BMI Healthcare Limited

BMI The Blackheath Hospital

Quality Report

BMI The Blackheath Hospital
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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
Urgent and emergency services	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Blackheath Hospital is an acute independent hospital that provides outpatient, day care and inpatient services. A range of services such as physiotherapy and medical imaging are available on site. The hospital offers a range of surgical procedures and cancer care as well as rapid access to assessment and investigation and level 2 critical care. Services are available to people with private or corporate health insurance or to those paying for one off treatment. The hospital also offers services to NHS patients on behalf of the NHS through local contractual arrangements.

The hospital provides surgery, services for children and young people, outpatients and diagnostic imaging. We inspected only surgical services at this inspection.

We inspected this service using our focussed inspection methodology to follow up on a requirement notice issued following a comprehensive inspection of the hospital in July 2016. This inspection was unannounced and our visit to the hospital took place on 15 January 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

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

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

During the inspection, we visited two wards, three theatres and a two-bedded high dependency unit. We spoke with 18 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with nine patients and two carers. During our inspection, we reviewed 11 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time of or during the 12 months prior to this inspection. The hospital has been inspected two times previously and the most recent inspection, prior to this one, took place in July 2016. At the July 2016 inspection, we found that the hospital was meeting all standards of quality and safety it was inspected against except regulation 12 Safe, care and treatment. This breach of regulation was due to poor decontamination practices in the endoscopy unit and the CQC issued a requirement notice for the hospital to take action. At this inspection, we found that this had improved since the last inspection and was no longer a breach in regulation. Please read the surgery report below for further details.

The hospital had an appropriately appointed registered manager who had started the role in October 2018.

Services we rate

Our rating of this hospital stayed the same. We rated it as **Good** overall.

We found good practice in relation to surgery:

- The service controlled infection risk well.
- The service had enough staff to provide the right care and treatment.
- The service made sure staff were competent for their roles.

Summary of findings

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff cared for patients with compassion.
- The hospital planned and provided services in a way that met the needs of local people.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The hospital and wider organisation had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The hospital used a systematic approach to continually improving the quality of its services.
- The hospital had effective systems for identifying risks, planning to eliminate or reduce them.

We found areas of outstanding practice in surgery:

- Daily head of department meetings with the executive director and all head of departments had a unique multidisciplinary approach which enabled colloborative working, easy sharing of learning, escalation of concerns and cascading of information to departmental staff.
- Patients received interactive exercise information which included demonstrations videos to help with their recovery at home.

We found areas of practice that require improvement in surgery:

- The hospital should ensure it complies with its own target for mandatory training.
- The hospital should ensure there is an appropriate space to store used surgical equipment.
- The hospital should ensure all incidents are reported in a timely manner.
- The hospital should ensure they compare the difference in patient outcome measures scores (PROMS) between NHS and private patients.
- The hospital should ensure its promotes an inclusive culture with regard to patients with additional needs.

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

Professor Edward Baker
Chief Inspector of Hospitals

Urgent and emergency services

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

Information about the service

We did not inspect this core service at the time of this inspection. Please see the January 2017 report for the detailed findings of this service.

Summary of findings

At the January 2017 inspection, we rated this core service as Good. Please see the January 2017 report for the detailed findings of this service.

Urgent and emergency services

Are urgent and emergency services safe?

Good

At the January 2017 inspection, we rated safe as Good. Please see the January 2017 report for the detailed findings of this service.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

At the January 2017 inspection, we rated effective as Good. Please see the January 2017 report for the detailed findings of this service.

Are urgent and emergency services caring?

Good

At the January 2017 inspection, we rated caring as Good. Please see the January 2017 report for the detailed findings of this service.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

At the January 2017 inspection, we rated responsive as Good. Please see the January 2017 report for the detailed findings of this service.

Are urgent and emergency services well-led?

Good

At the January 2017 inspection, we rated well-led as Good. Please see the January 2017 report for the detailed findings of this service.

Surgery

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

Information about the service

BMI The Blackheath Hospital is operated by BMI Healthcare. The hospital has 51 inpatient rooms. Facilities include three operating theatres, a two-bed level two high dependency unit (HDU), and X-ray, outpatient and diagnostic facilities. In the 12 months prior to inspection, the hospital undertook 7019 surgical procedures, of which 6778 were adult patients.

We inspected this service using our focussed inspection methodology to follow up on a requirement notice issued following a comprehensive inspection of the hospital in July 2016. This inspection was unannounced and our visit to the hospital took place on 15 January 2019.

Summary of findings

Overall we have rated surgery as **Good** because:

- The service controlled infection risk well.
- The service had enough staff to provide the right care and treatment.
- The service made sure staff were competent for their roles.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff cared for patients with compassion.
- The hospital planned and provided services in a way that met the needs of local people.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The hospital and wider organisation had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The hospital used a systematic approach to continually improving the quality of its services.

Surgery

- The hospital had effective systems for identifying risks, planning to eliminate or reduce them.

However:

- The hospital did not always comply with its own target for mandatory training.
- The storage room for decontaminated surgical equipment had limited space to work in.
- Incidents were not always reported in a timely manner.
- Staff did not compare the difference in patient outcome measures scores (PROMS) between NHS and private patients.
- The service did not always promote an inclusive culture with regards to patients with additional needs.

Are surgery services safe?

Good

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

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Training was provided in various formats which included classroom based and online e-learning. Staff told us they had protected time scheduled into their shift patterns to complete it.
- The compliance rates for mandatory training for hospital staff, at the time of inspection, are shown below:

Safeguarding Children Level 2: 96%

Safeguarding Vulnerable Adults Level 2: 88%

PREVENT (Protecting people at risk of radicalisation): 90%

Safeguarding Children Level 1: 90%

Safeguarding Children Level 3: 86%

Consent: 98%

Dementia Awareness: 90%

Waste Management for Handlers for Healthcare Waste: 90%

Waste Management for Primary Producers of Healthcare Waste: 94%

Waste Management for Disposers of Healthcare Waste: 100%

Conflict Resolution: 96%

Patient Moving and Handling: 87%

Waste Management for Waste Management Officers: 100%

Fire Warden / Fire Marshal Training: 95%

Infection Prevention and Control - Awareness Part 1: 95%

Infection Prevention and Control - Awareness Part 2: 68%

Introduction to WHO Safety Checklist: 81%

Safeguarding – Chaperoning: 88%

Surgery

Care and Communication of the Deteriorating Patient CCDP: 78%

Information Governance (2018): 92%

Safeguarding - Female Genital Mutilation (FGM): 66%

Overall: 88%

- Thirteen out of the 21 training modules met the 90% compliance target set by the hospital, however 8 did not; the worst of which was Safeguarding - Female Genital Mutilation (FGM) with only 66% compliance. However, we saw evidence was this was to be improved with scheduled training organised by the hospital.
- The hospital set a target of 90% for completion of mandatory training and their overall training compliance was 88%. This did not meet the required target, however we did see evidence that this had improved significantly over the previous 3 months.
- We saw evidence the introduction of new staff into the service had also significantly impacted on mandatory training compliance figures. In response to this, the hospital had scheduled training to ensure these new staff members had received the required training which would ensure that compliance rates would be met.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff knew who these safeguarding leads were and gave us examples of when they had escalated concerns to them.
- All clinical staff were required to be trained up to level 3 in both child and adult safeguarding, and all non-clinical staff up to level 2. A breakdown of safeguarding courses undertaken by hospital staff is shown below:

Safeguarding Children Level 2: 96%

Safeguarding Vulnerable Adults Level 2: 88%

PREVENT (Protecting people at risk of radicalisation): 90%

Safeguarding Children Level 1: 90%

Safeguarding Children Level 3: 86%

Safeguarding – Chaperoning: 88%

Safeguarding - Female Genital Mutilation (FGM): 66%

- The hospital set a target of 90% for completion of mandatory safeguarding training which was not met in all of the safeguarding courses. However, we saw evidence this had been impacted by new staff which would be remedied by up-coming scheduled training courses.
- Safeguarding incidents and updates were regularly discussed by management staff in monthly risk and governance meetings as well as in the daily head of department meetings which were attended by all head of departments in the hospital. Actions and learning arising from safeguarding incidents were identified in these meetings and we saw evidence of learning was shared with all hospital through hospital-wide emails and clinical bulletins.
- The hospital's policies on safeguarding, including the safeguarding adults policy and child protection policy, were in-date and easily accessible to staff on the hospital's intranet. These policies included checklists to ensure the correct escalations processes where followed by staff. The policies also included information on Female Genital Mutilation (FGM) and how to identify and escalate concerns around this.

Cleanliness, infection control and hygiene

- Staff kept the premises and equipment clean. They used control measures to prevent the spread of infection.
- Within all areas of the service we observed good practice by staff with regard to infection prevention and control, including appropriate washing of hands, use of personal protective equipment (PPE) and good adherence to clinical dress codes. This was an improvement since the last inspection.
- All staff in clinical areas were 'bare below the elbows', had their hair tied back and wore clinically appropriate clothing. There were changing facilities available for staff to change their scrubs and PPE which ensured any risk of cross contamination was minimised.
- PPE was available in all clinical environments where needed, in a variety of different sizes and was restocked regularly by staff.

Surgery

- The hospital had infection prevention and control link nurses which staff were aware of and would go to for any guidance regarding infection prevention and control (IPC) concerns.
- There were clear policies in place for IPC which were version controlled, ratified and in date for review and available to all staff through the intranet. The policies were in line with best practice and made reference to National Institute of Health and Care Excellence (NICE) guidance. Staff we spoke with were aware of the hospital's IPC policies.
- The hospital undertook regular IPC audits which enabled them to identify areas of good practice and those that required improvement. This was an improvement since the last inspection. The most recent audits in November 2018 showed 100% compliance in both the high dependency unit (HDU) and in theatres.
- We saw IPC information leaflets for patients and visitors which outlined key actions they could undertake to minimise the risk of infection.
- Hand washing facilities has improved across both wards since our last inspection. There was now dedicated hand wash basins in every patient room for staff and visitors and hand wash basins in treatment rooms were in line the Department of Health's Health Building Notice requirements (HBN00-09, Infection control in the built environment).
- There were posters on every door to a patient room which outlined the 'five moments of hand washing' to emphasise the importance of hand hygiene to staff, patient and visitors.
- The hospital conducted monthly hand hygiene audits. Audits from September, October, November and December 2018 showed compliance within the wards and HDU had been consistently 100% and in theatres 95% or above. This was an improvement since the last inspection.
- The hospital had isolation procedures in place and we saw these being used at the time of our inspection. We saw posters were placed on doors of patients to indicate to when a patient needed to be isolated and what procedures to follow in this instance These included information on appropriate hand hygiene and PPE practices as well as ensuring the door was closed always and no visitors permitted. We saw all staff were compliant with these procedures which was an improvement since the last inspection.
- The hospital undertook monthly IPC screening audits. These showed that there had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA), Methicillin-Sensitive Staphylococcus Aureus (MSSA) or clostridium difficile (C. diff) in the year prior to our inspection. This auditing was done in line with the hospital's own policy which was an improvement since the last inspection.
- Staff risk assessed patients for MRSA at pre-operative assessments and tested them if they identified as high-risk. If a test result came back positive then the operation was cancelled and a plan was put in place for the patient going forward.
- The endoscopy unit followed best practice in relation to IPC. This had improved since our last inspection as there were now clear separation between clean and dirty areas in the decontamination room and endoscopy scopes were now cleaned off the hospital site by an external company.
- All areas of the wards had hard flooring, rather than carpeting, which was an improvement since the last inspection. This was in line with the Department of Health's Health Building Notice requirements (HBN00-09, Infection control in the built environment).

Environment and equipment

- The hospital had suitable premises and equipment and looked after them well.
- The hospital held a local NHS contact to provide services to bariatric patients and had the appropriate equipment within theatres and on the wards to support these patients when required.
- The hospital asset register, maintenance logs and audit records showed equipment servicing was up to date, and where any servicing was required this was planned for. However, the management of medical devices policy was under review at time of the inspection and had been out of date from March 2018. However, we did observe that staff's practice had been appropriate with regard to management of medical devices during the inspection.

Surgery

- Staff told us if any equipment stopped working then it was easy to contact the maintenance team and equipment was either quickly repaired or replaced.
- Temporary curtains within theatres were changed regularly and were in date at the time of the inspection.
- Curtains within the recovery areas and in double rooms were visibly clean and checked by staff daily.
- Resuscitation trolleys were appropriately located throughout the wards, HDU and theatres. They were checked daily and included all the required equipment.
- Linen was appropriately stored away in cupboards and readily available within each ward.
- Staff had access to specialist equipment when required which included venous thromboembolism (VTE) stockings. Staff told us if any specialist equipment was required for patients this was ordered and would arrive on the same day.
- The provider ensured staff had access to pressure relieving devices for patients at risk of pressure ulcers, including air mattresses. This equipment was also used for any procedure lasting more than 45 minutes to reduce the risk of pressure ulcers.
- Theatres had recently been refurbished and met Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. Theatres had emergency call bells which were tested daily. Theatre equipment was also checked daily and these checks were recorded in checklist log books. Both the recovery area and the endoscopy unit had access to a difficult intubation trolley, resuscitation equipment, fluids and blankets. The resuscitation process was in line with current guidelines in endoscopy and standardised with the rest of the hospital.
- Theatre staff undertook daily environment equipment checks which identified any unclean or damaged equipment as well as any areas in the theatres which needed attention, like waste management or broken facilities.
- Theatres were secure with only authorised staff able to gain access. This was an improvement since the last inspection.
- The hospital asset register showed theatre equipment including anaesthetic, diathermy and suction machines and stack systems were checked regularly and had clear contact details attached to the machines in case of breakdown.
- The two-bedded HDU conformed to Faculty of Intensive Care Medicine (FICM) standards for a level two unit. The unit had easy access to emergency and investigative equipment when required. There were no patients in the unit at the time of our visit.
- Used surgical equipment was located in a small room which was next to theatres and led to the outside of the hospital and provided a safe flow of contaminated instruments. Used instruments were stored within large lockable metal trolleys before being transported off site. Although the hospital had an efficient system for sending out dirty instruments to be cleaned, the room had limited space and was difficult to work in. Hospital management were aware of the space issue and had implemented mitigating actions to minimise any risks. We also saw plans to redevelop the hospital site which would eliminate this issue in the future.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient.
- We saw evidence in patient records that patient risks were effectively identified, acted upon and reviewed regularly. This included separate pressure ulcer, moving and handling, falls and bed rail risk assessments.
- The hospital used the National Early Warning Score system (NEWS) which was audited regularly. The NEWS tool improves the detection and response to clinical deterioration in adult patients. We saw that scores were appropriately recorded within patient notes and escalated whenever necessary.
- The hospital had a monitoring the acutely ill adult patient with potential to deteriorate policy in place which was in date and staff were aware of. This included information on the NEWS procedure and an escalation process for staff to follow.
- Staff were trained in care and communication of the deteriorating patient (CCDP). This included training on identifying early signs of sepsis which was based on NICE quality standards. We observed a sepsis

six-pathway tool was displayed in the HDU area and relevant equipment was kept in the nearby medication room. We also observed leaflets on sepsis awareness to give to patients and carers.

- The hospital also had a discharge and transfer policy which outlined the process for transferring patients from the HDU to nearby hospitals in an emergency. This was supported by the service level agreements in place with these hospitals.
- Resident medical officer (RMO) cover was available 24 hours, seven days a week. They led the cardiac arrest team and held the cardiac arrest bleep on the wards. The anaesthetic and theatre recovery team held a cardiac arrest bleep in theatres.
- The RMO had contact details for all patient's consultants if required. If a consultant was on leave they would arrange for another consultant to cover their case load which the RMO would be aware of.
- There was an emergency on-call rota in place in theatres if patients required emergency surgery.
- The hospital had a provision of blood components in a major haemorrhage policy in place and a clear protocol to follow which staff were aware of. The hospital had a blood bank to access in an emergency.
- The hospital had a two-bedded HDU unit for critically unwell patients which was in line with FICM standards.
- All clinical staff were trained in basic life support (BLS) training and there were also some staff members trained in immediate life support (ILS). All RMOs, anaesthetists, and intensivists had training in advance life support (ALS). An intensivist is a board-certified physician who provides special care for critically ill patients. This meant there was always ALS trained staff in the hospital when required. These qualifications were up to date at the time of the inspection.
- Staff followed the five safer steps to surgery and we found that the World Health Organisation's (WHO) five steps to safer surgery checklists were appropriately completed. The WHO Surgical Safety Checklist is a checklist that was developed to decrease errors and adverse events, and increase teamwork and communication in surgery. A briefing sheet on how to use the checklist was included in all patient notes. We observed the checklist to be thorough and robust, including each required step.
- WHO checklist audits were carried out monthly and, for the six months prior to our inspection, compliance rates were consistently 100%. This reflected practice we observed on inspection.

Nursing and support staffing

- The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The hospital had an electronic rostering system which was also written on a white board within each department so staff could easily identify who was on shift.
- A corporate nursing tool was used to calculate acuity and dependency which was done two days before every shift.
- At the time of our inspection, we found that all areas of the surgical services were appropriately staffed, and in some cases, were above established levels. For example on an early shift on meridian ward, required staffing levels were four registered nurses and two health care assistants but the actual establishment was five registered nurses and three health care assistants.
- Staff told us that if further staff were required to cover sickness and patients with more complex needs this was managed well through reallocation of staff and bank usage. For example, staff on paragon ward told us they would often have smaller caseloads and therefore were able to move to the other ward when required. We also saw evidence of this within staff rotas.
- Staff told us that when a patient was admitted to the HDU two nurses were required to look after them. The hospital's lead HDU nurse and regular bank staff worked in the HDU when required as they were most familiar with the environment. These staff were appropriately trained to look after critically ill patients. There were no patients admitted to the HDU at the time of inspection so we could not observe this in practice.

Surgery

- Staff told us the use of agency was minimal and when required consistent agency staff where used. The rates of contracted, bank and agency in the six months prior to our inspection are outlined below: [July 2018 to December 2018; Hours by Staff Type (%)]

Wards: Contact - 99.4%, Bank - 0.4%, Agency - 0.2%

Theatres: Contract - 86.3%, Bank - 13.7% , Agency - 0.0%

Other Clinical: Contract - 90.4%, Bank - 9.2%, Agency - 0.4%

Non-Clinical: Contract - 81.7%, Bank - 17.9%, Agency - 0.4%

Grand Total: Contract - 86.6%, Bank - 13.1%, Agency - 0.3%

- Staff told us that there had been no agency staff in theatres in the year prior to our inspection which is supported by the table above. This is unusual for this type of clinical environment and, therefore, it is particularly impressive for the hospital to have achieved this.
- At the time of inspection, there was only one permanent staff vacancy for surgical services and six vacancies for bank staff. Management told us they did not struggle to recruit to roles and often had a full establishment of nursing and support staff roles.
- Handovers took place at the start and end of each shift. These included all the required staff and were fit for purpose. Every patient had a named nurse on every shift who handed over to the next shift's named nurse.

Medical staffing

- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The hospital had over 300 consultants who worked for them with practising privileges in place and only attended when their patients were there. We reviewed the hospital's documentation on consultants' practising privileges which we found to be managed well and all staff had a current Disclosure and Barring Service (DBS) checks in place. The currently hospital policy on practising privileges was thorough and in date.
- Consultants were recruited by the organisation after a thorough HR process which required sign off by the hospital's medical advisory committee after an interview and DBS check.
- Registered medical officers (RMOs) worked 7 days at a time before handing over to the next RMO. They were available 24 hours a day. If a RMO was required to work during the night, the day shift staff would be alerted during handover in the morning and allow the RMO to rest as required.
- The RMO undertook a medical ward round every 12 hours to review all inpatients. This was a general check to see if the patient was comfortable or required any pain relief. A patient's care plan was solely managed by their specific consultant.
- When patients were admitted to the HDU, an additional RMO was brought in to support them. Staff told us a consultant would stay with the patient until the additional RMO had arrived. We saw evidence of this in staff rotas.
- Consultants were available by phone and had alternative contacts to ring if staff were unable to get hold of them. Staff told us they generally had no problem trying to contact a consultant.
- There was on-call anaesthetic cover 24 hours a day, seven days a week. Anaesthetic consultants remained in the hospital until patients had left the recovery area of the hospital.

Records

- Staff kept detailed paper records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- All 11 patient records we reviewed were thorough and complete. They included signed consent forms with risks explained, signed Public Health England surgical site infection sheets signs, health questionnaires, pathology results, consultant letters, pre-operative assessments including MRSA screening, anaesthetic records and daily nursing notes.
- The daily nursing notes included within all the patient records showed nurses introducing themselves, asking patients about their current pain level and doing environmental checks of the patient's room.

- Records showed that ward round checks were completed every two to four hours throughout the day. These included checks on daily blood glucose charts, fluid balance charts and discharge from recovery information.
- Patient records were stored securely in a locked cupboard behind the nurses' stations in each ward.

Medicines

- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- Staff managed medicines well and completed drug charts correctly. We observed good practice when staff supported patients with medicines. For example, staff always checked patient names and dates of birth prior to administering medicines as well as explaining types and uses of the medicines being given.
- The on-site pharmacy team undertook daily spot check rounds on controlled drugs and other medicines as this was required by the wider organisation.
- Daily medical ward rounds identified patients that were due to be discharged on that day or the next. This information was given to the pharmacy team who would prepare medicines for them to take away on discharge.
- Staff told us they had a good working relationship with the pharmacy team and often went to them for guidance with any medicines queries they had.
- There were no medicines reconciliation audits as all medicines brought in were checked by the pharmacy team on their daily rounds. There were also no pharmacist intervention audits as all interventions were recorded on the inpatient prescription chart. This was the same as the last inspection.
- Across the surgical service, we saw that staff checked and recorded fridge temperatures daily. The temperatures recorded were within the accepted ranges, indicated within the log books.
- Emergency drugs, including an anaphylaxis kit, were readily available to staff and checked every day.
- All controlled drugs cupboards we inspected were securely locked with contents regularly checked. All controlled drugs were signed for with a witness signature against each administration in all the logs we checked on inspection.
- In theatres, controlled drugs cupboards were fixed to walls within locked rooms and all medicines trolleys we checked were locked when not in use. This was an improvement since the last inspection.
- Theatre staff we spoke with were aware of the correct process to dispose of wasted medicines. The procedure for disposal of out of date medicines was to send them back to pharmacy who would manage this. Staff told us they had received training on this and we saw evidence to support this. This was an improvement since the last inspection.
- In date medicine policies and resources were available on the hospital's intranet which were easily accessible to staff.
- The hospital undertook quarterly medicines management audits which included security and storage of medicines. In November 2018, the wards and theatres were 100% and 94% compliant, respectively, with appropriate standards set out by the hospital and in accordance with NICE guidelines. This was an improvement since our last inspection.
- The hospital undertook quarterly controlled drugs audits. In December 2018, the wards and theatres were both 100% compliant with regard to controlled drugs practices. This reflected practice we saw on this inspection.

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Incidents were reported on an electronic incident reporting system which used ratings to identify the severity of the incident. We reviewed incident investigations the hospital had undertaken over the past

year and found them to be thorough in identifying root causes, as well as effective in creating action plans. We also saw evidence that incidents and deaths were discussed regularly in clinical and governance meetings.

- All staff we spoke with knew what constituted an incident and how to report one. However, staff told us that on the day prior to the inspection there was an incident in theatres where a prosthesis was thought to be available but was later found not to be. Upon checking the incident reporting system, it was found that this incident had not yet been reported. We alerted hospital management to this at the time of the inspection, and it was logged on the system later that day.
- The hospital had an in-date policy for investigating incidents which gave guidance on the duty of candour (DoC), completing root cause analysis investigations and subsequent action plans.
- 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 reasonable support to that person.
- All staff we spoke to during the inspection were aware of the duty of candour and of their responsibilities in regard to it.
- From October to December 2018, the hospital reported 77 clinical incidents which were classified in terms of level of harm. All of these incidents were rated as low or no harm.
- From October to December 2018, the hospital reported 33 non-clinical incidents. These included a variety of different types of incident including equipment, financial, personal accidents and facilities.
- We saw evidence that learning from incidents was shared amongst staff. This was done through the daily head of department meetings which was then cascaded to departmental staff, department team meetings, staff information boards and hospital wide emails. We also saw that learning was shared across other hospital sites via the clinical governance and quality and risk bulletins.
- We saw evidence that staff had received further training on incidents in the past year. This included training on how to undertake a good root cause analysis, ensuring all staff voices are heard and working in a supportive and transparent manner.

Safety Thermometer (or equivalent)

- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- Performance figures on the safety thermometer were shown on information boards on the wards. These showed that a patient was unlikely to come to harm.
- Hospital records showed compliance for venous thromboembolism (VTE) screening was 100%, there were no pressure ulcers or falls and 100% of care was harm-free from July to December 2018.

Are surgery services effective?

Good

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff could access all policies and procedures through the staff intranet which they told us was easy to do.
- Most policies and procedures we reviewed were up to date and in line with current guidance. However, the management of medical devices policy was under review at time of the inspection and had been out of date from March 2018 but we did see evidence that the review of this had started prior to our inspection visit.
- We saw evidence that new guidance was discussed at clinical meeting and was cascaded to staff in monthly clinical governance and quality and risk bulletins.
- Staff adhered to antibiotic protocols which were displayed on the walls within the theatres. Displaying these was an improvement since the last inspection.

Surgery

- All patients were mobility assessed by physiotherapists before and after surgery. They then liaised with local NHS organisations to plan appropriate care for the patient after they had left the hospital. Patients told us they had received exercise information which included demonstration videos from the hospital's physiotherapists to help with their recovery at home.
- The hospital did not have an onsite occupational therapist (OT). Staff assessed patients' needs during pre-operative assessment and referred to the physiotherapist team if required once they had been admitted.
- External speech and language therapists were available by phone and through email if it was identified by staff they required this support.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- All patient records we reviewed included a completed malnutrition universal screening tool (MUST), regularly completed fluid balance charts and weight checks. A MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese.
- Patients told us they enjoyed the food at the hospital, which was provided by an external company. They told us there was variety in what they could order and they could cater different dietary requirements.
- Staff adhered to the fasting before anaesthesia policy which was in place. Fasting restrictions were checked and discussed with patients at their pre-operative assessment.
- Staff kept patients informed of any potential delays and ensured they were kept hydrated if they were to be delayed.
- An external dietician was contactable by phone if staff assessed a patient to need this support.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Patients told us their pain was managed well and monitored regularly by staff. Patient records included pain management care plans, patient controlled analgesia charts and pain scores recorded. Patients were also given leaflets on pain management.
- Nursing staff discussed pain relief with the RMO if they had any queries. If the RMO required further advice they would contact the patient's anaesthetist directly.
- There wasn't a specific pain nurse in place at the hospital but it did undertake regular audits on pain management, most recently in January 2019.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Unplanned readmission rates were monitored by the hospital monthly. They were low in the year prior to our inspection, with most months having none. This was below average when compared to other hospital sites.
- Unplanned return to theatre rates were monitored by the hospital monthly. They were low in the year prior to our inspection, with half of the year having none. This was below average when compared to other hospital sites.
- Physiotherapists in the hospital had adopted a Risk Assessment and Predictor Tool (RAPT) score to identify patients that may need more recovery support to facilitate an optimum recovery. This information was given to staff on the wards who could then ensure patients had an appropriate discharge plan.
- Patient outcome measures scores (PROMS) were collected monthly by the hospital and in two different ways, one set for private patients and the other for NHS patients. For private patients 2018 data showed a change in self-rated mobility of 28.1% and overall health of 18.2% for upper limb conditions. For NHS patients, 2018 data showed an average health score change of 12.7%. However, these indicated a significant difference in outcome and we did not see any evidence that the service compared these figures to find the cause behind this.

- These two separate sets of data were used locally and nationally to benchmark patient outcomes. The service also submitted data to the Private Hospital Information Network (PHIN).

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- We reviewed local and organisation-wide induction packs. These included information on training days, a mentoring system and mandatory e-learning. Staff were given protected time to complete induction and training.
- Staff told us they thought the induction process had been effective and supportive. They received two weeks induction into a department before being included in staffing numbers. Staff told us this was reviewed and extended if any staff required further induction time.
- Staff told us there was extra training courses available within the wider organisation and they could also request for external training and this was likely to be accepted. Staff told us they attended a pain symposium run by another hospital to improve their knowledge around pain management.
- Staff told us they received an annual appraisal which was useful and supportive. All permanent staff had an appraisal in the year prior to the inspection or were new starters and on track to meet the target appraisal deadline. This was an improvement since the last inspection.
- Practising privileges were reviewed annually. We saw evidence that this had been completed within the last year and privileges had been suspended or revoked where practice had been identified as below accepted standards.
- Consultants revalidation was included within the practising privileges policy and required if consultants wanted to keep their practising privileges at the hospital.
- An improvement since the last inspection was that endoscopy decontamination now took place off site and therefore staff were not required to be trained in this.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Throughout the inspection we observed strong working relationships between staff from different disciplines. Doctors, nurses, health care assistants, physiotherapists, administrative staff, engineers, diagnostic staff and pharmacy staff told us they worked well together to reach positive outcomes for patients.
- The patient records we reviewed showed strong multidisciplinary working and the structure of the records facilitated it. For example, the notes indicated and defined different clinical roles which were required to input into a patient's care at different stages in the patient's pathway of care. Doctors, nurses, health care assistants, physiotherapists and other allied health care professionals all contributed to patient records.
- The daily head of department meeting was led by the executive director and included all the heads of departments within the hospital. This included leads from theatres, pharmacy, inpatient services, outpatients, imaging, oncology, operations, engineering and a NHS lead. This meeting allowed all members to work together to discuss and manage immediate concerns which needed to be addressed that day. This meeting was also used to discuss and collaboratively manage and tackle on-going issues or any issues that had arisen over the previous week.
- The pharmacy team often met with other pharmacy teams from near-by BMI hospitals and worked with the BMI chief pharmacist on occasion.

Seven-day services

- The pharmacy within the hospital was open Monday to Saturday and closed on Sundays. The team also had an on-call pharmacist rota for queries out of hours. Staff could dispense most prescriptions themselves, except controlled drugs, without needing the pharmacy team. The RMO had access to prepared discharge medicines when the pharmacy was shut to ensure a patient's discharge was not delayed.

- The hospital site had a pathology service which was run by an external company. This was available on-call 24 hours a day, seven days a week.

Health promotion

- Staff told us they were passionate about supporting patients to manage their own health and wellbeing. We saw guidance booklets available to patients on how to manage their own health out of hospital. These booklets included 'The Good Health Guide', 'The Good Fitness Guide', 'Get up and go; a guide to staying healthy' and 'The Good Back Guide' which focussed on empowering patients to manage their own health needs once they had left hospital.
- The wards displayed health promotion information relating to the specific conditions the wards specialised in. For example, we saw displayed for patients on how to appropriately manage chronic back conditions and smoke free policy and guidance – which includes information on support for employees and patients with signposting information for support services.

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

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the hospital's policy and procedures when a patient could not give consent.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and could outline the key principles and practices when caring for and gaining consent from patients who may not have capacity to do so themselves. During pre-operative assessments and on the day of surgery, we observed good practice with regard to consent by staff. This was an improvement since our last inspection.
- All patient records we reviewed showed patients had consented to treatment. This was done at pre-operative assessment and the same-day of or day before surgery.
- The hospital had an in date mental capacity and deprivation of liberty safeguards (DoLS) policy which included an escalation process and DoLS flowchart for staff to follow. It also had an up to date consent for examination or treatment policy in place.
- Staff told us they rarely saw patients with capacity issues but, consent was always assessed by a nurse or doctor. Staff told us that if a patient was identified to have capacity issues at pre-assessment then they were to be referred back to their own GP.
- Staff were required to undertake training on consent. The compliance rate for this training, at the time of inspection, was 98%.

Are surgery services caring?

Good

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

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Patients spoke highly of staff and said they had been kind, attentive and caring. Patients said staff were helpful and understanding which had improved their experience in the service.
- The hospital routinely monitored patient feedback forms. From July to December 2018, patient satisfaction was consistently above 90%.
- We reviewed patient feedback forms which were overwhelmingly positive and included comments such as "very caring staff" and "nurses have been kind and caring".
- We saw many 'thank you' cards staff had received in gratitude of the care patients had received. Some comments included "so grateful to the amazing and kind staff" and "nurses have been so lovely".
- The wards had access to child friendly bed linen, toys and colour posters for patient rooms to make the environment more caring and less clinical for younger patients.

Surgery

- Throughout the inspection, we observed compassionate care with consideration of dignity and respect always. We saw doors were always closed when patients were receiving care and patients were appropriately covered when travelling to and from theatres.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Nurses told us they were available to support patients if they had received bad news and they had available space for patients to sit privately when distressed.
- There was a double room available on each ward in case a patient wanted a relative to stay overnight with them.
- Staff told us if patients needed support services they had relevant signposting information to give to them.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- During the inspection, we spoke with nine patients and two relatives. They said they were kept informed about their care and received regular updates about their treatment from consultants and nurses.
- Patients who had their surgery told us their consultants had been to see them promptly to tell them how their operation had gone.
- We saw patients were given information leaflets explaining their treatment and the processes around it. Patients told us they had been able to ask questions throughout their time at the hospital and felt staff had taken the time to answer questions and explain procedures.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- The hospital planned and provided services in a way that met the needs of local people.
- Staff told us, and patients we spoke to confirmed, that patients could book their own admission dates after discussion with their consultants. The hospital could accommodate admitting patients in the evenings and weekends if patients preferred.
- Patients could have pre-operative assessment in a way that suited them, depending on their procedure, either over the phone or at the hospital. The service also had an assessment tool to identify if a patient should require a face to face assessment.
- The hospital held a local NHS contact to provide services to bariatric patients to meet local demand. Bariatric equipment was readily available for these patients when required.
- Consultants started to plan discharge with patients at the pre-assessment stage but continued to update this plan throughout the patient journey as required. We saw evidence of this in patient records which also included information on emergency contacts for patients in case they needed to be informed of any changes in the discharge plan.

Meeting people's individual needs

- The service took account of patients' individual needs. The service made adjustments for patients' religious, cultural and other preferences.
- There were no policies in place for patients with additional needs, such as those living with learning difficulties or mental health conditions, however staff told us the hospital's exclusion criteria meant they did not receive any patients with additional needs. Staff told us any patients or carers enquiring about using their services would be signposted to more specialist services.
- The hospital did not have a dementia champion, however, staff told us they very rarely had patients who were living with dementia. Patients completed a questionnaire at pre-assessment which was used to identify any capacity issues. Staff told us any patients who had the potential to have a dementia diagnosis

were likely to be signposted back to their GP or more specialist services. They did note, however, that the double rooms on the wards could be provided to patients living with dementia, if required.

- The wards had a dementia-friendly resources box in case a patient living with dementia did attend the service. This included a large text clock, clear signage for the toilet, activities, 'this is me' care plan template and guidance for staff on how to help people with dementia. This was an improvement since the last inspection.
- Staff told us that translators could be booked, and would be done when the patient had arranged their pre-assessment, but they were rarely required to do so. Staff also had access to a telephone translation service which could be used for consultations or if a translator was needed at short notice.
- The hospital site was entirely accessible by wheelchair. Lifts were in place between floors and corridors throughout the hospital were wide enough to accommodate wheelchair access.
- The hospital undertook an annual disability access audit which checked if specific areas remained accessible to disabled staff, patients and visitors. These included the car park, hospital entrance, reception area, public telephones, floor surfaces, wall surfaces, passenger lifts, fire safety and disabled toilets. The latest audit showed that the premises were currently compliant which was confirmed during our inspection.
- There were no limits on visiting times within the hospital.
- Patients told us that their call bells were answered promptly when they used them.

Access and flow

- People could access the service when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.
- Standard theatre hours were from 7.30am to 8pm Monday to Saturday. The theatres would also run on a Sunday every few weeks for bariatric patients. Endoscopy hours were 7.30am to 8pm.
- A consultant would assess and agree an appropriate surgical pathway with the patient and then the consultant would complete a booking form. A nurse would then contact a patient to arrange a pre-assessment, either over the phone or at the hospital. Post pre-operative assessment, patients were sent an admission letter about their surgery.
- Theatre administrators scheduled procedures and operations. Any changes to theatre lists were discussed at team briefings.
- Theatre staff used an electronic booking system which highlighted any gaps in procedures. These gaps would often be used for training or meetings.
- Paragon ward was closed overnight as patients were only expected during the day. Staff told us the ward would remain open if they had a lack of bed space on Meridian ward.
- Management had future plans to bring the outpatients department closer to inpatients building. This would mean the pre-assessment area would also be nearer to outpatients and therefore help with patient access and flow.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- We reviewed some of the hospital investigations into complaints. We found these to be thorough, effective in identifying learning and provided a transparent and sympathetic response to patients.
- The hospital had an in-date complaints policy which staff were aware of. This policy outlined clear roles and responsibilities when responding to patient complaints.
- We saw evidence that there had been staff training on complaints in the year prior to our inspection. This included guidance on how to manage a complaint well, how to do a complaint letter, identifying actions and learning and making complaints personal to individual patients.
- Throughout the hospital we saw posters and leaflets with information on how patients could provide feedback on the service they had received, including general comments, compliments and complaints.
- Complaints and learning identified from them were discussed in the daily head of department meetings.

Surgery

- Learning from complaints was shared with staff in clinical bulletins, hospital-wide emails and departmental meetings.
- The hospital was able to monitor its response times to complaints and compare these against all other hospitals and against the regional average.

Are surgery services well-led?

Good

Our rating of well-led stayed the same. We rated it as **good.**

Leadership

- Managers had the right skills and abilities to run a service providing high-quality sustainable care.
- There had recently been changes with the local leadership, with several management posts being held as interim. Staff told us this had been challenging but were happy that this new local leadership was now permanent.
- The executive director had only been in post since October 2018. Despite this, staff found them to be visible, approachable and gave examples where they had listened and acted on concerns or queries they had raised to them.
- The hospital structure included an executive director, who managed the director of clinical services, quality and risk manager and the director of operations. The management roles within the hospital were well defined and we found management staff were aware of their roles, responsibilities and accountabilities.
- Staff spoke highly of their heads of departments and felt well supported by their managers and able to raise concerns, if necessary. In particular, the inpatients' service manager was well liked by ward staff, who gave examples of when the manager had personally supported many different staff members' career development and personal wellbeing.
- Management told us that regional leads, not based within the hospital, were visible and supportive.

Vision and strategy

- The hospital and wider organisation had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The vision for the wider organisation was "Serious about health. Passionate about care." This aligned to the hospital's local vision "to provide outstanding care, and become the hospital of choice for Southeast London for patients, consultants and staff".
- Since the new executive director started in October 2018, they had developed, alongside service leads, a new strategy for the hospital. This strategy focussed on quality improvement, focussed specialities work, developing relationships with local communities and fostering a collaborative, engaged and high performing workforce. Although this strategy was in its infancy, management had communicated it well to staff, through emails, posters and in team meetings.
- We saw detailed and realistic plans for a development of the main site of the hospital. This included plans to bring the outpatients department closer to the main site, for an ambulatory care facility, plans for a four-bedded intensive treatment unit (ITU) to replace the current two-bedded HDU and the closure of the urgent care centre (UCC) in favour of increased consulting rooms.

Culture

- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- As part of the new strategy, the hospital had implemented a new staff pledge to "respect one another as one team. With a trustworthy, no blame approach. Owning and delivering an outstanding service." As a new pledge, management were aware this would take time to embed but had already engaged with staff about it via emails, a staff forum in November 2018, team meetings and posters displayed within the hospital.
- Staff told us they were happy and proud to work for the hospital. Many staff told us had worked for the hospital for a number of years and that there was a very friendly atmosphere amongst staff.

- There was an open and transparent culture amongst staff. Staff told us they felt confident to challenge poor practice or raise concerns. They told us they would be supported to do so by other colleagues and managers.
- There was a focus on staff wellbeing within the hospital. For example, management organised a health and wellbeing day for staff in December 2018 where staff could receive massages and pamper sessions. The hospital also had an employee assistance programme to offer confidential support to staff during difficult personal times.
- Staff were recognised for their achievements and 'going the extra mile'. There was a monthly recognition of staff in each department which was fed up to daily head of department meetings. A name was then picked at random and that staff member would receive a prize. This was an improvement since the last inspection.
- The service did not always promote an inclusive culture. The service had worked to ensure the hospital had good disabled access throughout, however there were no policies in place for patients with additional needs, such as those living with learning difficulties or mental health conditions. Staff told us they did not have any patients with additional needs and they would be signposted to more other services that could support them.

Governance

- The hospital used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The clinical governance structure included clinical and operational committee meetings. These included quality, safety and risk management, medical advisory and clinical governance meetings. These reviewed performance and operations within the hospital and surgical division and identified any areas requiring improvement.
- There was regional oversight provided by the monthly regional executive director meetings. These discussed performance and local audits and the executive director cascaded relevant information to staff when appropriate.
- Staff meetings reviewed training, policies, incidents, audits and any other staff concerns. These meetings were minuted and therefore able to be audited if required. We reviewed several of these meeting minutes and we found them to be clear, informative and consistent.

Managing risks, issues and performance

- The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The hospital had a risk register which was regularly reviewed and actions to mitigate or eliminate when risks were identified. Each risk was rated with a red, amber or green status to their indicate severity, with red being high risk, amber being medium risk and green being low risk. We saw that risks were reviewed regularly and updated with any changes in a timely manner.
- The electronic incident reporting system was linked to the electronic risk management system which allowed incidents to be escalated into risks quickly.
- We saw evidence that guidance had been given to all BMI executive directors on how to manage risk and implementing and managing a risk register across all the BMI hospitals.
- The top risks identified were governance and lack of embedded learning culture, vacancies within the administration team and facilities. The new strategy developed by management aligned to many of the risks on the risk register and were likely to be eliminated when plans were underway. Staff we spoke with were aware of the hospital's top risks and the mitigations in place to minimise these risks.
- The hospital had a dashboard to monitor performance which was reviewed locally and regionally. This gave leadership oversight of key performance indicators including staffing levels, incidents, mortality, complaints, cancelled surgeries, readmissions and return to theatre rates.
- The hospital was able to benchmark itself against similar services and identify areas of good practice or those that require improvement. This was an improvement since the last inspection.

- The monthly clinical governance and quality and risk bulletins included information on lessons learned from incidents and complaints, National Safety Alerts and deaths. This was sent to all clinical staff within the hospital.
- There was quarterly medical advisory committee which discussed vacancies, activity levels, risks, incidents, complaints, deaths, updates to guidance, accreditation and audits.
- The wider organisation that the hospital worked under had set expectations for how their services should be managed. This enabled consistency across sites and allowed hospital sites to benchmark themselves against one another.

Managing information

- The hospital collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The hospital had safe and effective information management systems to record and monitor data and information.
- Local and regional staff reviewed a range of quality and risk information about the service. This included staffing, activity and incident levels. Local leadership staff shared information with regional leadership to enable benchmarking across services.
- Staff were trained in information governance and the compliance rate, at the time of inspection, was 92%.

Engagement

- The hospital engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- All patients were given patient feedback forms on discharge which were reviewed regularly in staff meetings. This had increased uptake in patient feedback since the last inspection.
- We observed posters and leaflets throughout the hospital encouraging patients to feedback on their care.
- Staff were sent regular emails and bulletins from local and regional management. These covered a wide range of topics including updates on guidance, incidents, complaints and staff recognition.
- There had been two recent staff forum drop-in sessions the executive director had organised. These sessions included information on new strategy, upcoming hospital plans, challenges and what they were doing well.

Learning, continuous improvement and innovation

- The hospital was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
- There been an introduction of a new discharge checklist used by physiotherapy assistants in summer 2018. This had been developed in response to low patient satisfaction scores for inpatient physiotherapy. This was believed to be the main factor contributing to the increased patient satisfaction which, at the time of inspection, was above 90%.
- The recent introduction of the daily head of department meeting with the executive director and all head of departments had allowed for timely action against areas of concern. This multidisciplinary approach had enabled colloborative working in a different way than had previously been seen at the hospital. It also allowed for easy sharing of learning, escalation of concerns and cascading of information to departmental staff.
- An 'impressions' board which included pictures of areas identified in need of repair or refurbishment were distributed to regional leads of BMI and shown to all the heads of department at the daily head of department meetings. This was regularly updated to show the improvements that had been made throughout the hospital.

Outpatients and diagnostic imaging

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

Information about the service

We did not inspect this core service at the time of this inspection. Please see the January 2017 report for the detailed findings of this service.

Summary of findings

At the January 2017 inspection, we rated this core service as Good. Please see the January 2017 report for the detailed findings of this service.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

At the January 2017 inspection, we rated safe as Good. Please see the January 2017 report for the detailed findings of this service.

Are outpatient and diagnostic imaging services responsive?

Good

At the January 2017 inspection, we rated responsive as Good. Please see the January 2017 report for the detailed findings of this service.

Are outpatient and diagnostic imaging services effective?

Good

At the January 2017 inspection, we rated effective as Good. Please see the January 2017 report for the detailed findings of this service.

Are outpatient and diagnostic imaging services well-led?

Good

At the January 2017 inspection, we rated well-led as Good. Please see the January 2017 report for the detailed findings of this service.

Are outpatient and diagnostic imaging services caring?

Good

At the January 2017 inspection, we rated caring as Good. Please see the January 2017 report for the detailed findings of this service.

Outstanding practice and areas for improvement

Outstanding practice

We found examples of outstanding practice in this service, outlined as follows:

- Daily head of department meetings with the executive director and all head of departments had a unique multidisciplinary approach which enabled colloborative working, easy sharing of learning, escalation of concerns and cascading of information to departmental staff.
- Patients received interactive exercise information which included demonstrations videos to help with their recovery at home.

Areas for improvement

Action the hospital SHOULD take to improve
Action the provider SHOULD take to improve

- The hospital should ensure it complies with its own target for mandatory training.
- The hospital should ensure there is an appropriate space to store used surgical equipment.
- The hospital should ensure all incidents are reported in a timely manner.
- The hospital should ensure they compare the difference in patient outcome measures scores (PROMS) between NHS and private patients.
- The hospital should ensure its promotes an inclusive culture with regard to patients with additional needs.