BMI The Princess Margaret Hospital

Quality Report

Quality report
Osborne Road
Windsor
Berkshire
SL4 3S
Tel: 01753 743434
Website: www.bmihealthcare.co.uk

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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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Princess Margaret Hospital is one of 59 hospitals and clinics provided by BMI Healthcare Ltd. It is located in Windsor, Berkshire, and on-site facilities include 78 registered beds, four theatres (three laminar flow), and an endoscopy suite. There is an outpatient suite offering consulting and treatment rooms, and an imaging department offering X ray, magnetic resonance imaging (MRI), computed tomography (CT) and ultrasound.

BMI Princess Margaret Hospital provides a range of medical, surgical and diagnostic services to patients, who pay for themselves, are insured, or are NHS-funded patients. Services offered include general surgery, orthopaedics, cosmetic surgery, ophthalmology, general medicine, oncology, dermatology, physiotherapy and diagnostic imaging, ophthalmology, endoscopy and orthopaedic services.

Medical services can be thought of as those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. The medical service consists of two separate components; oncology chemotherapy treatment, and a diagnostic endoscopy service. Endoscopy or chemotherapy services undertaken as a day case are therefore included within medical care in this report.

The announced inspection took place on 13 and 14 September 2016, followed by a routine unannounced visit on 23 September 2016.

This was a comprehensive planned inspection of all core services provided at the hospital: medicine, surgery, outpatient and diagnostic imaging. There are some surgical and outpatient services for patients under 16 years, and these are reported within the surgical report by Specialist Advisers, but the majority of patients are adults.

The Princess Margaret Hospital was selected for a comprehensive inspection as part of our routine inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology.

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean people are protected from abuse and avoidable harm.

- Patients were protected from the risk of abuse and avoidable harm across all inspected services.
- Staff reported incidents, and openness about safety was encouraged.
- Incidents were monitored and reviewed in most services and staff clearly demonstrated examples of learning from these.
- Clinical areas were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections. Where necessary, action was taken to address any identified learning.
- Staff received appropriate training for their role, were supported to keep their skills up-to-date and were further supported in their role through a corporate performance review process. BMI set a target of 90% compliance with mandatory training. Records provided by the hospital showed that the compliance rate for medical care staff was 89%.
- Staff followed national and local guidance when providing care and treatment.
- Equipment was maintained and tested, in line with manufacturer's guidance. There were appropriate checks and maintenance on the hospital building and plant.
- Medicines were stored securely and chemotherapy was prepared safely. Nursing staff were trained to administer chemotherapy.
- There was regular monitoring of patient records for accuracy and completeness. They were securely stored and available when needed.

Summary of findings

- Staffing levels and skills mix were planned, implemented and reviewed to keep patient's safe at all times. There was sufficient medical cover provided by resident medical officers (RMOs) who covered the hospital 24 hours a day for all specialities. Consultants were also available daily and would provide support and advice out of hours if necessary.
- Plans were in place to respond to emergencies and major situations.

Are services effective at this hospital?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- We found there were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE), and that care was delivered in line with best practice.
- There was a system for reviewing policies and these were discussed at the medical advisory committee (MAC) and other governance groups at the hospital.
- Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes and the hospital participated in relevant national audits.
- We found arrangements that ensured the doctors and nurses were compliant with the revalidation requirements of their professional bodies. All consultants had clear practising privileges agreements, which set out the hospitals expectations of them, and ensured they were competent to carry out the treatments they provided.
- Systems for obtaining consent were compliant with legislation and national guidance, including the Mental Capacity Act (2005) and these were adhered to by staff.

Are services caring at this hospital?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- We observed that patients were treated with dignity and respect and their privacy was maintained.
- Patients who shared their views were very positive about the care they received and spoke of kind and welcoming staff.
- Staff helped patients and those close to them to cope emotionally with their care and treatment
- Staff described how all children were involved in the discussions and decision making processes about their treatment and care, in a way which supported their understanding.
- Patients and relatives commented positively about the care provided and said they were involved in decision making.
- The hospital took part in the Friends and Family Test (FFT). For the reporting period November 2015 to February 2016, 100% of patients said they would recommend the hospital to their friends and families. Between 25% to 50% of patients responded to the FFT.

Are services responsive at this hospital?

By responsive, we mean that services are organised so they meet people's needs.

- Services were planned and delivered in ways which met the needs of the local population. Patients told us there was good access to appointments, and at times which suited their needs.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services being delivered.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the National Health Service (NHS) in England: this allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.

Summary of findings

- There was openness and transparency in how complaints were dealt with, and staff could demonstrate where learning and actions had taken place. Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the BMI Princess Margaret Hospital website. However, we did not see any guidance, posters or leaflets instructing patients on how to make a complaint.
- A complaints database enabled the executive director and the director of nursing to track progress and close complaints when the complainant was satisfied.
- For the reporting period March 2015 to April 2016, the hospital consistently met the target of 95% of non-admitted patients beginning their treatment within 18 weeks of referral.
- Patients were able to access services when needed and we found services responsive to meeting individual needs. They were satisfied with the appointments system. Most patients told us it was easy to get an appointment when they needed it.
- Patient Led Assessments of the Care Environment (PLACE) for 2015 showed comparable results to the previous year and above the England average. In the PLACE audit carried out in March 2015, dementia services at the hospital scored 83%. This was above the England average of 81% for independent sector acute hospitals but the hospital was devising a plan to provide more dementia-friendly facilities.

Are services well led at this hospital?

By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovations and promotes an open and fair culture.

- We found that most staff were conversant with the corporate and local vision and values and strove to demonstrate these in their daily work.
- There was an appropriate system of governance and managers knew the key risks and challenges to the hospital and were taking steps to mitigate the impact of these. Staff attended governance meetings and committees such as infection prevention and control meetings. Staff received feedback from hospital-wide meetings in emails and we saw team meeting minutes were available to all staff.
- Practising privileges were received, authorised and granted in conjunction with the Medical Advisory Committee (MAC) and kept under review. There was effective governance and oversight of the consultant's performance and behaviours through the MAC and by close working with the local NHS trust, where many of them worked.
- There were effective governance structures, and a hospital- wide risk register, which was updated regularly. Departmental risk registers also identified specific risks in that area which may affect staff, patients and visitors. The risk registers reflected actions to be taken to mitigate any risks. However in Surgery we found, although there were systems for identifying and managing risk, some were rudimentary with limited ability to spot trends. Risks were recorded and mitigations put in place. However, mitigations were not always checked to ensure they were effective.
- There was a culture of collective responsibility between teams and services. Information and analysis was generally used proactively to identify opportunities to drive improvement in care. However, in Surgery we found senior nurses did not always use the quality data generated to drive change and service improvement.
- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on the intranet and signed a declaration to confirm they had read and understood the policy relevant to their area of work.
- There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams.
- Senior managers were visible and had a thorough understanding of how services were provided at the hospital. They were open and honest about what they did well and where they knew there were areas for improvement. However, some senior staff did not feel empowered to drive positive change and lacked the confidence to challenge poor practice where this was seen. Some staff we interviewed found it difficult to challenge senior staff or consultants due to cultural differences.

Summary of findings

- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test
- The executive team knew and understood their main market very well and ensured that services developed to meet the needs of the local community.

We saw one area of outstanding practice including:

- The provider has access via the Consultant users to electronic information held by community services, including GP's. This meant clinical staff could access up-to-date information about patients, for example, details of their current medicine.

However, there were also areas of where the provider needs to make improvements.

Importantly, the provider must:

- Ensure all mitigations to risks identified are put in place and then monitored to ensure compliance. For example, in Surgery we found although a crossover of clean and dirty surgical instruments had been escalated to the risk register, processes to mitigate this were not being followed.

In addition the provider should:

- A suitable system is put in place to screen patients over 75 years of age for dementia, in line with national guidance.
- Pregnancy safety posters to be displayed in the diagnostic and imaging waiting area.
- The complaints procedure is made to be more easily accessible for patients.
- Stocks of medicines need to be checked to ensure they are in date and suitable for use.
- Patients undergoing an endoscopy should have comfort scores recorded.
- Staff should have access to a recognised visual analogue pain assessment tool, for people with a cognitive impairment.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	Overall we rated this service as good because: There was an openness and transparency about safety. Staff monitored patient safety and investigated incidents to enable them to improve care. Ward and clinical areas we visited were visibly clean. Care and treatment took account of current legislation and nationally recognised evidence-based guidance. There were sufficient staffing levels, with appropriate numbers of doctors and nurses available to meet the needs of the patients 24 hours a day. Patient feedback regarding their care and the service was positive. Patients told us they were included in decisions about their care and told us they felt informed about the treatment they received. The service was developing its cancer services to help it achieve BMI Flagship status. Staff within the service understood this shared vision and were working together to achieve this. Staff were competent to carry out their role and the hospital maintained a register of training required and undertaken by all staff groups. Staff told us the annual appraisal system worked well and was worthwhile. Appropriate governance structures were in place for clinical governance, health and safety, infection control and medicines management. Each area had committees meeting to review issues and concerns, and to direct improvements. Department heads and staff met regularly, in departmental meetings or daily huddles, to discuss and share information about the service. The oncology service had engaged with patients through focus groups during which they discussed patient concerns. This had resulted in changes to the environment and the provision of fresh fruit and bottled water.
Surgery	Good	Overall we rated this service as good because: Staff monitored patient safety; they investigated incidents and shared the learning to improve care.

Summary of findings

All the areas we viewed were visibly clean and well maintained. Equipment was available for staff, and there were regular safety checks on equipment and the environment.
Consultants followed a process to gain consent from patients. Patient records were well structured and staff completed all the relevant sections with few exceptions.
Staffing levels were sufficient to meet the needs of the patients. Doctors were available to provide care for patients 24 hours a day. The service had competent staff who worked well as a team to care for patients.
Staff told us training was available and they were given time to attend. Staff were up to date with their mandatory training and understood the safeguarding policies and procedures for adults. The hospital gave discharge information to patients when they went home and sent it to their GPs within 48 hours of discharge.
The service had policies and guidance to ensure staff provided care and treatment that took account of evidence based standards and procedures, except with regard to starving pre-operative patients.
The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals within the BMI group.
Staff supported and treated patients with dignity and respect, and the patients were involved in decisions about their care and treatment.
Patients told us they received enough information and were satisfied with the care and treatment they received. Information leaflets were available about the hospital services; however there was limited access to information for patients whose first language was not English.
There were appropriate governance structures in place with committees for clinical governance, health and safety, infection control, medicines management.

Outpatients and diagnostic imaging

Good 

Overall, this service was rated as good. We found outpatients and diagnostic imaging (OPD) was good for the key questions of safe, caring, responsive and well-led. We did not rate effective as we do not currently collate sufficient evidence to rate this.
There was a focus on patient safety within outpatient services. Medicines were stored safely and checks on emergency resuscitation equipment were performed

Summary of findings

routinely. Incidents and adverse events were reported and investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.There were sufficient staff with the right skills to care for patients and staff had been provided with induction, mandatory and additional training specific for their roles. Staff had appropriate safeguarding awareness and people were protected from abusePatient's privacy was always protected in outpatient and diagnostic areas. Staff knocked on doors before entering rooms, used curtains appropriately and were careful to avoid conversations in corridors.

Feedback from patients who use the service and those close to them was positive about the way staff treated them.

Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they felt involved in decisions about their care and they were treated with dignity and respect.

Patient's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.The leadership, governance and culture within the departments promoted the delivery of person centred care. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.

Summary of findings

Contents

Good

BMI The Princess Margaret Hospital

Services we looked at
Medical care (including older people's care); Surgery; Outpatients & diagnostic imaging;

Summary of this inspection

Background to BMI The Princess Margaret Hospital

BMI The Princess Margaret Hospital, located in Windsor, is part of BMI Healthcare.

The hospital opened in 1980 and has 78 registered beds with all rooms offering ensuite facilities, Wi-Fi, TV and telephone. The hospital has four main theatres, three with laminar flow, one minor operations room, two treatment rooms and 18 consulting rooms. There is no critical care or emergency facility at this hospital.

The hospital provides a range of services to patients who are self-funded, use private medical insurance or that are NHS funded. Services include general surgery, orthopaedics, cosmetic surgery, ophthalmology, general medicine, oncology, dermatology, physiotherapy and diagnostic imaging. Ophthalmology, endoscopy and orthopaedic services are available to NHS funded patients through choose and book. Inpatient and day case services are offered for children aged 3 years and above and non-invasive outpatient service for children of all ages.

The following services are outsourced:

- Catering
- Complimentary therapies
- Decontamination Services
- Grounds Maintenance -Mitie Group plc
- Histology
- Microbiology
- MRI (additional service)
- Nuclear Medicine
- Pathology
- Resident Medical Officers -RMO International
- Resuscitation Training

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at the three core services provided by the hospital: medicine, surgery and outpatient and diagnostic imaging.

The Registered Manager had been in post two months at the time of inspection.

Our inspection team

Our inspection team was led by:

Inspection Lead: Moira Black, Inspection Manager, Care Quality Commission (CQC)

The team included three CQC inspectors, an inspection manager, a surgical nurse, a radiology manager, a paediatric nurse, a theatre manager and a senior governance lead.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information that we held about the hospital. We carried out an announced inspection visit between 13 and 14 September 2016, and a routine unannounced inspection on 23 September 2016.

We spoke with staff and managers individually. We spoke with patients, relatives and staff from the ward, oncology day unit, operating department, endoscopy unit and outpatient services. We observed care and treatment, and reviewed patients' records.

Summary of this inspection

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at BMI The Princess Margaret Hospital.

Information about BMI The Princess Margaret Hospital

The hospital provides a range of services to patients at any age though most commonly patients are aged 16 years and over.

Between April 2015 and March 2016, 6% of the hospital's overall activity was care and treatment delivered to children between the ages of three and 15 years old. 1% of the overall activity was delivered to young people aged 16 or 17 years old.

The total activity in the same reporting period for children under the age of three years old was one percent. 11% of all inpatients were NHS funded.

Hospital activity during the year April 2016 to March 2016 included:

- 1,607 overnight inpatients;
- 6,174 day-case patients;
- 7, 064 visits to theatre;
- 18,063 outpatients (first attendees)
- 29,289 outpatients (follow up appointments)

Of the 7,064 visits to the theatre between April 2016 to March 2016 the five most common procedures performed were:

- Upper GI and colorectal (1850)
- Spinal (1337)
- Other orthopaedic and trauma (837)
- Gynaecology (686)

The most common medical procedures were:

- Diagnostic colonoscopy (589)
- Diagnostic oesophago-gastro-duodenoscopy includes forceps biopsy, biopsy urease test and dyespray (346)
- Image-guided injection(s) into joint(s) (324)

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care

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

Information about the service

The Princess Margaret Hospital is part of BMI private healthcare. The hospital is arranged across two wards; Sandringham Ward primarily used for inpatient stays and Balmoral Ward for patients having day surgery. All rooms are single with en-suite bathrooms. At the time of inspection, the inpatient ward had 26 beds, and the day case unit had 28 beds.

The majority of medical care provided by the service was oncology and endoscopy, and this core service report has focussed mainly on these specialties.

The BMI Princess Margaret Hospital policy was not to admit patients with primary respiratory or cardiac complaints. The ward occasionally admitted medical patients for blood transfusions or intravenous antibiotics for skin infections.

The hospital was working towards the Joint Advisory Group (JAG) accreditation in the endoscopy unit.

The oncology day-case unit was open Monday to Friday 8am to 6pm. An on-call service runs 24 hours a day seven days a week for patients. Patients treated in oncology had breast, colo-rectal, haematology and bladder cancers. The hospital has recently introduced an electronic prescribing for chemotherapy regimens.

The hospital has a dedicated breast care nursing team along with a team of chemotherapy-trained nurses.

The oncology day unit had two bays with “pods” with comfortable reclining chairs for patients. The hospital did not treat NHS oncology patients. The vast majority of oncology patients were funded through insurance. The minority were self-paying.

Patients who were not eligible for treatment on the NHS or patients that chose to pay for medicines not available on the NHS self-funded their treatment.

During our inspection, we visited the wards, endoscopy, and oncology suite. We spoke with seven patients and two family members. We spoke with 17 members of staff including, consultants, nurses, administrators and senior managers.

Throughout our inspection, we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment in use. We reviewed six sets of patient records, observed interactions between staff and patients and attended clinical handover meetings.

Good

Medical care

Summary of findings

We found evidence that medical services were 'good' for safe effective, caring, responsive and well led domains.

All areas of the service we visited were visibly clean, systems were in place to ensure nurses, medical, and domestic staff adhered to infection control policies and procedures. In clinical areas we observed all staff were bare below the elbows.

Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed organisationally and locally to reflect national guidance.

Consultants followed a process to gain consent from patients. Patient records were well structured and staff completed all the relevant sections with few exceptions.

Staffing levels across all staff groups were appropriate to meet the needs of the patients. There were appropriate numbers of nurses and doctors available to provide care for patients 24 hours a day. Hospital training records showed staff were competent to care for patients.

Feedback from patients about their care and treatment was consistently positive. We observed staff treat patients courteously and respectfully with kindness, compassion and dignity throughout our visit. Staff respected patients' privacy and confidentiality at all times. Patients told us that staff were always helpful and kind and that "nothing was too much trouble".

Patients told us they felt informed about their treatment and were included in decisions about their care. Staff told us anxious patients or patients with a learning difficulty given the opportunity to visit the treatment area before their treatment and care commenced.

Patients had a comprehensive assessment of their needs. The clinical staff monitored patients' pain levels regularly and responded appropriately with a variety of methods for pain relief.

Patients told us they had adequate and timely pain and sickness relief.

Patients were treated as individuals, and their needs and preferences were identified and met appropriately.

The hospital had a robust system for learning from complaints and concerns and there was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals.

There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.

Good

Medical care

Are medical care services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Incidents were monitored by staff and when incidents occurred they were investigated. We saw evidence that learning was shared following investigation.
- There was appropriate equipment for staff to use when caring for patients. There were regular safety checks and the equipment was maintained appropriately.
- All areas we inspected were visibly clean and tidy.
- There were safe systems for medicines to be appropriately stored and managed.
- There were systems for monitoring safety: these included checks on the environment, equipment, cleanliness and staff adherence to infection control policies.

However:

- Patient records were not always kept in locked cabinets.
- We found three out of date medicines in a ward clinical area.
- We found that there were no routine dementia assessments for patients over the age of 75 years.

Incidents

- In all ward, endoscopy and oncology areas, staff were aware of their responsibility to report incidents. They reported incidents either via an electronic system or to their manager who logged the incident on the reporting system. Staff we spoke with were confident to report incidents and challenge poor behaviour, by staff at any level, if they were concerned about poor practice that could harm a person.
- During the period April 2015 to March 2016, a total of 289 clinical incidents were reported. Of these incidents, 72% (209 incidents) occurred in surgery or inpatients and 28% (80 incidents) in other services.
- During the period April 2015 to March 2016, 89 non-clinical incidents were reported. Out of these 57% (51 incidents) occurred in surgery or inpatients.
- 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. All clinical staff we spoke with understood the duty of candour requirements for a written apology. All clinical staff told us they worked with the principles of the duty in mind, being open, offering verbal apologies and documenting errors in patient notes.
- From March 2015 to April 2016 there had been no never events relating to medicines. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Incidents were discussed by the senior management team at weekly meetings. Further discussion took place at monthly clinical governance meetings.

Safety thermometer or equivalent

- All patients whose notes we checked had venous thromboembolism (VTE) assessments completed on admission. Staff also screened patient for Meticillin Resistant Staphylococcus Aureus (MRSA) colonisation and carried out risk assessments for pressure ulcers.
- On each ward patient led assessment of the care environment (PLACE) results were displayed.
- Staff routinely assessed patients for venous thromboembolism (VTE). The VTE screening rate was 100% from April 2015 to March 2016. There had been no incidents of hospital acquired VTE or pulmonary embolism over the same period.

Cleanliness, infection control and hygiene

- Every department in the hospital had an infection control link nurse to carry out audits and attend infection control meetings.
- The National BMI infection control lead would be contacted if any patient contracted a hospital acquired E-Coli, Clostridium difficile (C-diff), MRSA or meticillin-sensitive staphylococcus aureus (MSSA) infection.

Good

Medical care

- From April 2015 to March 2016 the hospital reported no incidences of hospital acquired MRSA, MSSA or Clostridium difficile (C-diff) and one incident of hospital acquired E-Coli catheter associated urinary tract infection.
- All areas inspected were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored by audits, to reduce the risk of spread of infections. However, there was some dust in the ward corridor areas.
- Staff were clear who was responsible for cleaning equipment and areas. 'I am clean' stickers were attached to equipment so that staff knew they were clean for use and the cleaning manager had a daily schedule to ensure all areas were cleaned on an on-going basis. We saw there were systems in use to ensure nurses, medical, and domestic staff adhered to infection control policies and procedures.
- Six patients commented on their satisfaction with the standard of the cleaning at the hospital. One patient said "the cleaning staff are so friendly; they always knock and ask if they can clean my room" another patient said "You cannot fault the cleaning here".
- In clinical areas, we observed staff adhered to the bare below the elbows policy to enable proper hand washing and reduce the possibility of cross infection. The hand washing audit was carried out monthly. The hand hygiene audit for the period February 2016 to July 2016 showed 94.3% compliance against a target of 100% for staff on the ward and in theatres. There was on-going education for those staff or staff groups that were falling below the required target.
- Personal protective equipment such as disposable aprons and gloves were readily available. We observed staff washed their hands properly and wore gloves and aprons to administer chemotherapy. Staff wore gloves and eye shields for endoscopy procedures to prevent the spread of infection.
- Monthly endoscopy audits were conducted to ensure cleaning of equipment was in line with national guidance. The results of the audit showed the hospital complied with guidelines and the results could be used towards their Joint Advisory Group (JAG) accreditation.
- Nursing staff tested the endoscopy decontamination machines every morning, to ensure they reached the correct temperature for the required amount of time to decontaminate the used scopes.
- There was a system that tracked the use of endoscopy equipment on patients to ensure infection control standards were met.
- Annual checks of water were carried out by an external contractor. We saw up to date results of water quality checks and annual risk assessment. The results of these checks were shared with the microbiologist, IPC lead and the facilities management team. In addition, the hospital had water flushing protocols in place and low-use areas identified.

Environment and equipment

- The clinical areas and wards we inspected were visibly clean, and there were sufficient facilities for washing hands. We observed alcohol hand sanitising gels were available for patients and visitors to use throughout the hospital.
- Emergency mobile resuscitation trolleys were available in the wards, oncology and endoscopy recovery areas. There were adult specific trolleys and paediatric specific trolleys, which contained equipment appropriate to the size and age of patients. Paediatric trolleys were coloured red to alert staff which trolley was appropriate for children. Equipment was secured with tamper-evident tags and staff documented daily checks and tests.
- Clinical equipment was serviced and tested according to manufacturers' instructions. We saw minutes highlighting discussions of review of equipment service level agreements.
- All patient rooms were equipped with a shower room that had level access. There was also piped oxygen and suction to each patient room.
- We found medical equipment to be clean and ready to use. The hospital used a tape sticker system to identify items that had been cleaned. Medical equipment also had an asset tag to enable the hospital to trace and monitor the equipment.
- There was an appropriately maintained patient hoist and there were a variety of sizes of single patient use slings to fit the device. All medical equipment was stored correctly and securely and was found to be in date and ready for use.
- Where appropriate, medical equipment on the wards was checked for electrical safety within the last year.

- The hospital recognised that there needed to be a rolling replacement programme for equipment. This was itemised on the risk register so that the situation was appropriately monitored.

Medicines

- The on-site pharmacist supported the staff with medicines management. There was a pharmacy on site which was open Monday to Friday 8.30am to 5pm. The resident medical officer and senior ward nurse could together access the pharmacy out of hours to obtain the required medication should there be an emergency.
- The pharmacy team completed regular audits including missed dose, controlled drugs and medicines reconciliation. The surgical ward and day case units were found to be compliant against all their standards on these audits in June 2016.The team shared audit results at the medicines management meetings held every two months, with managers cascading the information at team meetings, confirmed in the minutes we looked at.
- The clinical staff locked and secured the medicine trolley when not in use.
- Ward medicine fridges were locked and clean with suitable minimal stock. Maximum and minimum temperatures were recorded daily and when checked were within safe parameters. There was evidence of pharmacy auditing fridge temperatures monthly to ensure the fridge was at the correct temperature for medicine storage.
- The designated staff nurse in each clinical setting completed medicine stock checks. The hospital pharmacist checked the stock lists on a weekly basis.
- We found three out of date medicines during our inspection. The ward sister was notified and they were immediately removed and disposed of appropriately.
- Controlled drugs (CDs) were stored in appropriate cupboards as required by the Home Office in their general security guidance for controlled drugs suppliers (May 2016). The ward nurse completed a daily stock check and documented this in the CD record book. We saw administration, stock checks and receipts of stock signed and countersigned in the CD record books including patients own CDs. Pharmacy staff completed a quarterly CD audit and any deficiencies identified had action plans.
- Anaphylaxis kits were in all clinical departments, these were provided in case of a patient suffering a severe allergic reaction to treatment. The pharmacist team sealed kits securely with tags and the kits were readily available if needed.
- The hospital executive director was the named controlled drugs accountable officer for the hospital. They attended the controlled drug local intelligence network meetings (CDLIN), and submitted CDLIN reports prepared by the pharmacy team. There was evidence of completion of quarterly audits; however, there was no evidence of any themes or learning used to improve the management of controlled drugs.
- All chemotherapy was prescribed through an electronic prescribing system, using local cancer network protocols. Oncology nurses used the electronic prescribing system to perform checks and record administration.
- Chemotherapy was supplied pre-prepared to the hospital, and staff reported this was a timely service. The hospital pharmacists verified prescriptions and checked blood results before releasing any chemotherapy for administration.
- Nurses worked within the hospital chemotherapy policy and did not administer chemotherapy to patients unless blood test results from within the previous 48 hours showed it was safe to do so.
- If oncology nurses saw a new drug prescribed, they accessed an official website and read the 'summary of product characteristics' (SPC) so they knew all the necessary information before administering it or asked the in-house pharmacist to give advice.
- Nurses followed the medicine policy and discussed medicines with patients before discharge from the hospital; the pharmacist was involved if the medicine was high risk.

Records

- Patient records were kept in cabinets next to the nurses' station. We noted the cabinets were able to be locked but that they were not always locked, although they were kept closed. Patient's notes could therefore be accessed by unauthorised persons as the cabinets were not secure.
- Staff stored risk assessments in the main patient record to ensure colleagues accessing the clinical notes understood risks. Staff gave patients a paper copy of their summary record on discharge from the hospital.

- We reviewed six sets of patient records. The care records contained patient assessments, observations, medical and nursing notes plus on going risk assessments and discharge planning documents. We saw all relevant timely assessments were completed; entries were signed, dated and legible.
- Electronic computer records were secure and access to the hospital systems was password protected.

Safeguarding

- During the period April 2015 and March 2016, there had been one safeguarding concern reported to CQC.
- The Director of Nursing was the safeguarding lead and had received level 3 adult and children safeguarding training. The safeguarding lead demonstrated a clear understanding of their responsibilities concerning both adult and children safeguarding concerns.
- Information received from the service regarding mandatory training in safeguarding vulnerable adults was not broken down into services but showed 89% of staff had completed level 1, 90% level 2 and 100% level 3 training against the target of 90%.
- Staff knew who the safeguarding lead was and told us they would contact a member of the on call senior management team if the lead were not available.
- Staff we spoke with knew how to access information about the statutory duty to report incidents of female genital mutilation (FGM), and the action they would need to take to protect these patients. Staff had access to policies for safeguarding children and adults in line with national guidance.

Mandatory training

- All staff at the hospital received mandatory training. This training included topics such as fire safety, manual handling, health and safety, infection control and prevention as well as equality and diversity, basic life support, the mental capacity act and deprivation of liberty safeguards.
- Immediate life support was mandatory for those senior staff that carried the cardiac arrest bleep, and records showed that this had been completed. The resident medical officer (RMO) was also trained in advanced life support.
- Data provided by the hospital showed the compliance rate for mandatory training was 89% against a target of 90% year to date to July 2016.
- Mandatory training for the RMO was also provided and delivered through e-learning. This training included topics such as health & safety, child protection (level 3), data protection in health, personal safety, child protection in health & social care, equality & diversity, safeguarding adults (level 2) and the mental capacity act.

Assessing and responding to patient risk

- Staff demonstrated confidence and competence during our discussions to request urgent medical assistance if a patient showed signs of deterioration using the National Early Warning Scores (NEWS) for adults. There was adequate medical cover and specialist availability for on-going treatment and care.
- In the case of patient's condition worsening, the RMO would review and liaise with the consultant for advice about managing increased risks and consider transfer to an acute NHS hospital if needed. There were formal agreements in place if adults or children needed to be transferred to an NHS hospital.
- We saw efficient medical patient care handovers between clinical staff. This enabled each team to highlight any patient concerns or queries such as barrier nursing for a potentially infectious patient.
- Patients booked for endoscopy procedures completed a medical questionnaire, reviewed by nurses on arrival at the hospital to identify risks such as allergies prior to the procedure.
- Clinical staff in the endoscopy theatre were consistently following the 'Five Steps to Safer Surgery', to reduce harm by consistent use of best practice, which included team brief, sign in, time out, sign out. This checklist was in the same format as the World Health Organisation WHO safety checklist used within NHS Trusts.
- Qualified nurses accompanied patients who had undergone an endoscopy back to the recovery area for further assessment and supervision. If a patient became unwell, they were taken to a ward and supervised until their condition was stabilised.
- Patients were given out of hour's telephone numbers on discharge from the hospital, in case they became unwell after their endoscopy, or chemotherapy treatment. Oncologists provided an on call service for patients who felt unwell and needed to contact the hospital out of hours and the resident medical officer (RMO) supported this process.

Good

Medical care

- Patients were risk assessed on admission to the hospital for falls, venous thromboembolism (VTE), pressure ulcers and nutrition. However, there was no dementia assessment carried out for patients over the age of 75 years. The hospital had recently appointed a lead for dementia to devise a plan to improve the care of patients living with dementia.
- Staff on the oncology unit only treated 'level one' haematology patients, any patient who might require high dependency care was not accepted for treatment at the hospital.
- Patients requiring chemotherapy had a medical alert card to carry, which advised them about the risks of developing an infection and told them what symptoms to act on and the hospital's contact numbers.
- Nurses followed the hospital policies and told us that if a chemotherapy patient's symptoms were cause for concern, or indicated signs of infection, the patient would be asked to attend the hospital for review by the RMO, immediate intravenous antibiotics and blood tests.
- Staff scheduled complex chemotherapy regimens so patient treatment times did not overlap, enabling staff to spend the required time responding to increased risks if presented.

Nursing staffing

- We saw appropriate safe staffing levels in all the clinical areas including the wards, endoscopy and oncology. There was a patient acuity tool to assess the dependence of the patients against the available nursing staffing. A months staffing rota for the wards highlighted safe nursing levels.
- The ward used bank nurses who had worked in the hospital over a year and were familiar with the policies and procedures. The use of agency staff on the ward areas was very low. Where agency staff were used, they were given a comprehensive induction of the hospital and wards.
- The endoscopy unit rarely used agency staff and managed staff shortages by working additional hours. The oncology unit said they had rarely used agency staff however when they did they used a regular member of agency staff who was familiar with the department.
- During the period April 2015 and March 2016, the sickness rate for inpatient nurses and health care assistants was, in general, below the average of other acute independent providers for which we hold this type of data.
- If there was a child aged 12 or over, a suitably skilled and qualified paediatric nurse was on site. If there was a child under the age of 12 years there would be a minimum of two trained children's nurses on site.

Medical staffing

- There was a resident medical officer (RMO) that was available to support staff and provide medical cover 24 hours a day. The attending consultants were available to provide support, were accessible to staff, and could attend quickly in an emergency. Any transfers to other hospitals were the responsibility of the patient's consultant that had admitting rights to the local NHS trust.
- The RMO had appropriate advanced life support training and skills, supported by a twenty-four hour a day seven days a week on-call contracted consultant cover rota.
- The RMO reported that the on-call consultant covering their own patients was available at any time of the day or night and responded quickly to any clinical concerns in the hospital.
- The hospital human resource team had a system for checking medical staff were current with practising privileges.
- The hospital had 232 consultants employed or practising under rules and privileges for the provider last six months. The hospital reviewed consultants practising privileges and removed those that had not practised at the hospital within a year. There was a robust process for checking the qualifications, registration and experience of consultants before they were granted practising privileges.
- RMOs were employed through a contracted service that was responsible for their employment checks and mandatory training. There was a formal handover process between RMOs as they worked two weeks on duty. There were arrangements in place for a standby doctor if the RMO became unwell.
- The RMO had timed rounds with the wards to ensure that senior nursing staff did not have to contact them unnecessarily; this ensured they had sufficient rest. However, they were on-call 24 hours a day and could be contacted at any time if necessary.

Good

Medical care

Major incident awareness and training

- The hospital had a major incident plan and provided major incident awareness training for staff, using an action card format.
- There was an on-call rota for the management team to enable them to support staff out of hours.

Are medical care services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation.
- There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services.
- Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice.
- Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.
- There was multidisciplinary working across the wards, endoscopy and oncology and staff worked together as a team for patients. There was good access to the advice of a pharmacist.
- Services were provided across seven days, and there was access to the resident medical officer and consultants when patients required this.

However:

There was no formal collection of patient comfort scores in endoscopy.

Evidence-based care and treatment

- Through discussion it was evident that staff had an awareness of the National Institute for Health and Care Excellence (NICE) guidelines.
- In order to monitor and assess any change in a patient's condition, the hospital used the national early warning system (NEWS). This was in line with NICE guidance CG50 and we saw in patient records that this was used effectively.
- We saw evidence there was a local and corporate annual audit programme. This included audits such as patient health records, Five Steps to safer surgical checklist, theatre, safeguarding, same sex accommodation, theatres, infection, prevention and control, falls, (IPC), VTE assessment and resuscitation.
- Staff discussed results at clinical governance meetings, appropriate sub-committees, and departmental meetings and during" huddles".
- We saw that policies were disseminated to staff to read, sign and implement using tracker documents to confirm understanding and their compliance. New NICE guidelines were sent to the hospital monthly by the quality care team. These were assessed within the hospital for their relevance by the Medical Advisory Committee and cascaded, including to consultants.
- The endoscopy unit had registered with the Joint Advisory Group (JAG), which monitors the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised. The unit were working towards JAG accreditation and had attended BMI steering group meetings that had JAG representation, to learn and share best practice.
- The endoscopy unit consisted of a treatment room, a scope washer room, drying room and a segregated recovery area for six patients in two bays. Following the endoscopy procedure, all patients were returned to the recovery room. The consultant saw all post-endoscopy patients to discuss findings prior to discharge.
- A summary of care and treatment was sent to patients' own GP within 48 hours of a patient being discharged from the hospital. This detailed the reason for admission and any investigation results, treatment and discharge medication. A copy of the discharge summary was given to all patients. There was no mechanism for staff to follow up patients post discharge, and staff said that they relied on patients to contact them if they had any concerns about their aftercare.

Pain relief

- Staff assessed and scored pain between zero and three; and gave the patient prompt patient pain relief.

- Oncology nurses could refer patients to the NHS palliative care team for pain management advice if necessary.
- In the endoscopy unit, there was no formal collection of patient comfort scores. Nurses in the unit reported patient comfort scores as being "quite good".
- Monthly pain audits were carried out. Results were fed into the local governance committees. Audits demonstrated a high level of compliance with the hospitals standard, and any non-compliance was raised with staff.
- Patient questionnaire feedback collated by the hospital reported that for the question 'did [we do] everything we could to help control your pain' 90% of those surveyed agreed (June, 2016). This did highlight that there had been a 3% decrease since June 2015.
- In response to this feedback and a further audit of 20 other patient experiences, the hospital had set up a pain group. Although patient's expectations were being managed by a pain information booklet that was sent out to pre-operative patients, this had identified that patients felt they were occasionally kept waiting for pain relief.
- Pain and pain control was also discussed at pre-assessment. Endoscopy nurses pre-assessed their own patients at which they discussed pain control.

Nutrition and hydration

- Staff offered patients a wide range of food and drinks to meet their nutritional and hydration needs.
- Staff offered oncology patients a range of alternative food choices if the menu choices did not appeal to them due to side effects of chemotherapy.
- Patients in the oncology unit could access fresh water, fresh juice and hot drinks. Patients in the endoscopy suite were offered fresh water and food when safe to do so after treatment.
- Patients were screened for malnutrition using a recognised tool. There was access to dietician advice if this was required.
- Fluid balance charts were maintained for patients on intravenous therapy.

Patient outcomes

- The Medical Advisory Committee (MAC) monitored outcome data for individual consultants as part of the biannual review of consultant's practising privileges. This included readmission rates, development of venous thromboembolism (VTE) and hospital acquired infection.
- Patient outcomes were monitored through patient satisfaction questionnaires and incidents such as suspected surgical site infections.

Competent staff

- The process enabling new consultants to be granted practising privileges at the hospital was managed by the executive director and overseen by the MAC. New consultants had to provide evidence of qualifications, training, experience and registration and revalidation
- A register of consultants with practising privileges was held and maintained by the hospital. The register contained information about indemnity insurance, review dates and appraisal information
- Senior managers ensured that relevant checks were made against the professional register, as well as information for the Disclosure and Barring Service (DBS).
- RMOs received mandatory training on advanced life support.
- All nursing staff, therapists and health care assistants successfully completed competency checks, even if they were experienced in a skill when they joined the hospital, prior to undertaking specific procedures. Assessment included a wide variety of skills, such as cannulation and use of the hospital's medical devices.
- Nursing staff told us they had received 'spill kit training' and competencies to safely deal with a chemotherapy spillage, which included the necessary personal protective equipment, safe handling and disposal to ensure patients and staffs not exposed to unsafe levels. Cleaning staff confirmed they had received training and competency checks in the 2015 BMI spillages cleaning policy.
- Oncology staff had received one-to-one training in assessing patients using the United Kingdom Oncology Nursing Society's (UKONS) 'Oncology/Haematology 24 Hour Triage Rapid Assessment and Access Tool Kit'. This service ensures that appropriate and consistent advice is offered to nurses and patients, and also allows for the early recognition of potential emergencies and side effects of treatment.
- BMI group had a computer system that tracked staff compliance with mandatory and other training. This was also the access for e-learning packages as well as

standard operating procedures and policies. Staff were able to record that they had read a policy on the learning system. Staff pay review was linked to compliance with mandatory training.
- Staff told us they had sufficient time provided to complete their mandatory training but also spoke positively about being given opportunities for further training if they had identified a need for it through the appraisal process.
- Staff told us the appraisal system was worthwhile and engaged them in improving themselves and the service to patients. The appraisal highlighted to manager and staff opportunities for further training and development. Staff told us there was funding available for further training and managers supported staff to access further training and development.
- At the time of our inspection there was a 75% appraisal rate (so far) for nursing staff working in the inpatient areas in the current appraisal year October 2015 to September 2016.
- Nursing staff told us they had received limited training in end of life care, however, discussed having strong links with the local hospice teams.

Multidisciplinary working

- Patients were discussed and treatment protocols agreed by the cancer multidisciplinary team (MDT), as part of BMI healthcare hospitals group cancer standards, to ensure that a team of experts came to a decision in line with national guidance about what was the best treatment for a patient, rather than one doctor making a decision alone; these matched Government standards.
- Oncology and endoscopy nurses had good working relationships with the resident medical officer and colleagues in pharmacy and x-ray. They told us oncology and endoscopy consultants trusted them and listened to their opinion.
- Staff in the oncology unit had good working relationships with their peers in other local trusts: for example; they administered the chemotherapy and prepared patients for stem cell transplant elsewhere.
- Oncology nurses felt able to challenge medical staff if, for example, they noticed a medicine protocol was not what they expected.

Seven-day services

- Nursing and medical care was provided seven days a week 24 hours a day.
- Consultants reviewed their patients every day and were on-call for them 24 hours per day during their admission. Nursing staff and the RMO told us that consultants were always accessible to discuss their patients.
- Appointments for medical treatments of cancer could only be accessed Monday to Friday, However to accommodate people working office hours, appointments for clinical assessments were available between 5pm and 8pm.
- As per NICE guidelines, “myeloma diagnosis and management guidelines 2016”, chemotherapy treatment was not administered out of hours.
- If a patient was admitted for symptom control, oncology consultants were on call to carry out weekend ward rounds. The resident medical officer said the consultant always visited the patient if this was required.
- Chemotherapy patients could access advice from the oncology unit between 8am to 5pm Monday to Friday. Out of hours there was a system for calls to be diverted to the RMO.
- Other support services were available as standard at the weekend, such as physiotherapy.
- Endoscopy ran lists on Saturday mornings and until 8pm on selected days during the week.

Access to information

- The nurses and patients we spoke with agreed consultant notes were always present for the appointment time.
- The hospital used a BMI corporate patient pathway document. This document enabled different clinical team’s access to key information about the patient. Clinical notes were hand written and were accessible to all staff, including agency staff. All the relevant information for each patient such as outpatient clinic letters, surgery records and observational charts were all stored in one file for ease of access.
- NHS consultant oncologists had access to the local NHS hospital’s pathology results so they could check the results of any chemotherapy patients’ blood tests out of hours.
- Staff had access to the intranet, and folders with policies and procedures were in all clinical areas. Notice boards reminding staff clinical information were in accessible areas such as the medication room.

- Patients and general practitioners received same day discharge information. This included future management of condition, supply of medication use and possible side effects follow up advice and support and what to do in event of a problem.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards was covered in the staff mandatory safeguarding training. Staff demonstrated good understanding about their role with regard to the MCA. The consent process for patients was well-structured, with written information and verbal explanation provided before consent for a procedure was sought.
- Consent was always obtained prior to examinations, observations and delivery of care. We saw patients being asked to provide this consent.

Are medical care services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- We saw staff giving care that was compassionate and treated patients with dignity and respect at all times. Patients told us that staff were always helpful and kind and that “nothing was too much trouble”.
- We spoke with staff who told us that they enjoy developing and promoting good relationships with patients. They told us this helps them to care for them to a high standard.

The hospital were using alternative therapies to aid patients with their treatment.

Compassionate care

- Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. Patients told us staff were helpful and supportive.
- The hospital took part in the Friends and Family Test (FFT). There was no breakdown of the figures therefore it was not possible to identify the significance of these figures with regards to outpatients. For the reporting period November 2015 to February 2016, 100% of patients said they would recommend the hospital to their friends and families. Between 25% and 50% of patients responded to the FFT.
- The hospital's FFT scores were similar to the England average of NHS patients across the period (Oct 15 to Mar 16) apart from in March 16, when the score was lower than the England average.
- Relatives and friends also commented to us that the staff were very caring and “nothing was too much trouble". Patients, and relatives, explained that visiting hours were flexible, and this allowed family to support patients during their admission.

Understanding and involvement of patients and those close to them

- Patients were provided with information about their procedure at their pre-assessment appointment. There were procedure specific information leaflets and a patient information booklet about their stay in hospital. Patients we spoke with told us that they had received “an excellent” standard of pre-operative information, and had the opportunity to ask staff questions.
- Patients were provided with, and were asked to complete, feedback questionnaires. Results were collated and used by the hospital for continuous improvement purposes. It also allowed the hospital to benchmark itself against others in the BMI group.
- Questionnaire feedback was reviewed each month. Trends were identified and were shared with staff at team meetings as well as being discussed at the clinical governance meetings.
- We observed staff listened and responded to patients’ questions positively.
- During our inspection, we saw there was a wide range of health promotion literature in waiting areas. This was available in English.
- We observed patients in oncology with young families. Staff knew the names of the patient’s children and included them in conversations about treatment, with the parents’ consent and when they felt it was appropriate.
- Costs and fees for treatment were clearly documented in patient records when agreed. There were staff available to explain the costs of treatment and payment options to patients and their families.

Emotional support

- Specially trained breast care nurses were available to provide on-going support to patients.
- The hospital had started to introduce some alternatives therapies such as reflexology and one patient we spoke with reported this service was “brilliant”.
- Staff worked together to help patients with their anxiety regarding their treatment. They did this by providing information to patients prior to treatment and time, if needed, to ask questions.

Are medical care services responsive?

Good

By responsive, we mean that services are organised so they meet people’s needs.

We rated responsive as good because:

- The hospital planned and delivered its services in way which met the needs of the local population.
- Patients told us that, in endoscopy and oncology, there was good access to appointments and at times which suited their needs.
- Staff treated patients as individuals, and their needs and preferences were identified and met appropriately.
- There was robust system for learning from complaints and concerns within the hospital.

However:

- We found information on how to make a complaint was not readily available for patients should they need to raise a complaint.

Service planning and delivery to meet the needs of local people

- The director of nursing had worked closely with local NHS commissioners and had been involved in the development of the nursing vision for Berkshire and the sharing of best practice.
- The hospital had service level agreements with the local NHS trust for acutely ill patients requiring intensive care treatment.
- Facilities and premises were appropriate for the services offered. Patients reported the waiting areas were comfortable and inviting.
- On-site car parking at the hospital was available and this was free of charge. Some patients we spoke with commented that car parking spaces at the hospital were insufficient and told us they had sometimes found difficulties finding space to park.
- All patients we spoke with reported they did not have any problems in finding departments in the hospital, as they were clearly signposted. In endoscopy and ward areas, members of staff escorted patients from the main reception to their department.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by the hospital. This included information leaflets on topics such as, information on fees, pain management, cosmetic surgery, women’s health and breast health.

Access and flow

- Patients entered the hospital via the main entrance and were registered at the main reception desk.
- Staff used an electronic system which tracked patients from the time they arrived at reception and indicated how long they had been waiting.
- The hospital did not have any waiting lists for endoscopy or chemotherapy treatments.
- Patients were offered treatment according to their availability, taking into account the need for a ‘cooling off’ period following consultation and the clinical need/ urgency for the treatment.
- During the period March 2015 and April 2016, the hospital met all of the NHS patients waiting times for admitted patients beginning treatment within 18 weeks of referral.
- Staff gave chemotherapy patients a choice of appointment times, while at the same time patients were scheduled to ensure there was flow through the unit, taking into account patients’ varying treatment times.
- Chemotherapy patients could choose, if they preferred, to receive their treatment in rooms located on the adjacent ward. Should a patient become unwell then they also used the rooms on the ward. The chemotherapy provided was intravenous or administered directly into the bladder via a catheter.

Meeting people’s individual needs

Good

Medical care

- The hospital had a standard operating procedure for chaperoning as part of the 'Privacy and Dignity' policy (2015), outlining arrangements for adults. We saw chaperone notices displayed around the hospital.
- Staff told us that occasionally patients receiving chemotherapy stayed overnight in the hospital if they were frail or nauseous and had no support at home.
- Staff we spoke with said they could access translation services for patients whose first language was not English. This meant that these patients were able to hold detailed discussions about their care and treatment.
- Patient Led Assessments of the Care Environment (PLACE) for 2015 showed comparable results to the previous year and above the England average.
- In the PLACE audit carried out in March 2015, dementia services at the hospital scored 92%. This was above the England average of 81% for independent sector acute hospitals but the hospital was devising a plan to provide more dementia-friendly facilities.
- A dementia lead for the hospital had been appointed. However, as the role was new there was, as yet, insufficient time to be able to see improvements in caring for patients living with dementia.
- 95% of staff had training in care of people living with dementia.
- Patients that required special diets could have these provided by the hospital.
- Care plans recorded patient's individual needs and preferences. Patients could have visitors at any time.
- The catering team told us that they took pride in presenting quality meals for patient, staff and visitors to the hospital.
- Patients received drinks from a regular drinks round. This was carried out six times per day. In addition, patients could contact the hospitality staff if they required any additional food or drinks. They could do this directly from their bedrooms.
- Patients told us the food was tasty and presented well and that staff assisted by getting positioning tables within easy reach to help manage eating.
- Patient feedback data on the quality of food was provided by the hospital and this had increased to 82% in June 2016 on the previous year's result of 74%.

Learning from complaints and concerns

- Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the hospital website. However, during the inspection we did not see any guidance, posters or leaflets instructing patients on how to make a complaint. Pre-admission documentation sent to patients contained information about the complaints process and states "that any member of staff will ensure that you receive a copy of the complaints procedure". However, this meant patients would have to request this from staff.
- Staff told us if someone had a concern or a complaint they would try and deal with the matter there and then. Failing that, they would provide the patient with a feedback card and escalate the issue to their manager.
- During the period April 2015 and March 2016, 58 complaints had been received; one of these was referred to the ombudsman. The rate of complaints was in line with other independent acute hospitals.
- A complaints log was maintained by the hospital and was kept up to date centrally. There was a clear and robust system for dealing with patient complaints with final signoff for all complaints through the executive director. Responses to complaints were made within 20 working days of having been investigated by the relevant head of department.
- During monthly leadership meetings complaints, concerns, compliments and themes were reviewed and discussed.
- Complaints involving consultants were reviewed by the medical advisory committee.
- Staff told us complaints were openly discussed to ensure all staff were able to learn and contribute to any improvement action that might be required.
- During the period April 2015 and March 2016, there were four items of feedback from the NHS choices website. Three of the four items of feedback were extremely unlikely to recommend. However, the hospital was unaware of these comments until immediately prior to our inspection.

Good

Medical care

Are medical care services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes and open and fair culture.

We rated well-led as good because:

- There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals.
- Quality of care was regularly discussed in board meeting, and in other relevant meetings below the board level.
- There was an effective and comprehensive process to identify, understand and monitor and address current and future risks.
- There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.

Leadership and culture of service

- There was a clear leadership structure and staff felt supported by the management team. Staff told us the leadership team was visible and approachable. For example, the executive director and nursing director were on site and did regular rounds within each department. This encouraged a culture of openness and equality.
- The hospital executive director had been in post for two months prior to the inspection. The executive director was focused to re-create the hospital as a flagship' hospital of the BMI group for the south region.
- Staff told us they were happy and felt proud to work at the hospital. They spoke highly of the new executive director and the mission to become a flagship BMI hospital for the south region.
- Not all staff were able to recount the vision and values of the hospital, but were aware of the mission statement and the objectives of their department.
- The hospital met the requirements related to duty of candour. Staff were able to tell us their individual responsibilities around the duty of candour to patients.

Vision and strategy for this this core service

- There was a corporate and local vision and strategy specific to the hospital. This included, the hospital achieving a 'flagship' status for all BMI hospitals in the south region. The hospital aimed to achieve this status by improving and introducing new services in line with patient demand. For example, by expanding and offering further clinical specialities such as critical care, cancer services, and urgent care at the hospital.
- Vision, strategy and values were discussed and reviewed regularly during, hospital leadership team meetings, senior management team meetings and departmental meetings.
- Staff we spoke with were familiar with the corporate vision and demonstrated a commitment to deliver patient care, in line with corporate strategy.

Governance, risk management and quality measurement for this core service

- The hospital works within the BMI hospital committee terms of reference. This structure allows for an appropriate cascade of information from the Hospital management team meetings via the Management team meeting (Heads of Department) and subsequently to individual departments.
- Clinical quality and governance matters are reviewed by the Medical Advisory Committee (MAC), which met bi-monthly. The minutes and actions from these meetings, the Integrated Clinical Governance Meeting and the various sub-committees covering both clinical and non-clinical compliance to statutory and organisation policy such as Health and Safety, Infection Prevention were reported to the MAC, and to the management team through the team service leads meetings.
- Staff told us they found the daily 15-20 minute 'huddle' a useful way of communicating information quickly across the hospital. Senior staff and heads of department discussed daily activity, incidents and complaints at these meetings.

Good

Medical care

- Staff reported risks to heads of department who escalated them to the senior team as required. Identified risks recorded at departmental level and a hospital wide risks register. Senior leaders recorded and monitored risks.
- Senior clinical staff maintained quality measurement and performance dashboards for each service. They discussed outcomes at the clinical governance meetings and made comparisons with other BMI healthcare hospitals group. Clinical staff had access to these performance dashboards.

Public and staff engagement

- During our visit we saw there were a number of collection boxes for patients to return their completed questionnaires or they could be returned by post. Survey results were completed by an independent third party, and results communicated back to the hospital on a monthly basis for action and learning. Staff we spoke with told us they frequently discussed patient survey results and learning was shared.
- The hospital had recently set up a patient focus group for oncology patients. They discussed patient concerns about the ward environment and nutrition. As a result bottled water and fresh fruit was provided for patients and the ward had been redecorated in a brighter colour.
- The clinical manager sent copies of any patient satisfaction surveys to staff specifically mentioned by patients or families.
- Staff received both electronic and paper hospital newsletters highlighting good practice, new ideas and praised staff. Staff told us that there was an “open door” approach of senior managers to discuss ideas or concerns and staff said they’ felt valued and respected’
- Staff loyalty was rewarded through long service awards.
- Staff told us patient feedback was raised and discussed during the morning huddle. The huddle was where teams from different departments got together to review, progress, discuss and plan improvement initiatives.

Innovation, improvement and sustainability

- The hospital was working towards the process of obtaining JAG accreditation for the newly built endoscopy unit.
- The hospital had highlighted to the CCG that it was treating more patients living with dementia. The hospital had therefore appointed a dementia lead and action plan for the year to support progress awareness of dementia care across the hospital. There was a hospital training strategy that underpinned a programme of training to be delivered.

Good

Surgery

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

Information about the service

The surgical service at the Princess Margaret Hospital is arranged across two wards, Sandringham Ward is primarily used for inpatient stays and Balmoral Ward for patients having day surgery. All rooms are single with en-suite bathrooms. The inpatient ward had 26 beds, and the day case unit had 28 beds.

There are four theatres, three of which are located on the ground floor with a further theatre and recovery suite on the second floor. Three of the four operating theatres are equipped with laminar flow air systems suitable for orthopaedic surgery. There was a four bay recovery area in the ground floor theatre, and a two bed recovery area on the top floor. All theatres had separate anaesthetic rooms.

The most common surgical procedures performed at the hospital were phako-emulsification of lens with implant (for cataracts), excision of skin lesion, knee arthroscopy, diagnostic endoscopic examination of the bladder, hysteroscopy and knee replacements.

The hospital provides surgical services to adults and children aged from three to 17 years. There have been 7,781 patient attendances at the day case and in-patient service between April 2015 and March 2016. Of these 11% were NHS funded and 89% were funded by self-pay or insurance.

There have been 19 inpatient children between three and 17 years between April 2015 and March 2016. 196 Children between 3 and 17 years were treated in the day case unit.

During the inspection we spoke with five patients, two relatives and reviewed six patient care records.

Summary of findings

Overall we rated this service as good because:

Staff monitored patient safety; they investigated incidents and shared the learning to improve care. All the areas we viewed were visibly clean and well maintained. Equipment was available for staff, and there were regular safety checks on equipment and the environment.

Consultants followed a process to gain consent from patients. Patient records were well structured and staff completed all the relevant sections with few exceptions.

Staffing levels were sufficient to meet the needs of the patients. Doctors were available to provide care for patients 24 hours a day. The service had competent staff who worked well as a team to care for patients.

Staff told us training was available and they were given time to attend. Staff were up to date with their mandatory training and understood the safeguarding policies and procedures for adults. The hospital gave discharge information to patients when they went home and sent it to their GPs within 48 hours of discharge.

The service had policies and guidance to ensure staff provided care and treatment that took account of evidence based standards and procedures, except with regard to starving pre-operative patients. The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals within the BMI group.

Staff supported and treated patients with dignity and respect, and the patients were involved in decisions about their care and treatment.

Good

Surgery

Patients told us they received enough information and were satisfied with the care and treatment they received. Information leaflets were available about the hospital services; however there was limited access to information for patients whose first language was not English.

There were appropriate governance structures in place with committees for clinical governance, health and safety, infection control, medicines management.

Are surgery services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

Overall we rated this service as good because:

- Staff monitored patient safety and investigated incidents when they occurred. There was evidence that learning from incidents was shared.
- Areas we visited were visibly clean and well maintained. Appropriate equipment was available for staff to use and there were regular checks on equipment and the environment.
- There were safe systems for medicines to be appropriately stored and managed.
- There were systems for monitoring safety: these included checks on the environment, equipment, cleanliness and staff adherence to infection control policies.
- Staff completed pre-printed care pathway documentation and five steps to safer surgery documentation consistently and accurately.
- We observed good handover practice on wards.
- Staff were generally up to date with their mandatory training at 89% against a target of 95%.
- Levels of staffing were managed to meet the needs of patients and provide safe care.

However,

- Although a crossover of clean and dirty surgical instruments had been escalated to the risk register, processes to mitigate this were not being followed.
- Cabinets that stored patients' records were not secure on the wards; it could not be guaranteed that unauthorised persons could not gain access to these if there were no staff at the desk.
- There was some low level dust in the corridor areas.
- No dementia assessment was carried out for patients over the age of 75 years.

Incidents

- There were no never events reported between April 2015 and March 2016. Never Events are serious incidents that are wholly preventable as guidance or safety

recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- There had been a death in the reporting period April 2015 to March 2016; this had been fully investigated by the hospital.
- There had been two serious incidents reported between April 2015 and March 2016, both of which were notified to CQC. There was evidence of a full investigation of these incidents and changes to practice had been made. The number of serious injuries is not high when compared with a group of independent hospitals that submitted performance data to CQC.
- Serious incidents were investigated and reviewed using a robust process. The process included terms of reference, identification of contributory factors and root causes as well as a record of the duty of candour. The review included an action plan, details of the evidence obtained to inform the investigation, and details of committees at which the incident would be discussed. Learning from incidents was shared with hospital staff, and one example incident we reviewed was shared regionally within the BMI group. This occurred when learning would benefit other hospitals in the group.
- There were a total of 289 clinical incidents in the period from April 2015 to March 2016. Out of the total number of these incidents, 72% (209 incidents) occurred in surgery or inpatients and 28% (80 incidents) in other services. The rate of clinical incidents in surgery (per 100 bed days) was above the rate for other independent acute providers that we hold this type of data for.
- A total of 89 non-clinical incidents were reported between April 2015 and March 2016. Out of these 57% (51 incidents) occurred in surgery or inpatients. The remaining 43% (38 Incidents) occurred in outpatients and diagnostic imaging.
- Data from NHS England showed the hospital had 14 surgical site infections for the period April 2015 – March 2016. The data does not suggest a pattern to these reported infections.
- Staff reported incidents and near misses on an electronic system. Staff told us there was an open culture and they felt supported to report incidents; they did not feel there would be any recriminations from doing so.
- Ward sisters and the theatre manager told us there had been a culture of some staff from overseas not feeling able to challenge and question the practice of consultants. Following a serious incident, theatre staff had undergone human factors training and felt more enabled to challenge poor or inappropriate practice in all staff.
- The senior management team held a weekly meeting to discuss incidents; they were further discussed at clinical governance meetings.

Safety thermometer

- The NHS patient Safety Thermometer is a monthly snapshot audit for measuring, monitoring and analysing patient harms and 'harm free' care. All patients whose notes we checked had venous thromboembolism (VTE) assessments completed on admission. Staff also screened patients for Meticillin Resistant Staphylococcus Aureus (MRSA) colonisation and carried out risk assessments for pressure ulcers.
- There were no incidents of hospital-acquired venous thromboembolism or pulmonary embolism in the period April 2015 to March 2016. There were no reports of catheter-associated urinary tract infections and no patient falls during this period.

Cleanliness, infection control and hygiene

- There was no incidence of MRSA or Meticillin Sensitive Staphylococcus Aureus (MSSA), Clostridium Difficile (C.Difficile) in the reporting period April 2015 to March 2016. All patients underwent screening for MRSA before admission to the hospital. There was a single incident of E.Coli catheter associated urinary tract infection in the reporting period April 2015 to March 2016.
- All areas inspected were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored by audits, to reduce the risk of spread of infections. However, there was some dust in the ward corridor areas, so this was escalated during the inspection and the area was re-cleaned.
- We observed hand-sanitising gels were available at designated points such as outside entrance and exits.
- Infection control audits were carried out monthly by the infection control and prevention lead. Audit results showed compliance on the surgical wards as 86% against the hospital target of 90%. The result for the same period in theatres was 93%. The compliance level

with hand hygiene in theatres had been escalated to the director of nursing and the medical advisory committee as it had been recognised from observational audits that medical staff were responsible for the non-compliance with the policy. Incidents of poor compliance against the standard were raised with staff at each audit observation. The hospital provided patients with a leaflet that explained hand hygiene requirements, and when alcohol gel should be used appropriately instead of hand washing. This was sent out to patients as part of their pre-admission information pack.

- Patients were also given written information about surgical site infection, explaining the risks and how the hospital staff would monitor patients.
- We observed staff adhered to the hospitals infection control policies, staff washed their hands between each patient contact and observed the bare below the elbow uniform policy to minimise the risk of spread of infection. Personal protective equipment (PPE) such as gloves and aprons were readily available for staff in all clinical areas and these were used as required.
- There was a lead nurse for infection prevention and control (IPC). This role was responsible for checking patient screening and swab pathology results, and supervision of IPC link staff. Audit was undertaken by the IPC lead (and facilitated by the IPC link staff) for catheters and central lines, as well as monthly surveillance of hip and knee wounds. Patients were also called by the IPC lead a month after surgery to check there was no sign of wound infection post operatively. The IPC lead also led on infection control training and assessed nurse competency in aseptic non-touch technique.
- The IPC lead carried out environmental inspection with the housekeeping team, using a quality improvement tool.
- There were some fabric chairs in use for patients that were steam cleaned when required. There were some patient's rooms with wall paper that would be difficult to decontaminate in the event of contact with body fluids.
- In some clinical areas, there was not always dedicated sinks for hand washing. This had been identified on the hospital risk register. There was a business plan in place for the provision of dedicated hand washing sinks. The lead for infection control had mitigated this until material changes could be made.
- The hospital had a microbiologist on call to give advice; the IPC lead reported that she found this service very responsive. The microbiologist attended quarterly meetings at the hospital to discuss IPC issues and surveillance data.
- Equipment in the clinical areas we checked was visibly clean and 'I am clean' stickers identified that items had been cleaned and were ready for use with patients.
- Surgical instruments and equipment was sterilised off-site by a contractor. In the operating theatre, there was a crossover of clean and dirty instruments as the clean instrument trolleys had to be delivered to the same area where the used ones are collected from. This had been noted on the departmental risk register; however, a process to mitigate the risks was not being followed.
- The instrument trays were delivered in a cleaned trolley daily, this was labelled "sterile instruments". This label was changed when the trolleys were used to accommodate used surgical instruments. There was appropriate management of sterile instruments to Theatre 4 (located on the top floor of the hospital and away from the other three theatres). There was an appropriate room for the dirty instruments to be checked and placed in a designated trolley for the return of used instruments.
- There were a total of 14 surgical site infections reported between April 2015 and March 2016. The rate of reported infections during primary knee arthroplasty procedures, from April 2015 to March 2016, was above the average of NHS hospitals (from April 2010 to March 2015). During the same period, the rate of infections reported for spinal, breast and vascular procedures was lower than the average of NHS hospitals.
- There were no surgical site infections reported from hip replacement or cardiothoracic surgical procedures.
- There were appropriate policies and arrangements for the segregation and disposal of waste. There was no build-up of waste in clinical areas. We observed the correct management of containers for sharps.
- The hospital had water- flushing protocols in place and low use areas identified. Annual checks of water were carried out by an external contractor, and the results were checked with the microbiologist, IPC lead and the facilities management team. The facilities management team were able to show us current results of water quality checks and annual risk assessment.

Good

Surgery

Environment and equipment

- The wards areas were visibly clean, and there were sufficient facilities for washing hands. Alcohol hand-sanitising gels were available for patients and visitors to use.
- Resuscitation equipment we inspected had been checked, and records were available to demonstrate that this occurred daily. Some equipment was provided for the resuscitation of children on the in-patient wards, for example infant defibrillator pads. We were told that these should not be on the adult trolleys as there was a dedicated paediatric resuscitation trolley. This meant that there was extra equipment on the trolleys that could have caused confusion in an emergency.
- There was a paediatric resuscitation trolley located on the children's ward. This could be moved to be located wherever there was a child as an inpatient. The trolley checked daily and contained appropriate equipment for resuscitation of children and infants.
- There were resuscitation trolleys on both wards and in the recovery areas. In addition there was a difficult airway trolley located in theatre recovery which was suitable to enable the effective management of both adults and children.
- Sterile medical supplies were stored in temperature controlled rooms with secure access.
- All patient rooms were equipped with a shower room with level access. There was also piped oxygen and suction to each patient room.
- Medical equipment required for patients was stored correctly and securely and was in date and ready for use. There was a suitably- maintained patient hoist and there were a variety of sizes of single patient-use slings to fit the device.
- All medical equipment on the wards was tested for electrical safety within the last year. There were asset tags in place to allow each item of equipment to be traced by the facilities management team. This ensured that items of equipment had been regularly checked, serviced and maintained. Medical equipment was clean, with the use of a tape sticker system to identify that items of equipment were clean and ready to use.
- The risk register highlighted that there needed to be a replacement programme for equipment, this was in progress.
- The main theatre suite was secure, with access for staff only, the second floor theatre entrance was not secure but located behind the nurse's station. Although the door was discreet access to the theatre was not always checked. The operating theatre suite of the second floor was spacious and well equipped.
- The main theatre suite had limited space especially in the recovery area, where the patient recovery bays were very narrow. This had been identified as a risk and resuscitation scenario training had been carried out to ensure the area was safe for use. There was also a large amount of equipment stored in the recovery area that could restrict access to patients in an emergency. This had been reduced after the identification of this as a risk.
- All theatres had a well-equipped anaesthetic room, with controlled drug and appropriate medicines storage.
- There were three theatres equipped with laminar airflow systems; these were used for orthopaedic surgical procedures.
- There was an issue identified with water ingress to theatre four recovery located on the second floor. This had been satisfactorily mitigated and was on the corporate risk register as requiring a refurbishment.
- There was appropriate and secure storage of instruments and equipment and implants required for surgery. Surgical instruments were owned by the hospital but decontaminated and sterilised by a contractor.
- All equipment used in surgical procedures was checked in and out of the hospital using a paper system. Any discrepancies in equipment were flagged to the sterilisation contractor directly.
- Patient records contained details of all consumable items used during surgery to ensure that each was fully traceable. This included records of implants.
- There was a small but pro-active facilities management team, the lead worked across this site and another BMI hospital nearby. Staff told us that the facilities management team were very responsive when dealing with issues. During the inspection, the lift call to the second floor was not working. This provided access to the theatre and wards. On investigation, the matter had been reported urgently to the lift company early in the morning and an engineer was awaited.

Medicines

- The hospital had a pharmacy on-site open Monday to Friday 8.30am to 5pm. There was an on-call service available during out of hours including weekends. The in-house pharmacist supported the staff with medicines management.
- On both the inpatient and day case ward and in theatres we observed that medicines, including controlled drugs (CDs) were stored securely. Outpatient prescription pads and tracking documents were also stored securely.
- Staff stored medicines at recommended temperatures. Refrigerator and room temperatures were recorded daily, and staff sought advice from pharmacy when temperatures were found to be outside recommended ranges.
- Emergency medicines, including oxygen, were available for use and expiry dates were checked to ensure they were safe for use when needed. Emergency trolleys were stocked with the correct medicines for adult resuscitation. The paediatric resuscitation trolley would be moved should a child be located on one of the surgical wards.
- Patient medicine administration records recorded known allergies. Pharmacy and nursing staff spoke with patients about their medicines.
- Patients' own medicines were kept in a locked drawer in their room, with the exception of controlled drugs. Additional oral painkillers were given to patients when they had been prescribed; these were stored with the patient's own medicines so that they were available for them to take.
- Pharmacists supplied medicines for theatres, inpatients and outpatients. Pharmacists carried out medicines reconciliation when patients were admitted to hospital for surgery.
- During the inspection, checks of controlled drugs (CDs) on the wards and in theatres found they were stored correctly and stocks of medicines were in date. There were appropriate records kept of the administration of controlled drugs in these areas. Pharmacy conducted an audit of CDs every quarter. In June 2016 there was an action plan devised as the CD audit had shown that dose administered/wasted was not recorded for all entries; there were not always the required three signatures to record wastage(as per hospital policy), and there were errors that had been over written in the register. The action plan had been communicated with staff, responsibilities were assigned and there was a timeframe for completion.
- Other medicines were stored correctly and were found to be in date.
- Theatres had temperature controlled medicines storage in each anaesthetic room; these were also subject to daily minimum and maximum temperature checks.
- We found the in-house pharmacy team had robust systems for checking and ensuring emergency drugs were available, as they carried out these checks at the beginning of each month and records were maintained. The pharmacy conducted a missed dose and antimicrobial stewardship twice yearly audit. The surgical ward and day case units were found to be compliant against all their standards on this audit in June 2016.
- Anaphylactic drugs were available for the treatment of potentially life-threatening allergic reaction that can develop rapidly.
- Patients who were prescribed antibiotic treatment had a sticker applied to their medicines administration record. This allowed the record to be easily audited, and also allowed nursing staff to escalate to the doctor or pharmacist when the course should finish if not indicated.
- Stickers were also used on medicines administration records when patients came in from home with their own controlled drugs.

Records

- Patient records were kept in lockable cabinets and although these were not locked, we observed that they were kept closed. These were stored adjacent to the nurses' station. There was usually a member of ward staff in the area, but this could not be guaranteed and patient's notes could be accessed by unauthorised persons as the cabinets were not secure.
- Pre-operative assessments were completed for all patients undergoing a surgical procedure. This included the five steps to safer surgery template. We saw that this was used correctly.
- Medical and nursing records in the surgical department were paper based; these were bound and maintained in good order. We reviewed six sets of patient records. All records were legible, signed and dated. Records contained all the relevant information including discharge letters to the patients' GP.
- Computer records were secure and were password protected.

- Records and treatment plans were detailed and contained good information about post- operative care.
- Staff maintained clear and consistent fluid records, including a record of intravenous fluids received by patients post-surgery.
- The Five steps to safer surgery checklist (based on the WHO Surgical Safety Checklist) was used fully in all of the six records we reviewed.

Safeguarding

- There had been one safeguarding concern reported to CQC between April 2015 and March 2016.
- The Director of Nursing was the designated lead for adult safeguarding and she had overall responsibility for children's safeguarding. There was a designated lead for children's safeguarding that was the lead registered children's nurse. The hospital had identified links with a local safeguarding team and had regular meetings.
- There were procedure flow charts for staff to follow in all clinical areas. These contained the information staff would need if they had to make a safeguarding referral. There were separate policies for safeguarding adults and children that reflected national guidance.
- Staff had completed mandatory training in safeguarding vulnerable adults. Information received from the service was not broken down into services but showed 89% of staff had completed level 1, 90% level 2 and 100% level 3 training against the target of 90%. Staff were able to tell us what constituted abuse and said they would report to the senior staff in charge.
- The service provided gynaecology care and clinics. Staff we spoke with knew how to access information about the statutory duty to report incidents of female genital mutilation (FGM), and the action they would need to take to protect these patients.

Mandatory training

- Staff received mandatory training on fire safety, manual handling, health and safety, infection control and prevention as well as equality and diversity, the mental capacity act and deprivation of liberty safeguards. There was mandatory basic life support training for all staff at the hospital; this included both adult and paediatric training. Immediate life support was mandatory for those senior staff that carried the cardiac arrest bleep, and records showed this had been completed. Data provided by the hospital showed the compliance rate for mandatory training was 89% against a target of 90% year to date to July 2016.
- The hospitals' resident medical officer (RMO) received mandatory training through e-learning this included; health & safety, child protection (level 3), data protection in health, personal safety, child protection in health & social care, equality & diversity, safeguarding adults (Level 2) and the Mental Capacity Act. The RMO was also trained in advanced life support this was verified by the employing agency. Although 49% of staff had been trained in basic life support (BLS), 80%had completed training in intermediate life support (this included BLS).

Assessing and responding to patient risk

- Early warning scores were used to detect deterioration in a patient's condition. Patient observation charts were filled out correctly and the early warning score was calculated in all the records we reviewed.
- There was a process that ensured a patient that was deteriorating would be seen by the RMO and the consultant informed, before transfer to the local NHS hospital was organised.
- We observed the use of 5 steps to safer surgery framework (WHO Checklist) for three operations. We also reviewed records where this had been used fully. There was a monthly audit carried out on the use of the WHO checklist on a sample of 10 patient records. The WHO checklist is a framework to help reduce surgical errors. The audit was completed using a BMI pro-forma, the results were reported as good.
- A process had been developed for the management of patients who may suddenly become acutely ill. The process was for nursing staff and the resident medical officer (RMO) to attend any emergency on the wards. Patients would be stabilised and/or transferred to the local NHS acute trust as required via 999 emergency ambulance service. The consultant would be made aware of the reason for transfer.
- There were formal agreements in place if adults or children needed to be transferred to an NHS hospital. There was also an agreement in place for transfer of children to an appropriate paediatric intensive care unit if required.

- Risk assessments for falls, venous thromboembolism (VTE), pressure ulcers and nutrition were carried out on admission. However, there was no dementia assessment carried out for patients over the age of 75 years.
- There was a system of screening all surgical patients pre–operatively for risks of venous thromboembolism (VTE) and appropriate therapy was prescribed according to risks. We saw that assessments had been completed and patients were prescribed appropriate therapy or preventative measures such as compression stockings or blood thinning medicines. This was present in all of the six patients' records we reviewed.
- Patients' post- surgery pathway included the monitoring of visual infusion phlebitis (VIP) score. This is a recognised tool for the evaluation of the condition of the intravenous and essential to ensure and maintain patient's safety.

Nursing staffing

- There was a patient acuity tool to assess the dependence of the patients against the available nursing staffing. The inpatient lead said she had sufficient time to arrange staffing numbers and skill mix for planned surgical patients. The needs of patients would always be assessed against nursing staffing numbers before their booked admission.
- Departmental nursing handover occurred between shifts, using a pre-populated handover sheet. This was undertaken in the nurse's office where patient details could be kept private. Details of patient's surgical status and any medical and nursing needs were discussed, as well as planned admissions and discharges.
- The hospital used its own bank for nursing staff to cover shifts. The use of agency staff on the ward areas was very low. Where agency staff were used they were given a comprehensive induction of the hospital and ward.
- There were sufficient staff to provide safe care and treatment across all areas. The regular staff covered absence and leave and also had a bank system which staff said worked well. We observed care was provided in an unhurried manner and staff took time to support relatives.
- There was a resident medical officer (RMO) who was available to support staff and provide medical cover 24 hours a day. The attending consultants were available to provide support, were accessible to staff, and could attend quickly in an emergency. Any transfers to other hospitals were the responsibility of the patient's consultant that had admitting rights to the local NHS trust.
- The sickness rate for inpatient nurses in the reporting period April 2015 to March 2016 was below the average of other independent acute providers that we hold this type of data for except for April 2015, February and March 2016.
- The sickness rate for inpatient health care assistants was below the average of independent acute providers that we hold this type of data for in the reporting period April 2015 to March 2016.
- Hospital data reported no unfilled shifts in the first three months of 2016. The rate of staff turnover among registered nurses, ODPs and healthcare assistants was lower than other comparable hospitals in the period April 2015 to March 2016.
- In the theatre department the roster was completed every two weeks, instead of monthly. However, the theatre lead told us staff were able to request duties and these were generally not refused. Staff we spoke with were happy with the theatre roster arrangement.

Surgical staffing

- The hospital employed 232 consultants under practising privileges over the last six months. Consultants carrying out surgical or endoscopic procedures within the hospital were responsible under practising privileges for the care of their patients across 24 hours. This also included planned and unplanned admissions from the Day Surgery Unit.
- All consultants, including anaesthetists, responsible for the care of children and young people were trained to Safeguarding Level 3. Those consultants who had not completed the required training had their practising privileges removed or suspended until the training had been carried out.
- The hospital had removed 35 consultants practising privileges between April 2015 and March 2016. Three consultants had been suspended pending GMC enquiries from their NHS practise. One of these consultants had their suspension lifted with restrictions on practise applied. However, the majority of those removed was as a result of an update and data-cleanse of the practising privileges register, removing those consultants that not worked at the hospital in the last 12 months.

Good

Surgery

- There was an on-call rota for consultant anaesthetists for post-operative patients, although staff told us many anaesthetists were happy to be called if required to review their patients.
- There was a resident medical officer (RMO) in the hospital 24 hours a day, seven days a week. They had immediate access by telephone to all consultant staff that remained responsible for their patients under practising privileges.
- The hospital employed RMOs through a contracted service that was responsible for their employment checks and mandatory training. There was a formal handover process between RMOs as they worked two weeks on duty. There were arrangements in place for a standby doctor if the RMO became unwell. The director of nursing met regularly with the RMO to discuss any welfare concerns. Although the RMO was on-call, they had timed rounds with the wards to ensure that senior nursing staff did not have to contact them unnecessarily and to ensure they had sufficient rest. The RMO we spoke with told us they were adequately supported in their role and enjoyed working at the hospital.
- The hospital had a lead paediatric consultant that was contactable for advice on issues around the care and treatment of children.

Major incident awareness and training

- The hospital had local and corporate business continuity plans with supporting action cards for use in a major incident.
- The hospital had a major incident plan, and they ran major incident awareness training for staff.

Are surgery services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- Staff used an effective system for monitoring patients for signs of deterioration after surgery.
- Patients were given pain relief and the effectiveness of this was checked. There was an audit of pain assessment and medicine administration.
- Patient outcomes were in line with the national average, and there were a low number of patients that required to be transferred to other hospitals. There were low numbers of unplanned readmission of patients.
- The staff were competent to carry out their roles. Staff were given time to undertake training, and there were mechanisms to check competence.
- There was multidisciplinary working across the surgical wards, and staff worked together as a team for patients. There was good access to pharmaceutical advice.
- Services were provided across seven days, and there was access to the resident medical officer and consultants when patients required this.
- Patients were consented for surgery appropriately, and their consent was sought before any care or treatment was given.

Evidence-based care and treatment

- Staff had an awareness of the National Institute for Health and Care Excellence (NICE) guidelines. For example, staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE Guideline [CG92].
- The hospital followed NICE guidance for preventing and treating surgical site infections as in NICE Guideline CG74.
- The hospital used the national early warning system (NEWS) to assess and respond to any change in a patients' condition post operatively. This was in line with NICE guidance CG50. In patient records we reviewed this was used effectively.
- The hospital participated in the National Joint Registry and submitted data for all patients undergoing hip and knee replacements.
- A summary of care and treatment was sent to patients' own GP within 48 hours of a patient being discharged from the hospital. This detailed the reason for admission and any investigation results, treatment and discharge medication. A copy of the discharge summary was given to all patients. There was a mechanism for staff to follow up patients post discharge with a telephone call.

Pain relief

- Patients were given written information about pain control before being admitted for surgery. This included an explanation of the 0-3 pain assessment tool and different types of medicines and techniques to manage pain. However, there was no visual analogue pain assessment tool which is a recognised tool for people with a cognitive impairment.
- Pain control was also discussed during their pre-admission assessment. Patients were assessed and prescribed pain relief prior to their operation.
- Paediatric trained nurses were involved in the pre-admission assessment process and saw children in outpatients to discuss pain relief.
- Patients that we spoke with said they had adequate pain control and pain relief was available to them when they needed it. We observed nursing staff asking patients to rate their level of pain using a 0-3 assessment score. This score was documented on care records we reviewed.
- A pain audit was carried out monthly, this showed compliance against the hospitals standards on pain control. The results of this audit fed into the local medicines management, clinical governance and risk management committees. Inpatient ward nurses also reviewed patient risk assessments and care plans which included pain. Audits demonstrated a high level of compliance with the hospitals standard, and any non-compliance was raised with staff.

Nutrition and hydration

- Patients were advised about fasting times prior to surgery at pre-assessment and in their admission letter. The hospital aimed to ensure that fasting times were as short as possible before surgery in order to prevent dehydration and reduce the risk of post-operative nausea and vomiting.
- There was no audit carried out on patient fasting times to demonstrate compliance with national guidance.
- Nursing staff we spoke with gave us examples of where day case patients given sandwiches were not provided with anything else when this was not enough to satisfy their hunger. Four staff also expressed disappointment at the quality of food provided in the staff Restaurant. This service was contracted to an external provider, and the senior leadership team were actively addressing some concerns with the current provision.
- Fluid balance charts were completed for patients that required fluid balance monitoring. We reviewed four fluid balance charts that were completed accurately.
- A regular drinks round was carried out on the wards, and patients were able to contact the hospitality staff directly from their bedrooms if they required any additional food or drinks.

Patient outcomes

- The hospital participated in national audits such as patient reported outcome measures (PROMs) for surgery of hips, knees and groin hernia. Data was collected from all NHS patients. PROMS measures the quality of care and health gain received from the patients perspective.
- Between April 2014 and March 2015, data from PROMS showed the hospital was within the expected range for both knee replacement surgery with regards to the oxford knee score, and hip replacement surgery with regards to the Oxford hip score. The Oxford knee score showed that from 19 records, 100% of patients had reported improvement. The Oxford hip score from 12 records reported that 83% of patients were reported as improved and 17% as worsened.
- The hospital also registered patients that had had joint replacements onto the National Joint Register (NJR). The NJR collected information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor the performance of joint replacement implants.
- The hospital also submitted data to Public Health England on Surgical Site Infection Surveillance for hip and knee surgery. This data was in line with other services. The hospital reported five cases of unplanned transfers of an inpatient between April 2015 and March 2016. This number is not high when compared with other independent hospitals that submitted performance data to CQC.
- There were nine cases of unplanned readmission to hospital between April 2015 and March 2106. This number is not high when compared with other independent hospitals that submitted performance data to CQC.
- There were six cases of unplanned return of the patient to the operating theatre, in the period April 2015 to March 2016. These had been reviewed individually and no themes had been identified.

Competent staff

- New consultants had to provide evidence of qualifications, training, experience and registration and revalidation to be granted practising privileges at the hospital. This process was managed by the executive director and overseen by the Medical Advisory Committee.
- The hospital maintained an up to date register of consultants with practising privileges. This included information about indemnity insurance, review dates and appraisal information. Senior managers ensured that relevant checks were made against the professional register, as well as information for the Disclosure and Barring Service (DBS).
- Resident medical officers had received mandatory training on advanced life support.
- All staff undertook a mandatory induction programme, and worked towards achieving competencies for their role. Competencies were self-assessed by staff and learning needs could be identified from these documents. Competencies and learning needs of staff were supervised by ward sisters.
- New procedures and equipment were only introduced after staff had undertaken appropriate training. The BMI group used a limited number of suppliers for implants, and the hospital insisted that consultants unfamiliar with these products were appropriately trained.
- Staff told us they had sufficient time provided to complete their mandatory training. Staff spoke positively about being given opportunities for further training if they had identified a need for it through the appraisal process. The BMI group had a computer system that tracked staff compliance with mandatory and other training. This was also the portal for e-learning packages as well as standard operating procedures and policies. Staff were able to record that they had read a policy on the learning system. Staff pay review was linked to compliance with mandatory training.
- Hospital data reported that there was a 75% appraisal rate (so far) for nursing staff working in the inpatient areas in the current appraisal year October 2015 to September 2016. We inspected in Mid-September. In the theatre department, 90% of nursing staff and 88% of operating department assistants and health care assistants had received an appraisal in the current appraisal year.
- Hospital staff told us they were proud of the programme of clinical training provided by the consultants with practising privileges at the hospital. They felt this demonstrated a sense of partnership and teamwork across the surgical areas.
- The hospital employed trained children's nurses. Children's nurses had signed competency documents and records of training that were reviewed on the inspection.

Multidisciplinary working

- During the inspection we observed good multidisciplinary working between different teams involved in patient care and treatment. There was clear communication between staff from different teams, such as the anaesthetist and operating department assistant, theatre and ward staff. Staff described the team as supportive and felt their contribution to patient care was valued.
- The hospital offered physiotherapy for both inpatients and out patients. Physiotherapists were involved in the pre-assessment of orthopaedic patients, and provided patients with advice and education about exercise and walking aids before their operation.
- Physiotherapists worked with post-operative patients to ensure they were recovering as expected. If patients were assessed as requiring equipment to use, such as a raised toilet seat or walking aid, the physiotherapist would assess for and provide this equipment.
- Physiotherapists worked as part of the team on the inpatient wards and in the day surgical unit. If referral was required to physiotherapy or occupational therapy outside the hospital, staff would write referral letters for patients and discuss post-operative needs with NHS or local authority therapy staff.
- There was a rota for physiotherapists should patients require support or intervention out of hours.

Seven-day services

- The hospital offered nursing care seven days a week 24 hours a day. The theatre suite was available for elective surgery between 8am and 8pm Monday to Friday, however there were also some operating lists that ran on a Saturday between 8am and 4pm.
- There was a resident medical officer (RMO) in the hospital 24 hours per day, seven days a week.

Good

Surgery

- Consultants are on-call for their patients 24 hours a day, during their stay at the hospital. Staff told us that consultants were always accessible to discuss their patients with nursing staff and the RMO. Consultants reviewed their patients every day.
- There were on-call rotas for anaesthetists and radiology, as well as senior managers which were available when staff needed them.

Access to information

- Records were available to all staff involved in providing patient care, this included physiotherapists and pharmacists.
- There was an intranet system via which staff could access hospital policies, standard operating procedures and guidance.
- Mandatory training courses and appraisal information was also available on the "BMI learn" system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for their consent prior to examinations, observations and delivery of care.
- Consent forms we reviewed were fully completed, and consent was re-checked if the patient had signed their form at pre-assessment before surgery.
- There was a consent policy in place that covered adults and children.
- Children below the age of 16 were asked their consent for procedures if they were deemed to have capacity to do this.

Are surgery services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- Staff provided care that was compassionate and treated patients with dignity and respect at all times. Patients told us that staff were always helpful and kind.
- Staff spoke about developing and promoting good relationships with patients and having the time to care for them to a high standard.
- Patients anxious about surgery were given time and information, their individual needs and preferences were taken into consideration. The needs of the patient's families were also taken into consideration.

However,

- There was no written information about how to make a complaint for patients to take away.

Compassionate care

- Visiting hours were flexible which allowed relatives to support patients. Relatives also commented to us that the staff were very caring and that "nothing was too much trouble".
- Patients anxious about their operation were given time and information to help to reduce their anxiety. Staff worked together to help patients with any concerns
- Patients told us call bells were answered promptly and that nursing staff had developed good relationships with them and their relatives. They also told us they were treated with the "utmost respect". Another patient commented that the hospital staff ensured their privacy and dignity at all times. Staff were observed to knock before entering patients' rooms on several occasions.
- The patient feedback we collected as part of the inspection was positive about the care patients received at the hospital. There was a detailed patient satisfaction questionnaire that patients were asked to complete. However, there was no written information about how to make a complaint. Reception staff told us they would provide the patient with a telephone number or e-mail address if they had an issue they wished to raise.
- The hospitals friends and family test (FFT) scores for NHS patients (in the independent hospital sector) were similar to the England average of NHS patients across the period October 2015 to March 2016, except for in March 2016. The hospital reported consistently high levels of overall FFT scores at 98%. The FFT survey response rate was below the England average except in October and November 2015.

Understanding and involvement of patients and those close to them

- Staff gave patients information about their procedure at their pre-assessment appointment. This included procedure specific information leaflets and a patient information booklet about their stay in hospital. Patients confirmed they had received an excellent

standard of pre-operative information, and had the opportunity to ask staff questions. A discharge letter was provided to the patients GP within 48 hours of discharge.

- Staff discussed care and treatment in detail with patients, including what to expect post-operatively including length of stay, and involved patients in their plans for discharge
- Patients were consulted on all aspects of their care and treatment. Relatives were involved in care if this was the patients wish.
- We observed staff in the anaesthetic room explaining care and treatment to patients and helping to reduce any potential anxiety
- Patients completed feedback questionnaires, the results of which were fed back to allow for continuous improvement and also benchmarked the hospital against others in the BMI group. The feedback from the questionnaires was reviewed each month to identify trends, and was shared with staff at team meetings as well as being discussed at the clinical governance meetings.
- Children that were admitted for surgery were given a soft toy and a certificate to take home.

Emotional support

- We observed staff in theatres providing emotional support to patients that were worried or anxious. For example, we saw a member of staff holding a patients hand to provide reassurance.
- Visiting hours were very flexible ensuring that patients were able to see their friends and family. Patients had telephones in their bedrooms to allow them contact and obtain emotional support from their family and friends during their recovery.
- We observed staff explaining procedures to surgical patients before and after operations in a way they could understand.
- Parents were encouraged to accompany their children to the anaesthetic room to support them before surgery. Parents were allowed to see their child in recovery as soon as this was appropriate.

Are surgery services responsive?

Good

By responsive, we mean that services are organised so they meet people's needs.

We rated responsive as good because:

- Services were planned and delivered in a flexible way that met the needs of the population.
- Patients were given written information to support them through the pre and post-operative period.
- Patients discharge was planned as soon as they were admitted to hospital, and the length of stay was flexible if required.
- The hospital monitored NHS patient waiting times; these showed that 90% of patients in most specialities began treatment within 18 weeks of referral.
- Patients were treated as individuals, and their needs and preferences were identified and met by staff.
- The hospital had a robust system for learning from complaints and concerns.

However,

- There was no evidence that patients aged 75 and over admitted to the hospital were screened for dementia. This was not in line with NICE guidelines in identifying patients as potentially living with dementia.

Service planning and delivery to meet the needs of local people

- The local NHS commissioners worked closely with the director of nursing at the hospital and she had been involved in sharing of best practice, and the development of the nursing vision for Berkshire.
- The majority of patients were seen in the outpatients department and followed a surgical pathway from there. Patients that require admission for a procedure were pre-assessed either face to face, or via a telephone interview. From pre-assessment, any specific needs or requirements would be identified to inform planning for admission. For example, the requirement for an interpreter, environmental or special dietary needs would be planned before admission.

- Patients received information before admission to hospital. This included information about specific surgical procedures, pain relief and hand hygiene as well as what to expect.

Access and flow

- Patients discharge was planned from admission. This included post-operative physiotherapy and equipment for orthopaedic patients, and discharge summaries were sent to the patient's GP within 48 hours.
- The hospital exceeded its target of 90% of admitted patients beginning treatment within 18 weeks of referral for April 2015 of the reporting period before the NHS targets were abolished (April to May 2015). However, in all specialities except gynaecology and urology over 90% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period April 2015 to March 2016.
- There was a monthly report produced by the hospital to provide audit of patient waiting times for treatment. Data was sent to commissioners every month in order to monitor contractual and treatment obligations.
- Operating theatre usage was from 8am - 8pm Monday to Friday, and 8am – 4pm some Saturdays. The theatre team could run flexibly until all patient procedures were completed which was sometimes later than 8pm.

Meeting people's individual needs

- A dementia lead for the hospital had been recently appointed.
- There was no evidence that patients aged 75 and over admitted to hospital were screened for dementia using the dementia screening tool. This was not in line with department health and NICE guidelines in identifying patients as potentially living with dementia.
- Staff's knowledge in relation to mental capacity was variable. However, information provided by the hospital told us that 95% of staff had training in care of people living with dementia.
- Patients that required special diets could have these provided by the hospital.
- Care plans recorded patient's individual needs and preferences. Patients could have visitors at any time.
- Prior to admission patients were sent and asked to complete a health questionnaire. This asked them to explain their individual needs and preferences. It also included assessment information about their home, social and cultural needs as well as arrangements for discharge. This document help staff plan for the patients' needs during admission and on discharge home.
- Children were able to visit the hospital prior to admission. Children undergoing surgery were admitted 1-2 hours prior to surgery to reduce anxiety. Parents were permitted to stay with their children and accompany them to the anaesthetic room. Visiting times for children allowed parents to stay, other visitors were allowed at any time at parental discretion.
- The hospital provided data from patient feedback surveys on the quality of food provided; this had increased to 82% in June 2016 on the previous year's result of 74%.
- In the operating theatre suite there was a recovery bay that was decorated specifically for use with children.

Learning from complaints and concerns

- Staff told us verbal concerns and complaints were dealt with at the time and these would be recorded in patients' notes. There was no system to record verbal complaints to enable the staff in identifying trends in order to develop action plan/ shared learning. Staff told us that if a patient wished to make a complaint they would be given contact details for the hospitals customer service manager.
- The team leads passed all written complaints to the quality and risk manager.
- There was a clear and robust system for dealing with patient complaints. There was a central complaints log maintained by the personal assistant to the executive director that was kept up to date. Final signoff for all complaints was through the executive director. Responses to complaints were made within 20 working days, having been investigated by the relevant head of department.
- Complaints, concerns, compliments and themes were discussed in the hospital leadership team meetings that occurred monthly, and at the quarterly Integrated Governance Committee Meetings and within the monthly Executive Board Meetings. Complaints involving a consultant were reviewed by the Medical Advisory Committee.
- Patients could access information about making a complaint; there was a leaflet in each patient room called 'please tell us' giving information on how to make

a complaint. There were also leaflets provided that were an in-depth questionnaire about patient experience of the service. The hospital website also provided a link that outlined the complaints process.

Are surgery services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes and open and fair culture.

We rated well-led as requires improvement because:

- Although there were systems in place for identifying and managing risk, some were rudimentary with limited ability to spot trends. Risks were recorded and mitigations put in place. However, mitigations were not always checked to ensure they were effective.
- Some senior staff did not feel empowered to drive positive change and lacked the confidence to challenge poor practice where this was seen.
- Some staff we interviewed found it difficult to challenge senior staff or consultants due to cultural differences.
- Senior nurses did not use the quality data generated to drive change and service improvement.
- Not all staff were able to recount the vision and values of the hospital, but were aware of the mission statement and the objectives of their department.

However,

- The culture was open and staff felt that they would be able to prevent harm to patients through the escalation of safety concerns; they did not feel that there would be any repercussions to themselves for using this mechanism.
- Staff were generally positive about the standard of care delivered to patients.
- There was a strong team ethos across the surgical service with staff working together to provide a safe service to patients.

Leadership / culture of service

- Some staff we interviewed found it difficult due to cultural differences, to challenge senior staff or consultants. The hospital had given training to theatre staff around 'human factors' and were encouraging staff to be able to speak up if they were concerned about sub-standard or unsafe care by any member of the team.
- Some senior staff were not empowered to drive positive changes such as in infection control and prevention. They relied on the director of nursing to provide authoritative leadership to challenge consultants. For example, there was a reduction in the compliance with hand washing in theatres in an observational audit caused by a consultant on more than one occasion. The IPC lead felt this needed to be challenged by the director of nursing.
- The hospital executive director had been in post for two months prior to the inspection. The focus of her concern was in delivering the corporate ambition of building the hospital to become a 'flagship' hospital of the BMI group for the south region.
- Staff told us they were happy and felt proud to work at the hospital. They spoke highly of the new executive director and the mission to become a flagship BMI hospital for the south region.
- The hospital used daily 15 minute communication meetings as a way of sharing information. This involved representatives from all departments meeting each morning to discuss the previous day and plan the day's activity. This mechanism allowed staff to discuss daily activity, incidents, staffing and raise concerns. Notes recorded daily discussions and these were followed up if required.
- Not all staff were able to recount the vision and values of the hospital, but were aware of the mission statement and the objectives of their department. This was to deliver safe care with a high standard of patient satisfaction.
- Staff told us that ward sisters were supportive, professional and experienced.
- The hospital met the requirements related to duty of candour. Staff were able to tell us their individual responsibilities around the duty of candour to patients.

Vision and strategy for this this core service

- The vision of the hospital was encapsulated in a newly developed mission statement. The hospital was aiming to be the 'flagship' hospital for BMI's South region. There was an ambition to consistently deliver a high quality and innovative service, which identified and responded

to the needs of their customers. To further develop services for their patients to ensure the best outcomes and a positive patient experience. Leadership vision was to encourage and promote staff to engage in their own development and the hospital's vision.

- There was a strong sense that staff tried to meet and exceed patient's expectations on the surgical wards and departments.

Governance, risk management and quality measurement

- The hospital used an electronic system for reporting incidents and risk; staff were undergoing training on a new system that was to be introduced in October 2016. The system was being changed to provide a better view of trends and easier reporting functions.
- The medical advisory committee reviewed consultant's professional registration documents, references and memberships before granting practising privileges. The hospital annually reviewed consultant's performance data and ensured they were up to date with documentation in line with the practising privileges policy. This provided the executive team with assurance that consultants were competent to perform surgery at the hospital.
- The executive director had overall responsibilities for the hospitals activities. This role was supported by a director of nursing, director of operations and chair of the medical advisory committee.
- The privacy and dignity score card for the Sandringham unit showed a dip in results in the 2016 PLACE survey at 89%, the ward sister was not aware of this or what issues contributed to this feedback. Although the data was recorded and displayed there was no evidence that it was used to make positive changes.
- The hospital held monthly clinical governance committee meetings. These meetings discussed the results of audit. These meetings had a standing agenda which included regulatory compliance, practising privileges, incidents and complaints as well as quality assurance. There were also weekly meetings to discuss incidents.
- There was a governance structure and process in place within the surgery division. Governance meetings took place on a monthly basis which reported on finance, performance and quality issues within the division. They looked at incidents such as the hospital's acquired infection reports and compliance with hand hygiene audits.
- Staff had access to a range of policies that were supported by standard operating procedures (SOPs) for them to refer to. For the wards and in the operating theatre suite policies and SOPs were available on the intranet. The SOPs we saw were within their review date. Policies and SOPs that were modified locally were signed off by the governance system across the BMI group.
- There was a programme of audit, those that we saw were carried out regularly and were robust. There were audits for infection control and prevention, environmental audits as well as audit of compliance with the preoperative checks in the WHO checklist and VTE assessment.
- Staff spoke positively about the support from their immediate team leads and felt they could raise concerns about patient safety or care.
- Systems and processes for mitigating risks were not always robust. For example, the mitigations for the clean and dirty instrument cross over in theatres were unsatisfactory when observed. The risk of having equipment for paediatric cardiac arrest present on the resuscitation trolleys had not been identified.
- There was a newly implemented 'glitch book' in theatres where issues could be recorded. The glitch book did not replace incident reporting, but was an additional communication tool between shifts of staff.
- There were regular monthly clinical governance and risk meetings. This meeting received reports from subcommittees and documents such as; the hospital risk register, key performance indicators and incident analysis.
- The hospital reported that 100% of nursing staff and ODPs that had been employed greater than six months had valid professional registration.
- Staff turnover in all staff groups was low at the hospital.

Public and staff engagement

- Patients and the public were given a wide range of information from the hospital's website for example information regarding NHS choices, self-funding options and performance outcomes.
- Organisational changes and regular updates were cascaded to staff via monthly online newsletters. The

newsletter also included staff charity activities, shared feedback from patient satisfaction questionnaires such as the friends and family test, and showcased improvements across the BMI group. The publication also informed staff of recently published policies, standard operating procedures and details of developments within departments, as well as feedback from audit and complaints. Staff were invited to contribute articles to the weekly news.

- The hospital reinforced corporate messages through regular senior management meetings and departmental meetings. The minutes of these meetings were shared with staff.
- The hospital encouraged patients to complete a detailed questionnaire which covered all aspects of their stay in the hospital. After patients had completed the questionnaire it could be mailed to the company by freepost.
- The hospital collected feedback from children on specially designed forms.
- Staff were empowered to suggest and promote new ideas. Staff spoke positively about the ward managers and felt supported by them.
- There were notice boards in the main theatre suite staff rest room and on the wards. This gave information for staff about training opportunities, staff meeting minutes and the results from audits and shared learning from incidents.

Innovation, improvement and sustainability

- The hospital had identified to the CCG that it was treating more patients living with dementia and requested a CQUIN around this. The hospital has appointed a dementia lead that has a role profile and action plan for the year to support progress awareness of dementia care across the hospital. There was a hospital training strategy that underpins a programme of training to be delivered.

Good

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at BMI Princess Margaret Hospital cover a wide range of specialities. These include ear, nose & throat, gynaecology, general surgery, orthopaedic surgery, gastroenterology, oncology, gynaecology and neurology.

Diagnostic imaging facilities provided by BMI Princess Margaret Hospital include x-ray, digital mammography and ultrasound. Magnetic resonance imaging (MRI) scans, CT scans, and outpatient physiotherapy services are also available on site.

Between April 2015 and March 2016, the outpatient department at the BMI Princess Margaret Hospital provided 18,063 new patient appointments and 29,989 follow up appointments. During this period 6% of these patients were NHS funded and the remaining 94% were funded by other sources.

The outpatient department operated between 8am and 8pm Monday to Friday, and on Saturday between 8am and 1pm. The operating times within diagnostic imaging services is between 8am and 8pm Monday to Friday, and on Saturdays between 8am and 2pm. On call services were available between 8pm to 8am.

There are eighteen general consulting rooms, and two clinical treatment rooms. Minor operations are carried out within the outpatient department and there is a dedicated room allocated for these procedures.

During the inspection we visited the outpatient department and diagnostic imaging services. We spoke with 16 patients and 13 members of staff including, nurses, radiographers, physiotherapist manager, patient service manager, occupational health, quality and risk manager, health care assistants, administrators and managers.

Throughout our inspection we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and at equipment being used. With the patient's permission, we observed care being provided. In addition, we took into account feedback from discussion and written communications from stakeholders.

Good

Outpatients and diagnostic imaging

Summary of findings

There was a focus on patient safety within outpatient services. Incidents and adverse events were reported and investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.

There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safe from abuse.

There were sufficient staff with the right skills to care for patients, and staff had been provided with induction, mandatory and additional training specific for their roles.

Patients' care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. Information about patient's care and treatment, and their outcomes, was routinely collected and monitored.

There was evidence of local and national audits, including clinical audits and other monitoring such as reviews of services. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice.

Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.

Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they felt involved in decisions about their care and they were treated with dignity and respect.

Patients told us that there was good access to appointments and at times which suited their needs. Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services being delivered.

There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the hospital's vision, values and strategic goals.

The leadership, governance and culture within the department promoted the delivery of person centred care. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.

There was an effective and comprehensive process in place to identify, understand and monitor and address current and future risks.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

Overall we rated this service as good because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- When something went wrong, there was an appropriate thorough review that involved all relevant staff and people who used the services.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safe from abuse.
- Improvements to safety were made and the resulting changes were monitored. Staff received up-to-date training in all safety systems.
- Staffing levels and skills mix were planned, implemented and reviewed to keep patient's safe at all times.
- Plans were in place to respond to emergencies and major incident situations.

Incidents

- In all outpatient areas, staff were aware of their responsibility to report incidents. Staff reported incidents either via an electronic system or to their manager who logged the incident on the reporting system. Staff we spoke with were confident to report incidents and challenge poor behaviour, by staff at any level, if they were concerned about poor practice that could harm a person.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- There were 289 clinical incidents reported across the hospital in the period April 2015 to March 2016. Out of 289 clinical incident 28% (80 incidents) had occurred in outpatients and diagnostic and imaging (OPD). The rate of clinical incidents that took place within OPD was lower than the other independent acute providers we hold this type of data for.
- In the same reporting period, there were 89 non-clinical incidents reported across the hospital. Out of 89 non-clinical incidents 43% (38 Incidents) occurred in outpatients and diagnostic and imaging.
- The rate of non-clinical incidents was similar to the rate of the other independent acute providers that we hold this type of data for.
- We reviewed clinical and non-clinical incident report documentation held in the OPD. We saw evidence that all incidents had been investigated and appropriate action had been taken.
- There were no never events reported in the period April 2015 to March 2016. Never events are serious, preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- The number of serious injuries was not high when compared to a group of independent acute hospitals that submitted performance data to CQC.
- The duty of candour (DoC) 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. Senior staff told us they had received information and training on the duty of candour.
- Staff were clear about their obligations under duty of candour and gave appropriate responses to scenario-based questions. There were no incidents that would trigger a formal duty of candour response.
- Senior staff told us they had received information and training on the duty of candour. We saw evidence DoC was discussed in team meetings.

Cleanliness, infection control and hygiene

- Overall, we found the outpatient and diagnostic imaging service complied with current legislation and guidance relating to prevention and control of infection.
- The BMI Princess Margaret Hospital had a 0% Meticillin Resistant Staphylococcus Aureus (MRSA) rate (April 2015 to March 2016), which was achieved through an effective MRSA screening programme. In the same period, there

was one incident of a catheter associated infection Escherichia coli (E. coli), and no incidence of Clostridium difficile (C. diff). The E.coli incident did not take place in OPD.

- Staff participated in infection control training as part of their annual mandatory training program. One hundred per cent of staff had attended training in the last year.
- All outpatient areas, both waiting rooms and clinical rooms were visibly clean and well maintained. The environment in waiting areas were light, airy and had a calm atmosphere.
- Clean equipment was labelled to indicate it was ready for use, for example, blood pressure monitors.
- The probes for the ultrasound machine were cleaned between patients and this was checked through monthly audits which demonstrated 100% compliance against the standard.
- Hand sanitiser points were available for patients, staff and visitors to use. This encouraged good hand hygiene practice.
- During the inspection staff we observed that staff adhered to 'bare below the elbow' policy to enable thorough hand washing and prevent the spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff to use in all clinical areas, to ensure their safety when performing procedures. We observed staff using them appropriately.
- We checked PPE equipment including x-ray protection lead aprons during the inspection: they were clean and in good condition.
- There were 'sharps' disposal bins in all consultation rooms, and we noted none of these bins was more than half full. This reduced the risk of needle-stick injury.
- Infection control practices were monitored by infection prevention and control lead. Regular infection control audits were conducted and a recent hand hygiene audit showed 100% compliance. Staff we spoke with were aware of the outcomes from audits and changes to practice needed, through information shared at meetings.
- Waste in clinic rooms was segregated and in different coloured bins to clearly identify categories of waste. This allowed the hospital to safely handle biological or hazardous waste safely and was in accordance with current legislation.

Environment and equipment

- The environment was clean and well maintained. We saw labels on equipment that recorded the last service date and review date. Items of equipment also had an asset number to ensure it could be tracked if it required servicing or planned maintenance.
- Safety testing of equipment was undertaken annually, and we saw records of this. Staff we spoke with were clear on procedures to follow if faulty or broken equipment was found. Repair work was completed by engineer's onsite.
- Staff did not report any concerns regarding availability or access to equipment. Staff told us senior management was supportive of requests for new equipment.
- All rooms had call bells fitted so that emergency assistance could be summoned quickly.
- Staff had access to emergency equipment, including, oxygen and resuscitation equipment. We saw evidence that staff checked this equipment daily, and emergency drugs were checked monthly by pharmacy.
- Patient examination couches and equipment were labelled with asset numbers and service or calibration dates. This helped to provided assurance that items were controlled and maintained in accordance with manufacturer's recommendations and policy guidelines.
- We saw sharps bins available in treatment areas and correctly used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations). The bins were secure containers, clearly marked and placed close to work areas where medical sharps were used. The bin labels included clear instructions for staff on safe disposal.

Medicines

- Medicines were stored safely in outpatients. We saw the medicines cupboards were locked and the keys were held by the lead nurse on duty. Staff we spoke with were aware of who held the keys.
- Prescription pads were seen to be stored securely on-site. Each prescription had a serial number on it. A registered nurse gave a pad to each doctor at the start of clinic who kept the pad with them in a locked clinic room. The pads were then checked and stored in a locked room at the end of clinic. This reduced the chance of a prescription form being lost or stolen.

- A limited range of To Take Out (TTO) medicine packs were available for a specific clinic, which were dispensed by the pharmacy team.
- Medicines requiring refrigeration were stored in locked fridges. We saw the temperature of medicine fridges was monitored daily and the fridge temperature remained within range. This provided assurances that staff stored refrigerated drugs within the correct temperature range to maintain their safety and quality.
- In imaging, we saw patient group directions (PGDs) for the contrast media being used. PGDs are documents permitting the supply of prescription-only medicines (POMs) to groups of patients, without individual prescriptions. We found the PGDs were in date and correctly completed.

Records

- At the time of inspection we saw patients' information and medical records were managed safely and securely. During clinics, all patient records were kept in a locked office and transferred to the consultant when the patient arrived for their appointment. Staff told us they had no difficulty in retrieving patient notes for clinic appointments.
- Medical records were only permitted to be taken off site by consultants, who were registered as data controllers with the Information Commissioner's Office. This is a requirement of their practising privileges agreement. Consultants were personally responsible for security of records when off site.
- All the staff we spoke with were aware of their responsibilities around the safe keeping of records and the confidentiality of patient information. Patient identifiable information such as patient records were stored securely in locked cabinets.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store clinical patient images. This system was available and used across the x-ray and imaging department.
- Image transfers to other hospitals were managed electronically via a secure system.

Safeguarding

- There had been one safeguarding alert reported to the CQC during the period April 2015 to March 2016.
- There were policies in place for children's and vulnerable adult's safeguarding.
- The Director of Nursing was the safeguarding lead and had received level 3 adult and children safeguarding training. The safeguarding lead demonstrated a clear understanding of their responsibilities concerning both adult and children safeguarding concerns.
- Nursing, radiology and physiotherapy staff we spoke with demonstrated a good awareness of what to do if they had safeguarding concerns and who to contact should they require advice.
- Staff confirmed to us that safeguarding vulnerable adults was included in their mandatory training. Hospital training records confirmed this.
- Processes were in place and followed to ensure the right patient received the correct radiological investigation at the right time. A senior radiographer reviewed all requests before patients were x-rayed. Consultant radiologists reviewed all GP referrals before patients were x-rayed.
- There was a cross checking system in outpatients to ensure the correct patient identity. Reception staff checked patient details on arrival. The consultant or nurse, when calling through the patient, carried out a further check. The clinical staff rechecked the patient details once in the consultation room, to ensure the patient and their notes and any electronic records related to the same patient.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction and updated them in line with the current training policy. Training included infection control, basic life support, Control of Substances Hazardous to Health (COSHH), fire safety, equality and diversity and adult and children's safeguarding.
- Training was mostly delivered through the BMI online learning package (BMiLearn) but there was also face-to-face teaching and practical sessions offered. Staff reported they completed online learning and booked dates for the practical and face-to-face teaching sessions.
- Each staff member was linked to a role-profile in the BMiLearn system so they were automatically assigned to a relevant mandatory training plan.
- The imaging and diagnostic team had a comprehensive induction checklist, and we saw evidence that competencies were checked for individual staff.

Good

Outpatients and diagnostic imaging

- The hospital did not provide data on what the target for compliance with mandatory training was. However, from the training records made available to us for the OPD, almost all staff were up to date with the mandatory training. We saw evidence that refresher training was booked for those who were due to for renewal.
- Training was monitored by the department leads, who notified staff when training was due for renewal.
- The hospital quality coordinator monitored consultants' compliance with their practising privileges agreement. This included evidence of a current revalidation certificate.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.

Assessing and responding to patient risk

- The outpatient's team had identified a risk with the security of patient records, when taken offsite by the consultants. At the time of inspection, consultants kept their own private patient records; the hospital did not retain a copy to ensure a complete contemporaneous record was available at all times. The outpatient's team had identified this as a risk, and had proposed that the hospital should implement its own notes, and for all notes to be kept onsite at all times. This matter was due to be formally discussed at the next Medical Advisory Committee (MAC) meeting and a decision was due to be made imminently. We noted during the inspection, this risk had not been recorded on risk register and this was fed back to staff. Action on this was taken immediately.
- Patients at the hospital always had access to a registered medical officer (RMO), provided by an external contractor. RMOs were trained in advanced life support. They provided medical support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would be transferred to the inpatient ward, or to the local acute NHS Trust in line with the emergency transfer policy. Staff reported this rarely happened.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas we visited and had been signed by all members of staff, which indicated they had read the rules. Diagnostic imaging staff had a good understanding of protocols and policies. Protocols and policies were stored in folders in each room.
- We observed good radiation compliance during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. We saw radiographers referring to the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) for patient's examinations. A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required, which complied with IRMER.
- There was clearly visible and appropriate radiation hazard signage outside the x-ray rooms for staff and patients.
- Lead aprons limit exposure to radiation to keep patients and staff safe. We saw lead aprons available in all imaging areas of the department.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation. However, we noted there were no pregnancy safety posters displayed in the diagnostic and imaging waiting area.
- There were clear and known protocols in place for the transfer of patients to the local NHS accident and emergency department by ambulance.

Nursing staffing

- The hospital used the 'BMI Healthcare Nursing Dependency and Skill Mix Planning Tool 2015', to ensure the right skilled and experienced members of staff were on duty at the right time.
- There were no set guidelines on safe staffing levels for the OPD. Outpatient and diagnostic imaging departments reported they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner.
- The outpatient clinics were staffed by registered nurses and health care assistants. Staffing rotas showed an appropriate skills mix to meet the needs of patients.
- Based on hospital data, the use of bank staff for outpatient nurses and health care assistants was not high in comparison to other independent acute hospitals.
- The rate of sickness for nurses working in outpatient departments was below the average of the other acute providers that we hold this type of data for.
- Staff teams had daily meetings to share important updates, such as changes to planned clinics or staffing for the day.

Good

Outpatients and diagnostic imaging

- Staff were willing to be flexible when needed and told us they liked the work and patient safety was a priority.

Medical staffing

- At the time of the inspection the hospital employed 232 consultant medical staff working under practising privileges. The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager liaised appropriately with the GMC and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- OPD clinics were timetabled to suit each specialist's availability and obligation as part of the consultant's practicing privileges agreement. There were sufficient consultant staff to cover outpatient clinics.
- Staff told us that medical staff were supportive and advice could be sought when needed.
- There was a registered medical officer (RMO) on duty 24 hours a day to provide medical support to the outpatient and imaging departments.

Major incident awareness and training

- We saw notice board displays showing recent fire and evacuation simulations. Staff also described participating in cardiac arrest simulations.
- Staff were aware of their roles and responsibilities during a major incident.
- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as internet or electricity failure. The business continuity plans were also available electronically.
- We saw evidence the business continuity plan was reviewed annually.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We inspected but did not rate the effective domain as we do not currently collate sufficient evidence to rate it.

- Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. Information about patient's care and treatment, and their outcomes, was routinely collected and monitored.
- There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services.
- Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice.
- Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE) and Royal College of Radiologists (RCR) Standards in the speciality areas we visited.
- We saw evidence of checks and audits that demonstrated the department monitored compliance with these guidelines. For example, we reviewed the annual image request form and reject analysis audits, which were completed and satisfactory.
- We saw evidence there was a local and corporate annual audit programme. This included audits such as patient health records, Five Steps to safer surgery checklist, theatre, safeguarding, same sex accommodation, infection, prevention and control (IPC), falls, VTE assessment and resuscitation.
- Staff discussed results at clinical governance meetings, appropriate sub-committees, and departmental meetings and during huddles.
- Staff described the use of NICE protocols and guidelines for scanning patients with cancer or that required a CT scan of their aorta.
- We saw that policies were disseminated to staff to read, sign and implement using tracking documents to confirm they had read them. New NICE guidelines were

sent to the hospital monthly by the quality care team. These were assessed within the hospital for their relevance by the Medical Advisory Committee and cascaded to staff, including consultants.
- The hospital Medical Advisory Committee met quarterly to review clinical performance, incidents or complaints and obtain feedback from the consultant body on new developments and initiatives from within the various specialities.
- Audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were completed. Actions taken as a result of these audits were seen.
- Diagnostic reference levels (DRL's) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe image for each body part.
- New practices were reviewed and signed off by consultant radiologists. These were also reviewed regularly at the Medical Advisory Committee (MAC) meetings.
- Consultant radiologists reviewed all GP referrals for imaging to ensure patients were not receiving unnecessary exposure to radiation.
- Staff meetings were held in outpatients and radiology to share information and promote shared learning.

Pain relief

- In OPD, staff discussed options for pain relief with the patient, during their consultation, and before any procedure being performed. Many procedures could be performed with the use of local anaesthetic, enabling the patient to go home the same day. Patients were given written advice on any pain relief medicines they may need to use at home, during their recovery from their procedure.

Patient outcomes

- We saw examples of physiotherapy and radiology outcomes listed in electronic records. There were a variety of processes described to measure and audit patient outcomes, including a quarterly internal audit programme and National Joint Register.
- The Medical Advisory Committee monitored outcome data for individual consultants as part of the biannual review of consultant's practising privileges. This included readmission rates, development of venous thromboembolism (VTE) and hospital acquired infection.
- Patient outcomes were monitored through patient satisfaction questionnaires and incidents such as suspected surgical site infections.

Competent staff

- All staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment or when they took on new responsibilities.
- All new staff had an induction package, which included core competencies, and knowledge requirements that were signed off by their line manager. We saw examples of this in the staff files we reviewed.
- All staff administering radiation were appropriately trained to do so. The staff in the diagnostic imaging department had worked there for a number of years and were always supervised in accordance with legislation set out under the Ionising Radiation (Medical Exposure) Regulations 2000.
- In the period October 2015 to September 2016, 100% of outpatient nursing staff had received an appraisal. In the same period, 100% healthcare assistants had received an appraisal. All radiographers and radiography department assistants had received an appraisal.
- Pre-employment checks were completed for all employees prior to commencing work. This included Disclosure and Barring Service (DBS) checks, references, qualification verification and an interview.
- There were processes for confirmation of practicing privileges. Consultants were recommended privileges by the medical advisory committee (MAC) only after Executive Director had received the necessary assurance documentation.

Multidisciplinary working (related to this core service)

- Staff across the hospital worked together with a multidisciplinary approach to patient care and treatment.
- We observed there was effective team working, between all staff groups. This was facilitated by a daily morning communication meeting (huddle), where a representative of each department was present. We observed one meeting which enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.

Good

Outpatients and diagnostic imaging

- Staff told us they felt supported by other staff groups and there was good communication within the teams. We heard positive feedback from staff at all grades about the "Brilliant Team" and "Great team spirit" within the hospital generally.
- Staff told us if there were unexpected findings following a radiology imaging, the radiologists contacted the referring clinician and the radiographers followed up on the results to ensure if any further action was needed it was completed.

Seven-day services

- The majority of outpatient clinics were held Monday to Friday, with clinics running from 8am to 8pm Monday to Fridays. Clinics were also held on Saturdays between 8am and 1pm. Patients we spoke with reported good access to appointments, at times which suited their needs.
- In diagnostic imaging, scans, x-rays and ultrasounds were available between 8am and 8pm, Monday to Friday. These services were also available on Saturdays between 8am and 2pm. Radiographers were on call during the weekends and overnight.

Access to information

- All staff we spoke with said they had access to policies, procedures, NICE and specialist guidance through the hospital's intranet. Overall, staff were positive about the corporate intranet and reported that managers communicated effectively with them via e-mail and at meetings.
- Medical staff mainly used their own private patient records during the outpatient consultation and took responsibility for ensuring these records were available for use when needed. X-rays and scans were available electronically for consultants to view in the clinic.
- There were appropriate systems to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment. Medical staff we spoke with confirmed the transfer methods used and understood the required security aspects of data transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered as part of staff mandatory safeguarding training. Staff demonstrated good understanding about their role with regard to the Mental Capacity Act. The consent process for patients was well-structured, with written information and verbal explanation provided before consent for a procedure was sought from the patient.
- Verbal consent was given for most general x-ray procedures and OPD procedures. Some consultants sought written consent from patients for procedures, such as Ear Nose Threat (ENT).

Are outpatients and diagnostic imaging services caring?

Good

We rated 'caring' as good.

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- We observed how staff interacted with patients and their families and found them to be polite, friendly and helpful.
- Feedback from patients and those close to them was positive. Patients told us they were treated with dignity, respect and kindness.
- Patient's privacy, dignity and confidentiality was respected.

Compassionate care

- We observed that staff took all possible steps to promote patients' dignity and they were afforded privacy at all times. We observed that all clinical activity was provided in individual consulting rooms and doors were always closed, to ensure privacy and confidentiality.
- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms. Staff told us that they always offered to chaperone patients undergoing examinations.
- Throughout the inspection, we saw staff speaking in a calm and reassuring way to patients. Patients told us staff were helpful and supportive.

Good

Outpatients and diagnostic imaging

- The hospital took part in the Friends and Family Test (FFT). The figures we were given was not broken down into departments, therefore it was not possible to identify the significance of these results for outpatients. The FFT reported that 100% of patients would recommend the hospital to their friends and families for the reporting period November 2015 to February 2016. The response rate for the FFT was between 25% to 50% of patients.
- The hospital's FFT scores were similar to the England average of NHS patients across the period (Oct 15 to Mar 16).

Understanding and involvement of patients and those close to them

- Staff ensured patients understood information given to them and were involved in their care and treatment. Patients told us they had been provided with the relevant information, both verbal and written, to make informed decisions about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- We observed staff listened and responded to patients' questions positively.
- During our inspection, we saw there was a wide range of health promotion literature in waiting areas.

This included leaflets on; women's health, abdominal aortic aneurysm, pain management, breast health and cosmetic surgery.

- Staff told us patients were provided with written, 'before and after' care information leaflets.

Emotional support

- Patients and relatives told us they had been supported when they had been told difficult diagnoses and that they had been given sufficient support.
- Staff clearly demonstrated their understanding of the impact a person's care, treatment or condition might have on their wellbeing. They explained how different treatment options were discussed with patients and their relatives. Patients were helped and supported by staff to make their own decisions regarding their treatment.
- When having conversations with staff, they were passionate about caring for patients and put the patient's needs first, including their emotional needs.
- Staff told us they always offered to chaperone patients undergoing examinations and we saw records that showed patients were supported in this way.

Are outpatients and diagnostic imaging services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as good because:

- Services in the outpatients department (OPD) were planned and delivered in way which met the needs of the local population.
- Patients told us that there was good access to appointments and at times which suited their needs.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services being delivered.
- Patient's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs and demands of patients. OPD clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.
- Clinics were held Monday to Friday, 8am to 8pm, with occasional outpatient clinics held at weekends to meet patient's needs.
- The hospital was a provider of Choose and Book which is a booking system for the NHS in England. This allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and book a convenient date and time for their appointment.
- Facilities and premises were appropriate for the services offered. Patients reported the waiting areas were comfortable and inviting. There were a variety of refreshments, magazines and newspapers in the waiting

area. Wi-Fi was available for patients to use and there was a television. A play area was provided for children, which was easily visible from all areas in the waiting room.

- On-site car parking at the hospital was available and this was free of charge. Some patients we spoke with commented that they had found difficulties finding space to park. Alternative car parks were available close to the main hospital site but transport from them to the hospital was not provided.
- All patients we spoke with reported they did not have any problems in finding departments in the hospital, as they were clearly signposted. In outpatients and diagnostic imaging, members of staff escorted patients from the waiting area to their appointment. Patients requiring an ultrasound scan, computerised tomography (CT) scan or magnetic resonance imaging (MRI) were escorted to these by a member of staff who also accompanied them back to the department.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by the hospital. This included information leaflets on topics such as, information on fees, pain management, cosmetic surgery, women's health and breast health.

Access and flow

- Patients entered the hospital via the main entrance and were registered at the main outpatient reception desk.
- Staff used an electronic system which tracked patients from the time they arrived at reception and indicated how long they had been waiting.
- Staff asked patients to wait in the main waiting area or the smaller waiting area near the physiotherapy and imaging departments when arriving for their appointment.
- In the diagnostic imaging department there were cubicles for patients to change before their investigation or scan.
- The consultants' secretaries arranged patient appointments with the outpatient reception team. They liaised with patients and gave them a choice of time for their appointment.
- We noted there was notice board behind the reception, which included information such as the nurse in charge
- Patients had timely access to initial assessment, diagnosis or treatment. All referral to treatment (RTT) waiting times for every month were above or met the target of 92% for 18 weeks for the reporting period between the period of April 2015 to March 2016. RTT measured the total period waited by each patient from referral to treatment and helped managed each patient's journey in a timely and efficient manner. Although these targets were abolished by the NHS, the service continued to monitor its performance against these targets.
- The hospital's own administration team managed the NHS patients who used the Choose & Book system and were subject to NHS waiting time criteria.
- Patients told us there was good access to appointments at times that suited their needs.
- Clinics ran on time and we observed this during our inspection. Patients we spoke with said they did not experience long waits from clinics running late and many reported being taken straight through to their appointment on arrival at the hospital.
- During the inspection we did not find any information relating to when there were delays, patients we spoke with said they were kept informed and offered an alternative appointment if they were unable to wait.
- Patients could get their x-rays carried out by the hospital on the same day as their appointment. Staff in the imaging department reviewed clinic lists daily to determine if any patients would require an x-ray. They liaised with OPD staff accordingly to schedule patients for imaging.
- The hospital had very low 'Did not attend' (DNA) rates. All patients who missed their appointment were followed up and audited. Subsequently, the referrer was notified of the non-attendance.

Meeting people's individual needs

- The hospital planned services and delivered them to take account of people with complex needs. Staff told us they were informed by the doctors if a patient with complex needs was attending and additional requirements for them were identified. In the Patient Led Assessment of the Care Environment (PLACE) audit carried out in March 2015, dementia services at the hospital scored 92%. This was above the England average of 81% for independent sector acute hospitals but the hospital was devising a plan to provide more dementia-friendly facilities.
- The PLACE audit for 2015 showed comparable results to the previous year and were above the England average.

Good

Outpatients and diagnostic imaging

- Staff knew how to support people with complex or additional needs and made adjustments wherever possible. However, staff told us there were rarely patients who had complex or additional needs.
- Adults in vulnerable circumstances, such as those living with a learning disability or dementia were identified at pre-assessment and steps were taken to ensure they were appropriately cared for.
- Staff told us patients with learning disabilities were able to attend the diagnostic department with family members prior to attending for investigations, so they could become familiar with equipment and procedures.
- Provision for larger or heavier patients was available within radiology including suitable equipment and gowns.
- All written information, including pre-appointment information and signs were in English. Staff told us these were available on request in other languages, in pictures or braille. Staff described there were rarely patients attending appointments whose first language was not English. There were policies for accessing translation services and staff knew how to access these should the need arise. The OPD considered the length of appointment needed for these patients.
- Patients were encouraged to bring a relative or carer with them to appointments. The consulting rooms in the outpatient department were large enough to accommodate extra people.
- Staff made sure patients and their relatives were given further information and time to ask questions about their care and treatment. Patients reported they were given as much time as they needed during the consultation and they were given leaflets, which staff explained to them. Contact numbers for the hospital, doctors and their secretaries were given including a 24-hour helpline number where they could discuss any concerns with a member of staff at any time.
- Patients reported they received information in a timely manner following their appointment. They were informed when and how they would receive results, when their next appointment was and knew whom to contact if they had any concerns. They also received a copy of any letters sent to their GP.

Learning from complaints and concerns

- Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the hospital website. However, during the inspection we did not see any guidance, posters or leaflets instructing patients on how to make a complaint.
- Staff told us if someone had a concern or a complaint they would try and deal with the matter there and then. Failing that, they would provide the patient with a feedback card and escalate the issue to their manager.
- Staff told us complaints were openly discussed to ensure all staff were able to learn and contribute to any improvement action that might be required.
- We reviewed 8 complaints received in the last 12 months and found the hospital had kept records of all written complaints received, investigated and responded to, where possible, to the patient's satisfaction with an apology.
- Patients we spoke with were aware of the process to follow if they wished to make a complaint.
- None of the patients we spoke with had ever needed to make a complaint.

Are outpatients and diagnostic imaging services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovations and promotes an open and fair culture.

We rated well-led as good because:

- There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals.
- Quality of care was regularly discussed in board meeting, and in other relevant meetings below the board level.
- There was an effective and comprehensive process in place to identify, understand and monitor and address current and future risks.
- There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.

Good

Outpatients and diagnostic imaging

Vision and strategy for this this core service

- The BMI corporate vision was documented in the corporate strategy. This outlined the key priorities, which included: governance framework, superior patient care, people, performance and culture, business growth, maximising efficiency and cost management, sustainability and information management. The Hospital Executive Director (registered manager) used this and corporate values as the basis of the hospital wide strategy and vision for high quality and safe care. This strategic document clearly highlighted key risks and future plans. Staff we spoke with were familiar with the corporate vision and showed commitment to deliver patient care, in line with corporate strategy.
- There was also a local vision and strategy specific to the hospital. This included, the hospital achieving a 'flagship' status for all BMI hospitals in the south region. The hospital aimed to achieve this status by improving and introducing new services in line with patient demand. For example, by expanding and offering further clinical specialities such as critical care, cancer services, and urgent care at the hospital.
- Managers in outpatients, physiotherapy and diagnostic imaging knew about the executive team plans for developing their respective services. The plans included new minor operations room, more office space for clinical staff and a new eye testing room for the imaging and diagnostic department.
- Vision, strategy and values were discussed and reviewed regularly during, hospital leadership team meetings, senior management team meetings and departmental meetings.

Governance, risk management and quality measurement for this core service

- There was a defined governance and reporting structure in the hospital, which fed into the hospital governance processes. For OPD, the radiology and physiotherapy leads reported to the director of operations and the outpatients lead reported directly to the director of nursing. Both directors were part of the hospital senior management team and were accountable to the executive director.
- There were robust structures for reporting against the governance framework in place for all BMI hospitals with regional and national benchmarking against other BMI hospitals.
- Daily communication meetings (huddles) took place, which enabled staff to share information and drive continuous improvement. These were attended by a representative of each department including the executive director. Items discussed at these meetings included: previous day and plan future hospital activity, incidents, complaints, staffing, raise concerns and share successes. Minutes we reviewed confirmed this.
- There was a hospital wide risk register, which was updated regularly. The outpatient and diagnostic imaging departments held their own departmental risk register, which identified specific risks which may affect staff, patients and visitors. At the time of inspection, we noted OPD risk register included risks such as: potential for poor nursing skill mix in consulting rooms due to new starters, failure of infection control process, poor lighting in car park area and leaking roof in various areas of hospital. We saw evidence the risk register also reflected what action was to be taken to mitigate these risks. The departments provided the senior management team (SMT) with a weekly report, which effectively updated them with operational information from that week. This included any risk issues.
- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on the BMI intranet. Staff signed a declaration to confirm they had read the policy relevant to their area of work.
- Policies for radiological examination were written up as standard operating procedures. Local rules (local instructions relating to radiation protection measures for the service) were on display in each x-ray room.
- An annual corporate audit plan was followed and monitored at local clinical governance committees along with specific relevant departmental audits such as diagnostic imaging that were reported to the radiation protection committee.
- The medical advisory committee (MAC) had a role in reviewing consultant contracts, maintaining safe practising standards among consultants and clinicians and granting practising privileges. Each consultant was required to complete biennial reviews with the MAC chair, where data on their clinical performance was discussed. The hospital also ensured that consultants had appropriate professional indemnity insurance in place and received regular appraisals.
- Any updates to NICE guidance or safety alerts were sent monthly from the clinical care partners and shared via the heads of department meetings.

Good

Outpatients and diagnostic imaging

Leadership / culture of service

- There was a clear leadership structure and staff felt supported by the management team. Staff told us the leadership team was visible and approachable. For example, the executive director and nursing director were on site and did regular rounds within each department. This encouraged a culture of openness and equality.
- Managers in the outpatient, radiology and physiotherapy departments had clinical roles and were easily accessible to staff and patients. Staff reported good support and guidance from their managers. Managers in all three departments were passionate about their teams, and caring for their patients.
- Although a new executive director was in post, the outpatient and diagnostic imaging departments had experienced sustained stable leadership, who in turn had been supported by the director of nursing. Staff spoke highly of the new executive director and were optimistic about the future of the hospital.
- The hospital was aware of and complied with the requirements of the duty of candour. The management team encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents. When there were significant safety incidents:
- The hospital gave affected patients reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

Public and staff engagement

- During our visit we saw there were a number of collection boxes for patients to return their completed questionnaires or they could be returned by post. Survey results were completed by an independent third party, and results communicated back to the hospital on a monthly basis for action and learning. Staff we spoke with told us they frequently discussed patient survey results and learning was shared.
- Staff told us that they enjoyed coming to work and that they were passionate about the care they gave to patients. We read that staff were proud to work at the hospital. One staff member said, “It’s absolutely great working here, we have a very supportive team”.
- Staff loyalty was rewarded through long service awards. We saw evidence that staff in the OPD were recipients of this award.
- The outpatient leads produced a regular consulting room update for all consultants. In the August 2016 update items included; minor procedures room, hand hygiene, late running of clinics, how many patients seen and procedures completed and staffing.

Innovation, improvement and sustainability

- Most staff reported the hospital supported innovation with the executive team being responsive to requests and suggestions for improvement.
- Staff reported they were positively encouraged and given opportunities to develop, and their heads of department were keen for them to learn and improve.
- A business plan was in place for a new minor operations room and a new eye testing room in the outpatient department. In addition, plans for refurbishment and renovations of the OPD area were also in place.

Outstanding practice and areas for improvement

Outstanding practice

- The provider has access via the Consultant users to electronic information held by community services, including GP's. This meant clinical staff could access up-to-date information about patients, for example, details of their current medicine.

Areas for improvement

Action the provider MUST take to improve

- Mitigations to risks identified are put in place and then monitored to ensure compliance. For example, in Surgery we found although a crossover of clean and dirty surgical instruments had been escalated to the risk register, processes to mitigate this were not being followed.

Action the provider SHOULD take to improve

- A suitable system is put in place to screen patients over 75 years of age for dementia, in line with national guidance.
- Pregnancy safety posters to be displayed in the diagnostic and imaging waiting area.
- The complaints procedure is made to be more easily accessible for patients.
- Stocks of medicines need to be checked to ensure they are in date and suitable for use.
- Patients undergoing an endoscopy should have comfort scores recorded.
- Staff should have access to a recognised visual analogue pain assessment tool, for people with a cognitive impairment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure all mitigations to risks identified in relation to infection control, were in place and did not monitor this to ensure compliance.**