw the practising privileges of consultants, in line with the policy, in circumstances where standards of practice or professional behaviour were in breach of contract. Fitness to practice issues for consultants were assessed

and acted upon by the hospital director and the consultant's forum. Information provided by the hospital showed that all practitioners were 100% compliant with practising privileges in May 2017.

- The hospital had an induction policy for new staff which included a checklist to be completed to evidence that staff were aware of the requirements of their role.

Multidisciplinary working

- Patients were managed by individual consultant surgeons and anaesthetists who would review the patients daily. Many patients attended for day surgery and would be seen prior to discharge.
- Physiotherapists attended the ward and would see appropriate patients and discuss their care with the nurses.
- Endoscopy staff were working toward JAG accreditation and were working with a consultant nurse who was also a JAG assessor to support them throughout the process. They also worked alongside local NHS hospitals.
- Medical staff liaised closely with local hospitals when transfer between hospitals was required.

Seven-day services

- Consultants were available 24 hours a day to support their individual patients. The patients also had access to RMOs within the same time period.
- Surgery lists were completed Monday to Saturday between 8am and 6pm with an on call service to return to theatres if required out of hours. The endoscopy unit performed approximately nine clinics per week.
- On site diagnostic imaging facilities were available, an external company provided mobile facilities for CT and MRI scans.

Access to information

- The hospital's current digital health facilities were compatible with the local NHS trusts.
- We found that when patients moved between teams and services, including at referral, discharge, transfer and transition, all the information needed for their on-going care was shared appropriately, in a timely way and in line with relevant protocols.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At our inspection in August 2015, we found that handwriting on six of the 15 consent forms we reviewed was illegible. On two of the consent forms there had been a significant period between completion and the date of operation.
- During this inspection, we reviewed 12 consent records and found that nine were completed fully. Three had a small amount of information missing such as the consultant's job title or printing of the name.
- Information provided by the hospital identified that they audited compliance with consent forms. Between January and July 2017, overall compliance was below the required standard of 100%. However with the exception of April 2017 where compliance was 82% the compliance had been consistent at 85% and had improved for the last two months.
- Consent was also audited within the endoscopy service, between March and July 2017 compliance varied between 85% and 100%. Compliance in May and July 2017 was 100%.
- All clinical staff were required to complete Deprivation of Liberty Safeguards (DoLS) training. Training information up to August 2017 was provided showing that all staff within the endoscopy team and 96% of theatre staff had completed the training. Only 65% of ward staff had completed the training, this meant that some staff were not up to date with DoLS training.
- At this inspection, we saw that a policy was available for staff, providing advice and guidance in relation to capacity assessment and best interest decision making which was in line with the Mental Capacity Act and Deprivation of Liberty safeguards.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership / culture of service related to this core service

Requires improvement

Surgery

- A new hospital director had been in post since November 2016; the senior management team was then restructured and strengthened to include two new posts. These were the peri-operative care manager and quality improvement manager. We saw that this team's leadership had developed and changed practice within the hospital in a short period of time, implementing systems and processes to support governance in the hospital. However there had been a period of time prior to this since the last inspection where change had not been implemented. Many systems had only been implemented since the new hospital director had been in place in November 2016.
- Staff we spoke with told us that there was a positive atmosphere and that senior staff were supportive. Staff felt valued, enjoyed coming to work at the hospital and held the senior leadership team in high regard.
- From April 2017 each area started to complete their own departmental audits which fed into the quality dashboard, this was to enable ownership and to manage the results. Further work needed to be embedded and for clinical staff to be accountable when audits were consistently not met.
- Staff within the theatre team had changed since the new hospital director had been in place, a theatre and deputy manager had been appointed. All staff we spoke with in theatre were positive about the culture and new leadership in the department. Staff in theatre showed an awareness of safety and risk; however, this was not mirrored or evident on the ward.
- The hospital had a freedom to speak up guardian in post.

Vision and strategy for this core service

- At our inspection in August 2015, we found that there was not an overarching vision and set of values for the hospital.
- During this inspection we saw that the hospital had a vision and set of values. We saw these were clear in the staff survey and quality accounts. Staff we spoke with were aware of the hospital values. We saw the values displayed on posters throughout the hospital.
- The Healthcare Management Trust (HMT) had a strategy for 2017 – 2021; this included the hospital and set out strategic goals regionally and locally. Staff told us of the plan to extend the hospital and to offer alternative treatment options.
- The hospital director spoke of their desire to extend the choices to patients and how to develop and strengthen the relationships with their local partners.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- We identified at our inspection in August 2015 that the hospital must ensure staff followed policies and procedures about managing medicines, including prescribing and documentation of administration. However during this inspection we were not assured that this had been fully monitored, staff still had not completed competency pathways for medicine management. Robust audits had not been completed for the review of medicine management.
- At our inspection in August 2015, we found the hospital did not collect specific evidence within the corporate scorecard.There was also no discussion of clinical audit plans or activity. Limited risks related to surgery on the hospital risk register and senior staff we spoke to had limited understanding 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.
- During this inspection we saw that risk registers were in place and discussed at the heads of department meetings.
- A meeting schedule was in place which fed into the senior management team for HMT. We saw that the hospital director met monthly with the senior team and heads of departments. Other meetings were in place such as clinical governance, infection control and staff forums.
- We reviewed minutes from various meetings. We saw that the reduction in audit results was discussed at the heads of department meetings and cascaded down into the department meetings. We reviewed ward meeting minutes following our inspection and they identified immediate action had been taken in relation to

concerns raised at the inspection by the senior staff. The ward manager identified that ward staff would become involved in the documentation audits to understand the areas that required improvement.

- The hospital had a bimonthly clinical governance meeting that was chaired by one of the clinical advisors. The senior leadership team and heads of department attended the meeting.
- The audit systems and processes that had been introduced did not identify all the shortfalls in the completion of records, the WHO safer surgery checklist and medicines management. We were not assured that local leaders took ownership of department audits or that clinical staff were accountable when audit standards were consistently not met.
- The hospital had set up a consultant forum in place of the traditional medical advisory committee (MAC). We reviewed a set of minutes from the consultant forum and found practice privileges, scope of practice, hospital development and quality issues were discussed.
- We saw evidence that the staff working under practising privileges held appropriate indemnity insurance in accordance with their professional body.
- The hospital had appointed five clinical advisors, consultants to represent the main specialities delivered. At the time of the inspection terms of reference for this group had not yet been developed. Improvements to services the clinical advisors identified had already been made, for example, a difficult intubation trolley had been put into theatres.
- Senior staff and the leadership team did not appear familiar with the national safety standards for invasive procedures (NatSSIPs) and the local safety standards for invasive procedures (LocSSIPs) and practice in relation to safety standards differed across departments. Providers of NHS funded care must be compliant with these safety standards.
- All consultants had to meet the criteria set out in HMT hospitals practising privileges policy to be granted authorisation by the medical director to undertake the care and treatment of patients in the HMT hospitals. Processes had been put into place for medical staff to follow such as a cancelling surgery for non-clinical reasons to ensure that it was in the best interest of the patient and hospital. This included a consultants cancellation policy that was effective from April 2017.

Public and staff engagement (local and service level if this is the main core service)

- At our inspection in August 2015, we found that there was no evidence of regular team meetings or future planned dates for team meetings on the ward or in the operating theatres.
- During this inspection, we saw that each department had their own team meetings. Minutes were circulated and copies were kept in the department, staff signed to identify they had read the minutes.
- Staff commented that they were involved in changes to the hospital and processes. For example staff were involved in changing the appraisal paperwork and took part in focus groups to look at the effect of the changes. Staff were appointed as champions to support others and implementation.
- The hospital had worked to improve the engagement with patients and actively engaged with Healthwatch. Healthwatch had participated in two site visits to the hospital to engage with patients and discuss their experience.
- A staff survey was completed in 2017 where the response rate had increased to 93%. Overall the findings had improved since the previous staff survey in 2016. For example 91% of staff felt valued by their immediate manager in contrast to 71% in 2016.Some staff requested feedback and the hospital director met with the staff in a group session and contributed to the survey.
- The hospital director provided staff forums for all the staff in every department every three months. Staff were provided with an update about the hospital, ongoing vision and also an update for HMT. Staff told us they found the forums effective and informative.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- As a non-profit organisation and registered charity surplus profit was used to develop charitable causes around dementia and health promotion. The hospital

supported the financing of research and employment of dementia care workers within the area. The hospital developed a relationship with a local based charity that provided people with dementia support. Part of the 2017 – 2021 strategy included working with the young, schools and communities to increase the awareness of dementia and loneliness in the elderly. The hospital director was keen for staff from the hospital to be involved with the wider community and attending sessions.

- The hospital had employed a health promotion officer who had developed proactive partnerships locally and regionally. Recent events had included bike riding events including the Grimsby 10km race. The hospital supported staff to participate in the 'cycle to work week'. The plan was to engage with further groups and support local charities in specific community projects.
- One of the recommendations from the staff survey was to consider mental and emotional wellbeing in addition to physical health which the hospital were looking into.

Good

Outpatients and diagnostic imaging

Safe	Good
Well-led	Good

Summary of findings

We rated this service as good overall. We rated safe and well-led as good.

Staff knew how to report incidents, received individual feedback from incidents and understood the principles of the duty of candour.

Compliance for mandatory training in the service ranged between 91-100% and staff were on target to complete the training by the end of the year.

The safeguarding policies were in date and procedures were accessible to staff in both outpatients and the imaging departments. Staff were aware of their responsibilities and the process they would follow if they identified a concern.

There were no incidences of hospital acquired infection.

The pre-assessment of patients had much improved and this had resulted in a lower cancellation rate when patients were admitted for an operation.

The hospital had a freedom to speak up guardian in post and the culture of the service encouraged candour, openness and honesty to promote the delivery of quality treatment and to challenge poor practice.

The outpatient management team engaged regularly with staff informally and formally through monthly team meetings.

The hospital had worked to improve the engagement with patients and other stakeholders.

However;

Dust was visible in the radiology department which meant that the area was not cleaned regularly.

The service was recruiting to vacancies including a pre assessment staff nurse and an imaging department manager.

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- During our inspection in August 2015, we found that the incident reporting system was paper based. The hospital was unable to provide detailed information about the number of incidents within the outpatient and the imaging departments. There was no formal sharing of information or evidence to demonstrate that lessons learnt from incidents had been cascaded to all staff.
- At this inspection, we found the hospital had a policy for the reporting and management of incidents, including serious incidents.
- Staff were encouraged to report incidents using an electronic reporting system, which commenced in January 2017. All staff we spoke with knew how to report incidents through the electronic system. They were aware of the type of incidents they needed to escalate and report and some staff we spoke with were able to give examples of recently reported incidents.
- Between January and September 2017, there had been no never events reported. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The hospital reported no serious incidents in outpatients and diagnostic imaging services. Serious incidents are incidents that require reporting and further investigation.

Good

Outpatients and diagnostic imaging

- During the same reporting period outpatients and diagnostic imaging services reported 46 and 38 incidents respectively. All of the incidents were classed as either no, or low harm.
- From August 2015 to the time of our inspection, the hospital had not reported any incidents to the CQC under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Staff in the radiology department understood their responsibilities for reporting IR(ME)R incidents.
- Staff we spoke with told us they received individual feedback from incidents. We saw in the incident review and management forms that a debrief and feedback was given to staff when requested. We also saw in the minutes of team meetings, evidence of sharing and learning from incidents. This was a standard agenda item for all team meetings in the service.
- The April to June 2017 incident reporting update for staff, showed examples of lessons learnt and themes from incidents reported. Examples included the use of patient known allergy sticker for the prescription charts. This helped ensure staff were aware of the patients who had an allergy. Staff were aware of the information and we saw evidence of the stickers in use (where appropriate) in the patient files we reviewed during the inspection.
- Staff we spoke with understood the principles of duty of candour (DOC). This included the importance of being open and honest with patients when mistakes were made. However, as there had not been any notifiable safety incidents in the outpatient and imaging departments, we were not able to evidence the implementation of the DOC.

Cleanliness, infection control and hygiene

- Between January and December 2016, there were no incidences of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C. difficile) or Methicillin Sensitive Staphylococcus Aureus (MSSA) within outpatient and diagnostic imaging services.
- We saw cleaning schedules and completed cleaning checklists.
- With the exception of the main diagnostic and imaging room, all of the outpatient consulting rooms were visibly clean and cleaning assurance stickers were used to indicate when a piece of equipment had been cleaned.
- High-level dust was visible in the diagnostic and imaging room which meant that the area was not cleaned regularly.
- Dust was present on a transfer board (used by staff when moving a patient in a semi reclined or lying position) and on a trolley containing clinical equipment in the ultrasound room. The cleaning sticker on the transfer board, which showed when it had been cleaned, was dated May 2017. The trolley did not have a cleaning sticker or a cleaning schedule in place. The radiographer was made aware of this information on day one of the inspection. When we returned the following day the cleaning shortfalls had been addressed.
- The hospital had four infection prevention and control (IPC) practitioners; the outpatient and imaging departments had an IPC lead nurse. Information provided by the hospital showed these staff were up to date with their IPC training.
- We saw evidence of infection prevention and control audits. These were carried out alongside a general environmental audit. The most recent audit was completed in June 2017. This showed a 94% compliance with the monitored infection control and environmental measures; which was close to the hospital target of 95%. The hand hygiene audit result for the same period was 100%.
- There was an up to date hand hygiene policy available to staff on the intranet. Hand washing facilities and antibacterial gel dispensers were available to staff and visitors.
- We saw staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons.

Environment and equipment

- In 2015, we found that the hospital 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.

- Prior to this inspection the hospital provided a copy of a PLACE audit completed in May 2016, from this we saw that actions had been implemented to address any areas of concern.
- At this inspection, we saw the areas identified as a concern, (which included the replacement of chairs in the consultation rooms and patient-sitting areas) had all been addressed.
- Equipment was readily available. There was a procedure in place for ordering specific equipment a consultant may request. The outpatients manager told us that they had a budget for ordering equipment and had recently placed an order to meet the increased demands of the service.
- There was a medical equipment servicing and maintenance agreement, dated February 2017, and a capital equipment replacement programme.
- The hospital had a resuscitation trolley which was based in the inpatient ward. Staff informed us that the trolley and equipment could be accessed in a timely manner should it be needed in the outpatients department. However the outpatients manager told us that a second trolley had been ordered and this would be kept in the outpatients department.
- We saw there was limited wheelchair access changing room facilities in the imaging department. However, there was alternative changing facilities available should this be required.
- Local rules for the imaging department were in place. The local rules had been produced 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 (IRMER).
- Safety testing of electrical equipment was in place and dated stickers were on the equipment to show it had been tested.

Medicines

- Procedures were in place for the safe storage and use of (FP10) prescription books. These were used by the consultants when prescribing individual patient medicines.
- Patients used local pharmacies to obtain their medicines as St Hugh's hospital did not have a dispensing pharmacy.
- There was a service level agreement in place for pharmacy cover at the hospital. Staff told us that the pharmacist visited weekly to check medicines were stored correctly and replace the stock drugs.
- We did not see any audits of the checks which had taken place by the visiting pharmacist.
- The medicines refrigerators, which were used for the storage of items such as single dose units of eye drops, were kept locked.
- The sample of medicines inspected were in date and records showed that the refrigerator temperatures were recorded daily. The refrigerator temperatures were maintained within the required temperature for the safe storage of medicines, between 2 and 8°C.

Records

- There was a single set of fully integrated paper records for all patients and when not in use these were stored securely in the medical records department on the hospital site.
- A tracer system was used to record the movement of records within the hospital to enable them to be easily located.
- Nurses we spoke with in the outpatients department told us it was rare for records to be unavailable for scheduled appointments.
- A monthly records audit was started in June 2017 when the departments compliance was 82%. The hospitals target was 100%. The compliance figures for July and August were 87% which showed that compliance was improving. Minutes of the ward team meetings showed that the audit results were discussed with staff.

Good

Outpatients and diagnostic imaging

- The outpatient staff had been invited to attend documentation training which was to be hosted by the Royal College of Nursing in September 2017.
- We inspected six sets of patient records. They were in paper format, in line with professional standards/ hospital policy and record keeping was of a good standard. However, in some instances we had difficulty reading the consultants handwriting.
- All records contained patient details such as, their past medical history, medication, allergies, drug intolerances, and discharge planning.

Assessing and responding to patient risk

- Patients having a general anaesthetic completed a pre-operative questionnaire. From this the peri operative staff reviewed the risks of those patients having a general anaesthetic. The patients identified as at risk had their case reviewed by the anaesthetist and where appropriate were seen in their anaesthetic clinic.
- The consultant anaesthetist we spoke with told us that the pre-assessment of patients had much improved. This resulted in a lower cancellation rate when patients were admitted for an operation due to risks being identified prior to admission.

Safeguarding

- Visitors to the service were required to sign in and wear a visible identification badge. This made sure patients and staff were protected from unauthorised personnel.
- The safeguarding policies were in date and procedures were accessible to staff in both outpatients and the imaging departments. Staff we spoke with could explain the process they would follow if they identified a concern.
- There were three named adult safeguarding leads within the hospital.
- At our inspection in 2015, we found the outpatient and imaging departments saw children and no one in the hospital had completed safeguarding children's training.
- The hospital no longer sees children. However, as children may accompany patients to the hospital, the clinical heads of departments and their deputies had completed safeguarding adults and children's level two training.
- The clinical services manager had completed level three children's safeguarding training.
- All staff completed an on-line electronic learning module as part of their mandatory training for safeguarding adults.
- We saw in the outpatient sitting areas posters relating to safeguarding. Safeguarding alerts could be made in confidence and the information posters stated who to contact; this included the local social services details.

Mandatory training

- During our inspection in 2015, we found not all staff had received mandatory training; the hospital's mandatory training target was 100%.
- At this inspection we found that mandatory training was delivered either face to face or by e-learning. It included topics such as level two safeguarding for adults and children level, deprivation of liberty safeguards (DoLS), infection control, manual handling, fire safety, information governance, equality and diversity, PREVENT (protecting people at risk of radicalisation) and dementia training.
- The hospital maintained a staff training log. Data provided by the hospital showed compliance for mandatory training in the outpatient and the imaging departments ranged between 91-100%. The service was on target to complete the training by the end of the year.
- Mandatory training figures for fire safety, manual handling, information governance, and PREVENT included all staff working in the hospital.
- For our detailed findings please see the safe section in the surgery report.

Nursing staffing

- 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 reviewed staff files.
- The departmental manager decided safe staffing levels for clinics when they arranged the duty rotas and these were written four weeks in advance.

Good

Outpatients and diagnostic imaging

- Vacancies within the department included a pre assessment staff nurse and an imaging department manager. Recruitment was underway at the time of our inspection.
- Staff sickness was reported at 2.8% which was less than the NHS target of 6%.
- The service reported the use of in house bank staff to fill the vacant post and no shifts had not been filled.

Medical staffing

- 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 held substantive posts in NHS trusts.
- A radiologist was available daily in the radiology department to report on images.

Emergency awareness and training

- The hospital had a business continuity plan which included the outpatients and diagnostic imaging services.
- All staff received fire safety awareness training.
- The hospital had recently completed a fire evacuation drill in partnership with the local fire brigade, which allowed staff to rehearse their response in the event of a fire.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- In November 2016, there was a change to the hospital director, and two senior management posts were created. These included a peri operative care manager and quality and improvement manager appointed in January 2017.
- The departments were represented at senior management level within the hospital. There was a clear management structure and all staff we spoke with were aware of their line managers. Staff we spoke with felt supported and said that senior staff were always accessible.
- The hospital director had an open door policy. Staff told us they were approachable, supportive and would find time for them.
- The hospital had a freedom to speak up guardian in post. The culture of the service encouraged candour, openness and honesty to promote the delivery of quality treatment and care and to challenge poor practice.
- With the exception of one member of staff, all staff we spoke with in the departments felt supported and positive about working there. However, one member of staff told us they did not feel supported in their role.

Vision and strategy for this core service

- During our inspection in 2015, we found that the service did not have a vision or a set of values.
- Staff we spoke with at this inspection were aware of the hospital's values. We saw the values displayed on posters within the department.
- Staff told us the hospital director kept them up to date with the strategy of the service and the changes this would bring.
- The strategy for the service was the same throughout the hospital. We have reported about the strategy in the surgery service within this report.

Governance, risk management and quality measurement

- At our inspection in August 2015, we found there was a lack of assurance that governance, quality improvement and risk management systems were operating effectively.
- At this inspection we found that the hospital director met monthly with the senior team and heads of departments. Other meetings were in place and included clinical governance, infection control and staff forums.

Good

Outpatients and diagnostic imaging

- We reviewed minutes from various meetings. We saw that the reduction in audit results was discussed at the heads of department meetings in April 2017 and cascaded down into the department meetings.
- We saw that the risk register was discussed at the April 2017 meeting and staff were informed where the hospital risk register was located. The heads of department were also asked to think about their risks in their departments for the next meeting.
- At this inspection the outpatient manager told us they did not have a risk register. They were able to tell us that the hospitals clinical risks included staff shortages due to sickness, and equipment.
- We reviewed the hospital risk register and saw the outpatient department clinical risk was clinic cancellations at short notice. We saw that a policy was in place to help manage clinic cancellations at short notice from consultants. Staff were aware that consultants now had to give four weeks' notice when they were not able to work in the department.
- The quality dashboard showed that in April 2017 outpatient cancellations were 18. Action had been taken to remind patients of their forthcoming appointments. In May 2017 the outpatient cancellations had been reduced to eight.
- We reviewed the outpatient meeting minutes and they identified action had been taken in relation to concerns raised at the inspection. This included hand hygiene audits taking place bimonthly, and monthly record keeping audits being introduced.
- The hospital had a bimonthly clinical governance meeting that was chaired by one of the clinical advisors. The senior leadership team and heads of department attended the meeting.

Public and staff engagement

- The outpatient management team engaged regularly with staff informally and formally through monthly team meetings. Minutes of these meetings were kept in the department for staff to see.
- The hospital had worked to improve the engagement with patients. During our inspection we saw electronic surveys were available for visitors and patients to complete.
- The hospital actively engaged with Healthwatch.
- For additional information about public and staff engagement in the hospital please refer to the surgery service within this report.

Innovation, improvement and sustainability

- A consultant anaesthetist told us that with the implementation of the peri-operative manager and pre-assessment nurse, the service had improved. This had reduced the cancellations on the day of operation.
- For additional information about innovation, improvement and sustainability in the hospital please refer to the surgery service within this report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff complete the medicine charts in line with the hospital policy and audit the content of the records.
- The provider must ensure that staff complete medicine management training and complete the medicine competency booklet.
- The provider must ensure that staff working in the surgical first assistant role have the skills and competence to do so.
- The provider must ensure that documentation is completed in line with professional standards and its own policies.
- The provider must ensure that the hospital is complaint with the national safety standards for invasive procedures (NatSSIPs) and local safety standards for invasive procedures (LocSSIPs) for patients receiving NHS funded care.
- The provider must ensure that world health organisation (WHO) safer surgery checklists are fully completed and the audit process to provide assurance of this is robust.

Action the provider SHOULD take to improve

- The provider should ensure that the radiology department is clean and dust free.
- The provider should ensure that junior members of staff understand the principles of duty of candour
- The provider should ensure that there can be no unauthorised access into areas where cleaning products are stored.
- The provider should ensure that all the emergency equipment is stored in a sterile environment where appropriate.
- The provider should ensure that there is a robust method of recording and reviewing the cleaning of equipment.
- The provider should ensure that the medication fridges are checked daily and staff understand the reasons behind this.
- The provider should ensure that staff complete national early warning score (NEWS) and blood transfusion training.
- The provider should ensure that all policies are reviewed in line with the hospital's new process.
- The provider should ensure that nutritional assessment is completed as part of the monthly audit programme.
- The provider should ensure that leadership is embedded in clinical areas to drive quality improvements.
- The provider should ensure the new process for managing practising privileges is embedded to provide assurance that staff working at the hospital are competent to do so.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • Four out of 12 World Health Organisation (WHO) safer surgery checklists were not completed fully. Observation of the process in theatre would indicate that not all actions were completed appropriately. One WHO checklist was completed in the reception area and the 'sign in' was not read out as indicated on the form. • One WHO checklist indicated the swab check complete but the swab check in notes was not completed in five out of seven records. • Correction fluid was used in one record. Records had spaces in entries. Nursing records did not always have the date and time recorded next to the entry and there was spaces between entries, in two entries a time documented was earlier than the previous entry. This was not line with the provider's policy. • Senior staff and the leadership team did not appear familiar with the national safety standards for invasive procedures (NatSSIPs) and the local safety standards for invasive procedures (LocSSIPs) and practice in relation to safety standards differed across departments. This was a breach of regulation 12(1)(2)(a)(b).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- The audit systems and processes in place did not identify all the shortfalls in the completion of records, the WHO safer surgery checklist and medicines management.
- We were not assured that local leaders took ownership of department audits or that clinical staff were accountable when audit standards were consistently not met.

This was a breach of regulation 17(1)(2)(a)(b)(c).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • During review of the staffing rota and theatre list on inspection there was evidence that staff in theatre were working in the role of surgical first assistant during orthopaedic surgery in theatre who did not have the skills or training to qualify them to do the job. This was a breach of regulation 18(1)(2)(a).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. 12(2)(g) the proper and safe management of medicines Why there is a need for significant improvements: • None of the medicine administration charts we reviewed on the ward were completed in line with the HMT Hospitals medicines management policy or professional standards. • Oxygen was not prescribed on the medicine administration charts in line with the HMT Hospitals medicines management policy or national guidance. • We were not assured that staff fully understood and could identify what would be classed as a medicine incident. • Staff were not working in line with professional standards and not adhering to the HMT hospitals medicines management policy. Some of the same practices were raised as a concern with the ward manager and hospital director in post at our August 2015 inspection. • We reviewed the medicine fridge on the ward and found that staff did not always record temperature checks daily. • Information provided by the hospital prior to the inspection showed that pharmacy and medicines administration chart audits completed by the hospital and the external pharmacy partner did not identify the concerns we found at this inspection.