BMI St Edmunds Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI St Edmunds is operated by BMI Healthcare. The hospital/service has 26 beds although at the time of reporting eight rooms were not in regular use. Facilities include three operating theatres, a three-bed level two care unit (recovery room), and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, and outpatients and diagnostic imaging. We inspected the surgery and outpatient services.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 6 November 2018, along with a further unannounced visit to the hospital on 12 November 2018.

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

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

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

Services we rate

Our rating of this hospital improved. We rated it as **Good** overall.

We found areas of good practice in relation to surgery and outpatient care:

- The hospital had systems and processes in place to protect patients from avoidable harm and abuse.
- The environment and equipment were clean and suitable for use and staff ensured patients were protected from infection by using the appropriate infection, prevention and control measures.
- Staff knew how and when to record incidents and there were systems to identify, monitor and share learning from incidents.
- Risk assessments were appropriately completed for people who used the hospital and staff protected confidentiality with well organised and managed individual care records.
- Outpatient contemporaneous consultation records were completed on triplicate forms and staff ensured there was always a copy in the patient records. This was a significant improvement since our last inspection.
- The hospital had comprehensive internal audit programmes in place to monitor services and identify areas for improvement and the hospital participated in national audits where applicable.
- Patient care and treatment was delivered in line with national guidance.
- Staff were competent for their roles and were encouraged to develop further. This was an improvement since our last inspection.
- Staff treated patients with care, kindness and compassion.
- Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care.

Summary of findings

- Complaints and concerns were taken seriously, responded to in a timely way and managed with face to face meetings with the complainant where needed.
- Managers were visible, approachable and performed well. This was an improvement since our last inspection.
- Staff we spoke with enjoyed their work and were proud to work at the hospital. They described an open culture and felt supported and listened to by their immediate managers.
- There were clear and effective processes for managing risks, issues and performance.

And some areas for improvement:

- Although overall mandatory compliance was generally good some courses showed poor compliance such as; manual handling on the ward (42.9%).
- Records showed that patients were fasted for longer than necessary to accommodate operating theatre list changes.
- Consent forms were sometimes completed on the day of surgery which did not follow best practice guidance.
- Consultants did not always record post-operative reviews in inpatient notes.
- There was inconsistent governance of consultant practising privileges in ensuring appraisals were submitted in line with the practising privilege policy.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients	Good	We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

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Good

Location name here

Services we looked at
Surgery and Outpatients.

Summary of this inspection

Background to BMI St Edmunds Hospital

BMI St Edmunds is operated by BMI Healthcare. The hospital opened in 1980 and became part of the BMI group in 2008. It is a private hospital in Bury St Edmunds, Suffolk. The hospital primarily serves the communities of Suffolk, Norfolk and Essex. It also accepts patient referrals from outside this area.

The hospital building has two floors and provides a range of elective surgeries for adult self-funded, insured and NHS patients, which include, but are not limited to, orthopaedics, general surgery, urology, ophthalmology, ENT, gynaecology and cosmetic surgery. BMI St Edmunds does not treat children.

The hospital has had the present registered manager in post since September 2009.

The hospital/service has been inspected four times. The most recent inspection took place in March 2017 which found that the hospital was not meeting all standards of quality and safety it was inspected against. The hospital was rated as requiring improvement for safe, effective and well led and good for caring and responsive, and was rated requires improvement overall. There were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance, appraisals and up to date competency records for staff, complete, and completion of contemporaneous notes on each patient. Three requirement notices were served relating to Regulation 17 and 18 of, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and two specialist advisors with expertise in surgery and outpatients.

The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology and carried out unannounced inspections on 6 and 12 November 2018. During the inspection, we visited the ward, operating department and outpatient areas. We spoke with 36 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with four patients and one relative. During our inspection, we reviewed 20 sets of patient care records

Information about BMI St Edmunds Hospital

The hospital is registered to provide the following regulated activities:

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

The surgery department consisted of one ward in three wings with 26 single en-suite rooms and an ambulatory care room for day case patients, two main theatres, one of which is laminar flow, one endoscopy theatre and a three bay recovery unit.

Summary of this inspection

The outpatient area has one treatment room, seven consulting rooms, with an additional audio booth, and designated ear, nose, and throat and ophthalmic rooms.

There is a Resident Medical Officer (RMO) on duty 24 hours a day.

Activity

- During the reporting period 1 August 2017 to 1 July 2018 there were 797 inpatient episodes of care of which 49% were NHS-funded and 51% other funded. There were 2,276 day case episodes of care recorded at the hospital.
- There were 12,839 outpatient total attendances in the reporting period; of these 68% were other funded and 32% were NHS-funded.

A total of 92 specialists worked at the hospital under practising privileges. This included 35 surgeons, 20 anaesthetists, 19 physicians and four radiologists. A further 14 specialists provided services such as pain management, audiology, podiatry and psychiatry. Two regular resident medical officers (RMOs) worked on an alternate weekly rota. The hospital employed nine registered nurses, nine healthcare assistants and 15 operating department practitioners, and one endoscopy practitioner, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- Zero never events
- Clinical incidents - 173 no harm, 18 low harm, 3 moderate harm, zero severe harm, zero death
- zero serious injuries

Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

Zero incidences of hospital acquired Clostridium difficile (c.diff)

Zero incidences of hospital acquired E-Coli

33 complaints of which two were referred to the Independent Healthcare Sector Complaints Adjudication Service.

A specialist bone densitometry service also operated on the site run by a separate organisation.

Services provided at the hospital under service level agreement:

- Blood Transfusion
- Pathology including some histopathology
- Grounds Maintenance, Window Cleaning, Pest Control
- DXA Service
- Resident Medical Officer
- Clinical Waste
- General Waste and Recycling
- Car Park Management
- Confidential waste service
- Agency Staff
- Decontamination Unit
- Resuscitation training and scenarios

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- The hospital had systems and processes in place to protect patients from avoidable harm and abuse.
- The environment and equipment were clean and suitable for use and staff ensured patients were protected from infection by using the appropriate infection, prevention and control measures.
- Risk assessments were appropriately completed for people who used the hospital and staff protected confidentiality with well organised and managed individual care records.
- Outpatient contemporaneous consultation records were completed on triplicate forms and staff ensured there was always a copy in the patient records. This was a significant improvement since our last inspection.
- Staff knew how and when to record incidents and there were systems to identify, monitor and share learning from incidents.

However,

- Consultants did not always record post-operative reviews in in-patient notes.
- Compliance with mandatory training was variable with some individual modules at 42.9% and 38.9%.

Are services effective?

Good

Are services effective?

We rated effective as **Good** because:

- Patient care and treatment was delivered in line with national guidance.
- The hospital participated in national audits where applicable.
- The hospital had comprehensive internal audit programmes in place to monitor services and identify areas for improvement
- Staff were competent for their roles and were encouraged to develop further. This was an improvement since our last inspection.
- Results from the hip and knee National Joint Registry for the period April 2016 to March 2017 (reported in August 2017) were similar or better than the national average.

Summary of this inspection

- There were no cases of unplanned readmissions within 28 days of discharge or unplanned returns to the operating theatre in the reporting period. This was an improvement since our last inspection.

However,

- Consent forms were sometimes completed on the day of surgery which did not follow best practice guidance.
- Records showed that patients were fasted for longer than necessary to accommodate operating theatre list changes.

Are services caring?

Good

We rated caring as **Good** because:

- Staff treated patients with care, kindness and compassion.
- Patients were very complementary regarding the care they received
- The NHS Friends and Family Test results were higher than the national average at 99% during the period February to July 2018.
- Patients were appreciative of the follow up telephone calls 48 hours post discharge to check that they had no problems or complications.

Are services responsive?

Good

We rated responsive as **Good** because:

- Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care.
- The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their appointments or surgery, subject to consultant availability.
- Complaints and concerns were taken seriously, responded to in a timely way and managed with face to face meetings with the complainant where appropriate.

Are services well-led?

Good

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

- Managers were visible, approachable and performed well. This was an improvement since our last inspection.
- Department managers had a good understanding of the challenges to quality and sustainability, and could identify the actions needed to address them.

Summary of this inspection

- Staff we spoke with, enjoyed their work and were proud to work at the hospital. They described an open culture and felt supported and listened to by their immediate managers.
- There were clear and effective processes for managing risks, issues and performance.

However,

- There was inconsistent governance of consultant practising privileges in ensuring appraisals were submitted in line with the practising privilege policy.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

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

In this section, we also cover hospital-wide arrangements such as how they deal with risks that might affect the hospital's ability to provide services (such as staffing problems, power cuts, fire and flood), the management of medicines and incidents, in the relevant sub-headings within the safety section. The information applies to all services unless we mention an exception.

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

Mandatory training

- The hospital had processes in place to ensure staff received mandatory training in safety systems, processes and practices. There was a mandatory training programme, which included but was not limited to topics such as infection prevention and control, moving and handling, fire safety, conflict resolution, safety, health and the environment, and information governance. The mandatory training programme was tailored to staff's individual needs and relevance to their role.
- Staff completed training through the corporate learning system 'BMILearn'; which was an online resource of training modules, e-learning courses, and some face-to-face sessions. They could access e-learning courses at work or home, and were compensated for training they completed in excess of their contracted hours. Staff could view their individual training needs, current compliance and access e-learning courses through the hospital's electronic training system. The system also alerted staff when mandatory training was due to be completed.
- Overall mandatory training figures were good with 95.1% compliance in theatres which was above the hospital target of 90% and 89.2% on the ward. There was some variability within the specific mandatory training courses with the lowest compliance being 'manual handling' at 42.9% on the ward and the 'care and communication of the deteriorating patient' at 38.9% in theatres. Staff reported that 'care and communication of the deteriorating patient' was a recently introduced (within the previous 12 months) module and that all staff were being encouraged to complete it, but places were limited. Senior ward staff acknowledged that manual handling mandatory training was challenging due to low staff numbers but there was a plan in place to ensure that all staff completed necessary mandatory training.
- Weekly reminders were sent to department managers and staff of mandatory training required and this was also discussed in governance meetings. The interim CSLW had scheduled dates for ward staff to meet requirements.
- The resident medical officers (RMOs) received their mandatory training from their agency and were not allowed to work at the hospital unless this had been completed.
- The RMOs were trained in advanced life support (ALS) and other clinical staff trained in immediate life support

(ILS). Non-clinical staff completed basic adult life support training (BLS). There was opportunity for staff to attend external ALS training and two staff members had enrolled.

- Data provided by the hospital following the inspection showed that 77.8% of theatre clinical staff and 71.4% of clinical ward staff were compliant with immediate life support training which did not meet the hospital target of 90%.
- There was a corporate sepsis policy and the 'care and communication of the deteriorating patient' mandatory e-learning module for clinical staff, included the recognition, diagnosis and early management of sepsis. Clinical ward staff compliance for this was 71.4% and as previously mentioned theatre staff was 38.9%. This meant that neither area had met the hospital target of 90% compliance and could represent a risk of staff not being able to recognise a deteriorating patient. However, all staff we spoke with were knowledgeable about the clinical signs of sepsis and how to escalate concerns.
- All theatre and endoscopy staff had competency and mandatory training files. We reviewed the files and, found they were all up-to-date, comprehensive and provided evidence of completion of mandatory training and competencies. This was a significant improvement since our last inspection
- Mandatory training was discussed at the induction day for all new starters. Staff signed an agreement on appointment about their responsibility to ensure they undertook the mandatory training relevant to their role. Senior staff commented that staff yearly pay increases were dependent on staff completing all mandatory training and they were confident that individual staff compliance would improve.
- Senior staff within the service monitored mandatory training compliance and arranged both external courses and in-house training to provide multiple platforms for learning. We heard about scenario based training life support training provided by an external organisation which staff found useful.
- The theatres had a monthly training afternoon where staff received time to complete training and the theatre manager arranged for additional speakers for areas of interest to attend. There was an induction programme for new staff. Staff who had attended this told us that it met their needs.
- Agency staff had an induction which covered the layout of the department, emergency procedures, paperwork and where to access essential information.
- The director of clinical services (DCS) received a weekly training compliance report, which was shared with the heads of department. Mandatory training compliance was also discussed at various meetings, including the clinical governance and departmental meetings, and the daily 'comms cell' staff brief. The comms cell meetings covered a range of subjects including but not limited to; a review of recent incidents, a health and safety update, training compliance review, planned clinics and risk review. This enabled staff to gain a wider view of risk, issues and general performance within the hospital.

Safeguarding

- The service had effective systems and processes to protect and safeguard vulnerable patients from abuse.
- The service had a corporate safeguarding policy which incorporated Mental Capacity, Deprivation of Liberty Safeguards and PREVENT advice. PREVENT aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves.
- There had been no safeguarding concerns reported to CQC in the reporting period of August 2017 to July 2018, however the hospital reported that there had been one safeguarding referral raised within that period. On discussing the process and outcome of the referral we were concerned that there was a lack of development of the necessary relationships with external organisations to ensure that people were referred to the correct organisations. Following the inspection, the provider produced evidence of an action plan to develop these external links moving forward.
- Staff were trained to level two safeguarding for adults and children provided via e-learning courses, with additional workshops held for female genital mutilation (FGM) training. The overall compliance was 96% in theatres and 91.8% on the ward. Training covered all aspects of safeguarding adults and children, including professional responsibilities, the Mental Capacity Act, categories of abuse, safeguarding processes, and child protection. PREVENT training was delivered separately as was safeguarding chaperoning and female genital

mutilation (FGM). Staff we spoke with knew how to access and complete safeguarding training and there was a plan to train all registered nurse staff to safeguarding level three for adults and children.
- The director of clinical services (DCS) was the hospital safeguarding lead for vulnerable adults and children, and trained to level three. Staff also had access to the BMI regional safeguarding lead trained to level four.
- Staff we spoke with had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children and could explain how to respond to and escalate a concern or make a referral.
- The hospital had a chaperoning policy and staff knew how to access it.
- The ward had a folder containing safeguarding information. Staff displayed safeguarding information posters on office walls, which contained information on how to contact the local safeguarding authority.
- All staff were subject to Disclosure and Barring Service (DBS) checks. DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare associated infection.
- The service had policies to manage infection prevention and control (IPC). Staff demonstrated how to access policies easily.
- The wards, theatre rooms, reception and other areas we inspected were visibly clean and well maintained.
- We observed staff following correct World Health Organisation seven steps handwashing procedure prior to, and post patient contact.
- Staff followed the hospital's policy on infection control, for example, complying with 'arms bare below the elbow' not wearing jewellery and the use of personal protective equipment (PPE), for example the use of gloves and aprons. PPE was available and hand wash gel was easily accessible in the clinical areas, individual patient rooms and the corridors. All hand wash dispensers that we checked were full and in working order.
- Housekeeping staff followed a weekly cleaning schedule. The CSLW checked and signed off the weekly cleaning schedule. Staff escalated any concerns or issues to them.
- The hospital had an IPC lead nurse and link practitioners in clinical areas. The link practitioners were responsible for collating audit data of cleaning schedules and producing actions to address compliance when necessary. For example, involvement in in hand hygiene audits.
- The hospital had recorded no surgical site infections in the reporting period 1 August 2017 to July 2018.
- The hospital followed current Department of Health guidance 'Who to Screen' for MRSA on the taking of swabs prior to admission. During the reporting period 1 August 2017 to July 2018 the hospital reported no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff), E-Coli.
- Staff completed annual training on infection prevention and control (IPC) as part of their mandatory training. Theatre and ward staff were required to complete two IPC training modules; IPC in healthcare and IPC high impact interventions. Data showed that IPC training completion rates were 94.7% for theatres and 78.6% for the ward and high impact training completion was 100% in theatres and 84.6% on the ward.
- We reviewed a range of monthly infection prevention and control audits from the ward and theatres from the months May to September 2018. These covered hand hygiene, patient equipment, invasive device management and theatre asepsis. All achieved 100% compliance. This was an improvement since out last inspection.
- Clean and dirty equipment were stored in separate areas therefore reducing the risk of cross infection.
- The hospital had processes for the disposal of waste and removal of dirty instruments. These were stored in a "dirty corridor" with access to the outside of the building. A transport trolley was used for dirty instruments awaiting collection for decontamination.
- Staff performed manual cleaning of endoscopes and reusable accessories prior to sending away for decontamination in line with national guidance such as the DH Health Technical Memorandum on decontamination.
- Decontamination and re-sterilisation of surgical and endoscopy instruments was provided at a separate BMI hub facility. The BMI organisation used a track and trace

system to trace all endoscopes, reusable accessories to ensure appropriate maintenance, correct decontamination and traceability to associated patients.
- The endoscopy department, was in the process of remodelling towards achieving Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation.

Environment and equipment

- The hospital was housed in an old building which had been extended, parts of which (staff called this area 'the house') were used for administration offices and parts of which had been closed off as they were not suitable for use. The fabric of the building was on the risk register and we saw that there were ongoing renovations to improve the environment.
- Rooms on the day case wing had hard flooring but this did not comply with the Department of Health, Health Building Note 00-10, which independent providers of healthcare must take account of when planning services. The floor did not have cap and cove which is a continuous return between the floor and the wall with a minimum height of 100mm to allow for easy cleaning. A business case was in progress for replacement.
- The ward and theatre department facilities, surgical and anaesthetic equipment including resuscitation and anaesthetic equipment were available, fit for purpose and checked in line with professional guidance.
- The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) assessments. PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. The hospitals PLACE scores for 2018 were better than the England average and the BMI corporate score in all but two domains, the condition, appearance and maintenance of the hospital and ward food which was better than the national average but not as good as the BMI corporate score.
- The ward and theatre environments were suitable for the level and type of care delivered. In-patients had an individual room with ensuite bathroom and toilet facilities. The rooms were comfortably furnished which patients said met their needs and included a bedside nurse call bell system. The ambulatory care unit was located near the theatres and had bathroom facilities attached.
- There was no piped oxygen or suction available in eight of the inpatient rooms on the ward which meant that they were only used for minor day case procedures where no general anaesthetic was used. Portable oxygen cylinders were available for use in the event of an emergency in these rooms.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- Theatre staff checked anaesthetic machines daily and the tubing weekly.
- Theatre ventilation complied with national guidance HTM 03-01. This meant that there were sufficient air changes to reduce the risk of infection.
- The hospital had its own onsite maintenance team who kept comprehensive records of equipment across all departments, this included current service history, and when the next service was needed.
- Equipment was labelled to show purchase, service and calibration dates where appropriate. We checked 14 pieces of equipment across the ward and theatres, including blood pressure monitors, hoists, scales and operating and anaesthetic equipment and found they all had current electrical testing and maintenance dates displayed.
- There were arrangements for managing waste which included the use of colour-coded bags to dispose of clinical and infected waste and sharps bins for needles etc. All sharps bins we saw were correctly assembled and not overfilled. There was a contract in place with an external supplier to dispose of clinical waste, which was stored securely until collected.
- Clinical specimens were labelled and stored securely in monitored specimen fridges. Both the theatre and ward specimen fridges had consistent records of daily high and low temperature to provide assurance that they were operating correctly.
- The hospital had a tracking system for details of specific implants and equipment to be recorded and reported to the national joint registry. We saw that all equipment, implants and prosthesis were tracked and traced. All records that we looked at had clear evidence of this with batch numbers recorded.

- Both the ward and the theatre suite had resuscitation trolleys for emergency use locked with tamper proof tags. Staff performed daily checks on the resuscitation equipment stored on top of the resuscitation trolleys and weekly checks on the contents. We reviewed a section of the records for trolley checks and found that they were consistently recorded without any unexplained omissions for both trolleys for the period August to November 2018. There was clear indication when the hospital was closed and checks not performed.
- The theatre suite had a difficult airways trolley with records confirming that this was checked weekly for the period August to November 2018. This trolley was not locked which meant that items might be removed and not be available in an emergency. We brought this to the attention of the senior manager and on our return unannounced inspection on 12 November 2018 we saw that this had been changed to a daily check.
- Equipment and consumable items such as dressings were neatly stored on shelves raised off the floor which enabled cleaning of the storage areas.
- The theatre department ordered operating equipment sets from a BMI central hub. If equipment was unavailable they had a good relationship with the local trust to 'borrow' equipment sets in an emergency.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who used the hospital and risk management plans were developed in line with national guidance.
- The service had a current admission policy with a strict admission criterion. Patients with complex co-morbidity and bariatric patients were not accepted as the service did not have the facilities for complex care.
- All patients having a general anaesthetic were assessed in a nurse led pre-operative assessment clinic prior to their surgery. Pre-operative assessment is a clinical risk assessment where the health of a patient is considered to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. It also provides an opportunity to ensure that patients are fully informed about the surgical procedure and the post-operative recovery period and can arrange for post-operative care at home.
- Consultant anaesthetists reviewed pre-admission records on a weekly basis and patients identified as being slightly more complex were risk assessed by an anaesthetist to confirm their suitability for surgery at the hospital. Patients booked for endoscopy or local anaesthetic received a telephone pre-assessment.
- The pharmacy department had also engaged with pre-assessment and a pharmacy technician attended pre-assessment twice per week to review notes from a medications viewpoint to identify patient risks and reconciliation. This process had been in place for 11 months and had been developed as a result of medication incidents impacting on patients not being fit for surgery. At the time of inspection this had not been formally audited to show improvement.
- Patients were swabbed to assess for any colonisation of MRSA at the pre-assessment clinic as per hospital policy. If results were found to be positive the surgery, was deferred and the patient provided with a treatment protocol to use at home, according to the hospital's MRSA policy.
- Staff completed patient risk assessments using nationally recognised tools, such as the Waterlow score to assess patients risk related to pressure ulcers, mobility, moving and handling, venous thromboembolism (VTE) and the national early warning score (NEWS). VTE compliance was audited quarterly and records showed that this was 100%.
- The NEWS is a scoring system applied to a patient's physiological measurements to indicate early signs of deterioration in their condition. We saw that these were documented in the patient's records and included actions to escalate for review . This meant that patients who were deteriorating or at risk of deteriorating were recognised and treated appropriately. Staff were in the process of training for NEWS 2 which is an updated version of the scoring system and due to be rolled out across the BMI organisation.
- Staff were able to describe how they would escalate concerns about a deteriorating patient. The hospital had a resident medical officer (RMO) on duty 24 hours a day to provide medical attention and attend any emergencies. Staff said that they were always responsive and attended when needed. The consultant medical staff were also available by telephone in the event of any concerns about patient care.
- The theatre team used the World Health Organisation (WHO) 5 steps to safer surgery, surgical checklist, and the Surgical Safety Checklist for Cataract Surgery which were designed to prevent avoidable mistakes. This

included checks such as patient identification, allergies and ensuring the consent form had been signed. We observed staff using the checklist prior to surgery during the inspection. The 5 steps to safer surgery checklist was audited monthly and we reviewed the audits from May to October 2018 and saw that they were 100% compliant.

- We observed the WHO 5 steps to safer surgery, surgical checklist being used and saw that it was comprehensive and included all steps to ensure patient safety during the anaesthetic and surgery period. We also observed patients being transferred from theatre to the recovery area, and saw that the anaesthetist, surgeon and scrub nurse verbally handed over the care and treatment carried out in theatre and discussed medication which had been prescribed for both recovery and the ward.
- The hospital had a sepsis screening tool and sepsis care pathway for staff to use if they suspected a patient had sepsis. The tool was in line with current best practice principles from The UK Sepsis Trust. Staff we spoke with were aware of the screening tool and pathway and told us they would escalate any patients displaying these symptoms to the RMO. Sepsis training was part of the mandatory training Care and Communication of the Deteriorating Patient CCDP module. Data supplied by the hospital showed that ward staff were 71.4% compliant and theatre staff had lower (at 38.9%) compliance. We acknowledged that this was a relatively new course and the hospital were in the process of training all clinical staff.
- Staff had immediate access to blood products, to stabilise patients with life threatening haemorrhage. They had also developed a temperature tracking system so that unused blood products could be returned to the local NHS trust to avoid wastage.
- There were on-call facilities which included a radiographer, theatre team, engineer, senior practitioner and senior manager if required in an emergency.
- The practising privileges agreement, that all consultants worked under, stated that consultants should be available to attend the hospital to respond to any urgent concerns within 30 minutes. The RMO and nurses told us that consultants were easily contactable 'out of hours' (such as at night or over a weekend) should staff be concerned with a patient's condition. Individual consultants remained responsible for the overall care of their admitted patients and made arrangements for colleagues to cover in their absence.
- There were arrangements in place with a local acute trust to provide 24-hour emergency support should patients require high dependency nursing or urgent diagnostics. If a patient deteriorated the consultant would arrange for transfer to the local NHS trust. There was a policy to support this process and a service level agreement (SLA) between the hospital and the local NHS trust.
- Patients who had concerns following discharge (including day surgery in the ambulatory unit) could call the hospital or the corporate BMI 24-hour telephone advice line or access 'live support' on the BMI website. The hospital also had a 48 hour follow up call service and staff on the ward were scheduled to provide this.
- The hospital had developed a number of local Safety Standards for Invasive Procedures developed to meet the National Safety Standards for Invasive Procedures. These were assessed against invasive procedures carried out and red, amber and green (RAG) rated on a gap analysis chart. Two were rated amber with the rest rated green indicating they had been achieved. The amber rated were; Teamwork & Human Factors, and Scheduling & List Management. There were plans to introduce human factors training in 2019 and for the Theatre Steering Group to review policy and list changes in December 2018.
- The hospital had an in date major incident policy and a business continuity plan. These included the loss of mains electricity and generator power, fire alarm activation or system failure, and loss of staffing. We saw business continuity action cards for each major incident which detailed the actions staff should take, and useful contacts and telephone numbers. Action cards were held on reception desks to provide immediate guidance to staff should a major incident arise.
- The hospital carried out scenarios with staff for emergency situations such as fire and cardiac arrest. Staff were provided with feedback and any lessons learnt were shared with the department.
- The hospital's resuscitation team was reviewed at the daily comms cell meeting. The comms cell was a meeting held at 9am every morning to review hospital activity and raise any concerns, staffing brief, emails, governance and team meetings, newsletters and noticeboards. Each member of the resuscitation team was allocated a specific role such as leader, airway management, defibrillation, recorder and floater. This was in line with best practice guidance.

- Fire safety training compliance for all staff groups met the hospitals 90% target.

Nursing and support staffing

- Ward nurse staffing consisted of the Clinical Services Lead-Ward (CSLW) who acted as ward manager, and six whole time equivalent (WTE) and two (30 hours) registered nurses (RNs), and three WTE health care assistants (HCAs). There was also one RN on maternity leave at the time of inspection. There were three RN and one HCA vacancy at the time of inspection and the Clinical Services Lead-Ward was an interim position.
- Nursing staff levels and skill mix were planned according to patient admissions which were known in advance. Staffing levels were calculated using the electronic BMI Healthcare Nursing Dependency and Skill Mix Planning Tool. This is an evidence based electronic patient acuity and dependency monitoring tool and ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs. The tool was populated five days in advance and reviewed on a daily basis.
- The CSLW had identified that the staffing tool did not take into account the additional workload when staffing the ambulatory day unit. The manager had escalated this to senior management including the assistant chief nurse and the hospital accountant which resulted in a decision being recently made to staff ambulatory and day case patients differently to inpatients.
- The staff had access to the BMI roster tool but it appeared that they used mainly paper rosters which meant that they were not adhering to the corporate BMI Rostering Policy.
- Two registered nurses were always on duty on the ward, one of whom was a substantive member of staff, plus an HCA. The CSLW was supernumerary. The staff completed a daily acuity tool which ensured there was an appropriate skill mix and staffing for the dependency of the patients.
- We reviewed the paper staff rotas for the period August to November 2018 and saw that all shifts were covered with the addition of bank and agency staff.
- From August 2017 to July 2018 monthly registered nurse bank and agency usage ranged between 19% and 40% of the total RN nursing staff. Staff reported that the agency and bank staff were regular which meant they were familiar with the environment, and processes at the hospital.
- Any shortages in staffing were discussed at the daily 'comms cell,' which was attended by a representative from all hospital departments.
- Theatre department staffing comprised of 10 WTE and six part time staff made up of operating department practitioners (ODPs) and HCAs. There was one HCA vacancy due to go out for advertising.
- Theatre staffing was planned using the theatre TM1 Tool. This tool is designed to automate analysis of a number of key theatre department process measures. The TM1 increases the efficiency of the department by refining staff allocation to patient numbers and procedure mix and therefore reducing staffing costs, creating capacity for additional caseload, improving patient safety and ultimately increasing satisfaction for patients, consultants and staff. The theatre department also used the BMI Resource Model in theatres which incorporated the Association for Perioperative Practice (AfPP) guidelines for safer staffing. The AfPP is a professional body for healthcare workers setting standards and guidance on best practice in operating departments
- The theatre manager provided the theatre rotas two-three weeks in advance. We reviewed staff rotas from September to October 2018 and saw that all shifts were filled. The theatre department did use regular bank staff but no agency staff.
- Senior staff told us that there were ongoing difficulties with recruitment and this was recorded on the risk register.
- Bank and agency staff, were provided with an orientation when new to the hospital, which included access to and the location of emergency equipment and fire exits.
- Staff undertook handover between each shift (day shift to night shift, and vice versa), which included an update on all patients currently admitted and highlighted any specific concerns (such as infection risks or safeguarding concerns) to all staff.
- Theatre staff attended a safety huddle in the morning to ensure all patient needs and risks were identified.
- Heads of department attended a daily comms cell meeting. We saw that there was clear analysis of

hospital activity; this included staffing, current risks, sickness levels, patient cancellations and the identification of staff cover for resuscitation as necessary.

Medical staffing

- Medical care was consultant led under practising privileges. A practising privilege is, "Permission to act as a medical practitioner in that hospital" (Health and Social Care Act, 2008). The hospital had granted 87 consultants/health professionals practising privileges, 20 of whom were anaesthetists, with the rest including but not limited to; specialist surgeons such as orthopaedic, ear nose and throat and urology.
- All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS.
- There was a Practising Privileges Policy for Consultant Medical and Dental Practitioners. We noted that this was a corporate policy and overdue for renewal in October 2018.
- The hospital practising privilege agreement set out the requirements for each consultant concerning their indemnity, appraisal, General Medical Council registration, Disclosure and a Barring Service (DBS) check and yearly mandatory and appraisal proof of compliance. DBS assists employers make safer recruitment decisions and prevents unsuitable or unqualified people from working with vulnerable groups, including children. We noted that not all appraisal checks had been completed for all consultants. This is further described in the well led section of the report.
- The practising privilege agreement also required that the consultant visits inpatients admitted under their care at least daily or more frequently according to clinical need, or at request of the executive director, director of clinical services or resident medical officer (RMO).
- Day to day medical cover was supplied by the RMO who provided a 24 hours a day, seven days a week service, on a rotational basis. RMOs were employed through an agency the company had a formal contract with. They worked a one week on one week off rota. This ensured that their duty weeks were balanced with consolidated periods of rest.
- The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. The external company that supplied the RMOs had a standby programme which could supply additional cover if the RMO had been woken during the night and not received enough sleep to continue working during the day or for absence cover.
- The RMO attended the twice daily ward handovers and performed a handover once weekly to their colleague coming on duty.
- The hospital maintained a medical advisory committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice. It is a requirement of BMI Healthcare's practising privileges policy, that consultants remain available both by phone and, if required, in person, or arrange appropriate alternative named cover if they were unavailable. This was to ensure that a consultant was available to provide advice or review patients at all times when there were inpatients in the hospital. The staff confirmed that this happened.

Records

- Patient individual care records were written and managed to ensure that they were accurate, complete, legible, up to date and stored securely. The computers were password protected and we observed that these were locked when not in use. This was in line with the Data Protection Act 1998.
- Patient care records patients were retained and stored securely within medical records department or an off site electronic archiving database. Consultants were required to register with the Information Commissioners Office (ICO) as independent data controllers and were required to work to the standard set by the Information Commissioner, this included how patients care records were stored and transported.
- The hospital dedicated medical records department had responsibility for filing, storing and maintaining an adequate medical record for patients treated. Staff within this department ensured that medical records were readily accessible for each episode of patient care. Appropriate staff had electronic access to the archived records. Staff within the medical records team provided support, or electronic access at the request of a clinician as required.
- All patient care records were in paper format and kept on the ward for three to five days post discharge.

- All information needed to deliver safe care and treatment was available and easily accessible to the relevant staff for example test and imaging results, care and risk assessments, care plans and case notes.
- All patients received appropriate pre-operative assessments prior to admission for surgery. Telephone assessments took place for patients being admitted for investigations for example endoscopies. The pre-operative assessment paperwork was fully completed and formed part of the paper record.
- Discharge letters were sent electronically to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided.
- We reviewed eight medical records of patients who had been treated in November 2018. We found documentation from all staff was completed thoroughly, with risk assessments, treatment plans, consent forms and completed medication charts, which had all been reviewed by a pharmacist. All contained a completed World Health Organisation (WHO), five steps to safer surgery checklist.
- Patient care records contained stickers identifying equipment and implants used during surgery. This meant that they could clearly be tracked and traced.
- Patient care records were stored in a filing cabinet behind the nurses' station on the ward. The cabinet was not locked but there was always staff at the station which meant that records were not accessible to the public. Records not in use were stored on site for a period of one year following discharge in the electronic swipe access locked records room.
- The hospital audited 20 random patient records quarterly. The audits looked at 49 areas under four headings; general, clinical risk assessment, WHO checklist and pharmacy. Data provided following the inspection showed that although overall scores were good at 90%, in both the June and September 2018 audits, there were poorly performing metrics such as; the patient having access to oral fluids up to two hours prior to surgery which scored 10% and 15% respectively, evidence that the consultant visited daily and wrote progress notes which both scored under 40% and consent signed on the day of procedure 40% and 60% respectively. An action plan was produced following the June audit but there did not appear to be any significant progress shown with the consultant visit and progress notes or the access to oral fluids. We were concerned that the impact of the poorly performing areas had not been properly addressed.

Medicines

- There were effective arrangements in place for the management of medicines.
- Medicines were appropriately prescribed, administered and supplied to people in line with the relevant legislation, current national guidance and best practice evidence.
- There was a pharmacy department on site operated by a pharmacy technician. This was open Monday to Friday, from 9am to 5.30pm three days per week and 9am to 2pm on the other two days. A pharmacist was contracted to attend the hospital 10 hours per week for support and patient medication reviews.
- All medication on the ward and in the theatre department was stored securely in locked trolleys, cupboards and fridges with stock medications stored in locked cupboards in the keycode locked clinical room.
- There was a small stock of 'to take away' (TTA) medicines available in the ward. These consisted of antibiotics and pain relief and could be dispensed by the nursing staff following prescription by the RMO or consultant.
- The hospital used the corporate BMI antimicrobial policy but were investigating linking with the local NHS trust in order to ensure there was consistency with antibiotic prescribing.
- We reviewed a random selection of medications (32 items) stored on the ward and the theatre department and found all to be neatly stored and within date.
- We checked the controlled drugs (CDs) on the ward and in the theatre department and found that these were correctly stored and matched the register. Two registered nurses checked controlled drugs daily and staff had consistently done this throughout the six-month period reviewed from May to October 2018.
- The locked medicine fridges (and separate blood fridge in the theatre department) were temperature monitored daily to confirm that the fridge temperature was suitable for the storage of medications. All anomalies were recorded and the action taken to resolve noted. The ambient temperature of the clinical room was also monitored.

- At the last inspection we were told that anaesthetists often prepared by drawing up controlled drugs ahead of the patient's arrival in theatre, and then left these unattended in anaesthetic rooms. This had improved with the anaesthetists locking the prepared drugs away and we did not see any unattended medications on this inspection.
- The pharmacy team undertook daily visits to the ward and carried out medicines reconciliation for inpatients. This ensured that patients' medicines were reviewed on admission and they continued to receive their medicines appropriately.
- The pharmacy department audited medication prescribing with the most recent audit of 10 medication charts in October 2018. The audit looked at areas such as allergy status recorded, medical history at pre-assessment, medicines reconciliation within 24 hours of admission and the overall score was 92%.
- The ward and theatres performed self-assessment medicines management audits in September and October 2018. Both scored 100% across 54 measurements of compliance.
- We did not observe the administration of medicines during the inspection but did review five medicine charts. Patient data such as weight and height were recorded and allergies identified. This meant that drugs could be prescribed appropriately for individual patients.
- Staff had to access medication guidance, for example the hospital's medicines policy and current British National Formularies.
- The resuscitation trolleys contained emergency medicines including those for the treatment of anaphylactic shock. Anaphylaxis is an adverse allergic reaction which can be life threatening and requires immediate treatment.
- There was piped oxygen in 18 patient rooms and these were set up ready for post-operative patients. Staff confirmed that oxygen therapy was prescribed as needed. For rooms without piped oxygen medical gases were stored safely and in an upright position in line with best practice.
- Between 01 May and 31 October 2018 the hospital reported 22 medication incidents. We reviewed the outcome of the incidents and saw that there were no specific themes and appropriate action was taken and learning identified and shared at team meetings.

Incidents

- The hospital had not declared any' never events' in the reporting period of August 2017 to July 2018. 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 for the same reporting period.
- Between August 2017 and July 2018 the hospital reported 194 clinical incidents of which 89.2% (173) were rated no harm, 9.3% (18) were rated low harm and 1.5% (3) incidents were rated moderate harm. The incidents were not broken down by specific service and covered the theatre department, ward, outpatient department, diagnostic imaging and administration areas. There were no non clinical incidents reported during the same period.
- Following our inspection, we reviewed the root cause analysis (RCA) of a surgery complication requiring the transfer of a patient to the local NHS trust. The RCA was completed 24 hours post incident and involved all of the relevant staff and services. The RCA identified areas where the organisation could have performed better and there were lessons learned for sharing at all relevant committees and the theatre meetings. Following the inspection we were provided with an action plan showing four identified actions which had all been completed. However, this did not include sharing with the rest of the hospital clinical staff or across the broader BMI Healthcare organisation. It should be noted that all clinical staff we spoke with were aware of the incident and that although it was not shared formally, staff had been informed. There was evidence in the RCA that duty of candour had been applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support and apology to that person.
- The hospital had a system for recording and reporting incidents. All staff we spoke with understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report them internally and felt confident to do so.

Good

Surgery

- Staff told us they were encouraged to report incidents and received feedback when they had been involved in an incident. Staff also reported that they received feedback about incidents that had occurred within the hospital and other hospitals within the BMI organisation through the monthly corporate clinical governance and risk bulletin. Information was also cascaded through the daily comms cell meeting, team meetings and at handovers.

Safety Thermometer (or equivalent)

- The hospital measured safety performance and also submitted safety data to the BMI Healthcare organisation. The hospital was performing within the expected parameters when compared to similar sized hospital within the group.
- During the reporting period August 2017 to July 2018 the hospital reported no surgical site infections, no pressure ulcer, no catheter or urinary tract infections or venous thromboembolism episodes and one patient fall.
- The service did not display safety information on the ward for patients and visitors to view.

Are surgery services effective?

Good

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

In this section, we also cover hospital-wide arrangements such as the use of current-evidence based guidance and how they ensure staff are competent to carry out their duties, in the relevant sub-headings within the effective section. The information applies to all services unless we mention an exception.

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

Evidence-based care and treatment

- The service generally provided care and treatment based on national guidance such as the Royal College of Surgeon and National Institute for Health and Care Excellence (NICE).
- Staff followed The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).
- Staff assessed patients pre-operatively with investigations and blood tests based on NICE guidelines to ensure they were fit for surgery.
- All policies were available on the hospital's electronic system. Staff were able to locate them easily when required.
- The National Institute for Health and Care Excellence (NICE) guidelines were reviewed at BMI corporate level cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. These were reviewed by the clinical governance board and recorded on a local register. Staff were required to sign to say they had read the policies.
- The hospital offered an enhanced recovery programme which meant that patients were mobilised out of bed on the day of their operation to help prevent post-operative complications and to encourage early rehabilitation.
- The hospital had a clinical audit programme, which was set corporately by the BMI Healthcare group. This meant that the hospital could benchmark the results from the audits with other hospitals of a similar size within the BMI Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the WHO safer surgery checklist, and medicines management. However the service did not always use the outcomes of audits to drive improvements as noted in the records section of the safe segment of this report.
- The hospital participated in national audit programmes for example: Patient Reported Outcome Measures (PROMS), National Joint Registry (NJR) and the surgical site infection surveillance programme conducted by Public Health England. BMI Healthcare participated in the Private Healthcare Information Network (PHIN). This enabled effective comparison with data available from NHS providers to assist with information transparency and patient choice.
- Audit and policy review were a regular agenda item on the medical advisory committee meetings. For example, in May 2017 a new antimicrobial stewardship policy was

discussed to ensure the hospital improved the use of antimicrobial medications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics, and decreasing unnecessary costs.
- The hospital participated in Commissioning for Quality and Innovation (CQUIN) national goals for NHS patients. We saw evidence that the local commissioning group commended the hospital for achieving the 100% target for in-patients with completed Edmonton Frailty tool. The CQUIN plan for 2018/2019 was based around staff health and wellbeing.

Nutrition and hydration

- Staff completed the malnutrition universal screening tool (MUST) to assess patient's nutritional status and their needs when they were first admitted and updated this during their stay.
- Intravenous fluids were prescribed as appropriate and recorded according to hospital policy. We observed that fluid balance charts were used to monitor patients' hydration status.
- Nausea and vomiting were formally assessed and recorded and patients were prescribed anti-emetic medicines (medicines to prevent/ relieve sickness) post-surgery. This was followed by a gradual re-introduction of food and fluids.
- The hospital did not always follow the Royal College of Anaesthetists, (RCA) pre-operative fasting guidelines for adults. This recommends that food can be eaten up to six hours and clear fluids can be consumed up to two hours before surgery. The patient records audits from June and September 2018 indicated that patients were frequently nil by mouth (NBM) for longer than two hours prior to surgery and on our inspection we observed that a patient was NBM from 6am but not taken to theatre until 11am. We discussed this with both the theatre and ward staff and were told that this was to facilitate sudden changes in the operating list. This did not meet best practice guidance.

Pain relief

- Pain control was discussed at pre-operative assessment and a choice of pain control methods was available and pain advice booklets (your guide to pain control) were given to patients for use post operatively.
- Staff assessed patient's pain as part of the national early warning score (NEWS) assessments. This ensured that pain management was monitored and patients received pain control medication in a timely way. We saw this took place in the medicine charts we reviewed.
- Both inpatients we spoke with were very satisfied with how staff had managed their pain and reported being pain free.
- Patient care records showed that anticipatory pain relief was prescribed and pain was assessed in recovery and on the wards.
- The hospital audited pain management in 20 random patient care records on the ward in August 2018. The audit measured 18 separate indicators with an overall score of 98%.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored.
- The hospital participated in the BMI Healthcare corporate audit programme. This included but was not limited to audits of; patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- The hospital participated in national audit programmes such as the Patient Reported Outcome Measures (PROMs) and National Joint Registry (NJR), and the Patient Led Assessment of the Care Environment (PLACE). PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. The NJR collects data about joint replacement surgery in order to provide an early warning of issues relating to patient safety. The PLACE audit is a national system for assessing the quality of the hospital environment, and focuses entirely on the care environment and not clinical care provision or staff behaviours.
- Results from the hip and knee NJR for the period April 2016 to March 2017 (reported in August 2017) were similar or better than the national average. The hospital submitted data to the groin hernia PROMS but there was insufficient patient responses to calculate an outcome. Submission of data to the cataract surgery PROMS was acknowledged as challenging due to the complexity of completing the outcome forms and the hospital was looking at ways to improve this.

- The hospital compared results on patient outcomes with other locations within the region and across BMI Healthcare group through the corporate quality dashboard. The dashboard compared a number of metrics including but not limited to; return to theatres, unplanned readmissions, transfers out, and infection rates reporting data from similar sized hospitals and the other local BMI locations. BMI St Edmunds performed well within the expected parameters and above similar sized hospitals within the BMI group in some areas.
- The hospital also measured patient satisfaction results, friends and family test (FFT), incidents, and complaints. These were reported on a monthly basis at the management team meetings, the clinical governance committee and medical advisory committee
- As part of the BMI Healthcare organisation the hospital contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements which were regulated by the Competition and Markets Authority (CMA).
- The hospital did not have a quality assurance system such as Joint Advisory Group (JAG) accreditation for collecting data for endoscopy patients but was working towards the standards for achieving accreditation. The outcomes for endoscopy patients were not measured therefore we were unable to assess the effectiveness of the service or patient outcomes.
- The hospital reported two unplanned in-patient transfers to the local NHS trust during the reporting period August 2017 to July 2018 and a further one in October 2018. Both of the earlier transfers were as a result of post-operative complications and the third due to anaphylactic reaction in theatre.
- There were no cases of unplanned readmissions within 28 days of discharge or unplanned returns to the operating theatre in the reporting period. This was an improvement since our last inspection. The senior management reported that there was no formal process for the local NHS trust to inform the hospital if a patient presented to them and was readmitted or returned to theatre but that relationships with the trust were good and they were confident that they would hear about any cases through the patient's consultant.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job.
- All staff were subject to disclosing and barring service (DBS) checks. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups
- There was a BMI Healthcare corporate induction programme for new staff and local induction processes dependent on the hospital department. Staff we spoke with confirmed that induction was relevant, useful and met their needs in the new workplace.
- Staff received the appropriate training to meet their learning needs to cover the scope of their work and were given protected time for training. For example, in the theatre department they had one afternoon per month when there were no surgical procedures performed which staff used for electronic training and also for external trainers/speakers to attend.
- The staff were given opportunities and encouraged and supported to develop. For example, we heard about a consultant colleague offering upskilling opportunities in recognising skin lesions to nursing staff with an interest.
- The theatre manager had oversight of theatre staff competencies and we saw that each staff member had an individual folder containing well organised certificates and competency evidence in the theatre resource room. This was an improvement since our last inspection.
- All staff received yearly appraisals and data supplied following the inspection showed that 15 out of 16 (93.7%) theatre staff and 8 out of 11 (72.7%) ward staff were compliant. The theatre staff appraisal rate was an improvement since our last inspection. The ward rate had fallen and the interim CSLW reported that there had been significant difficulties with a lack of leadership following the previous CSLW leaving.
- Four of the staff we spoke with said that the appraisals were useful to identify progression opportunities and as a result they were undertaking management and specialist courses
- The RMO received mentorship from the director of clinical services but reported that they also received support from the other consultants.
- Consultants only performed surgical procedures which they undertook in the NHS. As most of the consultants held NHS contracts they maintained their skills by working in the trust and had their appraisals completed by their NHS Medical Director.

- There was a process for the granting of practising privileges and the management of checks to ensure General Medical Council (GMC) registration, indemnity cover renewal and mandatory training and appraisals were undertaken.
- BMI Healthcare Practising Privileges Policy required clinicians with practising privileges to produce a number of pieces of evidence to confirm their eligibility to practice at the hospital. On our previous inspection we found that not all consultants had submitted scope of practice documentation. This meant that consultants were allowed to practice without having all their documentation in place.
- On this inspection we reviewed the hospital practising privileges governance process and found that three consultants had not submitted appraisals from 2017 and nine others were overdue from the beginning of the year. We escalated this to the senior management and on our return we clarified that it was two consultants not three who were overdue from 2017. One consultant had already been suspended, the other (a podiatrist) was subsequently suspended. We saw that contact had been made with all consultants that had not submitted their appraisals to ask for these urgently. The hospital had also raised this with the BMI Healthcare organisation as there was a lack of direction in the policy with regard to the timeframe allowed for appraisals to be submitted.
- Nursing staff registrations were checked against the Nursing and Midwifery Council (NMC) registers, nurses were not allowed to practice until they could provide up to date registration evidence and revalidation where appropriate. Revalidation is the process that all registered nurses and midwives in the UK need to follow every three years to maintain their registration with the Nursing and Midwifery Council.
- The registered staff we spoke with confirmed that they were supported with revalidation
- Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice.

Multidisciplinary working

- All of the necessary staff including those in different teams, and services, were involved in assessing, planning and delivering care and treatment and there was effective multidisciplinary team (MDT) working across the hospital. This included surgeons, theatre and ward staff and therapy staff, such as physiotherapists and radiologists.
- The pharmacy technician attended pre-admission clinics and physiotherapy staff mobilised patients post-surgery.
- Medical, nursing and theatre staff reported good working arrangements and relationships with the local NHS acute trust. The hospital had arrangements with the local trust to provide 24-hour emergency support should patients require high dependency nursing and we heard how there was collaborative support for loaning theatre operating equipment sets between the hospital and the local NHS trust.
- There was a strong MDT approach across all of the areas we visited. Staff of all disciplines and grades, worked together throughout the hospital. Staff reported that they worked well as a team.
- All team members were aware of who had overall responsibility for each individual's care.
- The RMO attended the twice daily ward handovers. This meant that they were informed of patients being admitted and who was scheduled for theatre.
- Staff discussed discharge planning with patients and their relatives at the pre-assessment appointment so that effective plans were in place to meet patient need when discharged.
- We saw effective discharge plans in patients' notes. The two patients we spoke with told us that they were involved in all aspects of decision making and care planning.
- Discharge letters were sent electronically to patients' GP's on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided.

Seven-day services

- The hospital provided inpatient care seven days a week, 24 hours a day with planned closure periods over Christmas, New Year, Easter and some Bank holidays. If there were no overnight patients the hospital closed.
- Routine surgery occurred Monday to Friday, 8.30-6.30pm with some late finishes until 8pm. There was occasional extra or urgent work at weekends.
- Routine physiotherapy input was Monday to Friday with cover available at weekends as long as there were patients who required it.

Good

Surgery

- Pharmacy services were available Monday to Friday from 9am to 5.30pm three days per week and 9am to 2pm on the other two days with occasional Saturday mornings. An out of hours service was available through a local commercial pharmacy.
- A senior nurse was always available for advice and support during working hours and there was a 24-hour, seven day a week management team on-call rota. Staff could access them for advice and support as needed.
- Consultants were on call 24 hours a day for patients in their care. The RMO was available 24 hours a day in the hospital to provide clinical support to consultants, staff and patients.
- There was an on-call service for theatre and radiography staff outside of usual working hours. On call staff are usually required to be within 30 minutes travel time of the hospital although we noted that during an incident in April 2018, an on-call radiographer was one hour travelling distance which was noted as an area for improvement.

Health promotion

- The service's website offered advice on a range of health promotion information and posters were seen promoting good heart health and keeping fit.
- Staff on the ward encouraged patients to mobilise early post surgery to help prevent post-surgical complications and encourage independence.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and other relevant national standards and guidance.
- We observed staff asking patients' consent before performing therapeutic treatment and post-operative observations.
- Possible lack of mental capacity to make a particular decision was assessed at the pre-admission stage. The hospital had an exclusion criterion which meant that patients unable to consent were not offered surgery at the hospital.
- Consent forms were completed correctly within patient records we looked at and appropriately identified the procedure planned and detailed the risks and benefits. The hospital consent forms complied with Department of Health guidance.
- Consent was part of the records audit data we received following the inspection. We saw that in the June and September 2018 audits consent was signed on the day of procedure in 40% and 60% of patients respectively. This does not conform to best practice guidance from the Royal College of Surgeons (RCS) which indicates that 'patients should take away a copy of the consent form alongside all relevant information, for reference and reflection. For an elective procedure they should also receive a letter or a copy of the letter to the GP/the referring doctor that gives an account of the discussion that has taken place'.
- Patients were given a two-week cooling off period between being seen in outpatients and a cosmetic procedure taking place. This gave the patient time to decide whether to go ahead with a procedure and allowed time to cancel if needed. This was in line with national guidance from the General Medical Council and British Association of Aesthetic and Plastic Surgeons.
- Training on mental capacity and deprivation of liberty safeguards (DoLs) was included in the mandatory safeguarding adults training.
- Staff we spoke with were able to describe how DoLS might be required and that would contact the director of clinical services and involve the consultant and relatives as appropriate. They also said that in actuality this was not something that they were likely to experience due to the limitations of the admission criteria.

Are surgery services caring?

Good

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

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

Compassionate care

- Throughout our inspection, we saw staff treating patients with compassion, dignity and respect. Patients told us that staff were kind and attentive. They felt that

they were kept well informed about their care and were involved in making decisions about their treatment at each stage. Staff explained the costs of treatment before admission.

- The Patient Led Assessment of the Clinical Environment (PLACE) privacy and dignity score was 96.6% which was higher that the BMI Healthcare average of 86%.
- Patients' privacy and dignity was maintained for example in the operating department only the area being operated on was exposed and in the recovery room and in transit, patients were covered with blankets. Staff knocked on the patient's door before entering their room and the door and curtains closed when requested.
- The hospital monitored patient feedback from their Patient Satisfaction Survey and the NHS Friends and Family Test (FFT). Between May and October 2018, the FFT inpatient scores were consistently above the England average of 96% ranging between 97% and 100%, with an average of 98.6%.
- The FFT is a survey measuring patient's satisfaction with the care they have received and asks if they would recommend the service to their friends and family. The scores related only to those patients seen and treated on behalf of the NHS.
- The patients we spoke with reported that the staff were 'in and out all day checking on them' and came very quickly if they used the call bell. They appreciated the level of care and felt safe. They also said that they were 'very happy and could not fault the service' and that they 'had no pain after their operation' and that 'staff were always asking and offering pain relief'.
- Staff understood and respected the personal, cultural, social and religious needs of people and how these may related to care needs. For example, they checked how patients preferred to be addressed and recorded this in the care pathway.
- Staff took the time to interact with people who use the service and those close to them in a respectful and considerate way.
- We observed that patients were spoken to in a polite and courteous manner and staff sought permission before providing treatment.
- Staff at the hospital encouraged patients to complete patient satisfaction questionnaires to review and improve patient experience. The results of the questionnaire were collated by an external company and a monthly report provided to the hospital for view and analysis and cascade to the hospital team. The monthly report showed patient response rates, rating within categories and ranking against all BMI hospitals. At the time of inspection the hospital was rated 9th out of 55 BMI hospitals nationally.

Emotional support

- Staff had a good understanding of the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. For example, one staff member talked about how they reassured a patient about scarring following a procedure on their face.
- People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Information was provided at pre-admission and they were signposted to other support services as required.
- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.
- The service had an open visiting policy; this meant that patients could be supported by friends and family when needed.
- Patients told us staff regularly checked on their wellbeing and to ensure their comfort.
- The hospital did not have its own chaplaincy service but had links with local services who attended if requested.
- Patients had access to counselling services if needed and staff would liaise with the GP as necessary.

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in their care planning and that they were given the opportunity to ask questions about care and treatment. Staff gave leaflets to support the verbal information provided.
- The two patients we spoke with said that they were satisfied with the way their consultant had explained their diagnosis and treatment and that they were fully aware of what was happening. The privately funded patient reported that, the cost for treatment was fully explained and there was written information, both general and individual to support what had been discussed verbally.

Good

Surgery

- Patients said that staff explained their care and treatment in easy to understand terminology and that all relevant risks and benefits of the operation had been discussed prior to the patient consenting.
- Patients felt comfortable asking questions and said that staff took time to explain and answer their queries.
- The ward staff performed follow up telephone calls 48 hours post discharge. A nurse was rostered to call patients to check that they had no problems or complications. Staff said that patients were appreciative of the service and that it enabled patients to ask questions that they had not thought about during their admission.

Are surgery services responsive?

Good

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

In this section, we also cover hospital-wide arrangements such as service planning and learning from complaints, in the relevant sub-headings within the responsive section. The information applies to all services unless we mention an exception.

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

Service delivery to meet the needs of local people

- The services provided reflected the needs of the local population served and ensured flexibility, choice and continuity of care.
- Patients and relatives attending the hospital had access to limited free car parking within the hospital grounds and the hospital was sited in a central location within the town, with access to transport links.
- The hospital worked with local commissioning groups to support NHS patients treated with a number of procedures including but not limited to cataract eye surgery, joint replacement, hernia repair and endoscopy.
- The hospital held weekly bed management meetings where they reviewed admissions for surgery for the following two weeks. The senior clinical and administration teams attended, ensuring a collaborative team approach. This enabled staff to ensure they were prepared and equipped for the patient pathway, discussing staffing, equipment, skill mix, and concerns.
- Theatre lists for elective surgery were planned with the theatre manager and bookings team. This ensured all aspects of patients' requirements were checked and considered before booking a patient on to the list and ensured that operating lists were utilised effectively.
- Between August 2017 and July 2018 51% of patients who stayed overnight were non-NHS funded and 49% NHS funded.

Meeting people's individual needs

- The hospital had an open visiting policy and encouraged contact with family and friends for support and assistance.
- There was level access for people with limited mobility and wheelchair users and lifts to access the upper floor.
- There was a variety of hoists and pressure relieving equipment for the safe management of patients.
- Staff identified the information and communication needs of people with a disability or sensory loss at the pre-admission stage and recorded this information on the patient pathway document. For example, interpreters, where English was not a first language, were available as was an online translation service. A loop induction coil was available on reception to support patients who were hard of hearing.
- Staff provided information leaflets for a range of conditions and to support care given. These were written in English but could be obtained in other languages.
- The hospital did not treat bariatric patients or those with complex needs due its admission/exclusion criteria.
- The catering arrangements were outsourced to an external provider and there was a variety of meals provided for patients which they said met their needs. Facilities were available for special diets including cultural dietary needs as required. Patients expressed a high degree of satisfaction with the food and fluids and said they were offered choices. The staff provided support with meals as needed and hot and cold drinks and snacks were readily available.
- The hospital used care pathways for surgical patients. These pathways promoted effective patient care based

on evidence based practice and ensured that individual patient's needs were recognised. They also provided flexibility to enable patients the option to stay an additional night according to need. This was evidenced in the way they reviewed the needs of older self-funding patients who may not feel safe to return home after two nights and, dependent on individual assessment, offered a third night at no additional charge to the patient.

- The hospital assessed all patients over 75 years of age using NHS guidelines and through the Edmonton Frailty tool which assesses 10 domains including cognitive impairment and balance and mobility. This was noted on the care pathways and addressed the risks of a hospital stay and subsequent discharge to ensure that these patients' needs were recognised and could be mitigated. This was part of the national Commissioning for Quality and Innovation CQUIN and the hospital achieved the 100% target for in-patients' assessment for the period assessed.

Access and flow

- The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their surgery, subject to consultant availability.
- Patients had access to assessment, diagnosis and treatment; the hospital had no waiting lists for surgery for private patients. A cooling off period between booking and surgery allowed patients to cancel or postpone their surgery, if they changed their mind.
- All patients having a general anaesthetic were assessed in a pre-assessment clinic prior to their surgery. This ensured that they met strict admission/exclusion criteria as the hospital did not admit patients with complex co-morbidity or bariatric patients.
- Patients' discharge planning began at the pre-admission assessment stage with involvement of allied health professionals as needed including but not limited to pharmacy and physiotherapy.
- Between May and October 2018, the hospital cancelled 19 patients' surgeries. 14 of these were cancelled due to patient condition and four due to a leak in the roof. The 5th patient was cancelled due to the previous surgery overrunning.
- When procedures were cancelled or were delayed, this was recorded as a clinical incident and appropriate actions taken. Cancellations were explained to people, and they were offered alternative date within 28 days apart from one patient who was rescheduled at 30 days.
- Staff said that generally operating theatre lists were well organised and ran on time, however they did change the order of patients on the lists on the day which meant that some patients waited longer than they needed to without food and drink. This was not best practice.
- Patients with the most urgent needs were prioritised. For example, those with diabetes were placed at the beginning of the theatre lists to minimise the impact of the surgery on their diabetes management. Staff told us that once any those patients had been treated, other funded patients were prioritised over NHS patients.
- The hospital provided an on-call theatre team however, in the event of a patient deteriorating and requiring further intervention there was a service level agreement (SLA) in place with the local NHS trust and ambulance service to transfer patients for more complex care and treatment.
- The hospital used telephone pre- admission clinics for ambulatory local anaesthetic procedures and a corporate telephone pre-admission service for endoscopy patients. This meant that the service was streamlined without the necessity for patients to attend the hospital for minor procedures.
- From April to October 2018 the NHS England average for patients who received surgery within 18 weeks of referral (referral to treatment inpatient pathway admitted) was 87.3%. However the service performance for the same period was lower, between 75.7% and 87.8% with an average of 81.5%. It is acknowledged that although data on admitted pathways are still collected, there is no longer an operational waiting time standard.

Learning from complaints and concerns

- Between August 2017 and July 2018, the hospital received 33 complaints, this was not broken down by service and represents the total number of complaints received at the hospital. There was a downward trend in complaints from the previous two years.
- We reviewed two complaints from non- NHS funded patients regarding post-operative care and saw that they were responded to within the corporate time frame and all effort was made to resolve the complaint including face to face meetings.

Good

Surgery

- The hospital had a transparent process for responding to complaints. There was a corporate BMI complaints policy date August 2018. The complaints policy followed a three-stage process in dealing with complaints, with clear timeframes.
- Staff we spoke with were aware of the complaints procedure and were encouraged to identify and address any patient (or relative) concerns or issues whilst the patient (or relative) was still on site and escalate to their line manager for prompt resolution. For more serious issues staff were encouraged to escalate complaints and concerns immediately to the executive director, director of clinical services, director of operations or the head of department on-call.
- We saw complaints leaflets, 'Please tell us', available throughout the hospital and saw the hospital website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email.
- Patient rooms had Patient Information Guides which included a section outlining the formal complaints procedure.
- The two surgical patients we spoke with knew how to make a complaint but stated that there were no reasons that they would consider it.
- The responsibility for all complaints rested with the executive director (ED) in liaison with their executive assistant (EA). On receipt of a new complaint the ED involved the head of the relevant department in the investigation of a complaint. Corporate protocols required that complaints were acknowledged in writing within two working days.
- The EA monitored the response process to ensure that timescales were being adhered to. If a response was not able to be provided within 20 working days a holding letter was sent to the complainant to keep them fully informed of the progress of their complaint.
- All complaints and their accompanying documents were loaded on to the hospitals incident/risk reporting system. Dependent on the nature of the concern, complainants were invited into the hospital for a meeting with the ED and associated manager to discuss the investigation findings. Following the meeting a response was prepared and sent to the complainant.
- We reviewed a selection of complaints received between 01 March and 31 July 2018 and saw that there were no specific themes and complaints were responded to within the specified time periods according to the complaints policy.
- The hospital reported that their most common complaint was about self-pay. To improve this, they improved signage in all consulting rooms and appointed a business development lead to manage the self-pay expectations.
- NHS patients who were unhappy with the complaint response had the option of Parliamentary and Health Service Ombudsman, private patients were signposted to the Independent Sector Complaints Adjudication Service (ISCAS). During the reporting period August 2017 to July 2018 two complaints were referred to ISCAS.
- Complaints were reviewed at the hospital governance meeting, heads of department (HODS) meeting, medical advisory committee (MAC) and department meetings. They were also discussed at the daily comms cell meeting.

Are surgery services well-led?

Good

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

In this section, we also cover hospital-wide arrangements such as, leadership, the management of risks and governance processes, in the relevant sub-headings within the well-led section. The information applies to all services unless we mention an exception.

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

Leadership

- The hospital was led by an executive director (ED) supported by senior management team members, which included an executive assistant (EA), quality and risk manager, patient liaison officer, director of clinical services (DCS), director of operations (DO) and the medical advisory committee (MAC) chair.

- The senior management team were supported by heads of department (HoDs) or managers for theatres, outpatients, pharmacy, diagnostic imaging, physiotherapy and the ward. The ward had an interim manager in place and the hospital were recruiting to the position.
- The clinical HoDs reported directly to the DCS, and non-clinical HoDs to the DO.
- The leaders had the skills, knowledge, experience and integrity that they needed for their roles.
- The department managers that we spoke with had a good understanding of the challenges to quality and sustainability, and were able to identify the actions needed to address them. For example, the theatre manager was aware that the endoscopy provision did not meet best practice guidance for facilities and would not meet Joint Advisory Group accreditation but they had a plan of remedial works in place and were working towards it.
- Staff we spoke with felt the organisation supported them to deliver the patients' care. They told us that the director of clinical services promoted a positive culture and valued staff.
- Consultant medical staff told us they had a good working relationship with the staff and senior management to deliver care and meet patients' needs.

Vision and strategy

- The hospital used the BMI Healthcare corporate vision, which was to offer "the best patient experience and best outcomes in the most cost-effective way". The vision had been translated into eight strategic priorities, which were entitled: Governance framework, Superior patient care, People, performance and culture, Business growth, Maximising efficiency and cost management, Facilities and sustainability, Internal and external communications, and Information management.
- The hospital had a five year plan (2015-2020) with details of the objectives and priorities aligned to the eight strategic priorities. The plan was robust, realistic and achievable for delivering good quality sustainable care. Progress against achieving the objectives was reviewed and monitored at various committee meetings, including hospital governance and heads of department meetings. We saw that some of the objectives had been achieved, for example; the introduction of the digital app for consultants to improve clinic and theatre diary management and a local reward and recognition programme for staff.
- The vision and five year plan was cascaded to teams through departmental meetings, staff forums and notice boards. A presentation was produced to facilitate communication at meetings. All staff we spoke with knew of the vision but not all were knowledgeable about their role in achieving it.

Culture

- The service had a caring culture. Staff told us that they enjoyed working on the wards and in the theatre department and felt well supported by their departmental managers.
- Department managers told us that they had an open door policy and that they were proud of their staff and their departments.
- Staff told us that they felt departmental managers were approachable. The theatre manager and the CSLW worked clinically and would provide clinical cover for sickness as appropriate.
- The executive director and clinical service director were well respected, visible and supportive.
- The hospital culture encouraged openness and honesty. Staff told us they felt comfortable raising concerns and felt the hospital had a "learning culture, not blame culture". Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.
- All staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care for their patients.
- Action was taken to address behaviour and performance that was inconsistent with the vison and values, regardless of seniority and we saw that poor performance management had recently occurred with a relatively senior staff member.
- There were mechanisms for providing all staff at every level with the development they needed, including appraisal, regular one to one sessions and career

development opportunities. For example the organisation supported staff to develop leadership and management skills, with courses available for all levels of staff.

Governance

- There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, and sustainable services.
- All levels of governance and management functioned effectively and interacted with each other appropriately and there was a quality and risk manager who oversaw local quality, risk and incident management processes.
- There was a clear governance structure in place with a variety of committees, for example, HoD meetings, infection prevention and control, and health and safety, which fed into the hospital's clinical governance meetings and ultimately reported to the BMI corporate board.
- We reviewed four sets of clinical governance meeting minutes and saw they were well attended by the senior management team, HoDs and clinical leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks.
- We reviewed minutes of the medical advisory committee (MAC), which met quarterly, from September 2017 to July 2018 and found a good mix of specialities attending, including an anaesthetist however we noted that there was no representation at any of the meetings for orthopaedics which was the largest proportion of surgical work at the hospital. The MAC chair had recently changed and they commented that they were keen to have more involvement from their colleagues with practising privileges.
- The role of the MAC chair included ensuring that all consultants were skilled, competent, and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document, these were reviewed bi annually. Registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, Disclosure and Barring Service check and indemnity insurance were all checked by the hospital and ratified by the MAC.
- During the inspection we reviewed the records of appraisals for consultants with practising privileges and noted that a number of consultants had not submitted appraisals due in 2018 and also from 2017. It was noted that there was no clear guidance for the period of grace in which to submit appraisals in the practising privileges policy. The lack of compliance was escalated to the ED. On our return unannounced inspection, we were provided with information which showed that all consultants missing appraisals had been contacted and two consultants had already been suspended
- Staff at all levels were clear about their roles and responsibilities and understood what they are accountable for, and to whom.
- There were strong links with the local NHS trust and evidence that arrangements with partners and third-party providers were governed and managed effectively.
- At our previous inspection there were concerns regarding the oversight and supervision of staff competencies specifically in theatres and diagnostic imaging. We saw that this had improved significantly and all competency folders were up to date.

Managing risks, issues and performance

- There were comprehensive assurance systems, and performance issues were escalated appropriately through clear structures and processes. These were regularly reviewed through a variety of regular committee meetings.
- The hospital had a corporate risk register which contained 37 risks and was regularly reviewed and updated to ensure that risks were monitored and appropriately managed.
- There were arrangements for identifying, recording and managing risks. Heads of departments had ownership, and managed departmental risk registers which fed into the hospital's risk register. The ward and theatre documented risks reflected what staff had told us. Risk performance was discussed through the committee meeting structure and there was good engagement from department leaders. This was an improvement since out last inspection.
- There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. However, we were not assured that this process was embedded as areas of poor performance noted in the June documentation audit although noted in clinical governance meeting minutes, did not show any improvement at follow up audits.

- The clinical governance committee (CGC), met every month and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, risk register review. There was also a standing agenda item to review external and national guidance and new legislation, such as National Institute for Health and Care Excellence (NICE) guidance. This ensured the hospital implemented and maintained best practice, and any issues affecting safety and quality of patient care were known, disseminated managed and monitored.
- The daily comms cell meetings covered a range of subjects including risk review, recent incidents, health and safety update, training compliance review, and any concerns that affected the hospital. This enabled staff to gain a wider view of risk, issues and general performance within the hospital.

Managing information

- Managers had a good understanding of performance monitoring, with information on quality, operations and finances used to measure improvement, not just assurance.
- There were clear and robust service performance measures, which were reported and monitored by the parent BMI organisation and the local commissioners. These included data and notifications that required submission to external bodies.
- Staff had access to a range of policies, procedures and guidance which was available on the service's electronic system
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre and post-operative records.
- Medical records storage had improved since our last inspection with the addition of a swipe card system to improve security, and tracking of notes for traceability. Historical medical records were a concern, but the hospital had set up a tracking system for notes leaving and returning to the secure note storage area.
- Information technology systems were used effectively to monitor and improve the quality of care. The corporate risk and incident recording system was updated relatively recently and provided the hospital with a platform to monitor and assess risks and assess trends.
- The BMI Group had policies and processes in place governing Information Governance, Security and Personal Data Protection. All data controller registrations for the processing of personal data were maintained in accordance with the requirements of the UK Information Commissioners Office and information security and governance policies were compliant with ISO/IEC27002 the Code of Practice for Information Security Management.
- The hospital had a 'Consultant App' which allowed remote login to clinics and theatre lists on a smartphone. The app enabled consultants to access clinic and operating theatre data. The application was downloaded using BMI credentials. No data was stored on the phone and a time out was applied for security.

Engagement

- The hospital actively gathered people's views and experiences through questionnaires but we were not made aware of any specific changes that had been introduced as a result.
- The hospital told us that before any change was implemented they spoke with staff about the benefits and reasons for the proposed change and sought staff feedback. This engagement happened through departmental and staff meetings and information was provided in the hospital weekly newsletters.
- Staff told us that managers at all levels were approachable and that they felt comfortable to raise any concerns with them.
- We observed that the corporate BMI 'Reward and Recognition' scheme had been introduced, and that each month an employee was nominated to receive a reward in recognition for going above and beyond their normal duties.
- Staff told us that there were positive and collaborative relationships with their external partners and transparency and openness with local stakeholders about performance. Senior leaders had regular engagement meetings with the local NHS trust and clinical commissioning group (CCG) to deliver services to meet the needs of the local population.
- We heard about local reward schemes such as providing hospital wide treats for staff when BMI ratings achieved a ranking of ninth throughout the organisation.

Learning, continuous improvement and innovation

Good

Surgery

- There were robust systems and processes for learning, continuous improvement and innovation. We heard about support for staff to develop extended practice and management courses.
- Within the theatre environment staff regularly took time out to work together to both for personal and professional development and review team objectives, processes and performance.

Good

Outpatients

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

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

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

Mandatory training

For our detailed findings on mandatory training, please see the surgery section of this report.

- Mandatory training subjects included, but were not limited to; infection prevention and control, conflict resolution, safeguarding adults and children and information governance.
- Mandatory training was delivered through variety of methods including e-Learning (electronic system named BMILearn) and face to face.
- Outpatient mandatory compliance was 93.3% which exceeded the target of 90% compliance set by the organisation.
- The outpatient lead oversaw mandatory training compliance within the department, and senior managers had oversight of all hospital staff.

Safeguarding

For our detailed findings on safeguarding, please see the surgery section of this report.

- There were effective systems and processes in place to safeguard vulnerable patients from abuse.
- Data provided prior to our inspection demonstrated that 100% of staff had completed safeguarding children and adults level one and 75% of staff had received safeguarding adults and children level two. The outpatients lead nurse reported that the hospital was in the process of arranging for level three adults and children safeguarding training for all registered nurses.
- Staff were clear in their responsibilities to identify and report any identified safeguarding concerns and all staff we spoke with knew who the lead was for safeguarding.
- Outpatient areas displayed flow charts to guide staff in decision making. Local authority contact numbers and referral information was available to staff.
- Staff had access to safeguarding policies for adults and children. The policies provided guidance on various forms of abuse including female genital mutilation, radicalisation and domestic abuse, neglect and child sexual exploitation. We reviewed the policies and noted they were in date and subject to regular review.
- Staff showed an awareness and understanding of recognising female genital mutilation (FGM) concerns and this training was being rolled out to all staff. At the time of inspection compliance was 57% with four out of seven staff having completed it.

Cleanliness, infection control and hygiene

- For our detailed findings on cleanliness, infection control and hygiene, please see the surgery section of this report.
- Infection prevention and control (IPC) was part of the corporate mandatory training and outpatient department (OPD) staff achieved 100% compliance.
- The outpatient service controlled infection risk well. Staff kept themselves, equipment and the premises

clean. They used control measures to prevent the spread of infection such as wiping down the equipment with cleaning wipes between patients and the use of paper couch rolls on couches.

- The outpatient lead was also the infection control lead for the hospital and they ensured that the daily, weekly and monthly cleaning regimes in place were adhered to. There were cleaning schedules displayed in each consulting room. These were all signed and dated to evidence regular cleaning took place.
- At the time of our March 2017 inspection, some consultation rooms were carpeted. This was not deemed best practice due to an elevated risk of infection. During this inspection, consultation rooms had been refurbished and hard flooring was in place to improve the hospital's compliance with infection, prevention control.
- There were reliable systems in place to protect people from healthcare-associated infections. Data confirmed there had been no cases of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) and E-Coli infections in the reporting period August 2017 to July 2018.
- Staff followed the corporate 'Hand Hygiene Policy (including training) (dated May 2016), which included training, types of hand hygiene, soap and water and wearing of jewellery. Staff adhered to the 'arms bare below the elbow' guidelines.
- The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.
- Equipment had dated, green 'I am clean' stickers showing that equipment had been cleaned and was ready for use.
- Staff had protocols to follow in the event of a patient attending with a suspected communicable disease or with a compromised immune system such as those receiving oncology treatments. They were seen at the end of a clinic if the service had prior knowledge, and rooms were decontaminated after the consultation.
- We reviewed the hand hygiene, equipment and IPC observational audits for the months May to September 2018 and saw that they achieved 100% compliance.
- The OPD used a nationally recognised three wipe system for the decontamination of flexible endoscopes used in OPD. Although not gold standard this did comply with national guidance such as the DH Health Technical Memorandum on decontamination.

Environment and equipment

For our detailed findings on environment and equipment, please see the surgery section of this report.

- The service had suitable premises and equipment and looked after them well. The outpatient service had seven individual consulting rooms, two pre-admission clinic rooms, one treatment room, a dirty utility area, an auditory room, and an outpatient waiting area.
- The OPD furniture such as chairs and couches were in a good state of repair and compliant with HBN 00-09 (that it was fully wipeable). There was a reception desk where patients booked for appointments. The consulting rooms were tidy and equipped with a desk and chairs for discussions with patients, and a couch for examinations.
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff to ensure their safety and reduce risks of cross infection when performing procedures. Hand sanitiser gel was available in all rooms.
- The treatment room contained a range of clinical consumable items and the department's drug cupboard. The clinical items were stored securely and well organised. All consumables we checked were within expiry date.
- The service had rooms allocated to specialties with appropriate equipment for investigations such as ophthalmology. This enabled equipment to be easily accessible to reduce waiting time.
- There were 'sharps' bins available in all the consultation rooms and the bins were correctly assembled, labelled, and dated. None of these bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.
- There was a resuscitation trolley in OPD which contained appropriate equipment and medicines in drawers locked with a numbered tamper proof tag. The equipment on top of the trolley such as the defibrillator and suction equipment was checked daily on days when clinics operated. The contents in the drawers were

checked weekly. Records indicated that checking was consistently signed for without unexplained omissions. All consumables were in date and the trolley was clean and dust free.

- Waste was separated and stored in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations.
- Staff monitored the temperature of the fridge used for storage of clinical specimens daily and records indicated that this was consistently checked with no anomalies.
- We checked six pieces of equipment such as observation monitors and fans and saw that they had stickers indicating maintenance and electrical testing within the previous 12 months.

Assessing and responding to patient risk

For our detailed findings on assessing and responding to patient risk, please see the surgery section of this report.

- Comprehensive risk assessments were carried out in the pre-assessment clinic for people who used services and risk management plans were developed in line with national guidance.
- There were clear pathways and processes for the assessment of people within outpatient clinics who were clinically unwell and required hospital admission.
- Patients who became medically unwell in outpatients were transferred to the local acute NHS Trust in line with the emergency transfer policy. We observed this in practice when a patient collapsed and required admission to the local NHS trust.
- Staff responded appropriately to changing risks to people who use services, including deteriorating health and wellbeing, and medical emergencies. OPD staff always had access to the resident medical officer (RMO), on duty, who was trained in advanced life support and paediatric life support.
- Basic and immediate life support were part of mandatory training. At the time of inspection OPD staff compliance was 100% for basic life support and 75% for Immediate life support.
- Care and communication of the deteriorating patient training had recently been introduced as new mandatory training. Data confirmed that five out of seven staff (71.4%) had completed this at the time of inspection.

Nurse staffing

- The OPD had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staffing levels and skill mix were planned according to booked clinics.
- The outpatient staff consisted of the clinical lead, one whole time equivalent (WTE) and two part time (15 hours and 12 hours per week) registered nurses (RN), and two part time healthcare assistants (HCAs), who worked 32 and 20 hours per week. A further WTE RN had been recruited for OPD and was due to start in January 2019. There was also a WTE HCA and a newly recruited WTE RN for the pre admission clinic.
- The OPD had used a regular agency member of staff to cover the pre- admission clinic prior to the recruitment of the new RN.
- There was a corporate induction policy and new and agency staff had a period of induction being supernumerary before working unsupervised.
- An agency staff member we spoke with confirmed that they received a comprehensive induction programme prior to working alone.

Medical staffing

For our detailed findings on medical staffing, please see the surgery section of this report.

- The service did not directly employ any medical staff and had a contract with an external company for the provision of resident medical officers (RMOs) who provided a 24 hours a day, seven days a week service, on a rotational basis. The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support.
- There were a total of 87 medical staff who provided treatment within the hospital under practising privileges. These staff worked across the outpatient department and inpatient wards. The majority of these also worked at other NHS trusts in the area.

Records

- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to staff providing care.
- The service used a paper based record system for recording patients care and treatment. We reviewed 13 patient records and saw that they contained all the information needed to deliver safe care and treatment including test and imaging results, care and risk assessments, care plans and case notes.
- Consultants recorded patient information on triplicate forms which enabled a copy to be kept in the patient records, one for the consultant to take with them and a patient copy. This was an improvement since our previous inspection when patient contemporaneous note recording was poor. The service had put an action plan in place following the inspection and monthly audit average was 86% compliance. Consultants not complying received a letter from the executive director and a reoccurrence was raised with the Medical Advisory Committee (MAC) chair, and reported in the MAC meetings.
- In the outpatient department, patient records for those attending clinic were kept in folders stored in a locked cabinet at the reception desk and collected by nursing staff prior to a patient's appointment time and given to the consultant.
- There was a dedicated medical records department with responsibility for filing, storing and maintaining medical records. Staff within this department ensured that medical records were readily accessible for the appropriate clinical department prior to the patient appointment time. There were checking processes to ensure that patients' notes were confirmed as available and complete the afternoon before a patient's attendance.
- In order to maintain a manageable level of patient records to ensure ease of accessibility, medical records were regularly sent to a secure electronic medical database (EDM) where they were scanned for archiving. Appropriate staff were able to directly access EDM to review and where required print archived medical records. Staff within the medical records team provided support, or access EDM at the request of a clinician as required.
- Information provided by the hospital confirmed that no patients were seen without medical records during the reporting period August 2017 to July 2018 and no patient appointments cancelled due to lack of records.
- Following a patient consultation, a letter was sent to the patient's GP to communicate any changes to treatment. This was usually the same day but the hospital did not measure or audit this.

Medicines

For our detailed findings on medicines, please see the surgery section of this report.

- The OPD managed medicines and prescriptions safely and securely. The pharmacy technician regularly checked stock levels and had processes to monitor expiry dates.
- The OPD did not use or store any controlled drugs. There were a small amount of limited medications stored safely in a locked cupboard and fridge. The temperature of the fridge was consistently monitored daily on the days the clinic was in use and the records showed that staff took appropriate action when temperatures were out of safe storage range.
- The service used in house prescriptions which could only be dispensed at the hospital pharmacy. Prescription sheets were monitored and logged to ensure traceability. Staff commented that they were reviewing the use of in house prescriptions with a view to moving to prescriptions that could be used at other pharmacies outside the organisation.

Incidents

For our detailed findings on incidents, please see the surgery section of this report.

- The OPD managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- All staff we spoke with were aware of their responsibilities to report concerns and incidents and able to give examples of when and how they would report an incident.
- The BMI corporate clinical governance and risk bulletin produced monthly newsletters and staff reported that they were useful for sharing learning from other hospitals within the organisation. We noted there was a copy of the most recent bulletin in the OPD and staff referred to learning from the bulletin. Information was also cascaded through the daily comms cell meeting,

team meetings and at handovers. The comms cell meetings covered a range of subjects including but not limited to; a review of recent incidents, a health and safety update, training compliance review, planned clinics and risk review. This enabled staff to gain a wider view of risk, issues and general performance within the hospital.

- Between July 2017 and June 2018, the OPD recorded 59 clinical incidents. The majority of these were attributed to incorrect filing of patient documentation followed by missing pre- assessment documentation for patients due to be admitted and patient failure to attend pre-admission appointments. The service had improved the tracking and storage of patient notes and we saw that incidents relating to records had reduced.
- Staff we spoke with had a good understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Are outpatients services effective?

Not sufficient evidence to rate

We do not rate effective.

Evidence-based care and treatment

For our detailed findings on evidence-based care and treatment please see the surgery section of this report.

- Specialities within the outpatient department (OPD) delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate.
- Staff in OPD had a good awareness of local policies and were able to give us examples of how to access policies electronically and when they had used them.
- We reviewed a selection of corporate policies prior to and during the inspection. All were found to be within their review date and referenced current national guidance.
- The OPD participated in a number of local audits including but not limited to; medical records, infection prevention and control and hand hygiene.
- Compliance with local audit was monitored at the daily comms cell meetings. Meetings took place at 9am and were attended by the outpatient lead to enable feedback to staff within the outpatient department.
- Staff used telephone preadmission assessments for minor procedures. This saved patients unnecessary trips to the hospital and helped to enhance the delivery of effective care and treatment and to support people's independence.
- Staff in the pre- admission clinic used a comprehensive pre-admission questionnaire to assess patient's suitability for surgery and there were specific patient pathways dependent on type of surgery/procedure.
- Older people who were identified at pre-admission to be frail or vulnerable were referred to appropriate services.

Nutrition and hydration

- Staff assessed people's nutrition and hydration needs at pre- admission clinic appointments in preparation for admission.
- There was access to free hot and cold drinks in the OPD waiting area and we observed reception staff inviting people to help themselves.

Pain relief

For our detailed findings on pain relief, please see the surgery section of this report.

- Patients we spoke with had not required pain relief during their attendance at the outpatient departments.
- Staff provided pain relief advice during the pre-admission clinic prior to patients being admitted for surgery.

Patient outcomes

For our detailed findings on patient outcomes, please see the surgery section of this report.

- The OPD contributed data to the BMI corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- The OPD contributed data to national Patient Reported Outcome Measures (PROMS) for hip and knee replacement surgery, hernia repair and cataract surgery and the National Joint Registry (NJR). Results were monitored and discussed at the hospital's governance

and medical advisory committee on a monthly basis, as well as at regional and corporate level. Outcomes were also benchmarked against other comparable hospitals within the BMI corporate group. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self- completed questionnaires. This health status information is collected before and after a procedure.

Competent staff

For our detailed findings on competent staff, please see the surgery section of this report.

- There were systems and processes in place to ensure staff were competent within their role, developed and regularly appraised.
- OPD staff achieved 100% compliance with annual staff appraisal and staff confirmed they received adequate support and supervision such as one-to-one meetings.
- The outpatient lead nurse, director of clinical services and executive director monitored compliance with training to ensure staff had the necessary skills and knowledge to safely carry out their role.
- A BMI corporate induction workbook provided a range of information to staff including signposting to learning resources including BMILearn (online training).
- Staff we spoke with confirmed they were given time to complete electronic learning and had access to external courses if identified it was applicable to their role.
- We spoke with staff who had undertaken extended roles such as phlebotomy (taking blood samples) who reported that they were supported and encouraged to develop.
- Registered nursing staff had access to online guidance to support with the revalidation process. Data showed all nurses were within their revalidation period at the time of our inspection.

Multidisciplinary working

For our detailed findings on multidisciplinary working, please see the surgery section of this report.

- All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- There was a strong multi-disciplinary team (MDT) approach across all the areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. We saw good collaborative working and communication amongst all members of the MDT. Staff reported that they all worked well as a team.
- Staff worked together to plan care for patients with additional needs and we heard about arrangements that were made following a pre-admission clinic to extend the planned stay for one patient who would not have coped following the normal surgical pathway.
- There was support from some NHS specialist nursing staff who accompanied consultants to OPD clinics.

Seven-day services

- The OPD offered clinic appointments Monday to Friday, 8am to 8pm with some Saturday clinics to accommodate increased demand for appointments.

Health promotion

- There was a range of health promotion leaflets and posters available in the OPD.
- Staff in the pre-assessment clinic identified health risks to patients and signposted them to appropriate support for example smoking cessation obesity, drug and alcohol dependency.

Consent and Mental Capacity Act

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and other relevant national standards and guidance.
- OPD staff told us they rarely encountered patients with dementia or who lacked capacity to consent due to these being part of the exclusion criteria for the hospital. However, they were able to describe the process they would follow if they suspected a patient lacked capacity, and knew who to contact for further support or advice.
- People were given the support and time to make decisions about treatment in line with relevant legislation and guidance.
- Consent was monitored and reviewed as part of the records review to ensure it meets legal requirements and follows relevant national guidance. Consent was generally obtained in the OPD at consultation however we noted that consent was not always obtained prior to the day of surgery which does not comply with best practice guidance. See the consent section of the surgery report for more detailed information.

Good

Outpatients

Are outpatients services caring?

Good

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

Compassionate care

- Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs.
- All staff introduced themselves and their role in a friendly and welcoming manner to put people at ease.
- Personal information was not discussed at the reception desk in order to protect patient confidentiality. We observed staff covering patient identifiable paperwork when people approached the desk. Any personal conversations happened in the private consultation rooms.
- Staff cared for patients with compassion. All three patients we spoke with were very complimentary of the care they had received in the outpatient department (OPD) and one person had used the service for a long period of time. Patients and their relatives told us staff were very friendly and helpful.
- Staff maintained patients' privacy and dignity at all times. At all times during our inspection we saw consultations took place in the privacy of consultation rooms, with doors closed. Staff were seen to knock, prior to entering.
- Chaperone posters were visible in every room and at the reception desk offering patients the option of a chaperone. Staff said that a chaperone was always available for intimate examinations.
- We saw staff taking the time to interact with people who used the service and those close to them in a respectful and considerate way. This was evidenced in the way a receptionist helped a patient when they had difficulty completing their paperwork.
- Staff encouraged patients to complete a detailed patient satisfaction questionnaire which was independently collated with a monthly report provided to the hospital for view and analysis and cascade to the hospital team. The monthly report showed patient response rates, rating within categories and ranking against all BMI hospitals. The hospital was recorded as being 9th out of 55 BMI hospitals nationally.
- Patient Satisfaction was discussed at the Clinical Governance, Head of Department Committee and within Departmental Meetings.
- The service contributed to the national Patient Led Assessments of the Care Environment (PLACE).
- The hospital participated in the NHS Friends and Family Test (FFT) feedback tool. The FFT is a survey that measures patient satisfaction with the care they have received. Between May and October 2018 the scores for OPD were consistently higher, ranging between 98% and 100%, with an average of 99.5%, than the national average of 94%.

Emotional support

- Staff told us that the length of appointment times was variable according to the type of consultation and the level of support each patient needed. Additional time was allowed for new patient appointments and certain specialties.
- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed and one staff member described the extra time given to a patient with mental health concerns in the pre-admission clinic to support them.
- We saw staff speaking with patients in a kind and supportive manner throughout the course of our inspection.
- Staff provided appropriate information regarding treatments and procedures in leaflet form and there was further information available on the corporate website and through the 24-hour corporate advice line.
- Patient's relatives and carers were welcomed to attend consultations for emotional support.

Understanding and involvement of patients and those close to them

- Consultants provided clear, concise information to patients in a language that they could understand. This was further supported by written information for the patient to take home explaining the benefits and risks of their planned procedure.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives said they felt involved in their care. They had been given the opportunity to speak with the staff looking after them.

Good

Outpatients

- We observed staff confirming that patients and their relatives understood the information provided and how they would receive results of investigations.
- Staff discussed consultation costs for non NHS funded patients at the point of initial assessment, with additional information available to patients either at the hospital or through the service's website.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

For our detailed findings on service delivery to meet the needs of local people, please see the surgery section of this report.

- The OPD facilities and premises were appropriate for the services that were delivered. The OPD clinics were held in rooms on the ground floor with access to facilities and refreshments.
- There was free on site parking within the hospital grounds with dedicated disabled parking spaces. A patient with limited mobility commented that they appreciated being able to park close to the entrance. The hospital was also centrally located in the town and close to public transport links and within a short distance from the local NHS hospital
- There was clear signage throughout the hospital to guide patients to the relevant outpatient, radiology, and physiotherapy departments.
- The OPD waiting area was in the main reception area of the hospital. All patients waited in one waiting area, where they were collected by staff and taken to the appropriate clinic rooms.
- The hospital had a good working relationship with the local clinical commissioning group (CCG) to offer services for NHS patients. The hospital also assisted with additional work from the local NHS hospital to help meet increased demand.
- The hospital had a strict exclusion/inclusion criterion. This meant that it did not treat patients that required more intensive care or those with more complex needs, bariatric patients or those with dementia.
- The hospital provided patients with information prior to their clinic appointment. This included hospital location, appointment time, consultant name and details of any information to bring with them and any investigations required.
- There were telephone appointments for minor procedure pre-assessment appointments as an alternative to face to face appointments.

Meeting people's individual needs

- The hospital had a hearing loop in place for those with hearing difficulties and access to translation services both on the telephone and face to face for those whom English was not their first language.
- The outpatient reception desk was at varied heights which accommodated patients attending in wheelchairs and all consulting rooms were wheelchair accessible. There were facilities for arranging transport for NHS patients with mobility difficulties.
- Patients had access to a variety of information leaflets in the hospital. All information leaflets were in English, however staff commented that they could access written patient information in other languages through an electronic system if required.
- The hospital provided access to NHS appointments through the choose and book portal which gave patients a greater choice of appointment time. Non-NHS funded patients were able to book appointments through the centralised booking team or the hospital website, which included a 'live chat' support function.
- New patient appointment slots were longer to allow patients time to ask questions and have follow-up tests.
- The hospital did not have any specific arrangements for people who had particular needs, for example a learning disability, sensory loss, or those living with dementia although they did have a dementia champion available on the ward. Due to the exclusion criteria this did not happen regularly but if a person was to attend staff said they would support them during their visit to the department by staying with them throughout their appointment.

Access and flow

- The service offered access to consultation and treatment in a timely manner for both NHS and self-funding patients.

Good

Outpatients

- The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). NHS referrals formed a reasonable proportion of the hospital's attendances with 32% of patient referrals coming from the local NHS trust.
- Data showed that the service met and exceeded the 92% RTT target during the period April to October 2018 apart from one month when it was 90%. Overall compliance figure was 95.9% which was better than the national average.
- Between May and October 2018, 311 patients did not attend (DNA) for their appointment. Patients who failed to attend were contacted and depending on the reason, offered another date for consultation.
- Rates of patients who DNA were monitored on a regular basis by the hospital's booking and senior management teams.
- Access to the service was reviewed on a daily basis at comms cell meetings.
- Regular engagement took place between the service and local clinical commissioning group to ensure that patients were being assessed and treated in a timely manner.
- Patients said that they did not have to wait for long before being seen and although there was no specific patient notice to inform of waiting times we did hear receptionist staff informing patients of slight delays.
- During the inspection we observed OPD clinics and saw that they flowed smoothly with very little delay.
- Short notice appointments could be facilitated for both NHS-funded and self-funding patients. A contact telephone number was provided for patients to call in the event of encountering any issues after treatment.

Learning from complaints and concerns

For our detailed findings on learning from complaints and concerns, please see the surgery section of this report.

- The Executive Director (ED) had overall responsibility for overseeing the management of complaints however, a number of other individuals were involved in the day to day administration of complaints, particularly the Operations Manager, Director of Clinical Services and Quality and Risk Manager, who undertook the initial investigation and collated relevant information.
- Complaints were discussed in a variety of forums within the hospital: at the daily comms cell meetings, daily senior management meetings and monthly heads of departments meetings. Heads of departments also cascaded complaints relevant to their departments at departmental meetings.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. For example, one staff member described learning from a complaint about pricing transparency.
- We reviewed complaints recorded between May and October and saw that there were no complaints attributable directly to the OPD.
- Information on how to make a complaint was visible in the reception area and consulting rooms.

Are outpatients services well-led?

Good

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

Leadership

- There was a clear leadership structure in place within the outpatient department (OPD). Staff reported to the outpatient manager, who reported to the director of clinical services (DCS).
- The OPD leader had the skills, knowledge, experience for the role and was passionate about the service they led. There was a strong sense of team working in the department and all staff worked well together, whatever their role.
- The leaders understood the challenges to quality and sustainability, and they identified the actions needed to address them.
- Leaders were visible and approachable and staff commented that the executive director (ED) and DCS attended the OPD daily following the comms cell meeting.

Vision and strategy

For our detailed findings on vision and strategy, please see the surgery section of this report.

Good

Outpatients

- There was a clear vision and strategy for the hospital, which had been communicated to staff who were aware of their role in delivering the vison and strategy however there was no formalised or individualised OPD vision or strategy.
- Staff told us that there had been improvements in making the pre-assessment process more effective and patient-centred moving away from the one size fits all approach.
- The strategy was aligned to local plans in the wider health and social care economy, and services were planned to meet the needs of the relevant population

Culture

- Staff told us they enjoyed their job and felt a sense of pride in their work with some stating they had worked at the hospital for many years.
- All staff we spoke confirmed that they felt respected, valued and supported in their role.
- One staff member said that the culture and teamwork had improved during the last year with the focus on patient centred care and commented that "the atmosphere is brilliant with more openness and transparency between teams".
- Managers encouraged learning and a culture of openness and transparency. They offered an 'open door policy' and encouraged staff to raise concerns directly. Senior staff visited the OPD during our inspection and staff told us this was a normal daily occurrence. We also observed senior leaders providing support to staff following a patient collapse incident.
- Staff we spoke with said they had no hesitation in raising concerns or incidents without fear of retribution and that their input was welcomed.
- There were mechanisms for providing all staff at every level with the development they needed, including appraisal and career development conversations.

Governance

For our detailed findings on governance, please see the surgery section of this report.

- The hospital had clear governance systems in place. The hospital held meetings through which governance issues were addressed. The meetings included medical advisory committee, clinical governance committee, heads of department (HoD) meeting, and infection control.
- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department according to an audit schedule and results were shared at relevant meetings such as the hospital clinical governance meetings.
- We saw that action plans for improvement in audit results were presented and reviewed at clinical governance meetings. Audit records and meeting minutes we reviewed confirmed that this process was embedded.
- Staff at all levels were clear about their roles and understood what they are accountable for, and to whom.

Managing risks, issues and performance

For our detailed findings on managing risks, issues and performance, please see the surgery section of this report.

- There were comprehensive assurance systems, and performance issues were escalated appropriately through clear structures and processes.
- Departmental risks were reviewed at regular intervals through use of an electronic risk register and each HoD had ownership of the risk register for their area.
- Following our last inspection, the hospital drew up an action plan to identify the areas they needed to improve. This was updated monthly and shared with local commissioners. At the time of our inspection over 90% of this was complete. The two most significant concerns were the carpets in clinical areas, and this had been resolved and the poor recording of contemporaneous notes in consulting rooms. This was much improved and at the time of our inspection, audit of contemporaneous averaged 86%, from less than 10% in March 2017.
- The OPD leadership had changed since our last inspection and there was significant improvement in knowledge and oversight of current risk and engagement with clinical governance.

Managing information

For our detailed findings on managing information please see the surgery section of this report.

Good

Outpatients

- Service performance data was routinely monitored, used to identify potential performance issues and reviewed on a daily basis at the comms cell meetings.
- There were clear and robust service performance measures, which were reported and monitored.
- Discussion took place around appointment waiting times, incidents and other various subjects including health and safety.

Engagement

For our detailed findings on engagement, please see the Well-led section in the surgery report.

- The OPD collected patient feedback through the 'how well did we do' questionnaire although we were not told of any specific changes as a result.
- Staff commented that the senior management were more visible and approachable and there was no 'them and us' culture.
- All staff felt comfortable approaching management with any concerns.

Learning, continuous improvement and innovation

For details on learning, continuous improvement and innovation, please see the surgery section of this report.

- The outpatient lead had developed a folder kept in the department with laminated pages containing information such as; tips for staff, quick guide to incident reporting, information security, mental capacity act-5 things staff should know among others.
- The hospital had introduced weekly consultant anaesthetist led pre-admission clinics for patients who were borderline suitable for treatment at the hospital to ensure safety.
- The pharmacy technician attended the pre-admission clinic twice weekly for medication notes review.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all staff complete all aspects of mandatory training.
- The provider should ensure that all patients are allowed clear fluids up to two hours, where appropriate, pre-operatively to comply with best practice and its own policy.
- The provider should ensure that consent forms are signed at least prior to the day of surgery as per best practice and its own consent policy.
- The provider should ensure that all patient post-operative reviews by consultants are documented as per its own policy.
- The provider should improve governance of consultant practising privileges to ensure appraisals are submitted in line with practising privilege policy.
- The provider should ensure that it continues to improve development of external safeguarding links.