BMI Healthcare Limited

BMI The Runnymede Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Medical care	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection of BMI The Runnymede Hospital on 1-3 August 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of medical care, surgery, and outpatients and diagnostic imaging as these represented the activity undertaken by the provider, BMI Healthcare, at this location.

We rated medical care, surgery and outpatients and diagnostic imaging as good.

Are services safe at this hospital?

- We saw evidence of comprehensive and detailed investigations into incidents and complaints with learning appropriately shared throughout the hospital to improve standards of care and avoid recurrence. Staff understood the duty of candour and we saw evidence of this in practice.
- Staff recognised and responded to changing levels of risk for the patient in line with current guidance and best practice.
- There were clearly defined and embedded systems to keep patients safe, with staff demonstrating knowledge of safeguarding and an understanding of referral processes. The Director of Clinical Services was the safeguarding lead for adults and children.
- There were effective handovers between shifts with information about patients being shared appropriately to ensure continuity of care. Nursing handovers took place three times per day and there was a formal handover between the RMOs who undertook regular ward rounds.
- There was a service level agreement with the local NHS hospital which allowed for the transfer of patients who needed additional care.

Are services effective at this hospital?

- Staff worked to national guidance and followed best practice standards to deliver consistently good quality care to patients, which the hospital monitored to ensure consistency of practice.
- The role of the medical advisory committee was clear, with comprehensive paperwork circulated in advance so that members could be fully prepared. We saw minutes which demonstrated robust discussions of policy, shared learning and appropriate challenges
- Mandatory training compliance was high across the hospital, with staff able to access additional training for personal development with the support of their line manager.
- Although there was no dedicated pain team, staff had received specialist training and were able to discuss anticipated pain levels with patients in advance of their surgery. Patients told us their pain had been well managed.
- There was a thorough system for managing the review and granting of practising privileges which ensured there was appropriate clinical and managerial oversight of this.
- We reviewed patient records and noted that informed consent was clearly documented, with details of risks and benefits being discussed with patients in a manner which could be easily understood.

Are services caring at this hospital?

- Patients and their relatives described the care they received at the hospital in very positive terms, with both clinical and non-clinical staff understanding the need for privacy and dignity and taking steps to ensure this.
- Patients knew the name of the nurse who was looking after them, and we saw how staff made the effort to include relatives in the care of patients and explained to them what was happening.
- The hospital made arrangements to allow parents to stay with their child overnight, and we observed staff being particularly gentle and reassuring with children undergoing procedures.

Are services responsive at this hospital?

Summary of findings

- Appointments were offered promptly to patients with flexibility to suit their preferences as far as possible. Patients told us they were seen on time.
- Although the hospital saw very few patients with dementia, all staff had been trained in dementia awareness and were sensitive to the needs of patients living with dementia.
- There was a clear process for managing urgent admissions which allowed for better planning and a more effective use of staff time.
- The complaints process was well publicised and patients who chose to complain were treated compassionately throughout the process. Senior managers would invite the patient in to the hospital for a meeting, and we saw evidence that managers had visited a patient in their home when the patient did not wish to return to the hospital.
- Provision was made to meet the individual needs of patients, including a hearing loop at reception for patients with a hearing disability, a list of languages that different staff members spoke, an interpreting service and careful planning of theatre lists to reduce anxiety for patients with a learning disability.

Are services well led at this hospital?

- Staff were aware of the overall BMI strategy as well as the local mission statement and understood how it applied to their role and work in the hospital.
- The senior management team was highly regarded by staff who told us they found them visible, approachable and supportive.
- The registered manager was on annual leave at the time of the inspection but this did not impact upon the smooth and effective running of the hospital. The overall leadership and culture was not dependant on a single individual but continued to be demonstrated by the management team in the director's absence.
- The management team had taken steps to address the difficulties around recruitment and retention of staff by researching salaries across their independent competitors and NHS trusts and ensuring there was pay parity, and by providing training and development opportunities to retain experienced staff.
- There was an effective system of governance with departmental meetings and a clinical governance committee with oversight by a well-managed and well attended medical advisory committee.
- There was a culture of transparency and honesty amongst staff, who told us that managers actively encouraged them to report incidents. Staff told us they felt valued and respected by their leaders.
- There were plans to develop medical services with the provision of four dedicated medical beds.

Our key findings were as follows:

- There were effective systems to keep patients safe and to allow staff to learn and improve from incidents.
- The hospital was visibly clean and we saw evidence that policies were implemented and monitored to prevent the spread of infection. Where audits had shown the need for improvement (for example, clinical staff being bare below the elbows), we saw measures had been put in place to improve performance.
- The process for obtaining consent from patients was clear and ensured that staff followed national guidelines and met legal requirements.
- Appointments were arranged so that patients could access care when they needed it.
- Care was delivered in line with national guidelines and BMI corporate policy.
- Staffing levels were adequate, with some vacancies which were managed through the use of bank or agency staff to ensure that there was no impact on patient care. There were robust arrangements to ensure that staff had the required training and skills to do their jobs.
- The leadership had the confidence and respect of their staff, who felt supported and motivated by them to provide the best possible care for patients.
- There was appropriate management of quality and governance through departmental meetings and committees with regular reports to the medical advisory group for comment, debate and decision. Managers were able to identify risks and challenges within the hospital and were able to escalate and take action as required.

Summary of findings

We saw several areas of outstanding practice including:

- The working of the medical advisory committee, with engagement from members, strong leadership from the chair and an effective working relationship between the chair and both the executive director and director of clinical services.

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

Importantly, the provider should:

- Ensure that the flooring in all clinical areas is fit for purpose.
- Ensure clinical staff who assess children are trained in safeguarding children level three.
- Ensure that the governance policy is up-to-date.
- Consider improving the environment for children in the outpatients department so that it is child-friendly.
- Consider providing written information to service users for whom English is not their first language

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Good 	Overall, we rated medical care as good. This was because: • Staff demonstrated a clear understanding of incident reporting and there was an effective process which ensured that thorough investigations were undertaken with learning shared throughout the hospital. Staff could describe the duty of candour and we saw evidence of how this had been applied in practice. • Staff were supported in doing both their mandatory training and undertaking additional training for development. Staff spoke highly of the support they received from managers to do this. • All medical staff who treated children were trained to safeguarding level three and the hospital had good links with the local safeguarding teams. • Despite some difficulties in recruiting which had led to a higher level of bank and agency nurse use, patients told us that the care they received was good, with staff taking the time to explain and reassure. • The Medical Advisory Committee met regularly and provided input and challenge where appropriate. • Although there were challenges around the physical environment in endoscopy which meant it could not achieve JAG accreditation, these issues had been raised on the risk register and there were measures in place to mitigate potential risk.
Surgery	Good 	Overall, we rated surgical services as good. This was because: • The hospital had effective systems to assess and respond to patient risk and we saw examples during our inspection. • Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. We saw that the hospital monitored this to ensure consistency of practice. • The hospital participated in relevant local and national audits and contributed to national data to

Summary of findings

monitor their performance such as the National Joint Registry (NJR). Staff we spoke to understood and fulfilled their responsibilities to raise concerns and report incidents and we saw examples of this.
- We saw the hospital fully investigated incidents and shared learning from them to help prevent recurrences.
- Patient consent was recorded in line with relevant guidance and legislation.
- We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff.
- There was a governance structure that promoted the delivery of high quality person-centred care.
- Leaders modelled and encouraged cooperative, supportive relationships among staff. The majority of staff told us they felt respected, valued and supported.
- Services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these appropriately. We saw when a delay occurred there was an immediate explanation and apology.

However:

- There was a low percentage of staff that had undergone an appraisal in 2016, and in addition only 11% of theatre staff had an appraisal in 2015.
- We saw that some of the clinical areas had carpets.
- Fire doors within the theatre suite did not have intumescent strips around the edges of doors or doorframes.
- In theatres we saw three bowl stands had rusty wheels.
- We could not find evidence of an electrical safety check on three patient trolleys.
- Electrical cables in theatres were not secured.
- In theatres there was a door on one of the preparatory rooms with a faulty closure mechanism which was potentially unsafe.

Outpatients and diagnostic imaging

Good

Overall, we rated the outpatients department and diagnostic imaging as good. This was because:

- The outpatients and diagnostic imaging departments provided a broad range of services for both privately

Summary of findings

funded and NHS funded patients. The patients we spoke with were complimentary about the care, treatment, and service they had received in both departments.

- Staff were competent and worked to national guidelines, and ensured patients received the best care and treatment.
- The culture within both departments was patient focused, open and honest. The staff we spoke with felt valued and worked well together. Staff followed policies and procedures to manage risks and made sure they protected patients from the risk of harm.
- There were short waiting times for appointments. Private patients were seen within one week, and NHS patients were usually seen within four weeks of referral. Patients described that they could get appointments with their chosen consultant and were seen on time.
- Patients we spoke with told us they were treated with dignity and respect. All patient feedback during the inspection was positive. They described the service as 'first class', 'very good' and 'professional'.
- Both departments were visibly clean.

BMI The Runnymede Hospital

Detailed findings

Services we looked at
Medical care; Surgery; Outpatients & diagnostic imaging;

Detailed findings

Contents

Background to BMI The Runnymede Hospital

BMI The Runnymede Hospital is an independent hospital which is part of BMI Healthcare Limited. It is located in Chertsey, Surrey, in the grounds of a large NHS hospital and is linked to that hospital by corridor. The hospital opened in 1992 providing 30 beds and has since seen extensions to both the ward and outpatient areas.

BMI The Runnymede Hospital provides services for both private and NHS patients. Services are provided by UK registered health care professionals and support teams across a range of specialties including orthopaedics, general surgery, gynaecology, urology, ENT, cosmetic surgery, cardiology, physiotherapy and endoscopy. Inpatient and day case services are offered for children aged three years and above and there are non-invasive outpatient services for children of all ages.

The majority of patients attending the hospital (79%) were adults aged 18-74, with 8% of patients aged 17 or younger and 12% aged over 75.

The hospital currently has 52 registered beds split equally across Burwood and Wentworth Wards. Ward rooms offer privacy and comfort with en-suite facilities, satellite TV, telephone and Wi-Fi internet. The majority are single but there are four double rooms. Two of the three operating theatres have laminar flow. In house, the hospital provides x-ray, mammography, ultrasound and physiotherapy services with a number of other clinical services such as CT, MRI, pharmacy, pathology/ histopathology and high dependency beds provided by third parties, which did not form part of this inspection.

Runnymede outpatient services include eight consulting rooms, treatment room, pre-assessment, diagnostic imaging, physiotherapy, phlebotomy and cardiology.

The registered manager was Leon Newth who had been in post for just over two years. The provider's nominated individual for this service was Elizabeth Sharp and the Controlled Drugs Accountable Officer was also Leon Newth.

Our inspection team

Our inspection team was led by:

Inspection Lead: Elizabeth Kershaw, Care Quality Commission Inspection Manager

The team included CQC inspectors and a variety of specialists:

- A consultant surgeon
- A radiographer
- Four nurses, including a paediatric nurse, a modern matron, a theatre manager and a Director of Nursing.

Detailed findings

How we carried out this inspection

We reviewed a wide range of documents and data we had requested from the provider. This included policies, minutes of meetings, staff records, results of surveys and audits and complaints and incident investigations. We placed comments boxes at the hospital before the inspection which enabled staff and patients to provide us with their views confidentially.

We carried out an announced inspection on 1-3 August 2016.

We interviewed the management team and spoke with a wide range of staff including nurses, the resident medical officer, administrative and support staff and consultants amounting to 67 interviews. We also spoke with 20 patients who were using the hospital at the time of the inspection, two relatives and seven children who were patients and their parents.

We observed care in the outpatient and imaging departments, in operating theatres and on the wards, and also reviewed patient records. We visited all the clinical areas of the hospital.

Facts and data about BMI The Runnymede Hospital

The hospital has eight consulting rooms, a treatment room, a phlebotomy room and a pre-assessment room.

The physiotherapy department has four cubicles and a gym.

In diagnostic imaging, there were general x-ray rooms, a mammography room, an ultrasound room, a screening room and a reporting room.

There were two laminar flow theatres with separate anaesthetic rooms, one minor/endoscopy theatre, a four bedded recovery room and a sterile store and dirty instrument room.

There were 168 doctors and dentists with practising privileges at the hospital, although 48% of these had not carried out any episodes of care between April 2015 and March 2016. Of those remaining, 15% carried out between one and nine episodes of care, 28% between 10-99, and 8% more than 100.

In April 2016 there were 16.1 Whole Time Equivalent WTE) registered nursing staff plus 14.7 in theatre and 2 in outpatients and 8.8 WTE health care assistants plus 5.8 in theatre and 1 in outpatients. The use of bank and agency staff for inpatient nurses in the reporting period (Apr 15 to Mar 16) was mainly higher than the yearly average of other independent acute hospitals, whilst for theatre nurses it was lower.

Staff turnover varied between core services and staff groups. The vacancy rate for inpatient nurses was 11% with a turnover rate of 31.8%, both of which are higher than other independent hospitals, but there were no vacancies for inpatient health care assistants. The staff turnover for theatre nurses was 2.4%, which is not high in comparison with other independent hospitals, but the turnover of ODPs and health care assistants was 40% which is higher than the average for other. There was a 50% vacancy rate for outpatient nurses ((89% staff turnover) and a 67% vacancy rate (20% staff turnover) for outpatient health care assistants.

There were 5,097 inpatient and day case episodes of care recorded at BMI The Runnymede Hospital in the reporting period (Apr 15 to Mar 16); of these 18% were NHS funded and 82% were other funded.

For this time period, patients staying overnight included 18% of all NHS funded patients and 27% of all other funded patients.

There were 33,590 outpatient total attendances in the reporting period (Apr 15 to Mar 16); of these 9% were NHS funded and 91% were other funded.

There were 1,311 inpatient attendances between April 2015 and March 2016, 3,788 day case attendances and 4,881 visits to theatre.

In this period, the most common medical procedures were Image-guided injection(s) into joint(s) (577),

Detailed findings

Diagnostic oesophago-gastro-duodenoscopy (OGD) includes forceps biopsy, biopsy urease test and dyespray (468) and Diagnostic colonoscopy, includes forceps biopsy (463).

The most commonly performed surgical procedures were multiple arthroscopic operation on knee (238), primary repair of inguinal hernia (119) and diagnostic endoscopic examination of the bladder (83).

The hospital's PLACE scores are the same or better than the England average for:

• Cleanliness (99% compared to 98%)

• Condition, Appearance and Maintenance (93% to 92%)

• Ward Food (98% to 94%)

The hospital's PLACE scores are worse than the England average for:

• Dementia (76% to 81%)

• Food (89% to 93%)

• Organisational Food (79% to 92%)

• Privacy, Dignity and Wellbeing (82% to 87%).

From April 2015 to March 2016, there were no incidents of MRSA or MSSA, no incidents of Clostridium difficile and three incidents of E-Coli.

There were three surgical site infections (SSI) in the period April 2015 – March 2016 and the rate of SSIs (per 100 surgeries) for primary hip arthroplasty is higher than the average of NHS hospitals.

There was one never event reported in September 2015. A never event is a serious incident which is wholly preventable and has the potential to cause serious patient harm or death. A root cause analysis investigation was undertaken by the hospital and this was reviewed during the course of the inspection. There were no reported serious injuries in this period, and one unexpected death.

There was a total of 170 clinical incidents in the reporting period (Apr 15 to Mar 16). Of these, 86% (147 incidents) occurred in surgery or inpatients and 5% (eight incidents) in other services. The remaining 9% of all incidents occurred in outpatients and Diagnostic Imaging (15 incidents). The rates of clinical incidents (per 100 bed days) in surgery, inpatients and other services are similar or lower than other independent acute providers.

VTE (venous thromboembolism) screening rates were above 95% (the target rate for NHS patients) from April 15 to March 16. There were no incidents of hospital acquired VTE or PE (pulmonary embolism).

There were no safeguarding concerns reported to the CQC in this period.

There were no complaints about the hospital made to the CQC in this time period. There were 35 self-reported complaints in the reporting period which is a decrease from 2014/15 when there were 41 complaints. No complaints have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in this reporting period. The rate of complaints per 100 day case and inpatient attendances is not high when compared to other independent acute hospitals. There are four items of rated feedback on the NHS Choices website for this hospital; three rated as extremely likely to recommend and one rated as extremely unlikely to recommend.

No whistleblowing concerns have been reported to the CQC in the last 12 months.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are will rate effectiveness where we have sufficient, robust information which answer the KLOE's and reflect the prompts.

Medical care

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

Information about the service

The BMI Runnymede Hospital is an independent hospital which forms part of the BMI Healthcare Limited Group. It is situated in the grounds of St Peter's Hospital, Chertsey and linked to St Peter's by a corridor. The hospital provides services for privately funded and NHS patients.

Paediatric patients were not admitted for medical care. Young people aged over 16 were seen for endoscopy as day cases.

The hospital did not provide us with exact numbers of medical patients for the data period April 2015 to March 2016. During the inspection we were told that there were approximately four or five medical and elderly patients admitted each week, but not necessarily every week. We saw evidence that for the four weeks from 27 June to 24 July 2016 there were three, four, five and four admissions, respectively. This would equate to just over 200 patients a year. Patients were admitted either from home or from the adjoining NHS hospital for reasons such as elderly care, chest infections, cellulitis, leg ulcers and anaemia. This report is based primarily on the current endoscopy service and not on the hospital's plans for future development of a medical service.

There were limited facilities for endoscopy. An endoscopy is a procedure where the inside of your body is examined using an endoscope a long, thin, flexible tube that has a light source and a video camera at one end. These facilities did not have Joint Advisory Group (JAG) accreditation. However, there were effective processes in place to mitigate. There were 1,297 endoscopy procedures carried out in the period April 2015 to March 2016. These were mainly upper and lower gastrointestinal (GI), as well as pain treatment.

The hospital clinical team is made up of medical staff, nurses and a resident medical officer (RMO) who is on duty 24 hours a day. A senior nurse is available at all times to assist patients following discharge and to arrange admissions for patients who require hospitalisation for unplanned surgical treatments. We spoke to 13 consultants and staff, including nurses and members of the housekeeping, medical records and administrative teams.

There was only one inpatient during the period of inspection for us to speak to. Four patients were contacted to ask for their permission for us to speak to them afterwards, but only one responded. As a result of this, following the inspection we spoke with one discharged patient and their spouse by telephone.

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Medical care

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Summary of findings

We rated medical care at BMI The Runnymede as good. This is because:

- Staff demonstrated a clear understanding of incident reporting and there was an effective process which ensured that thorough investigations were undertaken with learning shared throughout the hospital. Staff could describe the duty of candour and we saw evidence of how this had been applied in practice.
- Staff were supported in doing both their mandatory training and undertaking additional training for development. Staff spoke highly of the support they received from managers to do this.
- All medical staff who treated children were trained to safeguarding level three and the hospital had good links with the local safeguarding teams.
- Despite some difficulties in recruiting which had led to a higher level of bank and agency nurse use, patients told us that the care they received was good, with staff taking the time to explain and reassure.
- The Medical Advisory Committee met regularly and provided input and challenge where appropriate.
- Although there were challenges around the physical environment in endoscopy which meant it could not achieve JAG accreditation, these issues had been raised on the risk register and there were measures in place to mitigate potential risk.

Medical care

Are medical care services safe?

Good

We have rated the safety of medical services as good. This is because:

- Staff had a good understanding of incident reporting and the small number of clinical incidents that had occurred in the service were investigated thoroughly with learning shared appropriately within the department.
- Equipment was properly serviced and maintained with clear records kept.
- Medical records were available and stored safely and securely.
- All medical staff that treated children were trained to safeguarding level 3 in line with current intercollegiate guidance.
- There were effective systems in place to support staff in completing their mandatory training and an overall completion rate which placed them fifth out of 59 BMI hospitals.

However:

- The endoscopy service was not JAG accredited, although there were measures in place to mitigate risks and manage the service appropriately.

Incidents

- There were no never events in medicine in the period April 2015 to 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. The occurrence of a never event could indicate unsafe practice.
- BMI Healthcare Limited, the provider company, sent examples of any never events that occurred at any of their hospitals to all hospitals for discussion and action where relevant.
- The hospital reported four patient deaths for the period April 2015 to March 2016 of which there were no unexpected deaths in medicine.
- No incidents were reported as leading to “severe” harm in the period April 2015 to March 2016.
- For the same time period, the rates of clinical incidents (per 100 bed days) in surgery, inpatients and other services were similar to or better than other independent acute providers CQC holds this type of data for.
- The hospital reported that 147 (86%) of the 170 clinical incidents for the same period occurred in surgery or inpatients. It was not possible to identify any inpatient incidents for medical patients in the data provided. As there were a very low number of medical patients admitted to the hospital, we requested more recent data. The hospital stated that seven clinical incidents had occurred in respect of medical patients between January - August 2016.
- The hospital used a paper based document for reporting incidents . All completed incident forms were entered onto a web based database by quality and risk department staff. Where an investigation was required this was led by the appropriate head of department with 20 days to complete and return the investigation form.
- Any learning resulting from incident investigation was disseminated throughout the hospital with reports sent to various committees. These included clinical governance, medicines management, the medical advisory committee (MAC), health and safety and water safety.
- Themes were looked at to improve learning across the hospital.
- Staff we spoke with in the various areas we visited on the inspection were all able to describe the reporting process and the feedback at ward and departmental meetings. We also saw feedback on an investigation in the April 2016 team brief. Dissemination of feedback in this way ensured that all staff learnt from incidents to help prevent a recurrence.
- Endoscopy staff were aware of the incident reporting process. The theatre manager signed off every incident and investigated where required. We were told that there had been no harm to patients from known risks such as oesophageal perforation, (Anoesophageal perforationis a hole in the tube that food and liquids pass through on the way from your mouth to your stomach, which can occur following an injury during a medical procedure), no returns to theatre and no incidents of post procedure bleeding. All incidents were discussed at the clinical governance meetings, heads of department meetings and the MAC. The theatre manager attended all these committees.

Medical care

- Staff we spoke with demonstrated knowledge and understanding of the duty of candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The 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 them with reasonable support. There had been an issue with a specific piece of equipment and the consultant ensured that the patient was informed and a full discussion undertaken. There was no harm to the patient.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The hospital used the NHS Safety Thermometer, a national improvement tool for measuring, monitoring and analysing harm. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- We saw the results for the safety thermometer from May 2016 which showed that there had been no falls, no urinary tract infections, no VTEs and 100% of patients had been assessed for VTE.
- Day case patients were excluded from the safety thermometer.
- We saw safety thermometer data displayed in hospital areas which showed information about incidents and patient satisfaction.

Cleanliness, infection control and hygiene

- No episodes of hospital infections of methicillin-resistant Staphylococcus aureus (MRSA), Clostridium Difficile (C. difficile) or methicillin sensitive Staphylococcus aureus were reported between April 2015 and March 2016.
- The hospital reported three incidents of Escherichia coli (E. coli) in the same time period; we saw that a full Root Cause Analysis had been completed for each infection.
- Personal protective equipment such as gloves and aprons were readily available in all clinical areas we visited. This allowed staff to protect themselves and patients against infections.
- The patient-led assessments of the care environment (PLACE) scores for cleanliness and condition, appearance and maintenance were marginally better than the national average, for example 99% against 98% for cleanliness.
- The patient and relative we spoke with following the inspection felt that cleanliness was of a high standard.

Environment and equipment

- We saw evidence that the endoscopy equipment had been serviced with a log book kept in the unit. This provided assurances that it was safe and fit for purpose.
- We saw examples of weekly checks carried out in the unit such as water samples, silicone oil to scopes and valves and lens cleaners.
- We saw daily checks completed and when there was either no endoscopy session, or at a weekend, this was also clearly documented.
- The sharps bin was dated, signed and used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Safe disposal of sharp objects such as needle sticks helped protect staff against injury. There were two suction machines in the lifts. One had an expiry date of April 2017 and the other July 2017 and had been serviced in July 2016.
- We looked at various pieces of portable equipment and saw that these had been checked annually, for example eight blood pressure machines.
- In the dirty utility, we observed visibly clean commodes which had been labelled to indicate they had been cleaned.
- Resuscitation trolleys were available at the entrance to both wards with oxygen. We reviewed the checklists for both paediatric and adult resuscitation trolleys and confirmed that these had been fully checked for the last three months.
- We found that the endoscopy unit was not working towards the Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation as the environment and facilities would not reach the necessary standards to achieve it. The hospital and staff were aware of this and there had been a proposed new build put forward some years ago. BMI Healthcare at a corporate level was working with the local NHS trust to develop this proposal as they own the land the hospital is on.

- Staff followed the Choice Framework for endoscopy, now superseded by HTM -1-06, for decontamination of flexible endoscopes. There were corporate policies developed by the BMI Healthcare endoscopy group.
- The decontamination room was very small with three old washers. The sinks were very close to the washers and it would be difficult to avoid microbial spray which could spread infection. The decontamination facilities were on the health and safety risk register and the potential issues were well known. There was a standard operating procedure for managing the decontamination area which mitigated the risks posed by this.
- The risks were mitigated by the robust controls put in place by the lead endoscopy nurse. We saw that the daily cleaning and individual washer water checks were completed as well as weekly endoscopy check list. The unit adhered to the British Society of Gastroenterologists (BSG) guidelines for endoscope cleaning. We saw records which demonstrated that daily and weekly checklists had been appropriately completed.
- There was a risk assessment in respect of the washers. The health and safety link nurse in theatres worked closely with the endoscopy lead for risk assessments associated with this area. There was a contingency plan should any washer break down.
- Each endoscope was pre-checked before use to ensure that equipment was safe to proceed.
- We saw evidence that the equipment was properly serviced and maintained. The endoscopy lead attended a manufacturer's endoscopy day and was due to attend another. The endoscopy lead could access advice and support from the providers of the equipment and said they felt well supported by line management.

Medicines

- We found that medicines were managed well in the endoscopy unit. We saw that the controlled drugs register was well completed with no omissions. Controlled drugs are certain prescription only medicines which are controlled under the Misuse of Drugs legislation and include morphine and pethidine. We saw that the stock check was correct which meant that controlled drugs were being stored safely and securely which reduced the risk of patient harm.
- Three monthly pharmacy checks took place and where issues were found, action plans were developed.
- The sample medicines we looked at on two drug trolleys and drug cupboard were in date. All syringes and consumables were in date. Anaphylaxis kit was available on both wards.
- We checked fridge temperature records on the ward and found they were all correct. Staff checked the medicines fridge when the ward was open, and the fridge was not used when the ward was closed.

Records

- The hospital told us that relevant medical records were available for all patients admitted over the previous three months.
- We saw that the theatre register for endoscopy patients was well completed. This increased patient safety by ensuring that there were accurate and contemporaneous records of patients.
- We saw that patient records were securely stored in lockable filing cabinets in an office with a key code. This ensured the hospital protected patients' personal and confidential data in line with The Data Protection Act 1998.
- For NHS patients being treated as part of any waiting list initiative, the NHS medical records were requested and copies of all records for the episode of care, including the discharge summary, were filed in the NHS records before returning them to the relevant NHS trust. This allowed continuity of care and assisted with clinical decision-making.
- NHS medical records were stored in lockable filing cabinets whilst the patient was at the hospital.
- For NHS patients referred through Choose and Book, BMI hospital records were made up for the episode of care with the discharge summary sent to the GP, or other referring doctor. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic
- All patient records held by the hospital were scanned for archiving 10 months after the last activity. This meant they were available post treatment and could be recalled if required after that.
- We were told that all consultants were registered with the Information Commissioner's Office (ICO) which meant that they had appropriate arrangements in place to store confidential patient information safely and securely.

Medical care

Safeguarding

- The director of clinical services was the hospital safeguarding lead for both vulnerable adults and children. The director also chaired the BMI National Children and Young Persons' Committee.
- One hundred per cent of medical staff, including the Resident Medical Officer (RMO), who treated children, were trained to Safeguarding Level 3 as were the paediatric nurses. This was an appropriate level of training in line with national intercollegiate guidance. The hospital had worked closely with visiting consultants to ensure training was up to date and we saw the hospital's list of consultants who could treat children at Runnymede Hospital.
- The hospital had links with the local safeguarding teams and was represented by the Clinical Commissioning Group's safeguarding lead on both the children's and adult safeguarding boards.
- The care of children was discussed at the monthly clinical governance meeting, and staff received supervision and support.
- Staff told us that no children under 16 years old were treated in the endoscopy unit. The unit was in theatres and theatre staff were trained to Level 2, which was not in line with national guidance for working with children. However, only consultants on the hospital list would be able to undertake procedures on children up to 18 years of age and they were appropriately trained to Level 3.
- There was a robust process to ensure that only consultants with the appropriate level of safeguarding training were able to see children and young people as patients.
- We saw that the risk assessment for admitting 16 to 19 year olds had been reviewed in May 2016.
- The hospital reported no safeguarding concerns to CQC for the period April 2015 to March 2016.
- There were laminated flow charts for staff, should they have a safeguarding concern, available in all clinical areas we visited. These included where to seek advice within the hospital and all relevant contact numbers for social services and the police. These had been developed over the last two years and had helped staff to know how to flag concerns.

Mandatory training

- BMI Healthcare provided weekly reports to all hospitals of the mandatory training rates. This included a 'leader board' comparing the hospitals and we saw that the Runnymede Hospital was fifth out of 59 hospitals with over 92% completion rates. This made them the highest in the south region.
- We found good systems and processes in place that supported staff in completing mandatory training with information about relevant courses available to them both in the hospital and at other nearby BMI hospitals. Managers responsible for staff mandatory training were kept fully informed of attendance and completion.
- Mandatory training was electronically reviewed on a weekly basis by training topic. Where there were any concerns lists would be sent to the relevant heads of department. We saw that the hospital had 100% compliance for topics such as blood transfusion, medical gases and medicines management. Paediatric basic life support had 64% compliance and we saw that emails had been sent to staff with information about relevant courses at the hospital and also at other nearby BMI hospitals. We saw forms for staff to complete should they complete e-learning elsewhere as well as copies of attendance registers for courses that included a practical session.
- Staff we spoke with told us they had completed their mandatory training. We saw evidence of completed training such as equality and diversity, fire, and first aid.
- The RMOs were supplied by an agency. The RMOs completed all mandatory training through the agency and recorded this on their CVs. The hospital checked the agency documentation for assurances that RMOs were fully compliant with mandatory training before they started work.

Assessing and responding to patient risk

- We saw evidence in the four medical records we looked at of risk assessments such as skin viability, nutrition and falls. For patients at risk of falling there was a variety of equipment available to mitigate the risk such as mats and 'high/low' beds.
- The hospital used the national early warning score (NEWS) charts for tracking patients' clinical conditions and alerting the clinical team to any deterioration that would trigger timely clinical response. We saw variable completion of the NEWS sheet. We saw examples of good recording and examples where it was not always used as designed. We noted one record where a score should have prompted hourly checks but this had not

happened. This made identifying when to escalate appropriately more difficult as the NEWS score was not correct in every case. We were told that there was ongoing training for staff to improve use.

- Any concerns regarding communicable diseases would be identified at pre-assessment for patients to be admitted to the ward or for endoscopy. Staff would liaise with the infection prevention and control nurse to agree the way forward. The team would be informed at team briefings and the consultant made aware.
- The RMO provided medical cover 24 hours a day, seven days a week. This meant concerns regarding a patient could be escalated at any time of the day. The RMO could contact the relevant consultant as they were required to be available at any time of day when they had patients admitted to the hospital, or to make arrangements for cover. Staff told us this happened.
- There was a service level agreement in place with the local NHS hospital for specialist advice regarding deteriorating patients such as intensivist, microbiologist, cardiologist and pharmacy.
- We saw the joint transfer protocol between the hospital and the South East Coast Critical Care Operational Delivery Network. This meant that patients would be transferred to the nearest NHS hospital with an available critical care bed should they suffer, for example, a stroke.
- We were informed that screening rates for venous thromboembolism (VTE) for the period April 2015 to March 2016 were above 95%. There were no reported incidents of VTE or pulmonary embolism for the same period.

Nursing staffing

- We were told that the BMI Healthcare nursing dependency and skill mix tool is a guide to ensure the right members of staff are on duty at the right time and with the right skills, to ensure high quality patient care. The tool was used to plan the skill mix five days in advance with review and updates on a daily basis.
- BMI Healthcare carried out a review of the corporate nursing establishment tool in 2014. This affirmed that, "Professional and clinical judgement will always determine the best possible nursing intervention for patients admitted or attending a BMI Healthcare Facility." We saw examples of the monthly spreadsheets that all BMI hospitals completed to analyse and monitor staffing. The review included the minimum skill mix required for the various patient groups such as medical patients and elderly care.
- There was variable use of bank and agency staff for inpatient nurses for the period April 2015 to March 2016. This meant the rates were mainly worse than the yearly average of other independent acute hospitals CQC holds this type of data for. However, there was low use of bank and agency staff in respect of health care assistants for the same period.
- The one patient and relative we spoke with both said there felt there were sufficient staff on the ward during their stay.
- However, staff told us that whilst most agency staff used were regulars they felt more permanent staff were needed.
- There was a senior nurse available at the hospital as a contact point for both staff and patients, including to help resolve patient queries and to accept out of hours admissions.
- In addition to clinical and consultant arrangements, the senior management team operated a rota for on call support out of hours. There was also an on call rota operated by the pharmacy, radiology and physiotherapy teams should support be required out of hours, as well as an on call emergency theatre team.

Medical staffing

- Consultants were required under their practicing privileges to be available both by telephone and, if required, in person whenever they had patients admitted to the hospital. Consultants were required to arrange appropriate alternative named cover if they would not be available. Since many of the consultants worked at the adjoining NHS hospital, staff told us it was easy to contact them when needed.
- An RMO, supplied by an external agency, provided a 24 hour seven day a week service on a rotational basis. The RMO worked closely with the consultants in the care of the patients. Should the RMO become unwell the agency was called to provide cover.
- We saw the corporate BMI Healthcare Practicing Privileges Policy for Consultant Medical and Dental Practitioners, 2015. Adherence to the policy was monitored and we saw minutes which showed that any concerns were discussed at the Medical Advisory Committee.

Medical care

Major incident awareness and training

- As the hospital was linked by a corridor to the local NHS hospital, staff formed part of their major incident team with an emergency policy in place.
- The hospital had a business continuity policy in line with ISO 22301 Business Continuity Management Systems Requirements. We saw the individual guidance sheets for emergencies such as loss of the fire alarm system, loss of IT systems and water leak/internal flood. All included relevant contact numbers. All policies and protocols were on the hospital's shared IT system as well as paper copies in folders on all wards.
- There was a backup generator that started up after 15 seconds. We were told that this was tested monthly to ensure continued power in the event of a loss of mains electricity.
- The hospital provided scenario-based training exercises which included five paediatric and five adult resuscitation exercises a year. This enabled staff to keep their resuscitation skills up-to-date and staff told us they found them useful.

Are medical care services effective?

Good

We rated effective as good. This was because:

- There was a comprehensive system of audit and provider visits (an internal BMI audit process to monitor quality of care) to drive continuous improvement.
- Audits of pain management showed high levels of compliance with policy around pain relief with staff explaining to patients the level of pain they might expect and how this would be managed.
- Staff competence was ensured through comprehensive induction and regular and effective appraisals.

Evidence-based care and treatment

- Provider visits audited the endoscopy unit. We saw that the Scope Plus Audit Trail log books were completed. This is a system which enables the user to track the decontamination of an endoscope through manual wash, automated reprocessing, storage and finally to use on a patient. Completion of the log books gave assurance that the endoscope was safe and ready for use.
- We saw that endoscopic procedures were carried out in line with professional guidance.
- There was a system for alerts received from the Medicines and Healthcare Products regulatory Agency (MHRA) that could be cascaded through the hospital. We saw that these were discussed at the clinical governance meetings in sample minutes that we looked at.
- There was a BMI Healthcare policy for cannulation insertion, management and removal. The policy stated that a cannula should be re-sited before 72 hours in line with national guidance. In section 15.6 the policy stated, "The maximum time in situ should be no more than 96hrs". This equated to four days. One patient who had transferred from surgical to medical care had the cannula in situ for five days and we found some lack of clarity regarding this policy. However one nurse we spoke with demonstrated good knowledge and understanding of the policy and practice.

Pain relief

- Patients' pain was recorded on the National Early Warning Scores (NEWS) chart. The NEWS chart is a standardised chart for assessing and responding to acute illness.
- We heard from a patient that pain management was good, and that staff asked about their pain on a regular basis.
- Pain relief was audited via patient satisfaction surveys to monitor the way that staff assessed and explained pain to patients and the pain relief that was then offered. We saw the February 2016 audit which showed results for the previous six months. These showed that staff asked 100% of patients about their pain on admission, 100% had their pain score, where appropriate, assessed on the relevant chart at least every four hours, and 100% of patients had pain management planned and evaluated throughout their stay.

Nutrition and hydration

- We saw information regarding starving times provided for patients booked for endoscopy procedures. These patients were admitted as day cases.
- There was one medical patient on the ward during the inspection. They told us that the food was of a good quality and nutritious. They were well provided with hot and cold drinks during their admission. We were told there was a, "personal touch to everything [staff] do."

- Catering services were outsourced and there had been a change to another private provider. The Patient-led assessments of the care environment (PLACE) for the period February to June 2015 showed that some food measures scored 89%.This was worse than the national average of 93%. However, ward food scored 98%, which was better than the national average of 94%.
- We were told that the hospital were working with the catering services to improve patient satisfaction and we saw evidence in clinical governance committee minutes of continued ways to improve being discussed.

Patient outcomes

- Patient outcome data was compared with all hospitals across BMI Healthcare using the corporate clinical dashboard that gathered data from the group incident database and patient satisfaction surveys. Overall, BMI The Runnymede Hospital at the time of the inspection stood at 41 out of 59 locations.
- The hospital had a robust audit programme with audits completed online via the hospital audit calendar, and results discussed at the clinical governance committee and departmental meetings. These included documentation and consent audits for paediatric patients.
- The endoscopy service was not JAG accredited. The BMI strategy was to achieve JAG accreditation for all endoscopy services but staff acknowledged this would not be possible given the environment at the Runnymede.

Competent staff

- The agency that supplied the RMO provided the CV for a new RMO and this included their training records. Each new RMO undertook a full hospital induction.
- We were told of opportunities for development such as undertaking a mentorship course. This meant that staff were able to progress within the organisation.
- Registered and non-registered nursing staff undertook acute illness management training which meant they were able to identify clinical deterioration in patients.
- We were told of recently introduced speech and language therapy training such as swallowing to support staff in caring for medical patients. A senior nurse had attended this training.
- Staff had annual appraisals as well as a mid-year review. We were told that these were useful and identified additional learning needs.
- There was always a member of staff on shift who had been trained in Advanced Life Support.
- We saw that paper work relating to practising privileges was stored securely, with consultant information, such as appraisals and indemnity details, uploaded onto a corporate database. This ensured that any missing paperwork was chased up in a timely manner to maintain compliance with BMI requirements.
- We saw the list of consultants who had been approved to provide care to children. These required level three safeguarding training and specific paediatric training.
- Applications for practising privileges were reviewed by the MAC chair and signed off by the MAC.
- All theatre staff had been trained on manual decontamination for the endoscopy service. The relevant senior staff had attended an endoscopy decontamination course for managers.

Multidisciplinary working (in relation to this core service)

- We were told that patients were not admitted for end of life care and that there was no end of life care pathway. However, we saw that a patient admitted directly from outpatients for medical care was subsequently provided with end of life care. We saw that there was good input by the palliative care team from the adjoining NHS hospital.
- We saw examples of joint surgical and medical care where a patient was ready for discharge following surgery but had a medical condition so was passed to the care of a physician.

Seven-day services

- The hospital had medical cover from an RMO and senior nurse 24 hours a day, seven days a week as a contact point for both staff and patients.
- Patients had access to telephone advice from nursing staff 24 hours a day, seven days a week.
- There was also an on call rota operated by radiology and physiotherapy teams should support be required out of hours, as well as an on call emergency theatre team.

Access to information

- There were electronic systems that recorded all patients booked into outpatients, day case and inpatients.

Medical care

- Pre-assessment included past medical history, allergies and other patient information. This meant that staff were prepared for the patient when they arrived and could manage their care safely and effectively.
- The National Enquiry Centre allowed staff to access the diary of any consultant so that appointments could be booked appropriately and without delay.
- Policies were available on the intranet for staff to access and a regular Team Brief was circulated to all staff to inform them of key updates and developments.
- Any significant changes in policy or practice were emailed to consultants with practising privileges and they were asked to confirm receipt and acknowledge that they had read the information.
- Medical secretaries typed letters to the GP following the patient's attendance.
- Pathology services were provided under a service level agreement with the adjoining NHS hospital and an electronic link between the laboratory and the hospital ensured results were available in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff on the ward obtaining consent from patients before starting care or treatment. We noted that staff explained the planned procedure and interacted well with the patient to obtain consent.
- We saw that consent had been appropriately documented in a patient's record.
- Staff described an occasion when they had assessed mental capacity at pre-assessment.
- We were told that 45 out of 85 staff had received DoLS training. Deprivation of Liberty Safeguards (DoLS) relates to people who are placed in care homes or hospitals for their care or treatment and who lack mental capacity. Training for staff ensures that they understand the principles and can provide safe care and appropriate treatment for vulnerable adults. We spoke to staff who had received this training and they were aware of the principle issues, but felt they were unlikely to need to use it as the admissions screening tool would exclude patients where this might be necessary.

Are medical care services caring?

Good

We rated caring as good because:

- Although we were not able to speak to a large number of patients, the comments cards and the small number we spoke to reported excellent and compassionate care from staff.
- We observed clinical and non-clinical staff respecting the privacy and dignity of patients.
- There were well established links with the adjoining NHS hospital to provide spiritual support for patients where required.

Compassionate care

- We spoke with the only inpatient under medical care at the time of our inspection. They told us that staff protected their privacy and dignity, and were courteous and caring.
- The patient and relative we spoke with after the inspection told us that the staff were very caring and helpful. They felt their privacy and dignity were respected at all times. The relative said that the staff had the time to provide very good care.
- A patient told us that call bells had been answered promptly and they felt they never had to wait to speak to a member of staff.
- We observed that housekeeping staff protected patient privacy and dignity. They knocked before entering the room, introduced themselves, asked whether they could clean the room and spoke courteously with patients.
- Patients who had an endoscopic procedure received a telephone follow up call from nursing staff to check that they were well.
- We observed nursing staff providing compassionate care to a patient.

Understanding and involvement of patients and those close to them

- Patients told us that comprehensive information regarding care and treatment was provided throughout their hospital stay with staff explaining clearly the nature of tests required and the purpose of observations.

Medical care

- A relative told us that friendly staff had provided them with lots of information and were happy to spend time with them to explain what was happening

Emotional support

- One CQC comment card was completed by an endoscopy patient during the inspection. They were very positive about the care and treatment, "especially as I was nervous, they put me at ease."
- Spiritual support for patients was accessed via the adjoining NHS hospital.
- Ward rooms had both a telephone and Wi-Fi internet access so that patients could receive emotional support from friends and family during their stay.

Are medical care services responsive?

Good

We rated medical services as good for responsive because:

- Pre-assessment appointment times were discussed with patients to ensure that their preferences and needs could be accommodated.
- Although the numbers of patients living with dementia were very low, all 83 members of staff had received dementia training.
- Complaints were investigated thoroughly and learning shared from these at departmental meetings.
- The hospital had arrangements in place to provide interpreters, including sign language interpreters, if needed.

Service planning and delivery to meet the needs of local people

- NHS patients accounted for about 18% of total inpatient and day case activity. This was significantly different to the average across all BMI hospitals where 45% of patients are NHS-funded.
- There were very few medical patients admitted over the last 12 months although the hospital was unable to provide us with exact numbers.

Access and flow

- Patients were booked in for pain treatment and the details entered on to the hospital electronic system. Pre-assessment appointment timings were discussed with the patients to accommodate their preferences.
- Patients to be admitted either had a telephone pre-assessment or came to the hospital clinic where they were seen by a registered nurse and any other appropriate professionals such as therapists. Any tests were taken at the clinic, such as MRSA screening and blood tests.
- NHS patients referred through Choose and Book were booked into day case and outpatient slots by the consultants' secretaries with referral to treatment times checked daily. Reports were sent each month to the Clinical Commissioning Group.
- Patients told us they had been seen on time.
- As far as possible, people were able to access care and treatment at a time to suit them with flexibility around appointment times.
- The hospital had clearly defined criteria for medical admissions which used a score chart to assess a patient's suitability, and took into consideration their mental state, mobility and falls history.
- Two patients both reported that they felt their admissions had been well planned and that the hospital had been responsive to their needs.

Meeting people's individual needs

- Whilst we were told that the hospital did not admit many patients living with dementia we saw that all 83 members of staff had received dementia training. This included registered and non-registered nurses, theatre staff, physiotherapists and radiographers. This meant staff had the necessary training to enable them to better meet the needs of patients living with dementia,
- Although staff could not articulate a clear policy around the age limit for endoscopy, we reviewed records and found no examples of children under 16 years of age undergoing endoscopy procedures. Staff told us that should that be required, the endoscopy unit was in theatres with staff trained to work with children and only consultants on the hospital's list of those authorised to treat children would be able to undertake an endoscopic procedure.
- As there was only one medical inpatient during the inspection visit, the hospital wrote to four recently

discharged patients. They included a reply paid envelope and requested consent for CQC to contact them to share their experience. One patient responded and was contacted by CQC after the inspection.
- The patient and relative we spoke with following the inspection said that staff were quick to respond to the call bell, or any request for assistance.
- There was a register of languages that hospital staff spoke so that they could be asked to interpret if required. Staff knew how to access this and could also use the translation line in operation at the adjoining NHS hospital if needed.
- The hospital had a contract with an external company to provide sign language to patients who required this to communicate.
- Staff told us that the hospital was able to accommodate a patient's request to have all female staff.
- The hospital had a feedback form for patients to use, and in response to comments from children had developed a separate comment form for children to use.

Learning from complaints and concerns

- We saw the hospital complaints policy. The lead within the area receiving the complaint would be informed and commence an investigation. The leads contacted the complainant where possible and offered face to face meetings. We saw evidence that complaints were investigated and acted upon. They were discussed at appropriate committees and the daily huddle. We saw that 95% of complaints were responded to within 20 days, which was the hospital target. Learning from complaints was shared through team briefings and team meetings.
- We were told that the main themes for complaints were finance, communication and the time spent with consultants.

Are medical care services well-led?

Good

We rated medical care services as good for well led because:

- We saw evidence of good team working.
- The senior team was visible, approachable and supportive to junior staff.
- Clinical governance meetings had clear oversight of incidents and complaints with thorough investigations and dissemination of learning.
- The medical advisory committee had a robust structure and meeting minutes demonstrated constructive debate and thoughtful decisions.

Vision and strategy for this this core service

- There was an overarching BMI Healthcare strategy that all hospitals worked to which was developed corporately.
- The local vision and strategy stated that Runnymede should be the private hospital of choice for patients and consultants in West Surrey, to deliver high quality service, be the employer of choice and to continually improve and update their facilities and environment. This local mission statement was developed by the Executive Director in discussion with the heads of department.
- Staff we spoke with were aware of and understood the vision.
- There was a plan to increase medical services and develop ambulatory care.

Governance, risk management and quality measurement for this core service

- There was a corporate strategy for governance that provided a framework for local governance procedures.
- There were a variety of monthly meetings that discussed risk, incidents and complaints. These included the senior management team and heads of department meetings. Information from these meetings was disseminated to ward meetings. In turn, information from the departmental meetings was fed up to the heads of department. This ensured that there was good communication throughout the hospital and staff were aware of specific incidents and causes for concern.
- The hospital had a clinical governance committee (CGC) which met every other month. We saw samples of minutes that demonstrated that departmental and other meetings fed into the CGC such as theatre and ward meetings, patient experience committee and resuscitation committee. Clinical quality as well as governance was discussed at the quarterly Medical Advisory Committee (MAC) meetings.
- Ward meetings were held every other month and minutes we looked at showed discussions on topics

such incidents and infection prevention and control. Night staff meetings were held quarterly. The ward manager attended. We looked at the minutes for July 2016 and saw that the executive director also attended. Items included recent audits, complaints, completion of NEWS score sheets and recruitment.

- Each clinical area had a blue clinical governance folder that included emergency contact numbers, protocols such as urgent admissions, safeguarding flow charts and duty of candour. These were visible and easy to access.
- We were told there were 61 regular visiting consultants out of a total of 168. Consultant contracts, known as practicing privileges, were managed jointly by the hospital management and the MAC. There was also evidence of consultants suspended when they had not provided the required documentation requested by the hospital management and reinstated once they had. This demonstrated the hospital had robust procedures to ensure all consultants were competent and fit to care for patients.
- We saw that an extensive information pack was prepared and circulated prior to the medical advisory committee meetings. The pack included all incidents, root cause analysis investigations, complaints and audit results. This provided comprehensive information for discussion and allowed those attending to prepare for the meeting and spend the meeting time effectively. We saw from the minutes of MAC meetings that there was constructive debate and challenge to investigations where appropriate. We looked at the February to April 2016 clinical governance report for the MAC and saw there were two incidents in respect of medicine.
- No whistleblowing concerns were reported to CQC in the last 12 months.
- However, we were told of a member of the nursing staff who had given prescription only medicines at night without prescription, and had repeated this despite receiving additional training. We raised our concern at the time of the inspection with senior managers and they took immediate action to be assured of safe processes regarding administering medicine at night.
- The endoscopy environment was highlighted as one of the key clinical risks within the hospital and there were measures in place to mitigate this.

Leadership and culture of service

- Daily communication meetings ('huddles') were held with representatives from all departments to discuss the previous day's activities and plan for the day ahead. This meeting also allowed senior staff to raise concerns and report on incidents and complaints, where relevant.
- The lead for the endoscopy service clearly described the systems in place to mitigate the risks identified because of the environment, and demonstrated effective processes to assure staff competency and learning from incidents throughout the department.
- We saw minutes of team meetings which showed that incidents were discussed and learning shared to help prevent recurrences.
- Staff told us they felt supported by managers, and were encouraged around the completion of personal development.
- All staff we spoke with felt that the senior management team were approachable and visible. We saw good attendance at various committees.
- Staff told us that there had been a lot of work to improve incident reporting and create an open culture. They felt this had now been achieved and were able to raise concerns with both immediate line management and the senior team.
- The management team was addressing difficulties in recruitment and retention of staff by ensuring that salaries matched both their independent competitors and NHS trusts. Training and development were offered to staff to retain them, including a management and leadership course.

Public and staff engagement

- Senior nursing staff ran workshops for the nursing teams to support individuals in the re-validation process.
- Nursing staff had access to training and development to promote retention of staff, and last year there was a pay review to ensure that salaries were comparable with NHS pay scales.
- There were regular staff forums and a more formal 'team brief' to ensure that staff were kept aware of developments and updates.
- Patient satisfaction scores were consistently high, with 98% (of 410 responses) in June 2016 rating the hospital as either very good or excellent.

Innovation, improvement and sustainability

Medical care

- We were told of plans to have four dedicated medical beds from September 2016. Five physicians were involved in planning the increased medical service provision.
- There was a rolling programme to replace flooring (from carpet to laminate) and redecorate.

Surgery

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

Information about the service

Surgical services cover a range of adult specialties including orthopaedics, ophthalmic (eye), urology, general and gynaecology surgery.

Pre-planned elective surgery services are also provided to children and young people between the age of three and 18. Invasive procedures are not performed on children under the age of three. The hospital does not accept emergency children's admissions.

Between April 2015 and March 2016, there were 4,881 adult visits to theatre. The most common procedure undertaken was arthroscopy of the knee (238) (a technique in which a tube-like instrument is inserted into a joint to inspect, diagnose, and repair tissues.) Repair of inguinal (groin) hernia (119) (a hernia is a term used to describe a bulge through a structure or muscle) was the second most common operation.

There were 103 operations undertaken on children aged between three and fifteen between April 2015 and March 2016 and 28 operations undertaken on 16 and 17 year olds during the same time period. The most common operation (22) undertaken was myringotomy and insertion of tube through tympanic membrane (a surgical procedure in which an incision is made in the eardrum to relieve pressure caused by build-up of fluid, a tube is inserted into the eardrum to keep the middle ear aerated for a prolonged time and to prevent re accumulation of fluid.)

All children up to 16 years are cared for by two registered children's nurses. The service is supported by the lead children's nurse and specialist paediatric clinical advice and support is provided by the lead paediatrician who is based at a local NHS hospital.

On Burwood ward, four twin-bedded rooms were allocated close to the nurses' station for children and young people requiring inpatient or day care surgery. There was an allocated recovery area for children in theatres. A small supply of children's toys was available, including children's channels on TV, a DVD player and a children's menu was provided.

The theatre suite has three operating theatres, four recovery bays and two anaesthetic rooms. Theatres one and two have laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination.) A mixture of orthopaedic, gynaecology, vascular, general, urology and ear, nose and throat surgery is undertaken in these theatres. Theatre three does not have laminar flow and mainly undertakes local anaesthetic and sedation procedures for example, endoscopy, oral surgery and eye surgery.

Wentworth ward is used to care for day care patients. During our inspection Wentworth ward was not open due to a small number of admissions; however the environment and equipment were inspected. Both inpatient and day care patients recover from surgery on Burwood ward. The hospital has 52 beds split equally across Burwood and Wentworth wards. The majority of rooms are single, there are four double rooms and all rooms have en-suite facilities, satellite television, telephone and internet.

Surgery

We visited all clinical areas including theatres, ward areas and the preoperative assessment clinic during our inspection.

During our inspection, we spoke with 31 members of staff including nurses, doctors, allied health professionals, catering staff, domestic staff, administrative staff and the executive team. We spoke with six patients, one patient's relative and five children and their parents. We also received 34 patient comment cards with feedback from patients who had surgery at the hospital. We reviewed 14 sets of patient records and a variety of hospital data for example meeting minutes, policies and performance data.

Summary of findings

Overall, we rated surgical services as good. This was because:

- The hospital had effective systems to assess and respond to patient risk and we saw examples during our inspection.
- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. We saw that the hospital monitored this to ensure consistency of practice.
- The hospital participated in relevant local and national audits and contributed to national data to monitor their performance such as the National Joint Registry (NJR). Staff we spoke to understood and fulfilled their responsibilities to raise concerns and report incidents and we saw examples of this.
- We saw the hospital fully investigated incidents and shared learning from them to help prevent recurrences.
- Patient consent was recorded in line with relevant guidance and legislation.
- We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff.
- There was a governance structure that promoted the delivery of high quality person-centred care.
- Leaders modelled and encouraged cooperative, supportive relationships among staff. The majority of staff told us they felt respected, valued and supported.
- Services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these appropriately. We saw when a delay occurred there was an immediate explanation and apology.

However:

- There was a low percentage of staff that had undergone an appraisal in 2016, and in addition only 11% of theatre staff had an appraisal in 2015.
- We saw that some of the clinical areas had carpets.
- Fire doors within the theatre suite did not have intumescent strips around the edges of doors or door frames.

Surgery

- In theatres we saw three bowl stands had rusty wheels.
- We could not find evidence of an electrical safety check on three patient trolleys.
- Electrical cables in theatres were not secured.
- In theatres there was a door on one of the preparatory rooms with a faulty closure mechanism which was potentially unsafe.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Fire doors within the theatre suite did not have intumescent strips around the edges of fire doors or door frames. Intumescent strips are designed to expand under heat, and fill the gaps between the door edges and door frame, thereby preventing the passage of smoke and fire to other parts or compartments of the building.
- In theatres there was a door on one of the preparatory rooms with a faulty closure mechanism which was potentially unsafe.
- Medicines were used outside of the terms of use without correct approval and risk assessments.
- There were 'blanket' signatures of controlled drugs.
- In theatres we saw three bowl stands had rusty wheels.
- We saw that some of the clinical areas had carpets.
- There was a box of medication which contained drugs with different batch numbers.
- We could not find evidence of an electrical safety check on three patient trolleys.
- The World Health Organisation Surgical Safety Checklists were not always fully completed.
- Electrical cables in theatres were not secured.

However we also found:

- Staff told us that openness and transparency about safety was encouraged. When something went wrong there was an appropriate thorough review or investigation. This involved relevant staff and people who used services.
- Lessons were learnt and communicated widely to ensure improvement in other areas in addition to the services that were directly affected. Staff told us of a recent never event that had occurred and they described a no blame supportive process during the investigation.
- We observed staff recognised and responded appropriately to changes in risks to patients who used services. During our inspection we saw staff respond to and take appropriate action when a patient developed a temperature prior to the commencement of a blood transfusion.

- We saw a patient receive a sincere and timely apology when they were told the incorrect time to arrive at the hospital for their operation.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safe and safeguarded from abuse. These were appropriate for the care setting and were understood by all staff and implemented consistently.
- We saw staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. Any staff shortages were responded to quickly and adequately.
- We observed there was effective handovers at shift changes, to ensure staff could manage risks to patients. We heard at handover how two patients with the same surname were highlighted as a potential risk, and what action was taken to mitigate this risk.
- There were plans and procedures in place to respond to emergencies. Staff regularly undertook scenario training in emergency situations meaning their skills and knowledge were up to date.

Incidents

- 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.
- The never event was a retained swab after gynaecology surgery. We saw there was a full root cause analysis (RCA) undertaken which did not demonstrate a cause for the event. Staff described the investigation to us and it was obvious the event had caused staff concern and worry. Staff told us how they had been supported throughout the process by the management team, and that blame had not been apportioned. Learning from the incident and implementing changes to prevent a recurrence was limited as the cause was not identified. We saw from copies of theatre departmental meetings that the never event had been discussed.
- The hospital reported one unexpected death between April 2015 and March 2016. We reviewed the patient's notes and the RCA and found staff recognised and responded appropriately to the deteriorating health of the patient. We saw meeting minutes from the medical advisory committee (MAC) which showed the circumstances surrounding the patient's death had been reviewed. This meant that there was a full case review and any lessons learnt could be identified.
- The hospital reported one expected death between April 2015 and March 2016, we reviewed the patient's notes and considered the care and treatment of the patient had been planned for and managed appropriately.
- Surgical services reported 147 clinical incidents between April 2015 and March 2016, surgery reported 86% of all hospital wide clinical incidents. The hospital reported 0.6% of all incidents as resulting in severe harm or death. The remaining incidents were reported as resulting no harm, low harm or moderate harm. The information was not broken down to children or adults.
- For the same time period (April 2015 and March 2016) the assessed rates of clinical incidents (per 100 bed days) in surgery, were similar or lower than other independent acute providers that the provider held data for.
- Staff completed a paper clinical incident form, which they submitted to the appropriate ward or theatre manager. Managers then entered data from the form onto the computer system. Staff could all describe the process for reporting incidents, and gave examples of times they had done this. All staff we spoke to had confidence in the incident reporting process.
- Heads of departments investigated incidents with oversight and support from the Quality and Risk Manager. We saw clinical incidents were a standard agenda item at the Hospital Clinical Governance Committee, Hospital Health and Safety Committee, MAC, and Head of Departments meetings. Staff told us the relevant ward or theatre manager fed back to the team with learning from incidents at monthly ward or theatre team meetings. Learning was also shared via hospital bulletins. We saw copies of the theatre team meeting minutes, which showed feedback and lessons learned from incidents were discussed.
- Staff we spoke with were aware of the duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. 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 them with reasonable support. Staff knew what

duty of candour meant and could describe their responsibilities relating to it and gave examples. We also reviewed a sample of clinical incidents, patient notes and RCA's and saw evidence that staff had applied duty of candour appropriately. For example when a patient suffered a complication after surgery it was documented throughout the patient's notes conversations with the patient's next of kin.

- The hospital did not carry out mortality and morbidity review meetings as a matter of course. This was in part due to the relatively low number of patients treated and the consequent low numbers of patients that would fall into these categories. We saw that all deaths that had occurred were discussed and reviewed at the Hospital Clinical Governance Committee, Hospital Health and Safety Committee, MAC, and Head of Departments meetings.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to hospital inpatients. These include falls, new pressure ulcers, catheter and urinary tract infections (UTIs) and venous thromboembolism (VTE) (blood clots in veins).
- Between April 2015 and March 2016 the hospital reported no incidents of VTE or pulmonary embolism.
- In the same time period the hospital reported no pressure ulcers or UTIs for catheterised inpatients.
- We saw that safety thermometer data was displayed in both ward areas.

Cleanliness, infection control and hygiene

- The hospital reported no infections of MRSA, Clostridium difficile or methicillin sensitive Staphylococcus aureus between April 2015 and March 2016.
- We spoke to a pre-assessment nurse, who told us the hospital swabbed patients at risk of carrying MRSA, for example all NHS patients and patients who have previously had MRSA, at the pre-assessment clinic. Patients who had a telephone pre-assessment were made an appointment to come to the outpatient department to be swabbed.
- The hospital reported three incidents of Escherichia coli (E-Coli) in the same time period; we saw that a full RCA had been completed for each infection.
- The hospital reported three surgical site infections (SSI's) in the same time period. We saw that RCA investigations were undertaken for these three incidents. They were discussed at infection prevention and control (IPC) meetings and findings were shared with staff via departmental meetings.
- We saw copies of the BMI Healthcare group's hand hygiene policy, standard infection control precautions policy, antibiotic guidelines and clinical uniform policy. All these policies were in-date and referred to national guidelines, for example the World Health Organization (WHO) Guidelines on Hand Hygiene in Health Care (2010). These policies were readily available to staff on the hospital's intranet and in resource folders. Infection prevention and control was included in the mandatory training programme.
- We saw staff complying with infection prevention and control policies. For example, we saw nine members of staff wash their hands and 12 member of staff use alcohol gel hand sanitiser in accordance with the WHO "five moments for hand hygiene". We saw hand sanitiser bottles readily available throughout clinical areas in theatres and on the wards.
- All members of staff we saw in clinical areas were bare below the elbows to prevent the spread of infections in accordance with the BMI Healthcare clinical uniform policy and national guidance.
- We saw there was an infection control and prevention lead for the hospital; they were supported by departmental link practitioners. There was a monthly link IPC meeting led by the IPC lead. The meeting minutes demonstrated audit findings were reviewed and current topics relating to IPC were discussed. For example it was identified that bed mattresses were being stored on the floor when not in use, this was discussed and an action plan had been agreed.
- The Hospital Infection Prevention and Control Committee met quarterly and was chaired by the Director of Clinical Services. We saw copies of meeting minutes which demonstrated a variety of IPC topics were discussed, for example Public Health England audit requirements and the RCA of an E-Coli infection. In addition there was a BMI Healthcare Group lead IPC meeting every three months; this discussed any themes relating to IPC issues across the BMI Healthcare Group.
- We saw there was an infection prevention audit report and action plan for 2016 and this was discussed at IPC meetings.

- Equipment was marked with a sticker when it had been cleaned and ready for use and areas we saw were visibly clean.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we witnessed staff using these.
- Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations.
- Domestic staff were employed by BMI Healthcare, we spoke to two members of domestic staff both of whom had worked at the hospital for a number of years and enjoyed their work.
- We saw there was a variety of daily, weekly and monthly cleaning schedules; these were fully completed.
- The domestic supervisor conducted regular audits to ensure the compliance to the cleaning schedules.
- A member of theatre staff told us "high standards of patient care starts with a clean environment". We saw staff cleaning the theatres prior to the start of the operating session.
- Decontamination and sterilisation of instruments was managed in a dedicated facility offsite, the facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, ward and clinics.
- The clinical waste unit was secure and all clinical waste bins we checked were locked.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked 20 sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability.
- We saw posters displayed which outlined what action must be taken if a member of staff sustained a sharp injury; this information was also in departmental resource folders.
- We noticed that sharp safe cannulas (a thin tube inserted into a vein) and sharp safe hypodermic needles (hollow needle) were being used. These devices reduced the risk of a member of staff receiving a sharps injury.
- All taps and showers were tested twice weekly and run for two minutes at their maximum velocity. This was done to prevent legionella bacteria developing.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; local people go into hospitals as part of teams to assess how the environment supports a patient's privacy and dignity, food, cleanliness and general building maintenance.
- In the PLACE audit 2015 BMI Runnymede Hospital scored 99% in relation to cleanliness which is better than the national average of 98%. In relation to general building maintenance of the hospital BMI Runnymede Hospital scored 93% which is better than the national average of 92%.
- Hand hygiene audits in March 2016 showed 64% compliance in theatres and 90% compliance on the wards, this is worse than the hospital target of 100%.
- We saw a company representative was not permitted into theatres during our inspection because they were wearing false nails and jewellery which was against the provider's clinical uniform policy.

However:

- We observed an operation in theatres where staff placed surgical instruments outside of the laminar flow (clear air) area. This may have compromised sterility and increased the risk of infection to the patient.
- We observed staff wearing theatre 'scrubs' outside of the theatre environment. This is against the Association for Perioperative Practice (AfPP) 2011 publication which stated "theatre attire should not be worn outside the clinical area or public areas."
- We asked the theatre manager if staff were allowed to wear 'scrubs' outside of the theatre environment, they stated it was permitted, but staff were not allowed to wear them whilst eating in the canteen. We reviewed the BMI Healthcare group's clinical uniform policy which stated "Ideally staff should change into outdoor clothing before leaving the theatre environment."

Environment and equipment

- We checked 29 items on the adult emergency trolley and 40 items on the paediatric trolley in theatres and all were in date. We checked the emergency trolleys on both wards and all items were in date and ready for use.
- We saw in theatres and the wards staff had fully completed the trolley checklist throughout June and July 2016 to provide evidence they had checked emergency equipment. We saw on the staff allocation

board the member of staff responsible for checking the emergency trolley was highlighted by an asterisk. In theatres it was part of the daily check list to complete the emergency trolley.

- In theatres, we checked the anaesthetic machine logbooks for the anaesthetic machines. We saw staff had fully completed both logbooks with evidence of daily pre-use checks in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. This provided assurance that the anaesthetic machines worked safely.
- In the theatre recovery area, we checked 12 items on the difficult airway trolley. All 12 items were in-date. We saw there was a checklist to provide assurance of regular safety checks. The AAGBI guidelines, "checking anaesthetic equipment" (2012) stated, "equipment for the management of the anticipated or unexpected difficult airway must be available and checked regularly". Staff told us that the trolley's contents and layout had been designed to mimic the trolley that anaesthetists are familiar with in the NHS hospital.
- In theatres we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients' operations. This was in line with the Association for Perioperative Practice (AfPP) guidelines.
- We saw that portable appliance testing (PAT) labels were attached to electrical items showing that it had been inspected and was safe to use, however on some equipment it was difficult to locate the relevant sticker as there was more than one sticker type. We checked 45 electrical items and we could not find evidence of an electrical safety check on nine pieces of equipment.
- We checked 50 consumable items and five items (gloves) had expired.
- The hospital had an outside medical gas cylinder storage which was compliant with: The Department of Health (DOH) The Health Technical Memorandum (HTM) 02-01 Part A guideline stated medical gas cylinders should be kept in a purpose built cylinder store that should allow the cylinders to be kept dry, clean condition and secure enough to prevent theft and misuse.
- We inspected the gas manifold room that housed the piped medical gas supply. The room was located at the back of the building. Appropriate signage was in place to notify people what was contained within. The room itself was locked and this prevented any potential sabotage to the supply of medical gases.
- We saw that there was an adequate number of portable oxygen cylinders; we checked 16 cylinders which were in date and labelled.
- Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut.
- There was a hospital generator that was tested monthly; this ensures there was a backup supply of electricity if the main electricity supply failed.
- The staff we spoke with confirmed they had access to the equipment they required to meet peoples' care needs.
- We saw there was a full range of paediatric equipment available; however there was only one defibrillator in theatres. Staff explained that a porter would bring another defibrillator to the cardiac arrest as standard procedure. This meant the hospital had put a process in place to mitigate the risk. We saw it was clearly labelled on the paediatric emergency trolley that this was the process.
- Theatres used a smoke extraction system for all major surgical cases, in accordance with Health and Safety Executive Evidence which prevents exposure and harmful effects of diathermy plumes (surgical smoke) to staff (RR922) (2012) guidelines.
- We saw Health and Safety Control of Substances Hazardous to Health substances were stored in line with Health and Safety Executive guideline SR24.
- There were two collections and deliveries of instruments a day in theatres and an instrumentation coordinator who ensured relevant equipment was available.
- We saw there was a corporate five year equipment replacement programme .There were medical device leads in each department who had additional responsibilities. For example the lead in theatre was in the process of compiling an accurate equipment database which evidenced when equipment was last serviced.
- Staff told us that Runnymede hospital employed engineers who repaired and maintained some equipment but the majority of medical equipment was serviced and maintained by an external contractor.

Medicines

Surgery

- The hospital did not have their own pharmacy on site, they had a service level agreement (SLA) with the local NHS hospital, which supplied all medications and advised regarding pharmacy matters.
- We saw on the wards medicines were stored safely and securely in line with relevant legislation for the safe storage of medicines.
- We checked the controlled drugs (CD) cupboard on both wards. Controlled drugs are medicines liable for misuse that required special management. We saw the CD cupboard was locked, and only authorised staff with a key could access CDs. We checked the stock levels of two CDs. We saw the correct quantities in stock according to the stock list, and that all were in-date.
- We checked temperature monitoring charts for the drug fridges in anaesthetic room one, theatre two and recovery. The records showed staff had monitored the temperature of both fridges daily in the last month. This provided assurances the theatre team stored refrigerated drugs within the correct temperature range to maintain their function and safety.
- We saw the temperature of the drugs fridge on Wentworth ward was within the expected range. We asked two members of staff, and both knew the safe temperature ranges for the fridge and at what temperatures they should take action.
- We saw the temperature monitoring checklist showed staff had recorded the fridge temperature. There was a checklist for monitoring the ambient temperature of the medicines storage room. This was to ensure that drugs stored at room temperature remained within the manufacturer's indicated temperature range.
- We reviewed nine prescription charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on the chart and on their identity band which alerted staff to their allergy. The nine charts we reviewed demonstrated that prescribing was in line with national guidance and that all were compliant with the National Institute for Health and Care Excellence (NICE) VTE guidance. A section in the front of this chart confirmed a completed VTE assessment had taken place and that prophylaxis had been prescribed and administered. Staff recorded patient allergies on the patient's prescription chart.
- On Wentworth ward, there were accurate records of the quantity of private prescriptions in stock. This reduced the risk for blank prescriptions to go missing un-noticed. This was in line with guidance from NHS Protect which stated, "Prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded".
- Staff told us that if they needed advice regarding a medication they would either ring the pharmacy department at the NHS hospital or they would access the British National Formulary (BNF). We saw paper copies of BNF's contact details and instructions on how to access it on line.

However:

- We checked the CD book in theatre one, there were multiple occasions when only one signature was recorded, and instead of another signature 'surgery' had been written. We asked staff about this and they explained this occurred when CD's were given to the surgeon for use during surgery; however, the surgeon had not signed to confirm administration of the drug. This was against hospital policy and Misuse of Drugs Regulations 2001 and Safer Management of Controlled Drugs: a guide to good practice in secondary care (England).
- We checked the CD book in theatre two and recovery; we saw incomplete records of the CD's. This was because staff blanket-signed for the drugs rather than signing individually at each stage of the dispensary process. However, the daily checking process of CDs in theatres was otherwise robust.
- We saw in theatres that there was a mixture of two different batch numbers in a box; this was against the BMI Healthcare Safe Management of Medicines policy which stated "the transfer of medicines from one container to another will not occur."
- Staff told us that some surgeons used a mixture containing local anaesthetics and other pain killers. These mixed together in a sterile jug for injection at the end of hip and knee replacements. As a result of this practice patients were given medicines outside the terms of their licence. BMI had a policy and system to gain approval for medicines used outside the terms of their licence (BMI Healthcare Unlicensed Medicines, Medicines Out of Licence Policy) which we saw. We asked the provider to supply us with documents required by their policy supporting the use of this drug mixture but were not supplied with these. The policy required a register of approved and risk assessed

unlicensed medicines and the use of medicines outside of their product licence to be maintained. We requested, but were not supplied, with a copy of this register which contained this drug mixture.

- The policy also required prescribers to ensure patients were provided with accurate and clear information that meets their needs, including information on side effects when medicines were used outside of their licence. We did not see any evidence that supported compliance with this aspect of the policy. This meant the hospital were not compliant with their own policy.
- Mixing of medicines in this way was recognised by the BMI policy as increasing the risk of infection. The National Patient Safety Alert (NPSA) NHS/PSA/W/2015/005 Stage One: Warning Risk of death or severe harm due to inadvertent injection of skin preparation solution reinforces the alert that was issued in England in 2007. This alert stipulated that injections must be drawn up from the source bottle or ampoule directly into syringes that are labelled and checked prior to administration and that 'open systems' should never be used to contain medication prior to injection. The process staff described in the preparation of this mixture did not comply with this guidance. This meant patients were at increased risk of infection.

Records

- We saw there was BMI Healthcare Group Policy for the retention of records which was in date.
- Staff adhered to this policy, for example, staff stored notes securely in the nurses' office to prevent unauthorised access to confidential patient data.
- Patients' records were kept on site, during our inspection we requested several patients' records and these were obtained quickly.
- We examined 11 sets of patients' records; there was a good standard of documentation in all areas. For example, patients had care plans which identified all their care needs which were fully completed.
- We saw some patients followed standardised pathways, such as a total hip replacement pathway. This was personalised through individual risk assessments and notes made in the care plans. We saw thorough evidence of pre-assessment in all three sets of notes.
- We saw there was a BMI Healthcare nursing pre-operative assessment policy which referenced good practice guidance from NICE (National Institute for Health and Clinical Excellence).
- A nurse in pre assessment showed a pre assessment questionnaire; this was a paper based assessment completed by the patient to determine their suitability for their recommended procedure.
- We saw there was a variety of risk assessments used, for example infection control risk assessments and patient pressure area assessments.

Safeguarding

- There was a BMI Healthcare Group Safeguarding Children policy and a Safeguarding Adults policy.
- The Director of Clinical Services was safeguarding lead for children and adults but supported on children by the Children's Services Clinical Lead.
- One hundred percent of theatre and pre-admission staff had completed either level one or level two safeguarding vulnerable adults and safeguarding children training. This was better than the BMI Healthcare target of 90%.
- One hundred percent of ward staff had completed either level one or level two safeguarding children training. This was better than the BMI Healthcare target of 90%. One hundred percent of ward staff had completed level two safeguarding vulnerable adults training and 96.3% of ward staff had completed level one safeguarding vulnerable adults training. This was better than the BMI Healthcare target of 90%.The level of training undertaken was dependent on the staff member's job role and level of exposure to adults and children.
- Posters displayed 'What to do if you're worried about an adult's welfare'; these showed flowcharts on action to be taken and included contact details of who could be contacted for advice. This served to remind staff of the correct reporting processes.
- The Director of Clinical Services is the hospital's adult and children safeguarding lead and had overall responsibility for safeguarding within the hospital.
- Staff we spoke with could identify the safeguarding leads and described how to report safeguarding concerns.
- All consultant surgeons and anaesthetists who treat children and young people had undergone level three safeguarding training as part of their mandatory training in their NHS hospital.
- All contracted paediatric nurses were trained to safeguarding level three. Paediatric nurses who were supplied by an external agency were also level three trained.

Surgery

Mandatory training

- Overall mandatory training rates for theatre staff was 95.2% and for pre- admission staff was 98.7%; both rates were better than the BMI Healthcare target of 90%.Overall mandatory training rates for ward staff was 89.1% which was worse than the BMI Healthcare target of 90%.
- There were 15 mandatory training courses for surgical staff. This was a combination of online and classroom-based training. Staff completed the appropriate number and type of courses from this list relevant to their role. This was monitored through the staff member's appraisals and in addition managers received notification when a staff member's mandatory training had lapsed.

Assessing and responding to patient risk

- The hospital used the National Early Warning System (NEWS) track and trigger flow charts. NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. We reviewed four patients' NEWS charts. Staff had completed all four accurately and fully. We saw evidence of increased monitoring and intervention when clinically indicated in line with national guidance.
- An audit undertaken by the hospital in March 2016 showed that out of 20 patients 73% of all patients were being monitored on NEWS and 73% of patients were accurately scored and had evidence of appropriate and timely intervention. This meant that 27% of patients were at risk of deteriorating because of a lack of monitoring using NEWS.
- A Paediatric Early Warning System (PEWS) was used to identify deteriorating patients. We saw observations were recorded and calculated accurately in all three sets of paediatric care records we reviewed.
- The hospital had a service-level agreement with a local NHS hospital which was attached to Runnymede hospital. This enabled them to transfer any patients who became unwell after surgery and needed critical care support. We saw evidence of agreed Standards for the Transfer of Critically ill Patients. We also saw the BMI Healthcare group policy used by the hospital for the emergency transfer of patients to specialist units outside of BMI Healthcare.
- There was a transfer agreement with the local NHS hospital for the transfer of children if required. The NHS hospital could be accessed by an adjoining corridor from BMI Runnymede. There was also an agreement with the Children's Acute Transfer Service (CATS) for emergency retrieval of critically ill children if required.
- The theatre manager described instances to us when he felt it was not safe with the staffing levels to accept patients who required emergency surgery and were therefore transferred to the local NHS hospital.
- Pre- assessment of patients was undertaken either by telephone or face-to-face by a pre- assessment nurse. The nurse had access to anaesthetists should they have any concerns or questions.
- Pre-assessment of patients for surgery included a thorough assessment of risk. We reviewed two sets of patient notes on Burwood ward, and saw evidence of falls risk assessment, dementia screening, infection prevention and control risk assessment, risk assessment for pressure ulcers and assessment of nutritional status. These assessments were vital to assess a patient's suitability for surgery and to enable staff to make any necessary adjustments to ensure safe care. For example, staff allocated patients with a physical disability to a bedroom with a walk-in shower.
- Children attending for surgery were risk assessed by registered children's nurses, either face to face or on the telephone, before admission. A surgery date was only scheduled once the paediatric team had confirmed a child's suitability for surgery.
- Nursing staff told us medical support was readily available when required as the Resident Medical Officer (RMO) attended to patients quickly. We witnessed a nurse bleeping the RMO for advice regarding a patient who they were concerned about, they responded quickly and gave advice.
- The hospital's RMOs provided medical cover 24 hours a day, seven days a week. This ensured nurses could

always quickly escalate any issues concerning a deteriorating patient. The RMO also informed the patient's consultant in an emergency so that they could provide consultant-level care.

- A RMO told us that there was a robust support process in place should they require support or advice quickly initially via telephone and consultants would attend the hospital if needed.
- We saw all patients had a VTE assessment completed and all patients wore anti-embolic stockings. We saw completed neurovascular assessments and pressure area assessments were completed.
- A recent report on patient transfers to the local NHS hospital showed the hospital had transferred six surgical patients to the local NHS hospital between April 2015 and March 2016.
- We reviewed a sample of the patients' notes relating to the unplanned transfers and given the nature and volume of operation undertaken, all were appropriate and there were no common themes or concerns.
- There were five unplanned returns to the operating theatre for the period April 2015 – March 2016. We undertook a review of a sample of these unplanned returns and all had been treated appropriately.
- Ward nurses staff told us they checked the pregnancy status of female patients of potential childbearing age on the morning of planned surgery by asking them for the date of their last menstrual period (LMP). We saw a space on the hospital's pre-operation checklist to record this. However, guidance from the National Patient Safety Agency in their 2010 Rapid Response Report: Checking pregnancy before surgery highlights "the unreliability of LMP as a sole indicator for potential for pregnancy". Staff told us they did not routinely perform a urine test for pregnancy on all female patients before surgery.
- The hospital consistently met their NHS contracted 95% target screening rate for VTE risk assessment between April 2015 and March 2016.
- We observed theatre staff carrying out the WHO Surgical Safety Checklist for six procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre).We saw staff fully completed all the required checks.
- We reviewed ten completed WHO checklists; of these ten, one was missing the signature of the staff member who carried out the sign out element, one was missing a signature of the recovery practitioner and two were missing the signature of the consultant surgeon. This meant there was no assurance that the safety checks had been completed. Staff told us the practice of the surgeon signing the checklist was still being embedded.
- We observed staff using specific WHO checklists for different procedures, for example for eye surgery. This ensured staff checked the most important safety factors relating to a specific procedure.
- We saw that as a result of a National Patient Safety Alert: NHS/PSA/W/2015/005 Risk of death or severe harm due to inadvertent injection of skin preparation solution, the antiseptic skin preparation had been changed. The hospital was now using pre filled chlorohexidine devices, which minimised the risk of inadvertent injection of skin preparation solution.

Nursing staffing

- The theatre department had 20.5 whole time equivalent (WTE) staff; of these 5.8 WTE were operating department practitioners (ODP's) and Health Care Assistants (HCA's) and the remaining 14.7 WTE were qualified nurses.
- The theatre department had the full establishment of care assistants, nurses and operating department practitioners, with no staff vacancies in these areas.
- On the day of our visit, we saw staffing levels met the AfPP guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list.
- However, theatre staff told us staffing levels in theatres sometimes fell below AfPP guidelines, this usually occurred when there was a significant number of staff on sick leave or annual leave. We asked the theatre manager how often staffing fell below AfPP guidelines; they did not have the information available.

Surgery

- The theatre manager risk assessed all operating lists where this happened and told us if the outcome of risk assessment indicated it was unsafe to continue, managers would cancel the operating list.
- There was low use of bank and agency theatre nurses, ODP's and HCA's between April 2015 and March 2016, when compared to other independent acute hospitals that the provider benchmarked against. The highest (20%) use of theatre agency or bank staff was in October 2015 and was for ODP's or HCA's. The lowest (0%) use of theatre agency or bank staff was for three months during the same time period and was for ODP's and HCA's.
- The two surgical wards had 24.9 WTE staff; of these 8.8 WTE were HCA's and the remaining 16.1 WTE were nurses.
- There were two WTE posts vacant for inpatient nurses giving a vacancy rate of 11%. This rate was higher than other independent acute hospitals that the provider benchmarked against. Hospital managers told us that whilst recruitment had significantly improved, Runnymede hospital was located in a very competitive area for staffing which made recruitment of new team members difficult.
- There was variable use of bank and agency staff for inpatient nurses between April 2015 and March 2016, however, they were generally higher when compared to other independent acute hospitals that the provider benchmarked against. The highest (26%) rate of bank and agency staff use for inpatient nurses was in July 2015 and the lowest (12%) was in February 2016.
- There was low use of bank and agency staff for inpatient health care assistants when compared to other independent acute hospitals that the provider benchmarked against.
- There were two registered children's nurses who worked on the wards, theatre and recovery. The children's lead nurse told us that they worked between two sites; at the BMI Runnymede and another local BMI hospital approximately 12 miles apart in distance. The children's lead nurse had been in post for 19 months and the registered children's nurse had been in post for three months
- There were three daily nursing handovers, one at the beginning of the day, one at lunchtime and the other towards the end of the day. We attended a handover which was informative and included management plans for patients, upcoming consultant reviews, physiotherapy requirements and any safety issues. For example at the handover we attended it was highlighted that there were two patients on the ward with the same surname, the patients had been placed at opposite sides of the ward to try and reduce any risk.
- The hospital used the BMI staff planning tool. The planning tool calculated the nursing hours and skill mix needed for the planned patient numbers and acuity levels. The hospital told us they used the tool to plan the appropriate number of hours and skill mix needed to meet demand five days in advance, with continuous review on a daily basis. The hospital told us they also entered the actual hours staff worked retrospectively to understand any variances from the planned hours and the reasons for these.
- The Royal College of Nursing (RCN) recommends a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients; surgical services were compliant with this. We saw on the ward the nurse to patient ratios varied between 1:5 and 1:6, this was above the RCN recommendations.
- The hospital told us there was a nominated manager on call each day, we saw this displayed in the reception area of the hospital. During the night, the hospital had an on-call senior nurse rota to ensure the same level of service and to accept out of hours admissions.
- We saw that the daily actual versus planned staffing levels were displayed on the 'ward boards.'

Surgical staffing

- There were 168 consultants who had practising privileges at the hospital; 48% had not undertaken work at the hospital between April 2015 and March 2016. Practising privileges is a term which means consultants have been granted the right to practise in an independent hospital.
- Eighteen consultants had their practicing privileges removed in the same time period, the most common reason being due to retirement.
- Twenty five consultants had their practicing privileges suspended during the same time period, the most common reason (44%) were suspended due to non-compliance with paperwork but were reinstated when this was received.
- The hospital used an international agency to provide 24-hour, seven days a week Resident Medical Officer

(RMO) cover on a rotational basis. This ensured a doctor was on-site at all times of the day and night should an emergency arise. The RMO we spoke with worked a shift pattern of two weeks on followed by two weeks off.

- The RMO conducted regular ward rounds to ensure patients were safe. We saw the RMO providing medical cover on Burwood Ward. The RMO reported any changes in a patient's condition to their consultant and followed the consultant's advice regarding further treatment.
- The RMO told us the consultants were approachable, reacted quickly in emergencies and were easily contactable. The nurses and the RMO told us that consultant lead care was available out of hours and at weekends.
- All consultant surgeons, as a requirement of their practising privileges, were required to be available and remain within a thirty minute radius of the hospital for the duration of their patient stay or to arrange suitable cover with another consultant surgeon from the same specialty. The consultants had direct access to the ward by telephone. Surgeons were expected to visit their patients daily until the patient has met their discharge criteria or to arrange cover.
- The anaesthetist was also required to be available for the duration of the patient's stay in hospital. This ensured availability of anaesthetic cover should a return to surgery become necessary or if advice was required regarding pain relief. Staff told us anaesthetists were contactable and approachable when needed.
- Staff told us RMOs carried out a formal handover. However, we did not see this as there was no change over during our visit.

Major incident awareness and training

- The hospital provided scenario-based training exercises which included five paediatric and five adult resuscitation exercises a year. In addition we heard within the last 12 months a simulation fire evacuation exercise was undertaken in theatres.
- We saw the hospital's business continuity policy. The policy was in-date and produced with reference to the NHS England Core Standards for Emergency Preparedness, Resilience and Response (May 2015) and ISO 22301 Business Continuity Management Systems Requirements. The policy set out clear roles and responsibilities to ensure service continuity in the event of a business continuity incident.
- The hospital also had emergency policy including any major incidents occurring at the NHS hospital attached to Runnymede Hospital.
- We saw a paper copy of each policy was within a resource folder in each ward and department ensuring easy access to all staff in needed.
- The hospital had a back-up generator to ensure services could continue in the event of a disruption to the main power supply. Maintenance staff told us the generator was checked on a monthly basis, generator testing provided the hospital with assurance that the generator would provide back-up power and enable services to continue in the event of a power failure.

Are surgery services effective?

Good

We rated effective as good because:

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored and benchmarked to ensure consistency of practice.
- Patients had comprehensive assessments of their needs and their care and treatment was regularly reviewed and updated.
- The hospital participated in relevant local and national audits and contributed to national data to monitor performance such as the national joint registry.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were also supported to maintain and further develop their professional skills and experience; we saw staff in theatres were undergoing training to become first assistants.
- Staff obtained and recorded consent in line with relevant guidance and legislation.

Evidence-based care and treatment

- We observed how patient care and treatment reflected current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines.

- In theatres, and in the patient notes, we saw evidence of the hospital providing surgery in line local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine.
- In theatres we saw a patient's temperature was measured and documented before induction of anaesthesia and then every 30 minutes until the end of surgery. This adheres to: Hypothermia: prevention and management in adults having surgery NICE guidelines [CG65].
- We reviewed four patient records which all showed evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient's health post-surgery. Staff had completed all four observation charts in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.
- There were specialist clinical pathways and protocols for the care of patients undergoing different surgical procedures. For example the hip and knee replacement pathway, these were designed to specifically assess risks associated with these procedures. This demonstrated best practice and adherence to NICE guidelines.
- The hospital was meant to perform World Health Organization (WHO) checklist audits. This included one observational audit and one documentation audit a week, measuring 18 different indicators. The purpose of this is to check staff compliance with the WHO Surgical Safety Checklist. However, the theatre manager responsible for undertaking these audits told us they were not consistently undertaken. We asked the theatre manager why they were not undertaken and they said it was due to a lack of prioritisation. This meant there were not adequate assurances that the WHO checklist was undertaken consistently and in line with national guidance.
- The hospital provided data which demonstrated non-compliance with the WHO audit between July 2015 and December 2015. This meant the hospital could not be assured staff were performing the WHO checklist in a standardised and safe manner.
- The hospital provided data to the National Joint Registry (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 told us they had positive relationships with the local NHS Trust and Clinical Commissioning Group (CCG) and were fully committed to driving improvement through the Standard Acute Contract and Commissioning for Quality and Innovation (CQUIN's) on an annually basis, these were reviewed and updated quarterly.

Pain relief

- The pre assessment lead told us that patients were counselled on pain management and that the anaesthetist would discuss pain relief methods prior to surgery.
- The recovery staff told us that some staff had undertaken specialist study days in order to have a better knowledge of pain management, and they acted as a resource for other staff.
- There was no dedicated pain team at the hospital. However, consultant anaesthetists with an interest in pain relief gave advice on pain management.
- We spoke to two patients who had recently undergone surgery. Both told us their pain was well controlled and said nurses responded quickly when they requested additional pain relief.
- Nurses on Burwood ward asked patients whether they had any pain as part of their hourly ward rounds. We reviewed four sets of patient notes, which showed evidence of pain assessment as part of hourly ward rounds.
- We saw potent pain relief was prescribed for the immediate post-operative period when the patient was in recovery. This meant if a patient woke up from the anaesthetic and experienced pain it could be administered to the patient quickly rather than it having to be prescribed.
- We observed pain relief administration in recovery which included a reassessment of pain to monitor if the pain relief had been effective.
- We saw the use of a pain assessment tool and analgesia ladder in four sets of patient notes we reviewed. Staff

asked patients to rate their pain between one and 10, one meaning no pain and 10 being extreme pain. The analgesia ladder set out guidelines for the management of pain.

- We observed pain assessment tools used for children to communicate pain thresholds. Staff recorded pain scores in patients' care records; all care records we looked at showed pain scores with management plans if the patient was in pain. Children selected the tool they wished to use to communicate pain thresholds, for example, a child could point at a scale line from 0-10, ten being the most painful, or they could use 'smiley faces', where the child chose a face that best described their own pain level.

Nutrition and hydration

- The hospital used the Malnutrition Universal Screening Tool (MUST) as part of pre-assessment screening. The MUST tool enabled staff to identify patients at risk of malnutrition and make adjustments to mitigate any risk where appropriate. We reviewed three sets of patients notes, which all provided evidence of MUST assessment.
- All three notes also included a "dietary requirements record" completed as part of pre-assessment. This allowed staff to identify any special dietary requirements, such as gluten intolerance, before admission so they could advise the catering staff to prepare a suitable meal for the patient.
- We reviewed the notes of a patient who was unable to take food by mouth due to the operation undertaken and needed nutritional support via a feeding tube. We saw that a dietician from the local NHS trust had been involved in the patient's care which meant the patient had specialist nutritional support. In addition we saw the dietician had given training to the patient about their feeding tube and what action to take if they experienced a problem after discharge.
- An external contractor provided a range of pre-packed meals for the hospital; we spoke to the catering manager and the operations manager. They explained that they had a daily meeting to discuss specialist dietary requirements of the patients to be admitted the following day.
- Gluten free products were readily available in the hospital and different varieties of milk.
- The menu followed a four week rotation, however if a patient was admitted for longer than four days they could have a home comfort diet. The home comfort diet offered additional food options.
- The external contractor had a dietician who could be contacted for support and advice.
- There was a nutritional breakdown of each meal which meant staff and patients knew exactly the content and nutritional value of each meal.
- Puree and mashed food diets were available on request and specialist high calorie drinks were also available if needed.
- We reviewed patient menus and saw a balanced variety of choices. This included options for vegetarians.
- Patients told us nurses offered them drinks as part of their hourly ward rounds. We also saw patients had access to a water jug at their bedside to enable them to stay hydrated.
- Patients generally gave us positive feedback regarding the food, although some patients commented the choice was limited if admitted for a significant time.
- Families were welcome to bring in particular food for their child, if they wanted and there was a specific children's menu. Parents were provided meals when they accompanied their child. Parents commented that there was an excellent choice of food for children and children were encouraged to choose what they wanted to eat.
- The hospital scored 89% in the 2015 Patient-led assessments of the care environment (PLACE) audit for overall food which was worse than the national average of 93. In the same audit the hospital scored 79% for organisational food which was worse than the national average of 92% and 98% for ward food which was better than the national average of 94%.

Patient outcomes

- There were eight cases of unplanned readmission within 28 days of discharge between April 2015 and March 2016.
- The assessed rate of unplanned readmissions (per 100 day case and inpatient attendances) was not high when compared to a group of independent acute hospitals that the provider holds data for.
- The hospital reported five unplanned returns to theatre between April 2015 and March 2016, three were in July 2015 and two were in October 2015.

- We reviewed the incident forms for the unplanned returns to theatre. In the majority of cases post-operative complications was the reason for further surgery, although we saw there were no common themes. In all cases, we saw evidence staff treated patients with post-operative complications appropriately.
- The hospital provided data to national Patient Reportable Outcomes Measures (PROMS). PROMS uses patient questionnaires to assess the quality of care and outcome measures following surgery.
- The hospital provided PROMS data from two areas: hip replacements (Oxford Hip Score), and knee replacements. PROMS data was only collected and submitted for NHS patients.
- The provider does not have enough data available to calculate many elements of the PROMS scores. However the limited data demonstrated the hospital's adjusted average health gain for PROMS for Primary Knee Replacement was within the England average.
- The hospital told us it compared patient outcome data with all hospitals across BMI Healthcare group using the corporate clinical dashboard. BMI Healthcare also contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS.
- Results on patient outcomes were compared with other BMI healthcare hospitals within the region and across regions across BMI Healthcare through the corporate clinical dashboard which used data from their incident and risk reporting database (Sentinel). This allowed the hospital to review their data and compare this with hospitals of a similar size within BMI Healthcare.

Competent staff

- We saw a comprehensive introductory check sheet in use on the wards and in theatres to demonstrate the competency of new agency staff.
- We saw that all staff had a competency folder containing evidence of continuing professional development (CPD), such as certificates for study days attended. These showed that staff kept their knowledge current through continuous learning. This is required to maintain professional registration with the Health and Care Professions Council or the Nursing and Midwifery Council.
- The hospital reported all registered nurses working in inpatient departments had validation of professional registration.
- We saw competency records for a member of staff undergoing surgical first assistant training who was awaiting final sign off of her paperwork.
- Several members of staff were undergoing the surgical first assistant training. Currently first assistants were provided via a mixture of agency staff and surgeons providing their own. We asked the theatre manager if they held records of the first assistants, such as evidence of The Disclosure and Barring Service (DBS), indemnity insurance and evidence of training and qualification. The theatre manager said they did not keep DBS records for first assistants who accompanied surgeons but did hold records of indemnity insurance and evidence of training and qualification. Seventy eight percent of nurses working on the wards, 70% of health care assistants (HCA's) on the wards and 55% of other staff had undergone an appraisal in 2016. This is an improvement from 2015 when 28% of inpatient nurses, 0% of inpatient HCA's and 25% of other staff had an appraisal.
- In the theatre department only 11% of nurses and 0% of HCA's and operating department practitioners (ODP's) had an appraisal in 2016.This was better than 2015 when 5% of nurses and 0% of HCA's and ODP's had an appraisal. Lack of appraisals for staff may have meant the service did not address any potential staff performance issues.
- Data supplied by the hospital stated a consultant wishing to apply for practicing privileges is required to have held or hold a substantive NHS consultant post in the last five years or can demonstrate experience of independent practice over a sustained period applicable to working in the independent sector, and who can demonstrate a support network to provide safe cover and care for the patients. A CV together with detailed application form was reviewed by the Executive Director. An informal meeting between the Consultant and the Executive Director was arranged. Should the application be progressed, the Consultant forwarded all professional registration documents, references and memberships to be reviewed by the Medical Advisory Committee (MAC) who meet on a quarterly basis to review all new applicants, suspensions and removals.

- For practising privileges to be granted, the applicant must be licensed and on the specialist General Medical Council (GMC) register. The applicant was asked to demonstrate relevant clinical experience relating to practice.
- The MAC reviewed the application with respect to the credentials, qualifications, experience, competence, judgement, professional capabilities, knowledge, current fitness to practice, character of and confidence held on the applicant. Recommendations were formulated and passed to the Executive Director prior to the application being granted.
- If the MAC granted practicing privileges, an information pack was sent to the consultant including an offer letter to be signed accepting the terms, conditions and policies. An orientation was offered to meet with relevant heads of departments.
- Periodically, the hospital reviewed consultants' performance to ensure they are compliant with and have provided documentation in line with the practising privileges' policy using the Consultant Database (CRDB). Written reminders were sent prior to expiry as reminders. We saw examples where failure to provide up to date documentation resulted in suspension and ultimately withdrawal of practising privileges.
- The hospital provided data which demonstrated that 22 doctors had their practising privileges suspended in the previous 12 months because of non-compliance with paperwork.
- The agency provided Resident Medical Officers (RMO's) with up-to-date advanced life support training (ALS). We spoke to an RMO who confirmed they had ALS training every four years. This was in line with current guidance from the Resuscitation Council (UK).
- In addition RMO's were required to undertake the BMI Healthcare RMO induction programme.
- The hospital had verification of registration status for 100% doctors and dentists working under practicing privileges who had worked at the hospital for more than six months.
- Staff were supported to develop competencies through the use of study days. For example, two theatre staff successfully completed the Advanced Life Support (ALS) course. We saw this in the June 2016 team brief notes.
- The Runnymede hospital adhered to the BMI Resuscitation Policy for Children, which required the lead Children's Nurse and RMO to be emergency paediatric life support (EPLS) trained. All children's nurses, bleep holders, anaesthetic and recovery staff were paediatric life support (PILS) trained.
- There was always an RMO who is an EPLS provider on-site and the Children's Lead Nurse was also qualified as an EPLS provider.
- The Runnymede hospital had a service level agreement with the adjoined NHS hospital which provided an emergency resuscitation team to attend any emergency. All paediatricians, consultants and anaesthetists responsible for children and young persons had current paediatric resuscitation training, depending on their category of work.
- Anaesthetists and paediatricians were required to hold advanced level of paediatric resuscitation training.

Multidisciplinary working (in relation to this core service only)

- We saw copies of the pre-assessment questionnaire patients completed before coming to pre-assessment clinic. This questionnaire had recently been re-designed by the lead pre assessment nurse, with input from other disciplines in order to plan admission and discharge cohesively. We saw this included care planning with input from the multidisciplinary team.
- It included how appropriate the patient's accommodation was in regards to their discharge needs, for example did it have stairs. This information meant resources required for discharge could be obtained in advance.
- The hospital liaised with district nurses to arrange ongoing care for patients post-discharge where appropriate. For example we saw in one patient's notes information regarding feeding requirements had been faxed to the district nurse.
- We observed a nurse on Burwood ward discharge a patient. We saw the nurse give the patient a discharge pack. This included detail of ongoing care the surgery team had arranged, for example, outpatient follow-up appointments. This allowed the patient to leave the hospital fully informed about ongoing care.
- The multidisciplinary theatre team met bi-monthly, and we saw minutes from the last two meetings.
- Heads of departments (HOD's) met monthly and we saw minutes from the last four meetings.
- We attended a daily communication meeting "HOD huddle" this was a documented meeting which a

representative from each department attended. It discussed a variety of issues for example, infection control issues, expected visitors to the hospital, equipment requirements and any staffing issues. This meeting meant all departments had the opportunity to come together to discuss and resolve problems.

- We saw good multidisciplinary working between consultants, anaesthetists, nurses and ODPs and porters within theatres. We observed effective multi-disciplinary working between the RMO and nurses on Burwood ward.
- We saw nurses on the ward undertook ward rounds with a physiotherapist on a daily basis; this provided an update of the patients' progress and set future goals.
- There was a consultant paediatrician who represented children and young people on the medical advisory committee who supported and advised on paediatric matters.

Seven-day services

- Physiotherapy services were available between 8am-5pm on Saturday and Sundays, an on call physiotherapist was available after 5pm on weekdays and weekends.
- RMO services were provided by an agency as a 24-hour seven days a week service on a rotational basis.
- There was always a senior nurse available at the hospital as a contact point for both staff and patients, including help to resolve patient queries and to accept out of hours admissions.
- It was a requirement of BMI Healthcare's practising privileges policy that consultants remain available at all times when they have inpatients in the hospital (both by phone and, if required, in person) or arrange appropriate alternative named cover if they will be unavailable.
- In addition to clinical and consultant arrangements, the senior management team operated a rota for on-call support out of hours.
- There was also an on - call rota operated by the radiology should support be required out of hours, as well as an on-call emergency theatre team and on-call rota for consultant anaesthetists.
- There was a service level agreement (SLA) in place with the local NHS trust for specialist advice regarding deteriorating patients such as intensivist, microbiologist, cardiologist and pharmacy.

Access to information

- We saw a resource folder in each in each department which contained useful information for staff for example policies and useful contact numbers.
- The hospital held patient notes on-site. As well as keeping confidential patient data safe, this ensured timely access to information needed for patient care. We requested some patient notes during the inspection; these were found by staff efficiently and quickly.
- All protocols we saw were in-date, for example we reviewed the BMI Healthcare document: 'Clinical Services Policies and Procedures: Policy statement '(2015).This document set out all clinical care must be underpinned by best practice and, where possible evidence based practice. Its purpose is to ensure that all clinical practitioners were aware of where to locate the most up to date standard operating procedures (SOPs), and policies and procedures that underpin clinical practice.
- We saw RMO's were also issued with a RMO clinical handbook; this contained relevant information for example the correct format for writing medical notes and reporting to consultants.
- Patients were given two copies of their discharge summary on discharge one copy was for the patient and the other copy was for the patient to take to their GP. This meant the GP got a copy quickly, in addition the hospital also sent a copy to the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 10 consent forms for surgery. Patients and staff had fully completed, signed and dated the consents to ensure they were valid.
- The consent forms did not contain any abbreviations that a patient may not have understood. One of the consent forms included percentage rates of different complications relating to the patient's procedure. This showed staff had fully informed patients of the possible risks and obtained informed consent.
- We reviewed three paediatric consent forms which were fully completed and signed. They also documented the benefits and risks of the procedure and explained them to children's parents. We observed staff who provided information to the child in a way they could understand. Parents commented that explanation was given to their children in an age appropriate way.

Surgery

- We saw a copy of the hospital's 'Consent form four- statement of healthcare professional for adults who are unable to consent to investigation or treatment.' This documented the best interests' decision-making of staff for patients who lacked capacity in accordance with the Mental Capacity Act 2005.
- We did not see a completed '"Consent form four' which is used when a patient has been assessed as not having capacity to consent for a procedure or operation. However a member of staff described a recent occasion when one had been used for a patient who had undergone a mental capacity assessment (MCA) which concluded the patient did not have capacity to consent for themselves.
- Staff we spoke to were aware of DoLS, however staff on the ward told us they had never needed to apply it. They were able to describe the process of applying for a standard authorisation from the local authority. A standard authorisation gave permission for hospital staff to restrict a patient's liberty who lacked mental capacity when this was necessary and proportionate to keep the patient safe from avoidable harm.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback we received from patients and people, those who are close to them and stakeholders was positive.
- Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff are positive.
- Staff anticipated patients' needs and their privacy and confidentiality were respected at all times.
- Patients understood their care, treatment and condition. Patients and staff worked together to plan care and there was shared decision-making about care and treatment.

Compassionate care

- Between October 2015 and March 2015, the friends and family test for NHS patients scored 100% with the exception of January 2016 when the score was not available. This showed that the vast majority of patients would recommend BMI The Runnymede Hospital to their family and friends.
- The response rate for NHS patients was varied in the same time period, with the lowest response rate (12%) in December 2015 and the highest response rate (70%) in March 2016.The response rate was worse than the national average between October 2015 and January 2016.
- There were four items of rated feedback on the NHS Choices website for BMI The Runnymede Hospital between April 2015 and March 2016, three patients were extremely likely to recommend and one patient were extremely unlikely to recommend the hospital.
- There were posters in the two wards displaying comments from patients about their experiences of care.
- We saw that staff always respected patients' privacy and dignity. We saw staff in recovery closing the curtains around patients in recovery to protect their privacy when they needed to check the operation site.
- We saw a male nurse caring for patients in recovery and because a female patient's operation site was in an intimate place, a female nurse checked the site instead. This demonstrated that the patient's dignity was given consideration by the male nurse.
- Parents we spoke with told us they were very happy with the care their child was receiving, saying they "understood everything that was going to happen and couldn't fault anything".
- The parents we spoke with praised staff for the way they communicated with them and how they were always smiling. One parent commented "staff were excellent".
- We received 34 patient comment cards from patients who recently had surgery at the hospital. We reviewed these comment cards and only two had negative comments and these were about organisational issue and not related to the care they received. Positive comments on the cards included: "Fantastic staff, I was treated with dignity, respect and humanity, I would feel confident to recommend them," and "my treatment was first class."
- The hospital scored 82% in relation to treating patients with dignity and respect in the Patient-led assessments of the care environment (PLACE) audit which was worse than the national average of 87%.

- **Understanding and involvement of patients and those close to them**
- Patient comment cards stated "staff answered to your needs and questions" and "they responded to your

needs and care, when they came into the room they were totally focused on my care, it was like I was the only person important to them at that time also, they made my husband feel comfortable and managed to work around him."

- These comments reflected patient centred care and involvement of those close to them.
- We spoke to three patients, who all told us they had been kept well informed at every stage of their care.
- The patients we spoke to all knew the name of the nurse looking after them.
- The service involved patients' relatives and people close to them in their care. We saw a patient's relative stay with them for the majority of the day and we saw staff involved them in the patients care, for example describing the checks undertaken before the start of a blood transfusion.
- We observed staff providing patient's visitors with hot and cold drinks.
- In most cases, the hospital provided self-paying patients with a fixed price treatment package. This ensured patients had peace of mind and would not have unexpected costs to their bill.
- Written information given to self-paying patients was very clear of the requirement to pay their bill before treatment started.
- One parent told us that they were especially grateful for a twin-bedded room as she was able to take a rest whilst her husband accompanied their child in recovery. Both mum and dad were pleased with overall care received.
- We observed nurses applying topical anaesthetic cream to children prior to cannulation (introduce a cannula or thin tube into a vein) in theatre; it was done in a very gentle reassuring manner.
- Parents were able to escort children to the anaesthetic room to provide support and were able to collect their child from recovery after the operation.
- We saw a hand held computer playing a cartoon was used to distract children in the anaesthetic room.

Emotional support

- We witnessed a patient in theatre undergoing an operation under local anaesthetic which lasted for one hour and ten minutes. During the operation staff kept the patient informed, reassured and had good banter with the patient about which football team they supported.
- We heard at a nursing handover, that a patient was struggling with their newly formed stoma, one of the nurses suggested contacting the stoma nurse specialist to provide support. This showed they cared that the patient was anxious and wanted to provide the appropriate support.
- We saw staff in theatres providing emotional support to patients who were worried or anxious. For example, we saw an anaesthetist holding a patient's hand whilst they were anaesthetised to provide comfort and reassurance.
- We saw staff in recovery asking patients if they were warm enough and offering them sips of water to ensure they were comfortable.
- In recovery we saw a child was spoken to kindly when they awoke from the anaesthetic.
- We saw a consultant came into recovery and spoke to a child appropriately and simply, the child's mother was advised regarding the operation performed. In addition they advised that they would follow up with further explanation at the outpatient appointment.
- The hospital provided counselling services for patients. We saw counselling leaflets and posters around the hospital which contained details of how to book an appointment.
- There was a variety of nurse specialists that could be accessed at the local NHS trust for example a vascular nurse specialist and diabetic nurse specialist.
- All patients received a follow up phone call 48 hours after discharge from one of the nurses to check on their welfare and recovery. This enabled patients to feel supported by staff after they left the hospital.

Are surgery services responsive?

Good

We rated responsive as good because:

- The needs of different patients were taken into account when planning and delivering services (for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation).
- Facilities and premises were appropriate for the services being delivered.

Surgery

- Waiting times, delays and cancellations were minimal and managed appropriately. Services ran on time. Patients and their relatives were kept informed of any disruption to their care or treatment.
- It was easy for people to complain or raise a concern and they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with.
- Complaints and concerns were always taken seriously, responded to in a timely way and listened to.

Service planning and delivery to meet the needs of local people

- We saw there was a responsive service for patients who required urgent admission for surgery, daily 9am head of department meetings took place with all departments represented. This enabled all potential admissions for that day and the next five days ahead, to be discussed and planned for to ensure that the patient could be admitted safely.
- Staff in theatres told us until recently theatre lists often did not end until late at night; this led to tiredness and despondency of the theatre staff. The management team introduced a new five day rule which meant all patients that consultants wanted to admit for surgery within five days had to be agreed to by departments.
- This ensured better planning of the service and enabled staff to be used effectively for example staff in theatres started their shift later to cover evening operating sessions. In addition it enabled pre assessment to be undertaken in a timely way and ensured equipment and bed availability.
- Staff told us since the five day rule had been introduced there had been a significant reduction in the late finish times within theatres.
- Service planning for patients who may require specialist input of higher dependency of care was easier to arrange because of the proximity and links to the adjoining NHS hospital.
- The most common operation (236) performed at the hospital between April 2015 and March 2016 was a multiple arthroscopic operation on the knee (key hole surgery). This type of surgery is easy to plan for as the patients are usually fit and healthy and did not need to stay in overnight, meaning less pressure on the service.
- The theatre manager reviewed operating lists in advance. This ensured there was sufficient time to arrange all necessary staff and equipment.
- The hospital used the BMI Healthcare staff planning tool to plan appropriate staffing ratios based on the planned number of patients.
- We saw that the theatre and ward facilities were appropriate for the services provided.
- The two wards were altered to reflect the needs of the service, for example during our inspection the activity was low so all surgical patients were cared for on Burwood ward. This meant the staff from Wentworth ward went to look after the day case patients on Burwood ward. This saved the expense of having an underutilised ward open and gave staff an opportunity to work together.
- When children were seen in the outpatient department the consultant needed to check with the hospital that there were children's nurses available prior to booking a date for surgery.

Access and flow

- On arrival at the hospital, staff showed surgical patients to Burwood ward if they were staying overnight and either Burwood ward or Wentworth ward if they were having a day case procedure.
- Children were admitted to Wentworth ward, where four twin-bedded rooms were allocated close to the nurses' station for children and young people requiring inpatient or day care surgery. Children followed the same pathway as adults.
- Patients got changed and prepared for surgery in their room. Staff then escorted patients to the theatre suite for their operation. The majority of patients walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for patients in the recovery room.
- Once patients were stable and pain-free, staff took them back to the ward to continue recovering. Patients had a responsible adult to collect, escort and stay with them for 24 hours if they were a day case. Inpatients stayed on the ward for one or more nights after surgery.
- The hospital cancelled 10 procedures between April 2015 and March 2016; of these, seven patients were offered another appointment within 28 days of the cancelled appointment.
- Throughout our visit, theatre lists generally ran on time.
- Referral to treatment waiting times (RTTs) patients having inpatient surgery at the hospital showed that, on average, 95.7% of patients received treatment within 18

weeks of referral between April 2015 and March 2016. This was better than the national target of 90%. The worst month in this period was December 2015 where RTTs were met 80% of the time.
- Theatre staff participated in an on-call rota. Consultants were on-call whenever they had a patient in the hospital. Anaesthetists also participated in an on-call rota. This system ensured staff were available should a patient need to return to theatre at night or at a weekend.
- At discharge, nurses gave patients a direct telephone number to the ward in their discharge pack. Patients could call this number to speak to a nurse anytime of the day or night if they had any concerns. We observed a nurse give this information to a patient at discharge.

Meeting people's individual needs

- Staff told us the hospital could book interpreters for both NHS and private patients. A pre-assessment nurse told us staff identified any language requirements at the pre-assessment stage.
- We saw the department resource folders contained a list of staff who spoke different languages, this meant staff could be accessed quickly if required to interpret for patients.
- Staff told us that patients with learning difficulties or additional needs would also be highlighted at the pre assessment stage. The purpose of this was to alert clinical staff to the patient's individual needs. This allowed staff to plan effectively, for example by arranging theatre lists in a way that lessened anxiety for patients with learning disabilities.
- One hundred percent of theatre and pre admission staff had completed dementia awareness training; this was better than the BMI Healthcare target of 90%.Ninty seven percent of ward staff had undertaken dementia awareness training, This was better than the BMI Healthcare target of 90%.
- We saw from a patient comment card that a transgender patient had commented on how staff were diligent to ensure their privacy and dignity was respected. This demonstrated that each patient's individual needs were paramount to the care staff delivered.
- We observed nurses explained to children and parents that fire alarms would be tested at 9am to ensure the children were not scared.
- We saw a teddy bear was given by recovery staff to children as a present and to provide reassurance and a distraction for the child. Children were also encouraged to take their own soft toy to theatre with them.
- There was a dedicated paediatric bay in recovery which was decorated in a child friendly way for example stickers of cartoon characters.
- There was a small supply of children's toys available, and children's channels on TV, a DVD player was provided.
- We saw how an explanation of a child's status in the recovery room was explained to parents with the analogy of the seven dwarfs, for example the child could be snoozy or grumpy. This demonstrated that staff were responsive to the needs of parents.
- Booking forms are sent to the children's nurses when received by the bookings team, to confirm appropriate cover is in place.
- We were told when children were pre assessed the pain score tool was explained with the child in preparation for admission. In addition the nurse discussed with the child any preferences, phobias, or requests and offered a tour of the hospital.
- Children were normally nursed by the same nurse who saw the child for pre-admission visit, this meant the child had a familiar face and knew in advance who would be looking after them.

However:

- The hospital did not routinely screen patients for dementia as part of pre assessment. This meant staff were unable to identify patients who may lack capacity early in order to plan appropriate care to meet their needs.

Learning from complaints and concerns

- There was a clear complaints management process in place; this was articulated to us by the Director of Clinical Services and the personal assistant (PA) who was the administrator for complaints.
- We saw all patient rooms had a patient guide and this included an opening letter from the Executive Director and a section which covered the formal complaints procedure. In addition copies of the BMI leaflet entitled "Please tell us" were located throughout the hospital to make patients and relatives aware of how they could highlight any concerns.

- All patients were encouraged to complete a patient satisfaction survey during or after their admission which allowed the hospital to evaluate the service provided to patients.
- Hospital managers told us they encouraged staff to identify and address any patient or relative concerns and issues whilst the patient was still in the hospital.
- If required, complaints were escalated to the relevant heads of department, the Director of Clinical Services or the Executive Director whilst the patient or their relative was still at the hospital to prevent issues developing into a formal complaint.
- BMI Healthcare followed a three stage process in dealing with complaints, with clear timeframes set out in BMI Healthcare's complaints policy.
- The responsibility for all complaints rests with the Executive Director. On receipt of a new complaint the PA to the Executive Director logged the details.
- An acknowledgment was sent out upon receipt of the complaint explaining the investigation process and timescales of the investigation. The details were then passed onto the relevant head of department(s) to start the investigation and produce a draft response.
- During the complaint investigation the process was monitored by the PA to the Executive Director to ensure that timescales were adhered to.
- Responses were being provided to a complainant within 20 working days (in line with BMI complaints policy). If a response was not able to be provided within this timeframe a holding letter was sent to the complainant so that they were kept fully informed of the progress of their complaint.
- The Executive Director was responsible for final verification of the response and sign-off.
- Patients were invited into the hospital for a face to face meeting to discuss the investigation findings.
- The hospital told us all complaints were logged onto the hospital management system where they could be monitored. Learnings and themes from complaints were shared at monthly head of department meetings, departmental meetings, clinical governance meetings and health and safety meetings.
- The hospital received 35 complaints between April 2015 and March 2016; this was a decrease from 41 in the previous year.
- The assessed rate of complaints was not high when compared to other independent acute hospitals the provider held data for.
- We reviewed five complaint responses; the level of investigation and subsequent investigation of learning varied. For example the standard of statements taken from staff varied in their quality and when face to face meetings had taken place between the complainants and hospital manager the discussion was not recorded in detail.
- In addition one of the complaints we reviewed demonstrated significant learning was needed. This was not fully identified and there was not a full action plan implemented. We saw that learning was identified and shared locally through team meetings, evidenced by minutes of the meetings, however changes to practice as a result of complaints could not be evidenced.

Are surgery services well-led?

Good

We rated the hospital as good for well led. This was because;

- Staff in all areas knew and understood the service's vision, values and strategic goals.
- There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
- The leadership team were knowledgeable about quality issues and priorities, understood the challenges and took actions to address them.
- Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity.
- Leaders modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.
- Candour, openness, honesty and transparency were evident throughout the service.

Vision and strategy for this this core service

- The service shared the BMI Healthcare vision. This was to provide the best outcomes, the best patient experience and the most cost-effective care.
- In addition Runnymede hospital had its own vision which was: to be the private hospital of choice for consultants and patients in West Surrey by delivering the best possible outcomes and a positive experience for patients; to consistently deliver a high quality and innovative service, which identified and responded to

the needs of customer; to be the employer of choice in West Surrey for both clinical and non-clinical personnel, attracting the best staff and sustaining a team of motivated and talented individuals and promoting an environment that continued to nurture.
- Their strategy aimed to further develop services for privately insured, self-funding and NHS patients by further improving their quality standards, developing existing services and introducing new services.
- We asked four members of staff and all four could tell us what the vision was. This meant the vision had been embedded with these staff members.
- The executive team told us about areas they were working to improve. In surgery for example we saw evidence of approved funding for a carpet replacement programme.

Governance, risk management and quality measurement for this core service

- We saw a diagram of the hospital's governance structure.
- The hospital had a quality and risk manager to oversee hospital-wide quality and risk, who reported to the director of clinical services.
- Surgery staff reported to either the ward manager or theatre manager. Managers met on a monthly basis and reported to the director of clinical services. The hospital's medical advisory committee and clinical governance committee also provided quality and safety assurances to the executive team. Consultant surgeons, anaesthetists, ward manager and theatre manager represented surgery on the medical advisory committee (MAC).
- The executive team consisted of Director of Clinical Services, Operational Services Manager, Hospital Administrator, PA to the Executive Director and the Executive Director.
- Clinical governance responsibility was shared between the Head of Clinical Services and the Quality and Risk Manager.
- The hospital's clinical governance committee met every two months. Reports from other committees were circulated prior to the meetings to ensure staff were prepared. The clinical governance committee was responsible for ensuring the hospital used appropriate systems and processes to deliver safe, high quality patient care.
- We saw from meeting minutes that, patient satisfaction, incidents, infection prevention and control, complaints, the risk register, trends, external/national guidance and new legislation, and clinical performance/compliance were discussed at the clinical governance meetings.
- Monthly quality and risk reports were produced which included National Midwifery Council referrals, supervision of consultants for safeguarding and other incidents. These reports were all reviewed and signed off by the Executive Director.
- The hospital had started a children's steering group in February 2016. We saw the agenda which included and was not limited to topics such as terms of reference, patient safety, children's incidents, and patient experiences. However, there were no minutes to support the meeting. Terms of reference for this group stated that it will meet three times annually. However, the documentation provided by the hospital showed only an agenda for the February meeting.
- The blood transfusion committee, medicines management, health and safety and infection prevention and control committees met quarterly.
- The BMI Healthcare group produced a monthly group clinical governance bulletin. This contained details of incidents, never events, and internal quality inspection visits from hospitals across the BMI Healthcare group. The purpose of the newsletter was to share learning from governance issues in all hospitals across the group.
- The hospital's MAC provided the formal organisational structure through which consultants communicated. The MAC advised the executive team and worked to maintain high standards and improve the quality of services. The MAC met every three months.
- We saw from the MAC minutes that the committee reviewed consultant's practicing privileges. This provided the executive team with assurance that consultants were competent to perform surgery at the hospital.
- We saw from the March 2016 meeting minutes that one consultant's practicing privileges were to be delayed until confirmation of the consultant's role in the NHS hospital.
- We reviewed the hospital's risk register, although there was no local risk register specifically for surgery. We saw that some of the areas of risk we identified, such as a lack of intumescent strips on fire doors, were on the risk register. The executive team told us that there was a rolling programme to replace them.

- The risk register also aligned with areas the executive team told us they were working to improve. This showed the executive team understood the areas of risk relating to surgery. The Executive Director had overall ownership for the risk register; it was embedded in quality and risk report, and discussed at regional meetings.
- We saw that the risk register was generally used for issues when control lay outside the hospital. The executive team told us that they would not necessarily put something on the risk register if it could be resolved locally.
- We saw a comprehensive clinical audit schedule to provide quality assurance. Audits related to surgery included infection prevention and control, hand hygiene, venous thromboembolism (VTE) screening, theatres, and the WHO checklist for safer surgery.
- The hospital utilised daily communication meetings (huddle) as an effective way to share information and drive continuous improvement.
- The hospital worked under the guidance of the BMI corporate policy for the care of children.
- There was a hospital children's and young person's(CYP) advisory group which met quarterly and was responsible for ensuring current BMI corporate policies and procedures were implemented and compliance was monitored, and that national guidance and legislation was discussed and shared with staff.
- In addition the committee advised on any identified risks associated with children's services in the hospital and recommended actions to reduce or minimise risk and reviewed any clinical incidents in relation to children and young persons. This group reported into to the hospital clinical governance committee.

Leadership / culture of service related to this core service

- We saw leaders valued and respected staff. Staff generally felt valued and told us that leaders were visible and approachable. Staff told us they felt supported by their managers and colleagues.
- Staff told us one of the best things about working at the hospital was their colleagues. We saw that staff worked well together and respected each other and worked as a team.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents.
- There was a staff turnover of 2.4% for theatre nurses between April 2015 and March 2016; this rate was not high when compared to other independent acute hospitals the provider held data for.
- There was a 40% staff turnover for operating department practitioners and health care assistants in theatre during the same time period. The rate was higher than the yearly average when compared to other independent acute hospitals that the provider held data for.
- There was a 31.8% staff turnover for inpatient nurses in the same time period reporting period. The rate was higher than the average turnover of this staff group when compared to the other independent acute hospitals that the provider held data for.

Public and staff engagement

- The hospital monitored staff feedback through an anonymous annual survey and was committed to responding positively to feedback. The results of the survey were fed back to the team through staff briefings held by the Executive Director.
- Staff loyalty was rewarded through long service awards – the PIN Awards.
- All staff were given the opportunity to seek funding to support their professional development and the hospital has funded a wide range of courses for the benefit of the individuals and the hospital.
- The hospital implemented the BMI appraisal policy to ensure that all staff understood their personal objectives, and how they fit with the departmental and hospital objectives and vision.
- Social interaction was encouraged through a range of events for example the pin awards, above and beyond awards and charitable initiatives to encourage staff engagement in a social context.
- Opportunities for staff to engage with the management team occurred daily informally or through department meetings and staff forums.
- The hospital actively engaged to seek the views of patients and their relatives. We saw patient satisfaction questionnaires available throughout the hospital for patient feedback.
- The hospital also sought feedback through the NHS choices website and the NHS friends and family test.
- The hospital's website provided a range of information about the services provided. It also provided details of

consultants who worked at the hospital and their credentials. Members of the public could use this information to help them decide whether they wanted to receive treatment at the hospital.

- We saw that there were no photographs of the paediatric nurses on the wall on Burwood ward; this meant the paediatric nurses may feel excluded and undervalued

Innovation, improvement and sustainability

- Development plans in surgical services for the future included implementation of ambulatory care pathways.
- The hospital took part in BMI Healthcare provider visits. This was where staff from other BMI Healthcare hospitals carried out internal quality inspections. Provider visits gave the hospital feedback to enable a continuous cycle of improvement

Outpatients and diagnostic imaging

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

Information about the service

BMI The Runnymede Hospital is an independent hospital which forms part of the BMI Healthcare Limited Group. It is situated in the grounds of St Peter's Hospital, Chertsey and linked to St Peter's by a corridor. The hospital provided an outpatient service for various specialties which was not limited and included diagnostic imaging such as x-ray, ultrasound and mammography, ear, nose and throat (ENT), physiotherapy assessment and treatment, orthopaedics and dermatology. There were 33,590 outpatient attendances between April 2015 and March 2016, of which 91% were privately funded (self-paying or through medical insurance) and 9% were NHS funded appointments. Of the 33,590 attendances, 1% was children age 0 to 2 years, 6% was 3 to 15 years and 1% was age 16 to 17 years.

Outpatient facilities comprised a waiting area, eight consultation rooms and one treatment room located on the ground floor. The treatment room was used for minor procedures such as wound checks, dressings and removal of sutures.

The imaging department included magnetic resonance imaging (MRI) and computerised tomography (CT) scanning, ultrasound, fluoroscopy (ophthalmology rooms) and an x-ray area. MRI and CT scanners were part of a mobile service sited in the hospital grounds and provided by an external contractor. This facility was not part of this inspection. There was a physiotherapy office and four treatment rooms including a gymnasium. The imaging and physiotherapy departments were located on the ground floor, and both had their own small waiting areas.

The outpatients and imaging departments were opened Monday to Friday, 8am to 8pm and Saturday, 9am to 1pm. Inpatient physiotherapy services were available seven days a week.

We spoke with 12 patients, and two parents. We also spoke with 23 staff members, ranging from managers, care assistants, nursing staff, radiographers, consultants and support staff. We reviewed documentary information such as meeting notes and policy papers. In addition, we observed activities, staff interaction with people using the service, checked equipment and the patient environment, and reviewed five sets of patient records.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatients department and diagnostic imaging as good. This was because:

- The outpatients and diagnostic imaging departments provided a broad range of services for both privately funded and NHS funded patients. The patients we spoke with were complimentary about the care, treatment, and service they had received in both departments.
- Staff were competent and worked to national guidelines, and ensured patients received the best care and treatment.
- The culture within both departments was patient focused, open and honest. The staff we spoke with felt valued and worked well together. Staff followed policies and procedures to manage risks and made sure they protected patients from the risk of harm.
- There were short waiting times for appointments. Private patients were seen within one week, and NHS patients were usually seen within four weeks of referral. Patients described that they could get appointments with their chosen consultant and were seen on time.
- Patients we spoke with told us they were treated with dignity and respect. All patient feedback during the inspection was positive. They described the service as 'first class', 'very good' and 'professional'.
- Both departments were visibly clean.

Are outpatient and diagnostic imaging services safe?

Good

We rated the services as good for safety because:

- People were protected from avoidable harm. There were effective processes and systems in place to mitigate risks for the prevention and control of infection, safeguarding people from abuse and medicines management.
- There were appropriate safeguarding arrangements that were delivered in line with current national guidance. Staff demonstrated a good understanding of the hospital policy and there were embedded systems to identify and act upon any concerns about patients' safety.
- Openness and transparency about safety was encouraged. Staff understood their responsibilities and were supported to report concerns, incidents and near misses. Opportunities to learn from incidents locally and corporately were identified.

However:

- Flooring in some of the consultation rooms did not comply with Health Building Note (HBN) regulation.
- Some clinical staff who undertook assessment of children were not trained to safeguarding children level three
- The children's waiting area was limited and there was a lack of age appropriate toys. The area was very small and was combined with the main waiting area for adults.

Incidents

- No never events were reported in the period 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.

Outpatients and diagnostic imaging

- There were no serious incidents reported for outpatient and diagnostic imaging services between April 2015 and March 2016.
- Between April 2015 and March 2016, 15 clinical incidents and 12 non-clinical incidents were reported within outpatient and diagnostic imaging services. There were no themes apparent and the rates of incidents per 100 outpatient attendances were lower when compared to similar independent hospitals.
- Staff understood how to report an incident and explained the process that they would follow. Staff reported incidents using a paper based reporting system. The information was transferred onto an electronic based system by the quality and risk manager. Incidents were discussed at staff meetings.
- Staff described an incident where a consultant looked at patients' records of another consultant, which was a breach of confidentiality. In response to this, staff took action to replace the cupboard with a new lock, and the keys were made accessible to nursing staff. This was documented in the January 2016 staff meeting notes. This meant that staff reported incidents and learned from them by taking the appropriate action. This was in line with the hospital incident policy.
- Staff confirmed that imaging incidents were reported to the Care Quality Commission (CQC) under the Ionising Radiation (Medical Exposure) Regulations (IRMER). The Radiation Protection Adviser (RPA) carried out a regular review in relation to radiation doses and any anomalies would be reported back. We saw that the last review was carried out on 8 May 2016 and the radiation dose was within an acceptable range.
- Staff described the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This 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. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised and informed people of the actions they had taken.

Cleanliness, infection control and hygiene

- We found the outpatient and imaging department waiting areas, consultation rooms and treatment room were visibly clean and tidy.
- Cleaning schedules with daily tasks were clearly displayed, dated and signed in the five consultation rooms and treatment room.
- Staff cleaned the couches with detergent wipes and prepared them with clean linen for patients to lie on between each patient. The couches were intact and clean.
- In the five consultation rooms we inspected, we saw hand wash sinks had taps which can be operated without the use of hands. This complied with HBN 00-10 Part C: Sanitary Assemblies. The HBN states that, 'basin taps used in clinical areas and food-preparation and laboratory areas are required to be operated without the use of hands.' They complied with the HBN 95 standard as the hot and cold taps were separate.
- Staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene', from the World Health Organisation (WHO) guidelines on hand hygiene in health care. Information was displayed demonstrating 'five moments for hand hygiene' near handwashing sinks.
- We noted that all personal protective equipment (PPE), for instance, disposable gloves were available in the five consultation rooms. Disposable aprons were also noted in the treatment room. This met the Royal College of Nursing Essential Practice for Infection Prevention and Control, Guidance for Nursing Staff.
- We saw sharps bins available in treatment areas where sharps may be used. This demonstrated compliance with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw fully completed labels on sharps bins which ensured traceability of each container.
- We saw 'sharps' audit compliance rates improved from 73% to 93% between May and July 2016. These audits were discussed in staff meetings, heads of department meetings and daily handover meetings. The results were displayed on staff notice boards.
- A biohazard spill kit (containing relevant equipment to manage blood and other bodily fluid spillages) was located in the treatment room that was secured steadily on a cabinet, and was accessible in the event of a spillage.
- Infection control audits were completed, including hand hygiene. Monthly audit results for hand hygiene

demonstrated that consultants including imaging doctors were compliant ranging from 30% in January 2016 to 90% in August 2016, which showed much improvement in hand hygiene practices. All other staff were compliant ranging from 90% in January 2016 to 96% in August 2016. We saw audit results discussed in the hospital clinical governance meeting notes and actions to encourage 100% compliance. We saw results displayed on staff notice boards. During inspection, we saw all clinical staff in outpatient and imaging including physiotherapy were 'bare below the elbow' and complied with hand hygiene in line with the hospital's hand hygiene policy.

- We found the x-ray room and ultrasound room visibly clean and tidy. Within the x-ray room, a diagnostic imaging department environmental checklist included daily tasks to be checked for example, the x-ray unit, image intensifier and lead aprons. We saw completed checklists on the days the department was in use.
- We saw disposable curtains used in clinic rooms, dates on them indicated they had been changed within six months.
- We saw a cleaning schedule which was up-to-date and signed for the toys in the limited children's area combined in the main waiting area.
- Patient led assessments of the care environment (PLACE) score for cleanliness was 99%, higher than the England average of 98%.
- We saw two out of five consultation rooms did not comply with the Department of Health Building Note (HBN). The rooms had carpets and did not comply with HBN 00-09: 'Infection control in the built environment Hospital building note (3.82) which states that carpets should not be used as this area has a high probability of body fluid contamination'. However, the hospital confirmed there is a planned programme of works to replace the flooring by May 2017.Staff told us that clinical procedures were not carried out in carpeted rooms until the flooring was replaced.
- One of the five consultation rooms had laminate flooring and did not have a continuous run between the floor and wall. This did not comply with HBN 00-10 Part A: Flooring, where the floor joined to the wall. The HBN states that, 'In clinical areas and associated corridors, there should be a continuous return between the floor and the wall. For example, coved skirting with a minimum height of 100mm allow for easy cleaning'. However, the hospital confirmed there is a planned programme of works to replace the flooring by May 2017.

Environment and equipment

- We saw two resuscitation trolleys, one was for paediatric use and the other for adult use. They were situated side by side and were located in the waiting area of the outpatient department. The trolley was tamper proof and all consumables were in date. Staff checked the trolley daily; we saw up-to-date complete checklists to confirm this was done.
- One defibrillator was shared between both resuscitation trolleys. However, there were no records to indicate that the defibrillator on the resuscitation trolley was serviced or safety checked. The manager informed us the defibrillator was new and assured us that a safety check would be arranged immediately. We saw records that it was new and fit for purpose. This was escalated to the head of department who told us that there was a review of all equipment to be completed by end of August 2016.
- We saw all other equipment labels demonstrated that they were within service date and had been PAT tested.
- The manager told us consultants did not bring in their own equipment and there was no specific policy in place for consultants bringing in their own equipment. However we were told that consultants were aware that equipment would need to be fit for purpose if they were to use their own equipment.
- Staff told us the mammography unit located in the x-ray room was ageing. However, checks were undertaken to ensure it remained fit for purpose. We saw the equipment was in service date. We saw the hospital risk register June 2016 identified the ageing mammography unit. The hospital planned to replace this but we were not provided with a replacement date.

Medicines

- A British National Formulary (BNF), which is a pharmaceutical reference book, was found in five of the consultation rooms and treatment room we inspected. In one room, where children were seen, there was an additional paediatric BNF. All BNFs seen were valid until September 2016.

- Records of daily temperature checks were completed in the x-ray and treatment rooms, medication cupboard and fridge, and were within the limits. This was to ensure the correct temperature was maintained and medication was stored safely.
- Prescription pads were stored safely and secured in a locked cupboard and the duty lead nurse had access to the key. There was a process where prescription pads were kept safe. We saw reference log numbers completed for prescription pads.
- We saw medicine safely stored and secured in the imaging department in a locked cabinet, and the duty radiographer had access to the key.

Records

- We saw examples of checklists used that were adapted from five steps to safer surgery, based on the World Health Organisation (WHO) Surgical Safety checklist. This included 'sign in' checks where the patient identity and operative site was confirmed and 'sign out' checks where the instruments used were counted back and any specimens are labelled and sent to the laboratory. We saw these forms completed in five patient records who had a minor procedure.
- We saw all five patient records were fully completed, for example patient allergies, regular medication and previous operations. Risks and benefits were also recorded including the procedure being explained to the patient.
- We saw all five patient records were legible, dated, signed, intact and stored securely in a locked cabinet. Staff returned the records to the medical records department on-site the same day after patients' attendance. Records were then kept at the hospital for ten months and then sent off site for storage. We saw a track and trace system in practice which meant staff knew where records were and were able to access records when required.
- Hospital patient records were not removed from site by a consultant. Should a consultant need to take the hospital records off-site, advance permission was sought in accordance with their care records policy.
- Staff were provided with individual accounts to access the electronic hospital outpatient appointment system. We observed that staff logged out from the electronic system when leaving the computer station at the nursing staff desk. This meant that staff complied with the hospital information governance policy, including the Data Protection Act (DPA).
- Information provided to us before the inspection identified that data was not captured if patient records were not available at the time of appointment in outpatients and imaging department. Staff informed us that it was rare that patients were seen without their care records for NHS and private patients. Staff said that as clinics were prepared in advance, they were able to request the hospital medical records department for care records and had access within 48 hours. This meant that patients received safe and timely care.

Safeguarding

- There was a BMI Healthcare Group Safeguarding Children policy and a Safeguarding Adults policy.
- Posters displayed 'What to do if you're worried about an adult's welfare' in the five consulting and treatment rooms, and throughout the outpatient and imaging departments. These showed flowcharts on action to be taken and included contact details of who could be contacted for advice. These were displayed to remind staff of the correct reporting processes.
- The Director of Clinical Services was the hospital's adult and children safeguarding lead and had overall responsibility for safeguarding within the hospital.
- The Children's Services Clinical Lead also supported the Director of Clinical Services for safeguarding children within the hospital.
- Staff we spoke with could identify the safeguarding leads and described how to report safeguarding concerns.
- All consultants undertook level three safeguarding training as part of their mandatory training in their NHS hospital.
- All contracted paediatric nurses were trained to safeguarding level three.
- There were no safeguarding concerns reported to CQC in the reporting period between April 2015 and March 2016.
- One agency outpatient nurse told us they had undergone level two safeguarding training. However the nurse told us they undertook weighing and measurement of height for children. This did not comply with the Intercollegiate document 2014 and the hospital safeguarding children policy, which state "level 3 -

clinical staff working with children, young people and/or their parents/carers and could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns".

Mandatory training

- The overall hospital mandatory training report demonstrated 92.4% compliance.
- Some of the topics covered by mandatory training included fire, infection control, manual handling, safeguarding, and equality and diversity.
- All new staff, including agency staff, completed an induction. Topics were not limited and included cardiac arrest procedure, fire, dealing with complaints, data protection and the department layout. This ensured that all staff on site were familiar with local procedures and received the same training.
- Training was available through a mixture of e-learning method and face to face training. Staff told us they were able to access courses on planned dates and via the hospital intranet. Staff were given protected time to complete training.

Assessing and responding to patient risk

- Staff were knowledgeable about the actions they would take if a patient deteriorated in the outpatient department. Staff explained the process and were aware of where the nearest resuscitation trolleys were located.
- Immediate or emergency assistance could be summoned by the use of the hospital 'crash call' or resuscitation team. Medical assistance was provided by the resident medical officer (RM) and the patient's consultant when required.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas we visited and signed by all members of staff, which indicated they had read the rules. Diagnostic imaging staff had a clear 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.
- The Radiation Protection Advisor performed an annual quality assurance check on equipment in the diagnostic imaging department. Departmental staff also carried out regular checks. This helped to assure the hospital that equipment was working correctly and these mandatory checks were in line with Ionising Regulations 1999 and the IRMER 2000. We saw records of these checks during our visit.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging suite, in line with best practice. This helped the hospital prevent potentially harmful exposure to radiation to unborn babies.

Nursing staffing

- Data provided to us before inspection indicated the vacancy rate of two full-time equivalent (FTE) posts for outpatient nurses giving a vacancy rate of 50%. There were two FTE posts vacant for outpatient health care assistants (HCA's) giving a vacancy rate of 67%. However, we were told recent recruitment meant that all vacancies in outpatient would be filled by October 2016. Bank and agency staff were used to fill the gaps and this had ensured sufficient staff were on duty.
- The manager told us there were always two nurses and two care assistants working at any shift to maintain safe staffing levels.
- Data provided to us before the inspection indicated that the hospital used a high number of bank and agency staff in the outpatient department between April 2015 and March 2016. The bank to agency ratio in the last three months of the reporting period was 1 to 3.17 and 100% use of bank HCA's. The manager told us bank and agency staff were used to cover any holiday, sickness and vacancies. They would see a reduction in this use when the new recruits started work by end October 2016.
- Bank and agency staff who worked in the outpatients and imaging departments were mostly established. This meant patients could be assured that staff were familiar with the service provided and the needs of the patients.
- The manager informed us that sickness rates in the outpatient and imaging department were low. Information provided prior to inspection demonstrated

the sickness rate was 0% for nursing staff and care assistants between April 2015 and March 2016, with the exception of January (just above 25%) and March 2016 (5%), both months for care assistants.

Medical staffing

- Each consultant attended the outpatient department on set days at set times. This meant that the department knew in advance which consultant was attending and were able to allocate nursing staff appropriately to the clinics.
- The hospital employed 168 medical staff with practicing privileges in the reporting period between April 2015 and March 2016, of whom 18 had their practicing privileges removed due to retirement from private practice, non-compliance of paperwork or no longer worked at BMI The Runnymede. Practicing privileges of 25 medical staff were suspended due to non-compliance of paperwork, no longer worked at BMI The Runnymede or general medical council (GMC)/safeguarding issues with an NHS Trust. The hospital reported no medical staff on supervised practice and any medical staff under supervised practice in their NHS post were suspended from their practising privileges at BMI The Runnymede.
- The granting of practising privileges is a well-established process within the independent hospital healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. There should be evidence that the provider has complied with legal duty to ensure that the regulation 19 in respect of staffing and fit and proper persons employed are complied with. Where practising privileges are being granted, there should be evidence of a formal agreement in place. We saw that these agreements were in place for all medical staff with practising privileges and there was a robust process in place to ensure medical staff had the requirements to provide safe care.
- Consultants in clinic were supported by a resident medical officer (RMO) if required. RMOs were provided by one agency. They worked a two-week on and two-week off rotation for a period of at least six months. Rotas were set by the agency and sent to the hospital in advance. Emergency RMO to cover sickness was provided seven days a week.

Major incident awareness and training

- Staff were aware of actions to take in the event of a major incident, including if there was a fire. One staff member was able to describe in detail the actions they would take and the training they had. This included taking part in role play as a patient. We were informed that this allowed the staff member to be able to reassure a patient in the event of an emergency and empathise with any anxieties they may feel. This meant that staff complied with the hospital emergency policy.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain for outpatient and diagnostic imaging services was inspected; however, this domain is not currently rated.

- The outpatients and imaging department planned and delivered care and treatment in line with current evidence-based guidance, standards and best practice.
- Staff had the right qualifications, skills, knowledge and experience to do their job. The learning needs of staff were understood. Staff were supported to participate in training and development.
- Multi-disciplinary teams worked well together to provide effective care.
- Consent to care and treatment was obtained in line with legislation and guidance.

Evidence-based care and treatment

- We saw examples of policies and procedures in the hospital referring to professional guidance. For example, the chaperone policy referred to professional guidance from the Royal College of Nursing (Chaperoning: The role of the nurse and the rights of patients, 2002). Posters informing patients of their entitlement to have a chaperone and how to request one were clearly displayed in the waiting area
- Staff followed the National Institute for Health and Care Excellence (NICE) and Royal College of Radiologists (RCR) standards. For example, we saw staff monitored

radiation doses which ensured that patients did not receive unnecessary radiation doses. This demonstrated the department monitored compliance with the guidelines.
- New NICE guidelines were assessed within the hospital for their relevance by the medical advisory committee (MAC) and cascaded, including to consultants.
- The hospital had a MAC, which 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 specialties.
- Staff accessed policies from the hospital intranet site. We saw how policies were disseminated to staff to read, sign and implement using tracker documents to confirm understanding and their compliance.
- Staff undertook numerous clinical and non-clinical audits. These were not limited and included infection prevention and control, cleaning, hand hygiene and radiation doses. We saw a regular audit programme and observed examples of audit results shared in team meeting notes and on staff notice boards.

Nutrition and hydration

- Staff told us patients were offered refreshments if they were delayed being seen, although the maximum waiting time was usually 10 to 15 minutes. We saw self-dispensing hot drinks and water units available to patients in the waiting area.
- Refreshments were offered to patients who had a minor procedure or if the patient had undergone a fasting blood test. If a patient needed additional food, staff could request a sandwich or toast from the hospital kitchen.
- This meant patients' nutrition and hydration needs were met as required when attending the outpatient department.

Pain relief

- Staff told us they were rarely required to administer pain relief due to the nature of the clinics. However, nurses asked patients about pain during appointments. Nursing staff informed the consultant if the patient had complained of pain to them.
- Pain assessments were documented in patient care records when they attended for a minor procedure. We reviewed a random sample of five records which evidenced this.

Patient outcomes

- The hospital participated in the National Joint Registry audit where data for all joint replacements was submitted. This allowed the hospital to collect data about joint replacement surgery to provide an early warning of issues relating to patient safety. The primary purpose was to monitor the outcomes achieved by brand of prosthesis, hospital and surgeon, highlight where they fell below expected performance, and allowed prompt investigation and follow-up action.
- The hospital also participated in Patient Reported Outcome Measures (PROMs) for three clinical procedures for NHS funded patients such as hip and knee replacements and groin hernia. The hospital provided provisional data for this which was published on 12 May 2016. PROMs calculate the health benefits after surgical treatment using pre-and post-operative surveys. This meant that the hospital was able to assess the quality of care delivered to patients.
- The hospital participated in the National Clinical Audit Programme (NCEPOD).

Competent staff

- The appraisal rate provided before the inspection was 33% for outpatient and imaging staff. However, the head of department confirmed the rate had improved following the introduction of the new electronic system. We saw 100% completion rate and staff we spoke with told us they had up-to-date appraisals
- The head of department confirmed that all professional updates and best practice for physiotherapy staff were checked by the hospital including training records to ensure patients were treated by competent staff.
- The manager informed us that competencies were maintained by completing mandatory training. All new staff members were inducted corporately and were supernumerary until they had completed their induction. One bank HCA told us they were supernumerary until they had completed their induction.
- Staff confirmed they had protected time to complete competency training. This included IRMER training for radiographers.
- All doctors with practising privileges were at consultant level and were registered with the General Medical Council (GMC). This meant patients could be assured that they were treated by registered practitioners.

Outpatients and diagnostic imaging

- We saw from the MAC minutes that some consultants had been suspended from practicing at the hospital, as they had not provided the necessary paperwork.

Multidisciplinary working (related to this core service)

- Staff told us there was a good working relationship with the reception, imaging, physiotherapy, administrative and cleaning teams. We saw evidence that the nursing team and reception team communicated well together and supported each other. Staff told us that they were supported by their peers and other staff groups within the hospital. We heard positive feedback about the "good teamwork" throughout the departments generally.

Seven-day services

- Outpatients and imaging were open five and a half days a week as was the outpatient physiotherapy service. Inpatient physiotherapy and pre-assessment services were available seven days a week.

Access to information

- The hospital confirmed that copies of NHS records were kept on site for ten months and original records would be returned to the relevant NHS hospital the day after the outpatient appointment. Staff told us NHS records were always available for appointments.
- Consultants were responsible for their own records relating to private patients as part of holding practising privileges where they must also be registered as independent data controllers with the Information Commissioner's Office (ICO).
- Imaging staff were able to access information from other hospitals through the use of a picture archiving and communication system (PACS). This provided convenient access to images when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us consent was obtained from a patient before a minor procedure was carried out in the outpatients department. This consisted of a written consent and a copy was kept by the patient and consultant.
- We reviewed a random sample of five patient records that had undergone a minor procedure and noted that patient consent was obtained as required. The risks and benefits were noted on the document.
- We spoke with a range of clinical staff who all clearly described their responsibilities in ensuring patients consented when they had capacity to do so or when decisions were made in their best interests. This met with the hospital consent policy.
- Gillick competence is concerned with determining a child's capacity to consent to medical treatment or intervention. Staff we spoke with demonstrated awareness of the hospital consent policy and how they would apply the Gillick competence test for children and young people when required. We did not observe any situations where the Gillick competency test needed to be applied during inspection.
- The hospital had a Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLs) policy. This showed a March 2016 review date and was therefore out of date. We escalated this to the hospital during inspection and they took immediate action to update the policy. We did not observe any situations where this policy needed to be applied during the inspection.

Are outpatient and diagnostic imaging services caring?

Good

We found outpatient and diagnostic imaging services to be good for caring because:

- Patients were positive about the way staff treated them and found staff to be professional, attentive and welcoming.
- Patients were involved in decisions around their care and treatment and found leaflets informative regarding any potential surgery.

Compassionate care

- We received 10 comment cards from patients related to experiences in the outpatient and imaging departments.
- The comments were very positive and praised the hospital staff and environment. Patients talked about staff being, "kind and caring". One physiotherapy patient we spoke with said the service was "first class".

Outpatients and diagnostic imaging

- Several patients told us that staff and their consultant had the time to explain things in detail and allowed time for any questions. Patients reported feeling part of the decision-making about their treatment and care.
- Consulting and clinical treatment room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy. All clinic room doors had 'free/engaged' signs and we observed staff using these.
- We saw curtains drawn in the imaging department's changing facility to maintain patient's dignity.
- Patients told us staff were professional, attentive and welcoming. One patient who had received physiotherapy treatment for one year described the service and care as 'first class'.
- We observed staff to be friendly and professional when they spoke with patients. We saw staff who were polite and respectful of confidentiality. Patients were able to have conversations with staff without being overheard and minimal patient identifiable data was discussed.
- The NHS friends and family test (FFT) scores in the reporting period between October 2015 and March 2016 were 100%. FFT is a national survey that asks for patients' views after receiving care or treatment across the NHS. The survey was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed.

Understanding and involvement of patients and those close to them

- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need.
- Patients told us they were informed about the fees for their consultation before their appointment. This meant patients received appropriate information in relation to costs to enable them to make an informed decision about their appointment.
- We saw a variety of health-education literature and leaflets produced by BMI. Some of this information was general in nature while some was specific to certain conditions. This literature was available in all waiting areas of the outpatient departments.

Emotional support

- Patients told us that staff and consultants working in the outpatient clinics were approachable and "had the time to explain everything". Information such as side effects of medicine was also made clear.
- We saw relatives who were invited to accompany patients into consultation rooms, which indicated that the hospital encouraged a friend or partner to attend the appointment in order to provide emotional support.

Are outpatient and diagnostic imaging services responsive?

Good

We found outpatient and diagnostic imaging services to be good for responsive because:

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
- Patients were kept well informed of waiting times in clinics and delays rarely occurred.
- Actions from concerns and complaints were dealt with effectively in a timely manner and feedback was used to improve the quality of care
- Patients were informed about relevant fees for their consultation before they attended for their appointment.

However:

- All written information, including pre-appointment information, leaflets and signage was in English only.

Service planning and delivery to meet the needs of local people

- The hospital had service level agreements (SLAs) in place with a local NHS hospital with regards to some services, for instance magnetic resonance imaging (MRI) and computerised tomography (CT) scans. This demonstrated that the hospital worked with local providers to ensure patients received a streamlined service.
- The hospital had good working links with the local clinical commissioning group (CCG), who set criteria

within the contract with the hospital for NHS patients. This meant local commissioners and other providers were involved in planning services to meet the needs of the local population.

- Staff told us when a new consultant started at the hospital, the consultant liaised with the head of department to ensure a consultation room was available. Some consultation rooms were used for specific specialties, for example ear, nose and throat (ENT). This meant consultants would be able to work in an appropriate room according to their specialty and staff could be arranged to support and deliver the service.

Access and flow

- A legal requirement by NHS England gives patients the right to access services within a maximum waiting time. This applied to NHS funded patients only.
- The hospital met the target of 95% referral to treatment (RTT) waiting times for non-admitted patients. This was for patients beginning treatment within 18 weeks of referral for each month in the reporting period between April 2015 and March 2016,
- Staff confirmed that a patient's first appointment was booked through the national enquiry centre (NEC). With the exception of choose and book NHS patients, appointments were booked through the NHS referral system. Follow up appointments were booked while the patient was still at the hospital. Patients were informed what days the consultant had a clinic and the time of the appointment was flexible to meet the patients' needs. We observed this.
- Patients felt that the booking system for appointments was excellent. One told us they were referred by their GP, seen within a few days at the hospital and did not have to wait for their appointment on arrival to the hospital.
- Patients would be contacted if they did not attend (DNA) for their appointment. If the patient no longer needed an appointment, a note was put on the patient's file and the consultant informed. The same process was followed for NHS patients. If the patient still needed an appointment, a further one would be made. However, if the patient DNA for a second time the hospital discharged the patient and recorded its decision on the patient's file.
- MRI and CT scans were carried out at the local NHS hospital. A referral from BMI The Runnymede hospital would be made by fax and the NHS hospital would contact the patient directly to make an appointment. This meant there was a reduced risk in delays to patient care and treatment and patients were able to access the relevant services.

Meeting people's individual needs

- Free car parking was provided on-site for the convenience of patients and visitors.
- Another patient told us that they were given good advice and information, including a leaflet about the pre-procedure preparations, the procedure and information for when they were discharged from the hospital. This meant patients were fully informed of their care and treatment.
- Leaflets provided were in English language only. However, staff told us that they rarely had the need to provide leaflets in a different language and could access leaflets in a different language when required.
- A telephone interpretation and translation service was provided by an external company. Staff we spoke with told us that they could access the service when required.
- A ramp was provided for wheelchair users at the front entrance of the main building to access the outpatient department. There was a toilet with facilities for people living with a disability in the waiting area and a suitable changing cubicle in the imaging department.
- A hearing loop was available in the outpatient department for patients living with hearing difficulties. This meant some adjustments had been made to remove barriers and meet individual needs.
- Weight limits on the x-ray and ultrasound equipment meant that patients over this limit would need to attend another hospital for an imaging appointment. Staff told us that the patients would be sympathetically informed at the time of their consultation.
- It was not clear how the outpatient and imaging department planned and took account of people with complex needs such as dementia. Staff were unable to give us any examples of reasonable adjustments to make the environment dementia friendly. Staff told us they received dementia training via e-learning.
- The children's waiting area was limited and was combined into the main waiting area. We saw a lack of toys and toys that were available were not age appropriate. For example, colouring pencils were available but did not come complete with paper or a

book to draw or colour with. There were several building blocks and a few books only suitable for younger children. Staff told us parents had commented on the lack of space and age appropriate toys for their child.

Learning from complaints and concerns

- Patients were aware of the complaints process. Patients told us they were happy with the service; however they knew how to raise a concern or complaint if they had one.
- The hospital had a complaints policy and all staff were aware of it and how to support patients who wanted to complain. However, staff told us that they would seek to resolve any concerns in the first instance.
- The hospital's complaints log demonstrated that between October 2015 and June 2016, all complaints were acknowledged within two working days as outlined in the complaints policy. The hospital informed us that 95% were responded within twenty working days as outlined in the policy.
- The hospital identified a theme of finance complaints where patients did not know what the final bill was. The hospital confirmed that they are working to change their practice to improve the experience for patients. We saw from the hospital complaints log of a patient being billed incorrectly for physiotherapy treatment. The hospital rectified this by sending the patient the correct bill with a written apology. We saw this discussed in the staff meeting notes.

Are outpatient and diagnostic imaging services well-led?

Good

We found the outpatient and diagnostic imaging services good for well-led because:

- There was a BMI corporate vision and there was awareness of the local vision and strategy amongst outpatient and imaging staff.
- Staff told us they felt supported by their managers and managers told us they were proud of their team and the teamwork.
- Managers told us that they felt able to 'challenge' consultants if care practices were compromised and would escalate to executive director for staff related incident.
- There were leaflets to encourage patients and their carers to give feedback to the hospital about the care they had received.
- Staff felt supported and valued.

However:

- The hospital governance policy had a review date of 30 June 2016 and was therefore out-of-date.

Vision and strategy for this this core service

- Staff were aware of the local vision and strategy for BMI Runnymede. Staff told us that part of the local vision was to be the private hospital of choice for patients and consultants in west Surrey, to deliver high quality service, be the employer of choice and to continually improve and update their facilities and environment.

Governance, risk management and quality measurement for this core service

- We reviewed the hospital risk register and noted one risk related to the lack of a clinical hand wash sink in the physiotherapy clinic room. The risk register detailed actions to mitigate the risks such as a new sink was fitted to the room.
- Staff told us examples of risks in outpatient and imaging departments such as lessons were not always learned and ageing equipment in the imaging department, which we saw on the hospital risk register. However, we saw examples of lessons learned being disseminated in staff meeting notes. The notes also demonstrated that information was disseminated about learning from incidents and infection control. This meant actions were taken and there were sufficient governance systems in place to assess, monitor and mitigate risks.
- The hospital maintained a MAC whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice. Minutes from the March 2016 meeting demonstrated various topics were discussed. These were not limited and included clinical incidents and root cause analysis, complaints and patient satisfaction, NICE guidance, clinical audits and clinical policies.
- There was a framework and governance structure. Meetings were held regularly for heads of departments

and clinical governance committee. The information from these meetings was shared either through email or via a daily team brief. Staff meetings took place monthly and sharing of information and learning was seen in the April 2016 staff meeting notes.
- The hospital clinical governance policy had a review date of 30 June 2016, which was out of date.

Leadership / culture of service

- There was a clear reporting structure with the executive director leading the hospital. The director of clinical services and an operational services manager reported to the executive director. Both clinical and non-clinical departmental leads reported to the director of clinical services and operational services manager respectively. Within the structure, there were named leads such as a MAC chair, two leads for infection prevention and control, children's services and safeguarding.
- MAC meetings were held regularly every quarter. These were very well documented, with an enormous amount of information circulated in advance. Minutes demonstrated robust discussions and appropriate challenges. An example from the March 2016 meeting minutes demonstrated the suspension and withdrawal of practising privileges for issues such as safeguarding, misconduct allegations and incorrect paperwork, and practising privileges were revoked for some consultants who did not provide the required paperwork.
- Managers were proud of their staff and provided an example where staff had opportunities to progress within the department such as being promoted for taking on additional responsibility.
- Staff felt valued and said the managers in the hospital were approachable.
- Staff were aware of who the executive team were and told us that the executive leaders frequently visited the departments during the working day. Staff told us that the senior management team had an 'open door' policy and were approachable.
- Nursing staff felt supported by their managers. Staff told us they enjoyed interaction with patients, colleagues were friendly and there was good teamwork. Managers told us they were proud of their staff within their departments.
- Staff were encouraged by the executive team to raise concerns. The executive team operated an 'open door' policy. The executive team acknowledged that discussing concerns about the workplace could be a stressful experience for an individual member of staff and told us there was free access to counselling sessions for all staff; staff could access these without referral and they were confidential.
- Staff were able to challenge consultants when patient care was compromised. Where staff were unable to challenge some consultants in other situations, they escalated the incident with the management team. For example, a staff member who witnessed a consultant raise his voice in front of patients at another staff member who carried on with duty without reporting the incident, reported it to the management team.

Public and staff engagement

- Patient experience surveys were available in the outpatient department. The hospital received high satisfaction rates. We saw 98% of 410 responses rated good or excellent in June 2016.
- There were leaflets in waiting areas encouraging patients and their carers to provide feedback about the care they received. We saw staff encouraged patients to fill in feedback forms.

Innovation, improvement and sustainability

- Staff in the diagnostic imaging and physiotherapy departments shared learning across the BMI network to encourage improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure that the flooring in all clinical areas is fit for purpose.
- Ensure clinical staff who assess children are trained in safeguarding children level three.
- Ensure that the governance policy is up-to-date.
- Consider improving the environment for children in the outpatients department so that it is child-friendly.
- Consider providing written information to service users for whom English is not their first language