BMI Thornbury Hospital

Quality Report

312 Fulwood Road
Sheffield
South Yorkshire
S10 3BR
Tel: 0114 266 1133
Website: www.bmihealthcare.co.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI Thornbury Hospital is operated by BMI Healthcare Group. Facilities at the hospital included four operating theatres and an endoscopy suite and a four bedded critical care unit. The hospital is registered with the Care Quality Commission (CQC) for 64 beds.

We inspected the hospital as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. It was a routine planned inspection. We inspected the following five core services at the hospital: medicine, surgery, critical care, services for children and young people, and outpatients and diagnostic imaging. We carried out the announced part of the inspection on 24, 25 and 26 November and 4 December 2015. We also carried out an unannounced visit on 17 December 2015.

We rated the hospital as requires improvement overall. Services for children and young people and critical care services were rated as requires improvement. Medicine, surgery and outpatients and diagnostic imaging services were all rated as good. For the hospital overall we rated the safe and effective key questions as requires improvement. The effective, caring and responsive key questions were all rated as good.

Are services safe at this hospital

We rated the safe key question as requires improvement overall. We found that patient records were not fully completed. We found that the resuscitation trolley for children on the Fulwood Suite was not well organised to allow staff to find equipment quickly in an emergency and syringes to inflate resuscitation masks were not immediately available on the ward or in outpatient areas. We had concerns about the management of the deteriorating patient and emergency situations in the critical care unit. Early warning scores were not recorded and patients did not have easy access to call bells. This meant that there could be a delay in identifying and responding to a deteriorating patient. The critical care unit was cramped. We were not assured that there were adequate arrangements in place to mitigate the risks associated with the critical care environment.

The hospital was visibly clean. There were audits of infection prevention and control practices. Staff did not always follow infection prevention and control practices. Incidents were reported and there were robust processes for sharing learning with staff. Staff were aware of the duty of candour. There had been no never events or serious incidents in the reporting period July 2014 to June 2015. The resident medical officer (RMO) was based in the hospital and provided medical cover 24 hours a day. We reviewed RMO cover and found it was sufficient. Staffing levels and projected occupancy ratios were reviewed daily. Mandatory training was in place for all employed staff and training compliance rates were high. Staff received mandatory training in the safeguarding of vulnerable adults and children and the nursing and medical staff we spoke to were generally aware of their safeguarding responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children. The Director of Clinical Services was the named safeguarding lead for the hospital. However, we saw no evidence in staff files that paediatric nurses had level three safeguarding training. The hospital has subsequently confirmed that this training is in place. For medical staff, mandatory training records were not completed or checked with substantive employers. We reviewed files for six consultants working under practising privileges and saw no evidence that recent training compliance was logged. There was a deteriorating patient pathway and a clinical escalation policy in place. There was a formal arrangement for patients to be transferred to the local NHS hospital if their clinical condition could not be safely managed at the hospital. The hospital would use the Embrace paediatric transfer service to transfer children whose clinical condition had deteriorated but there was no formal arrangement with the Embrace service.

Are services effective at this hospital

Summary of findings

We rated the effective key question as requires improvement overall. We saw that pain scores were not routinely recorded in some areas and that some policies we reviewed were out of date. Some staff had not undergone annual appraisals. The hospital did not complete audits for children and young people and there was no data collected on the outcomes for children and young people following surgery. Staff in theatres had not all completed Paediatric Intermediate Life Support Training as required.

Patients were cared for in accordance with evidence based practice. Policies were mostly developed nationally. Clinical indicators were monitored corporately and compared with similar hospitals in the company through the production of a monthly quality dashboard. The hospital participated in a number of national audits to measure patient outcomes such as Patient Reported Outcome Measures and the National Joint Registry. There had been 19 unplanned readmissions to the hospital within 29 days of discharge in the period July 2014 to June 2015. This rate was "similar to expected" compared with other independent acute hospitals. Consultants were granted practising privileges to work at the hospital. Practising privileges are when authority is granted to a doctor or dentist to provide patient care in the hospital by a hospital's governing board. Staff appraisal rates varied across the hospital This had been recognised by senior management and there were plans in place to address this. There were consent procedures in place and training rates for Mental Capacity Act training were good.

Are services caring at this hospital

We rated the caring key question as good overall. Patients were cared for compassionately and with dignity and respect. Patients and relatives spoke positively about care and treatment and felt involved in the planning of their care. Staff gave examples of providing emotional care to patients. We observed positive interaction between staff and patients. The hospital had a high score (above 85%) in the Friends and Family Test but response rates were low (less than 30%). The hospital's internal patient surveys showed generally high (above 90%) levels of patient satisfaction, particularly in relation to the quality of care.

Are services responsive at this hospital

We rated the responsive key question as good overall. Services were planned to meet the needs of local people and individual patients. There were plans to develop the endoscopy and oncology services and the endoscopy service was working towards achieving Joint Advisory Group (JAG) accreditation. The cancer care (oncology) service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015. There were clear inclusion/exclusion criteria for accepting surgical patients. Patient discharge was planned so that patients were discharged with the right level of care and support. Referral to treatment times data for the reporting period July 2014 to June 2015 showed that the hospital had routinely exceeded the targets for admitted and non-admitted patients to be seen or treated within 18 weeks. The hospital had not cancelled any operations in the three months prior to the inspection. The number of complaints made about the hospital had increased in recent years. However, complaint volumes were benchmarked against other hospitals in the company and this showed that the number of complaints received at Thornbury Hospital were low when compared with other similar hospitals. There were systems in place to share findings and learning from complaints with staff.

Are services well led at this hospital

We rated the well led key question as good overall.

There was a vision and strategy in place at the hospital, which the majority of staff could articulate. The hospital had an action plan in place detailing further actions to be taken up to 2016 to continue to engage staff and provide ongoing training in line with the vision and strategy. There was vision and strategy in place at service level and staff could generally articulate this. The hospital had a governance structure, with a clinical governance committee in place. The clinical governance committee fed into the Medical Advisory Committee (MAC). The hospital fed into the corporate governance arrangements via the hospital's executive group. We reviewed the hospital's risk register. There were no risks that had been opened prior to 2015 and all risks had mitigating actions and review dates identified.

Summary of findings

The monitoring systems to ensure that doctors working in the hospital under practising privileges were safe to practise were not robust. We reviewed six files for doctors working under practising privileges. Appraisals were out of date in all files we reviewed and Disclosure and Barring Service checks were either missing or out of date in five of the files we reviewed. Senior managers were aware of these issues and we saw evidence that they were working to address this. Systems to ensure that nurses had valid professional registration were also not robust. Staff generally described the leadership and culture within the hospital positively. Staff told us they were able to raise their views and opinions with their managers and were asked to share their ideas and to make service improvements. The hospital had formed a patient satisfaction group and had made a number of changes to improve patient experience in response to themes identified in patient feedback.

The service for children and young people did not have robust systems in place to identify and mitigate risk. For example, the risk of the resuscitation equipment not being stored appropriately and some staff not knowing how to use it had not been identified. There had been an abrupt change in leadership in the outpatient team and senior managers acknowledged that work was needed to develop the vision and a positive culture in this service.

We observed outstanding practice in the hospital's daily "comms cell" meetings which were held between the hospital's senior management team and the heads of department. Comms cell meetings were used to discuss matters such as patient admissions, staffing, risk and incidents. Information from comms cell meetings was then cascaded to staff through departmental meetings. Comms cell meetings were supported by comms cell boards in the main staff areas that displayed information on incidents, audit outcomes, clinical audit data and staffing. The comms cells ensured there was a robust system of communication in place in the hospital.

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

Importantly, the provider must:

- Ensure that comprehensive patient records are maintained, particularly in relation to recording pre-assessment, risk assessment, consent and early warning scores.
- Ensure that paediatric resuscitation equipment is stored appropriately, all required equipment is immediately accessible and staff know how to use paediatric resuscitation masks.
- Ensure that all staff adhere to the hospital policy for the administration of controlled drugs.
- Ensure that there are appropriate arrangements in place to manage the risks associated with the critical care environment, including ensuring patients have access to call bells and managing emergency situations in the critical care unit.
- Ensure that staff follow infection prevention and control practices.
- Ensure that, in relation to the service for children and young people, there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified, assessed and managed.
- Ensure that there is a robust process for ensuring that medical and nursing staff have the skills, competency, professional registration and good character to practise in the hospital, including evidence of current professional registration, up-to-date appraisal and training and Disclosure and Barring Service checks (DBS).
- Ensure that theatre staff involved in the care and treatment of children have child-specific training, as recommended by the Royal College of Anaesthetists.

In addition the provider should:

- Ensure that daily controlled drug stock checks are done when the critical care unit is open.
- Run a simulation of a patient collapsing in the bathroom in the critical care unit.
- Ensure that a system of pain scoring is used in the critical care unit.
- Ensure that cover is available for staff working in the critical care unit to have a break.
- Review and formalise arrangements for paediatric transfer.

Summary of findings

- Ensure that the BMI corporate policy is adhered to concerning children's nurse staffing in outpatients.
- Consider formally monitoring and auditing waiting times, clinic cancellation and patients that do not attend for outpatient appointments.
- Consider developing a suitable 'did not attend' policy concerning outpatient appointments.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	Overall we rated this service as good. There were safety systems in place to support the delivery of care and treatment. The endoscopy service was working towards achieving Joint Advisory Group (JAG) accreditation in 2016. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it delivers against a range of quality improvement and assessment measures. Required improvements to ensure processes and the facilities would satisfy JAG requirements had already commenced with the recent installation of a new endoscopy monitoring stack system and new endoscopes. Staff in the endoscopy service were trialling new equipment which would improve the quality of decontamination of equipment within the service. The consultants and staff monitored patient outcomes through the multidisciplinary team (MDT) meetings within the NHS and at subsequent follow-up treatments and outpatient appointments at the hospital. Oncology staff worked effectively and had strong links with local cancer support agencies, other BMI hospitals and with colleagues within the local NHS services. Patients we spoke with told us they were fully aware and involved in their pathways of treatment and care. They spoke positively about the quality of the oncology service provided at the hospital and were very complimentary of the staff. The September 2015 local patient survey results showed patients had reported very positive experiences with the oncology service at the hospital. Patients attending the endoscopy services provided immediate written feedback of their experiences and our review of 13 feedback cards completed by patients on the 24 and 25 November 2015 showed they thought they had received very good to excellent care. The cancer care (oncology) service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015. The MQEM is ‘a

detailed quality frame work used for assessing whether cancer care environments meet the standards required by people living with cancer'. Following the recommendation from a visit and recent meetings with service users, plans were agreed to upgrade the unit's décor and furniture within the cancer care unit.
Medical records were generally well organised and securely managed. Concerns were identified in the accuracy and completion of patient records within both endoscopy and oncology.

Surgery

Good

Overall we rated this service as good. Patient safety was monitored, incidents were investigated, and learning was shared to improve care. Patients received care in a visibly clean and suitably maintained environment. Patient records were well structured but we found staff did not complete all sections of the patient record and did not record reasons why sections were not completed. Staffing levels were sufficient to meet the needs of patients. The service had competent staff who worked well as a team to care for patients. Doctors were available to provide care for patients 24 hours a day. Staff were up to date with their mandatory training and staff were aware of safeguarding policies and procedures for adults and children.
The service had policies and guidance to ensure staff provided care and treatment in line with evidence based standards and procedures. The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals in the company.
Staff supported and treated patients with dignity and respect. Patients and their carers were satisfied with the care they received.
Services were planned and delivered to meet the needs of the local population. There was daily planning by staff to ensure that patients were admitted and discharged in a timely manner with the right level of care and support. Patients told us their pain was managed effectively. The service had identified concerns with the management of pain and had set up a pain group to review and improve the management of pain for patients. The

Summary of findings

hospital had access to interpreters for patients whose first language was not English. Information leaflets were available about the services were available in all areas we visited
There were clear governance structures in place with committees for clinical governance, health and safety, infection control and medication.

Critical care

Requires improvement 

We rated this service as requires improvement. This was because of practice we observed in relation the administration of controlled drugs and storage of record books. We also had concerns over some of the environmental factors in the unit. For example, the lack of patient call bells and the ability to access a patient in an emergency situation as this could result in a delay in attending to a patient. Early warning scores were not recorded for patients in critical care ; this could mean deteriorating patients were not identified at an early stage.
Two of the five critical care staff we spoke with had not completed their annual appraisal. We also saw that pain scores were not routinely recorded on critical care and that some policies we reviewed were out of date. The hospital also did not submit data to the Intensive Care National Audit and Research Centre (ICNARC), although there were plans to do this in early 2016.
Care was evidence based and staff were appropriately trained. Staffing levels were in line with the core standards for intensive care. There was an ongoing programme of audit with results collated in a dashboard, and actions taken as a result if needed.
A care pathway had been developed for deteriorating patients in response to information gathered about patients who had been transferred from the unit. Patients were treated with dignity and respect and involved in their care, and individual care needs were identified at pre-assessment.
The unit was responsive to the needs of patients and additional beds and appropriate staffing could be arranged at short notice.

Summary of findings

The critical care unit had a clear vision and strategy and the governance arrangements enabled clear identification of risk and sharing of information.

Services for children and young people

Requires improvement 

We rated this service as requires improvement. Although patient records were well structured, we found staff did not complete all sections of the patient record. The resuscitation equipment for children on the ward was not well organised to allow staff to find equipment quickly in the event of an emergency. Three staff did not know the procedure for using the resuscitation masks. A children's nurse was not routinely available on site when children attended for outpatient appointments, as required by corporate policy. A lead children's nurse was in place and was contactable by telephone off site.

The hospital did not complete audits for children and young people because the service had only had small numbers of children admitted for surgery. There was no data collected on the outcomes for children and young people following surgery. Staff in theatres had not all completed Paediatric Intermediate Life Support Training as required.

The service had incident reporting systems in place and there had been no serious incidents reported between July 2014 and June 2015.

Staff supported and treated patients with dignity and respect. Patients were involved in the planning of their care. Patients and their carers were satisfied with the care they received. Patients told us they received enough information about their care and treatment.

Services were planned and delivered to meet the needs of the local population. There was planning by staff to ensure patients were admitted and discharged in a timely manner with the right level of care and support. There was a complaints system in place. The hospital investigated and responded to complaints within the designated timescales

The hospital had access to interpreters for patients whose first language was not English. Information

Summary of findings

leaflets were available about the services were available in all areas we visited. However, there were no child-friendly or easy-to-read information leaflets available throughout the hospital.
There was a vision for the services provided at the hospital. There were clear governance structures in place with committees for clinical governance, health and safety, infection control and medication. Staff were positive about the culture and the support they received from managers.

Outpatients and diagnostic imaging

Good

We rated this service as good. There were clear systems embedded for reporting risk and safeguarding patients from abuse. All staff had received appropriate training in adult safeguarding. Staff were aware of how to raise incidents and we saw evidence of incidents being appropriately investigated and learning being shared. The radiology service took appropriate steps to screen patients before exposing them to radiation and clear signage was in place to warn patients when entering designated areas. The departments were clean and medications were stored safely.
Staffing levels were safe and were generally appropriate, but management in the outpatient department identified a shortage of staff and were recruiting to these posts.
Although below the hospital target of 100%, compliance with mandatory training was high. There were variable rates of compliance with annual appraisal and this had been flagged as an issue by the hospital.
The services provided varying levels of cover, from five to six-day services dependent on the department involved. Appropriate access was available to multidisciplinary meetings within the local NHS trusts.
The service was exceeding referral to treatment targets for patients due to be seen in outpatients and physiotherapy. Although not formally monitored, staff explained most patients could be seen within one week of making an appointment.
Radiology imaging was available on site and reports were routinely made available to staff within 24 hours of imaging. Patients we spoke with

Summary of findings

raised no concerns about timely access to services being available. Some 'one stop' clinics were available to reduce the number of visits a patient needed to make to the hospital.

The service used evidence based guidance to inform practice and we saw that appropriate guidance from NICE and the royal colleges was in use. Systems were in place to ensure that medical staff had competencies regularly assessed once being granted practising privileges, although we found that these were not consistently applied. In the main, appropriate systems were in place to ensure that deteriorating patients could access emergency care.

Staff had a broad understanding of capacity and consent. All staff had undergone appropriate training in the mental capacity act and deprivation of liberty.

All patients we spoke with told us that staff had treated them well and the majority felt that they had received timely and informative care. The service had measures in place to protect the privacy and dignity of patients. Staff provided emotional support to patients and gave examples of when this had been necessary. Signage in the departments and the patient information provided also helped to ensure that patients and their families understood relevant information about their care and their visit to the hospital.

An appropriate system was in place to log and investigate complaints and we saw complaints about the wider hospital being discussed in staff meetings to share learning.

Appropriate governance systems were in place and the majority of staff spoke highly of their immediate line managers and colleagues. However, there had previously been cultural challenges within the outpatient department. This resulted in an abrupt change in management within the past six months and staff reported feeling under pressure and unsupported during this period. The new management team were addressing the issues and staff told us things were improving.

Summary of findings

Contents

Requires improvement

BMI Thornbury Hospital

Services we looked at

Medical care; Surgery; Critical care; Services for children and young people; Outpatients & diagnostic imaging

Summary of this inspection

Background to BMI Thornbury Hospital

BMI Thornbury Hospital is operated by BMI Healthcare Group. The hospital became part of BMI Healthcare Group in 1996. It is a private hospital situated in Sheffield and primarily serves the communities in the South Yorkshire area.

Facilities at the hospital included four operating theatres and an endoscopy suite. There was a four bedded critical care unit located off one of the wards and two further beds with on the ward which could be used as high dependency beds. The hospital was registered with the Care Quality Commission (CQC) for 64 beds, of which 57 were inpatient beds and seven were day case beds. There were also x-ray, outpatient and diagnostic facilities.

The hospital had three wards, the Mappin, Fulwood and Rivelin. The Mappin suite had 26 beds, all with en-suite facilities. The Fulwood Suite had 27 beds, all with en-suite facilities and two ambulatory care rooms containing nine recliner chairs. The Rivelin Suite had seven day case beds. The outpatient department had 19 consulting rooms, two treatment rooms, a physiotherapy department and a gymnasium. The hospital had a range of diagnostic imaging services including x-ray, ultrasound and a new digital mammography unit. A CT scanner with a cardiac package and a new MRI scanner with breast coil package were located in a separate building in the hospital grounds. The hospital provided outpatient services for children of all ages, with the exception of neonates. The hospital provided non-complex day case surgery for children over the age of three years on dedicated paediatric theatre lists.

The hospital had been inspected by the CQC five times since initial registration with the CQC. The most recent inspection took place in December 2013 and the hospital was found to be meeting all the standards of quality and safety it was inspected against.

This inspection was conducted as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. It was a routine, planned inspection. The inspection team inspected all five core services provided at BMI Thornbury hospital:

- Medicine
- Surgery
- Critical care
- Children and young people
- Outpatients and diagnostic imaging

At the time of inspection, the registered manager had been in post for one year and two months.

Our inspection team

Our inspection team was led by:

Inspection Lead: Berry Rose, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a senior manager from another healthcare provider, nurses, a consultant surgeon and an expert by experience, who had personal experience of using the type of service we were inspecting.

Why we carried out this inspection

We carried out the announced part of the inspection on 24, 25 and 26 November and 4 December 2015. We also carried out an unannounced visit on 17 December 2015. We talked with patients and members of staff, including managers, nursing staff (qualified and unqualified), medical staff, allied healthcare professionals, support staff and managers. We observed how patients were being cared for and reviewed patients' clinical records.

Summary of this inspection

Prior to the inspection we reviewed a range of information we had received from the hospital. We also distributed comment cards for patients to complete and return to us. We also asked the local clinical commissioning group to share what they knew about the hospital.

How we carried out this inspection

We carried out the announced part of the inspection on 24, 25 and 26 November and 4 December 2015. We also carried out an unannounced visit on 17 December 2015. We talked with patients and members of staff, including managers, nursing staff (qualified and unqualified), medical staff, allied healthcare professionals, support staff and managers. We observed how patients were being cared for and reviewed patients' clinical records.

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Information about BMI Thornbury Hospital

Activity (July 2014 to June 2015)

- 3,013 overnight inpatients
- 6,025 day case inpatients
- 8,630 visits to theatre
- 37,224 outpatient appointments (including follow-up appointments
- The most commonly performed surgery was phacoemulsification of lens with implant – unilateral (614 procedures) and knee and hip surgery (914 procedures)

Core services offered

- Critical care
- Diagnostic imaging*
- Endoscopy*
- Gynaecology*
- Medical care*
- Oncology

*Services offered to children and young people

Staffing (headcount and full time equivalents)

- 247 doctors and dentists working under practising privileges
- 50.2 nurses:

- Inpatient departments 25.6
- Theatre departments 17.2
- Outpatient departments 7.4

- 6.8 operating department practitioners
- 21.4 care assistants:

- Inpatient departments 9.5
- Theatre departments 5.4
- Outpatient departments 6.5

- 17.5 allied health professionals
- 35.3 administrative and clerical staff
- 46.6 other support staff

At the time of the inspection the registered manager, Margaret Falconer was the controlled drugs accountable officer.

At the time of inspection none of the services were accredited by a national body.

Outsourced services

- Pathology – Emergency and Blood products
- Pathology
- Histopathology
- Resident Medical Officer provision
- Catering
- Decontamination
- Microbiology Advice
- Critical Care Advice
- Resuscitation Support and ILS Training
- Medical Equipment Servicing
- Baxters and ITH

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Notes

We will rate where we have sufficient, robust information which answer the key lines of enquiry (KLOESs) and reflect the prompts.

Good

Medical care

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

Information about the service

A significant proportion of the medical care provided at BMI Thornbury Hospital related to planned elective endoscopy and medical oncology. Therefore, the medical care we looked at under this core service related to both these services.

The dedicated endoscopy unit provided care and treatment for NHS and private adult patients only. The unit was situated adjacent to the main theatre suite and had a fully equipped endoscopy theatre treatment room, separate decontamination room, clinical utility rooms and a five-bedded recovery bay. The unit opened for elective endoscopy from 7.30am to 9pm Monday to Friday. Endoscopy procedures were performed with or without sedation. The procedures included gastroscopy, colonoscopy, flexible sigmoidoscopy, flexible cystoscopy and rigid hysteroscopy. The service provided around 1200 endoscopy procedures each year.

The dedicated cancer care unit 'the Rivelin Suite' provided medical oncology chemotherapy and supportive therapies for private adult patients only. The unit had six individual treatment rooms with en-suite facilities, one consulting private room and clinical utility rooms. The service provided flexible opening and closing times mainly between the hours of 7.30am to 9pm Monday to Friday. At the time of our visit, two patients were using the service. We were told that around 20 to 30 patients were actively receiving treatment at various stages of their treatment regimens with around six to eight patients treated weekly. Due to the nature of the treatment regimens this equates to 484 treatment episodes over the last 12 months.

We visited both units to talk with patients, relatives, staff and to observe care. We spoke with five nurses, one patient and one consultant within the endoscopy unit and with two nurses, one consultant, two patients and their relatives within the cancer care unit. We reviewed 14 sets of patient notes, eight endoscopy and six medical oncology chemotherapy. We looked at a range of other hospital records such as policies, procedures and audits.

Good

Medical care

Summary of findings

Overall we rated this service as good. There were safety systems in place to support the delivery of care and treatment. The endoscopy service was working towards achieving Joint Advisory Group (JAG) accreditation in 2016. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it delivers against a range of quality improvement and assessment measures. Required improvements to ensure processes and the facilities would satisfy JAG requirements had already commenced with the recent installation of a new endoscopy monitoring stack system and new endoscopes. Staff in the endoscopy service were trialling new equipment which would improve the quality of decontamination of equipment within the service.

The consultants and staff monitored patient outcomes through the multidisciplinary team (MDT) meetings within the NHS and at subsequent follow-up treatments and outpatient appointments at the hospital. Oncology staff worked effectively and had strong links with local cancer support agencies, other BMI hospitals and with colleagues within the local NHS services. Patients we spoke with told us they were fully aware and involved in their pathways of treatment and care. They spoke positively about the quality of the oncology service provided at the hospital and were very complimentary of the staff. The September 2015 local patient survey results showed patients had reported very positive experiences with the oncology service at the hospital.

Patients attending the endoscopy services provided immediate written feedback of their experiences and our review of 13 feedback cards completed by patients on the 24 and 25 November 2015 showed they thought they had received very good to excellent care. The cancer care (oncology) service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015. The MQEM is 'a detailed quality frame work used for assessing whether cancer care environments meet the standards required by people living with cancer'. Following the recommendation from a visit and recent meetings with service users, plans were agreed to upgrade the unit's décor and furniture within the cancer care unit.

Medical records were generally well organised and securely managed. Concerns were identified in the accuracy and completion of patient records within both endoscopy and oncology.

Good

Medical care

Are medical care services safe?

Good

We rated safe as good because:

- Staff across both services knew how to report incidents and we saw incident feedback provided to staff following daily meetings. The majority of the staff also confirmed that information on lessons learnt from incidents was shared with them during meetings.
- Staffing levels met the capacity demands of both the oncology and endoscopy services. The admitting consultants provided medical cover and a resident medical officer (RMO) provided 24 hour seven day a week cover for all specialities. Admitting consultants were also responsible for providing on call cover and for providing advice out of hours.
- Training records showed that qualified nursing staff were trained to provide intermediate life support and non-qualified nursing staff trained to provide basic life support in both services.
- Staff knew how to identify and respond to any safeguarding concerns.
- Training records showed that the staff on both units were 100% compliant with their mandatory training. We also saw further evidence of staffs continuing professional development and ongoing competence training.
- Equipment was serviced maintained and calibrated.

However:

- Concerns were identified in the accuracy and completion of patient records within both endoscopy and oncology services.

Incidents

- Neither service had reported any never events or serious untoward 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”.
- There were 16 incidents reported between November 2014 and November 2015. Twelve incidents were in the endoscopy service, the majority of these related to equipment. There were 4 incidents reported in oncology, which all related to security.
- Paper clinical and non-clinical incident forms were in place for staff to report incidents. Staff submitted incident forms to the managers, who forwarded them onto the governance and risk manager for logging and allocation for investigation.
- Ward and department managers and/or a representative reported and discussed incidents at the daily briefings ‘comm cells’ with senior managers.
- Incidents were assigned for investigation within set timescales and were monitored through the electronic reporting system until completion. We saw from the August to September 2015 incident report that incidents reported were investigated, time tracked and the report showed all of the reported incidents had been presented at daily comm cells briefings.
- We observed feedback provided to endoscopy staff following the comm cells meeting on the 26 November 2015. The feedback included the one incident we identified in relation to endoscope traceability records. Other feedback included clinical and operational updates.
- Following investigation of incidents, staff received feedback. Monthly governance meeting minutes from May to August 2015 showed incidents were a standing agenda item and included key learning points from incident investigations.
- Staff within both units were aware of their responsibilities under the Duty of Candour regulations. Supporting information was available to staff for reference.

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

- Safety thermometers were not in use within the endoscopy and oncology service as both units were not inpatient areas.
- However, we did see from our review of patient oncology notes the chemotherapy pathway of care and treatment included completed and ongoing monitoring of risks of venous thromboembolism (VTE), mobility, falls, pressure ulcers, malnutrition and weight.

Cleanliness, infection control and hygiene

- Staff in both units used personal protective equipment (PPE) such as disposable gloves and aprons and performed hand washing whilst caring for patients.
- Infection control link nurses were identified in both units and they were involved in undertaking monthly infection prevention control (IPC) observational audits, and attended IPC committee meetings.
- The October 2015 IPC results showed endoscopy and oncology staff had achieved 100% compliance with hand hygiene and bare below the elbows policies. Bare below the elbow means clinical staff were not wearing long sleeves, jewellery and false nails.
- Disposable curtains in the five endoscopy recovery bays were within date. The recovery area was carpeted and we were told these were due to be replaced with a more suitable floor covering through the capital investment programme to achieve JAG accreditation.
- One of the recovery bays not in use for patient care at the time of our visit was cluttered, untidy and used as a storage area. This was a risk because staff used this area to vacuum seal clean endoscopes.
- The endoscopy treatment room appeared clean and well-organised, cleaning schedules, room and equipment checks were up to date. There was a clearly identified dirty to clean flow for staff to follow when decontaminating endoscopes.
- The dirty utility area appeared generally clean and uncluttered. There was no cleaning schedule in place for this area.
- We revisited the unit the following day and saw the bay area had been tidied, the floor area cleared and safe working space created for staff operating the endoscope vacuum sealer equipment. The dirty utility area had been added to the cleaning schedule.
- Actions identified from the March 2015 IPC oncology audit were completed and dated. The unit's clinical lead told us that the last audit was completed in March 2015. The unit overall appeared clean, uncluttered and cleaning schedules were up to date.
- We observed staff undertaking hand washing procedures and wearing PPE whilst administering intravenous chemotherapy, to minimise the risks of spreading infections.
- Clinical waste including cytotoxic waste was disposed of safely using the correct coloured waste containers. The containers were labelled correctly.

Environment and equipment

- To ensure processes and the facilities would satisfy JAG requirements, improvements had commenced with the recent installation of a new endoscopy monitoring stack system and new endoscopes. We were told ongoing capital investment in this area was a priority.
- Scheduled servicing and validation checks of the endoscopy washers together with weekly testing on the total viable count (TVC) of water quality for microorganisms such as bacteria, yeast and mould were up to date.
- The clinical lead told us that a high TVC was incident reported on the 1 October 2015 and they explained the actions taken to safely resolve and manage this issue effectively. The learning outcomes from this event had been communicated to the staff through meetings and were displayed on the communication board. Staff were able to explain the procedures to follow and the actions to be taken if the TVC tests showed unacceptable levels of microorganisms.
- The replacement of the endoscopy washers was included on the risk register as they did not comply with JAG requirements and were prone to frequent breakdown. Actions to manage the existing endoscopy washers were identified and actioned on the risk register. The clinical lead received confirmation at the time of our visit that a trial to replace the endoscopy washers was agreed.
- A new mobile flexible endoscope vacuum sealer system was being trialled at the time of our visit. This is a system, designed to reduce the frequency of reprocessing endoscopes and prolongs their aseptic storage and reduces the risks of damaging the endoscopes during movement. The system included full electronic tracking and traceability of the endoscopes in compliance with national standards.
- Equipment on the unit had up to date checks. Resuscitation equipment was available and checked within both services.

Medicines

- Controlled medicines (CD's) were correctly stored and checked at the start and end of each day in the endoscopy unit. CD's were not held in the oncology unit.
- The endoscopy medicine fridge was locked and we saw daily temperature checks along with ambient temperature of the clinical room recorded correctly.

- Medicine keys in both units were under the control of a qualified nurse. Medicine stock items were in date, stored safely and securely in both units.
- Internal prescriptions pads were issued from pharmacy to the oncology unit. We saw the prescriptions were numbered sequentially and numbers corresponded with the issue records held by the pharmacist.
- Also stored in the oncology medicine cupboard were a small number of FP10 prescriptions stamped with the name of one of the admitting consultants and for private use. The staff told us they stored- these prescriptions safely on the consultant's behalf in case oncology patients needed to be prescribed a controlled drug out of hours.
- The consultant prescribed chemotherapy preparations along with any other associated oncology medicines. We saw in the records we reviewed that the consultants obtained signed consent for treatment.
- Patients attended for a blood test prior to receiving each cycle of chemotherapy preparations and the consultant reviewed their blood test results to determine whether to proceed.
- Chemotherapy preparations were not dispensed until the decision to precede with treatment was determined. Local cancer network protocols were used in the prescribing of cancer treatments and chemotherapy.
- Intravenous chemotherapy preparations were prepared and supplied by an external company and delivered within sealed containers and fully labelled with the patient's details.
- Two qualified nurses checked chemotherapy preparation against the prescription and completed checks to correctly identify the patient prior to commencing their chemotherapy treatment; this is in-line with good practice.
- Extravasation kits were available for use. An extravasation kit is equipment used to remove an intravenous drug or fluid that has leaked from a vein into the surrounding tissue. Anaphylaxis kits, for treating anaphylactic shock, were also available with the contents clearly labelled.

Records

- We looked at 14 sets of patient notes, eight endoscopy and six oncology sets. We saw gaps and inconsistencies in completing care and treatment records.
- The endoscopy generic pathways included a section for recording the patient's physiological observation such as pulse and blood pressures prior to the procedure. Six pathways did not include records of these observations. Pre procedure checklists included a check that consent was completed. In three of the eight records, these checks were not recorded even though consent forms were completed, signed and filed in all of the notes we looked at. In one set of notes we saw entered in the pre procedure checklist consent is 'to be obtained'. The consent form was completed, signed and filed in the notes.
- Staff on both units were scoring through sections of the treatment pathways with a single line with no explanation as to why these sections had not been completed. Patient identity labels were not consistently applied to all the records we looked at. This meant there was a risk that patient notes may not be correctly identified.
- A revision of the generic endoscopy pathway had been completed to reduce the number of anomalies in the existing pathway. This was in draft form and we were told once this was agreed and introduced, this would improve the accuracy of records.
- Following reprocessing of endoscopes, electronically generated records for tracking and traceability were produced. A copy was entered into the patient notes and a copy entered against the patient's identifiable label in the unit's traceability register.
- Traceability records were seen in all of the eight sets of notes we looked at. On checking the traceability records in the patient's notes against the unit's traceability register we identified one of the records did not match.
- We established through further review involving the clinical lead, the traceability record of the patient had been incorrectly entered against another patient name treated on the same day.
- The error was formally recorded as an incident and discussed at the following day comm cell briefing. An investigation was commenced.
- We identified two gaps in one set of oncology notes relating to two separate chemotherapy cycles of treatments. The patient toxicity assessment on the 26 August 2015 cycle was not recorded and the discharge information on the 09 September 2015 cycle was left blank.
- Patient notes and other confidential information were managed and safely stored in both units during the time of our visit.

- Audits of 10 sets of notes were completed each month on the tracking and traceability of endoscopes. The results from the last audit October 2015 showed 100% compliance.

Safeguarding

- Flow charts for adult and child safeguarding and escalation procedures were seen within both units and staff knew how to escalate any concerns. Staff were aware of the safeguarding policy and no safeguarding incidents were reported in the past year.
- Mandatory training records showed that 100% of the staff in both units had completed safeguarding training.

Mandatory training

- Staff were required to be 100% compliant with mandatory training to be considered for a pay review. Training records for both units showed that staff were 100% compliant with their mandatory training.
- The mandatory training matrix for BMI Healthcare includes guidance for staff who spend 50% of their 'BMI working time' working within a hospital environment and any bank staff who work 80 hours or more per month were required to complete mandatory training.
- This matrix also details the mandatory training programme courses, times for completion, the subjects methods of delivery whether eLearning, workshops, assessments and the each subjects target audience.

Assessing and responding to patient risk

- Staff knew how to escalate if a patient deteriorated. National early warning score (NEWS) charts were used based upon risk assessments and chemotherapy drug regimens.
- Emergency resuscitation equipment was available and equipment checks were up to date on both units. The hospital had a designated crash team drawn from other areas of the hospital including the resident medical officer (RMO) who was trained in advanced life support.
- Mandatory training records showed the majority of qualified nursing staff were trained to intermediate life support level and non-qualified nursing staff at basic life support level.
- If any medical problems or complications were identified at pre-assessment the nurse would seek further advice from the consultants and/or the RMO.
- Major haemorrhage procedures and escalation plans were developed for staff to follow. These were displayed and easily accessed for reference within both units.
- The clinical lead for oncology told us the nurses on the wards were provided with in house training on the use of the UK Oncology Nursing Society (UKCONS) oncology/haematology triage tool.
- The tool guides staff on how to assess treatment toxicity. They were provided with a pocket size version of the triage tool for ease of reference should they receive calls from patients requiring clinical advice or were experiencing complication out of hours and at the weekends following their chemotherapy regimens.

Nursing staffing

- The oncology unit was staffed by two permanent qualified nursing staff and supported by a qualified oncology bank nurse. One of the permanent staff worked full time the other part time.
- The clinical lead for the unit was full time and staffing levels were planned to a ratio of one nurse to three patients. The average daily staffing was two qualified nurses on duty when day case admissions were planned. On days where no patients were planned for admission, the service reduced to one qualified nurse on duty during the day. There were two qualified nurse on duty at time of our visit.
- Endoscopy was staffed by six permanent members of staff, four qualified nurses plus one clinical lead and one healthcare assistant at NVQ level 3. Three qualified endoscopy bank staff supported the rotas. Daily staffing aimed to provide five staff on duty, two staff covering admissions and recovery, two staff covering treatments and one member of staff working in the decontamination area. There were five staff on duty at the time of our visit. Endoscopy was staffed by six permanent members of staff, four qualified nurses plus one clinical lead and one healthcare assistant at NVQ level 3. Three qualified endoscopy bank staff supported the rotas. Daily staffing aimed to provide five staff on duty, two staff covering admissions and recovery, two staff covering treatments and one member of staff working in the decontamination area. There were five staff on duty at the time of our visit.

Medical staffing

Good

Medical care

- Admitting consultants for the oncology services were mainly NHS consultants performing private work. Endoscopy included both NHS consultants and consultants who solely worked within private practice.
- We were told around 12 to 14 consultants working in endoscopy and six consultants with specialist interests in a number of tumour sites working in oncology had approved practice privileges.
- Consultants attended the oncology unit to review patients during their planned admissions for chemotherapy treatments. The consultants working within endoscopy had an agreed number of treatment sessions allocated for their practice.
- Admitting consultants were required to live within reasonable travelling distance of the hospital to provide on call cover and were available for advice out of hours. The RMO provided 24 hour seven day a week on site cover for all specialities.

Major incident awareness and training

- A general business continuity policy was available and staff were aware on how to access this policy. Staff knew how to escalate and report faults with equipment and utility services both in and out of hours.
- A number of action cards were also available for staff to refer covering a wide range of business continuity actions, including key emergency numbers of agencies to call in the event of a major incident. The cards were developed in line with the general business continuity policy.
- Hospital engineers provided 24 hour cover seven days a week. Generators off load checks were carried out weekly and on load tests monthly.
- The hospital had an internal fire team and the fire panel was tested weekly.

Are medical care services effective?

Good

We rated effective as good because:

- The endoscopy and oncology services followed evidence based guidance and best practice. JAG accreditation in endoscopy had commenced in October 2015.
- Patient oncology outcomes were monitored by the admitting consultants and oncology staff through the multidisciplinary team (MDT) meetings within the NHS and at subsequent follow-up treatments and outpatient appointments at the hospital.
- Patients receiving chemotherapy treatments had malnutrition risk assessments completed and monitored as part of their regime.
- Patients we spoke with told us they were fully aware and involved in their pathway of treatment and care and they spoke positively about the quality of endoscopy and oncology services at the hospital.
- We found staff were competent, skilled and knowledgeable within their clinical specialism. There was good multidisciplinary working with local cancer support agencies and NHS colleagues.

Evidence-based care and treatment

- The endoscopy lead told us the service followed British Society of Gastroenterology guidelines, which link to JAG and with the National Institute for Health and Care Excellence (NICE). They also told us the service adhered to the choice framework for local policy and procedure for the management and decontamination of endoscopes (CFPP-01-06).
- The development plans for endoscopy service was to work towards achieving JAG accreditation in 2016.
- Local and national cancer network protocols were used in the prescribing of cancer treatments and chemotherapy. Three cancer pathways were developed following NICE guidance for breast, gynaecology and chemotherapy. A bowel cancer pathway had been drafted but not implemented at the time of our visit.
- Oncology staff followed best practice guidance in caring for the patients using NICE sources, and up to date clinical aspects. The September 2015 cancer strategy quarterly meeting minutes showed that clinical updates in treatment and care were discussed and actions agreed.
- Consultants, the director of clinical services, hospital clinical lead for cancer services, ward and department based clinical staff attended these meetings. The meetings served to promote collaborative working within the oncology teams and the wider NHS. The information was then disseminated to the respective teams and to the clinical governance committee.

Pain relief

- Oncology patients usually managed their own medicines when attending for day case chemotherapy treatments. The pharmacy was able to provide prescribed medicines if any changes were made to their regimens following review by their consultants.
- The consultant we spoke to within endoscopy confirmed that prescriptions for pain relief were not prescribed routinely.

Nutrition and hydration

- The majority of the patients using the endoscopy services were short stay cases. Refreshments were available if required.
- Patients receiving chemotherapy treatments malnutrition risk assessments were completed and monitored as part of the cycle of their chemotherapy regimens. All of the patient notes we looked at included malnutrition risk assessments. The patient's weight was monitored at each cycle of treatment.
- Oncology staff provided general advice on nutrition and hydration. If patients required advice that is more detailed this was discussed with their admitting consultant and at MDT meetings.
- Menu choices and refreshments were available to patients admitted to the oncology unit and following recent feedback from service users, selection choices had been improved.
- Patients we spoke with confirmed the selection of menu choices and refreshments were appropriate and available during their stay.

Patient outcomes

- Both services monitored patient outcomes via a range of measures including, local audits such as infection prevention and control, local and national patient experience surveys, incidents, complaints and compliments.
- Oncology patient outcomes were monitored by the consultants and staff through the multidisciplinary team (MDT) meetings within the NHS and at subsequent follow-up treatments and outpatient appointments at the hospital.
- Staff worked effectively and had strong links with local cancer support agencies and with colleagues within the local NHS services and MDT.
- Patients we spoke with told us they were fully aware and involved in their pathway of treatment and care and they spoke positively about the quality of endoscopy and oncology services at the hospital.
- Patients attending the endoscopy services provided immediate written feedback of their experiences and our review of 13 feedback cards completed by patients on the 24 and 25 November 2015 showed they had received very good to excellent care.
- The results from the September 2015 local patient survey rated the oncology service as very good to excellent and patients reported very positive experiences with the service overall.

Competent staff

- The staff working within both units were appropriately trained. The clinical lead for oncology had attended a range of specialist training events examples include; Yorkshire and Humber Chemotherapy Education Programme November 2015, Control of Substances Hazardous to Health (COSHH) August 2015 and intermediate life support May 2015.
- We saw evidence of annual competence assessments completed of chemotherapy administration for all three members of staff employed in the unit August to October 2015 and venous cannulation assessments were completed in October 2014.
- The clinical lead for endoscopy is a member of the corporate Endoscopy and JAG Accreditation Sub Committee. This group is multi-disciplinary and included; clinical, finance, engineer's infection prevention control specialist and commercial manager representatives. The meetings served to promote collaborative working and standardise practice within endoscopy services across the business.
- Endoscopy staff had attended competency based training events in the care, maintenance and decontamination of endoscopes in October 2015. The manager had also completed an external specialist training course in endoscopy decontamination in October 2015.
- Clinical supervision was not embedded throughout all of the specialities within the hospital. Staff did tell us they received informal supervision and new starters were assigned mentors. One of the new bank nurses we spoke with confirmed this.

Good

Medical care

- We did see evidence of clinical supervision meetings in September 2015 with two of the oncology staff. Actions from the meeting were agreed with dates for completion but there was no further detail as to when these actions would be reviewed or a date set for the next meeting.
- The quality assurance dashboard 2015/2016 showed that 80% of the staff had received a personal development review between October 2014 to September 2015. Appraisal records for endoscopy and oncology staff showed the majority had received appraisals with further review dates planned.

Multidisciplinary working (in relation to this core service)

- The clinical lead for endoscopy was a member of the corporate Endoscopy and JAG Accreditation Sub Committee. This group was multi-disciplinary and included clinical, finance, engineer's infection prevention control specialist and commercial manager's representatives. The meetings served to promote collaborative working and standardisation of endoscopy services across the business.
- The clinical lead for oncology attended the hospital cancer strategy group quarterly meetings. Clinical updates in treatment and care were discussed and actions agreed. This group included admitting consultants; the director of clinical services, ward and department based clinical staff representatives. The meetings served to promote collaborative working within the hospital oncology teams and the wider NHS.

Seven-day services

- Endoscopy and oncology services were open Monday to Friday between the hours of 07.30 to 21.00 hours. Endoscopy services operated an on call rota for out of hours and weekends.
- Admitting consultants were required to live within reasonable travelling distance of the hospital to provide on call cover and were available for advice out of hours if necessary. The RMO provided 24 hour seven day a week on site cover for all specialities.
- Networks and liaisons with the palliative care teams from the nearby NHS trust were established and patients were offered the choice of referral for further support from the palliative care team if required. One of the patients we spoke with confirmed this.

Access to information

- A comprehensive 'your chemotherapy record booklet' was given to patients and brought in with them at each cycle of treatment. This record booklet included their cycle of chemotherapy treatments, along with other important symptomatic information noted by the patient. This information benefitted both nurse and clinician when reviewing the patient's progress.
- The booklet included key contact numbers should the patient need further assistance in an emergency and/or whilst at home.
- Access to cancer information was available in other languages through active links with local cancer support groups.
- One of the patients we spoke with told us information relating to their endoscopy procedures and pre-operative checklist was provided prior to admission.
- Staff told us that the pre-operative checklists were reviewed with the patient on admission and discharge information was provided appropriate to the outcomes of their procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was obtained before proceeding with endoscopy procedures and chemotherapy regimens. All of the notes we looked at included signed consent. Staff were aware of their duties in relation to obtaining consent.
- Staff were up to date with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
- Oncology staff confirmed they were trained in DoLS but they had never been involved in the process and they would seek advice should the need ever arise.
- The oncology staff told us if patients or relatives presented with speech or learning difficulties, they used the guide for carer's books, which was available on the unit and included diagnostic and treatment, symptoms, screening and staying healthy to assist their understanding.
- End of life care was not provided at the hospital.

Are medical care services caring?

Good

We rated caring as good because:

Good

Medical care

- We found medical care services provided good care and treatment to patients. Nursing and medical staff were caring, compassionate and patient centred in their approach.
- Observations of staff interactions with patients were polite, sensitive to their needs and we saw displays of empathy. The majority of the patients provided written positive feedback on their experiences and they reported feeling informed about their treatment.
- Patients attending the endoscopy services provided immediate written feedback of their experiences and from our review of 13 feedback cards completed by patients on the 24 and 25 November 2015 showed the patients had received very good to excellent care.
- The oncology service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015. The MQEM is a 'detailed quality framework used for assessing whether cancer care environments meet the standards by people living with cancer'.

Compassionate care

- Patients were well cared for. Staff were very welcoming to patients and treated them with privacy and dignity. The endoscopy recovery bays had curtains installed to protect patient privacy and dignity. We saw curtains drawn at all times when patients were being cared for.
- Staff were heard adjusting their speech when interacting with the patients within the recovery bays. Treatment room doors were kept closed during patient discussions and treatments.
- One of the patients on the oncology unit reported their stay always 'feels like home". Staff allowed time for questioning prior too, during and following treatments.
- Friends and Family test results showed satisfaction results of 95% and above for NHS, insured and self-pay patients.

Understanding and involvement of patients and those close to them

- We spoke with five patients and relatives who were fully aware and involved in the pathways of their treatment and care. They spoke positively about the quality of the endoscopy and oncology services at the hospital.
- The patient satisfaction group included members of staff from across all areas of the hospital. The minutes from the meeting July 2015 showed the group were working collectively to improve the patient experience. Actions were noted and these were followed up at the September 2015 meeting. The group reported into the clinical governance committee.
- 13 patient comment cards were reviewed of the patient experience of endoscopy services on the 24 and 25 November 2015. All 13 rated the service as very good to excellent and patients reported they were involved and informed about their treatment.

Emotional support

- The oncology service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015.
- There is a private room available within the oncology unit for supporting patients and relatives receiving distressing news. Wherever possible the consultant is accompanied by an oncology nurse at these times.
- Patients described how the staff had helped them through difficult times during the course of their treatments and they were assured if they needed any support they knew they could contact the staff.

Are medical care services responsive?

Good

We rated responsive as good because:

- There were development plans for oncology and endoscopy services to meet future demand, for example working towards JAG accreditation. Both services had commenced improvements and further plans were in place to continue improving facilities and equipment.
- Oncology patients were able to access services when needed and the service was responsive to individual patient needs. Oncology and ward nurses provided phone triage for concerned patients whilst at home.
- There had been few complaints in the service, staff were aware of learning from complaints across the hospital.
- The oncology service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015. The MQEM is a 'detailed quality framework used for assessing whether cancer care environments meet the standards by people living with cancer'.

Good

Medical care

Service planning and delivery to meet the needs of local people

- The development plans for the endoscopy service was to work towards achieving JAG accreditation in 2016. Improvements to the service had started at the time of our visit.
- Plans to improve the environment in oncology to benefit patient comfort had been agreed and improvements had started at the time of our visit.
- Endoscopy and oncology were elective services and patients told us they were given their appointments within a relatively short space of time
- Endoscopy lists were managed to ensure patients were seen in a timely manner and patients were provided with suitable appointment times to meet their needs.
- Staff within the cancer care service liaise closely with community teams/services. Marketing and GP liaison services were in place

Access and flow

- There were systems to manage the scheduling of endoscopy lists and medical oncology admissions so appropriate staffing could be ensured to support effective flow of patients through the department.
- Patients reported they did not have to wait long for their appointments. Any further appointments were arranged prior to the patient's discharge and choice of dates and times that suited them best were offered.
- The 18-week NHS referral to treatment times (RTT) targets were consistently met with percentage scores above the national averages at 98% and above.
- Medical oncology treatments were provided for private patients only and we were told that around eight to 10 patients were being treated weekly. All admissions were planned to effectively manage access and flow in accordance with the patient's treatment regimens.
- Endoscopy treatments were provided for both NHS and private patients. Admissions were by appointment, treatment lists and scheduling were managed in conjunction with the consultants to effectively manage access and flow.

Meeting people's individual needs

- The oncology service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015. The MQEM is a 'detailed quality framework used for assessing whether cancer care environments meet the standards by people living with cancer'.
- We saw a comprehensive 'your chemotherapy booklet' given to patients and brought in with them at each cycle of treatment. This booklet kept a record of the cycle of chemotherapy treatments received, along with other important symptomatic information noted by the patient. This information benefitted both nurse and clinician when reviewing the patient's progress.
- Staff recognised the need to support people with additional needs and made adjustments wherever possible.
- Oncology staff told us if patients or relatives presented with additional needs such as sensory and learning difficulties they used a number of aids to meet these needs. They included CD's, DVD's, guide for carer's books and access to information in other languages and braille was available through the links with the local cancer support networks.
- Networks and liaisons with palliative care teams from the nearby NHS trust were established and patients were offered the choice of referral for further support if required. One of the patients we spoke with confirmed this.
- An interpreter service was available and staff were aware of how to arrange this service.
- There was no mandatory training related to dementia awareness or those with a learning difficulty. Any patients presenting with complex risks and needs were identified at outpatient appointments and it would be unlikely that treatment at the hospital would be offered. One of the consultants we spoke with confirmed this.
- All patients prior to treatment completed a medical questionnaire and this questionnaire is clinically pre assessed. Any risks identified from the assessment are referred to the consultants for a final decision on whether to proceed with treatments at the hospital.
- Patients attending the endoscopy services provided immediate written feedback of their experiences and our review of 13 feedback cards completed by patients on the 24 and 25 November 2015 showed the had received very good to excellent care.

Learning from complaints and concerns

- There were systems and processes in place to acknowledge, investigate and respond to complaints

within a defined period of 20 days. Complaints were discussed to share findings at a number of committees including hospital clinical governance and medical advisory committees.
- Staff told us there were very few formal complaints received for their services. Complaints were part of the daily comm cells briefings and sharing of learning from complaints were discussed at monthly heads of department and sisters meetings for dissemination to the hospital teams.

Are medical care services well-led?

Good

We rated well-led as good because:

- There were clear visions for service improvement, services were driven by performance, and improvements were continuing to take place.
- Staff were aware of the future plans for the hospital and for service developments. Clear governance processes and structures were in place with constant monitoring and review.
- Risks were identified and actioned.

Vision and strategy for this this core service

- The development plans for the endoscopy service was to work towards achieving JAG accreditation in 2016. JAG is an organisation that provides; 'UK wide support for endoscopy services to ensure they have the skills resources and motivation necessary to provide the highest quality, timely, patient centred care'. JAG accreditation is 'the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global rating scale (GRS) standards'.
- The cancer care (oncology) service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015. Further plans were proposed to upgrade the unit's décor and furniture within the consulting room and treatment rooms following feedback from the visit and from a recent meeting with service users.

Governance, risk management and quality measurement for this core service

- There were clear lines of accountability at department level. Heads of department met monthly with the executive team in which information could be fed back from corporate and hospital governance along with issues affecting the running of individual departments were discussed
- There was a clear governance reporting structure within the hospital-to-hospital clinical governance and medical advisory committees, which fed into the corporate governance processes.
- Both services held their own team meetings and clinical leads were involved in service strategy planning development at hospital and corporate level.
- Departmental risk assessments were up to date and controls assurance to manage risks were reviewed and actioned. Significant risks were escalated to the hospital's risk register.

Leadership and culture of service

- Medical services were well-led at departmental and hospital level. There were clear visions for service improvement, services were driven by performance, and improvements were continuing to take place.
- Staff told us they were able to raise their views and opinions with their managers and were asked to share their ideas and to make service improvements.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of tell us your experience cards, local and national patient satisfaction questionnaires and for NHS patients by the Friends and Family Tests.
- Friends and Family test results showed satisfaction results of 95% and above for NHS, insured and self-pay patients.
- The patient satisfaction group included members of staff from across all areas of the hospital. The minutes from the meeting July 2015 showed the group were working collectively to improve the patient experience. Actions were noted and these were followed up at the September 2015 meeting. Plans to invite service users to the meetings were being developed.
- Results from the September 2015 local patient survey rated the oncology service as very good to excellent and patients reported very positive experiences with the service overall.

Good

Medical care

- Patients attending the endoscopy services provided immediate written feedback of their experiences and from our review of 13 feedback cards completed by patients on the 24 and 25 November 2015 showed they had received very good to excellent care.

Innovation, improvement and sustainability

- The oncology service had been awarded the Macmillan Quality Environment Mark (MQEM) following an external assessment visit in October 2015. The MQEM is a 'detailed quality framework used for assessing whether cancer care environments meet the standards by people living with cancer'.
- The development plans for the endoscopy service was to work towards achieving (joint advisory group) JAG accreditation in 2016.
- The company is planning to offer oncology e-prescribing a single standardised prescribing model for chemotherapy across all of its hospitals providing chemotherapy services. The service is due for roll out over the next 12 months and will offer significant benefits for maximising patient safety and improved medicines management.

Good

Surgery

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

Information about the service

Thornbury Hospital provided general surgery, orthopaedics, gynaecology, urology, ear, nose and throat, oral surgery and cosmetic surgery. There were 59 inpatient beds and seven day case beds available on Mappin Suite and the Fulwood Suite. The Fulwood Suite had two ambulatory care rooms with nine recliner chairs.

There were four theatres open for elective surgery from 8am to 9pm Monday to Friday and 8am to 4pm every Saturday.

Between July 2014 and June 2015 there were 3,058 overnight adult inpatients and 5,933 adult day case patients.

We spoke with 23 members of staff including consultants, ward managers, nurses, health care assistants, theatre staff and porters. We looked at 23 sets of notes and we talked with 15 patients and their carers.

Summary of findings

Overall we rated this service as good. Patient safety was monitored, incidents were investigated, and learning was shared to improve care. Patients received care in a visibly clean and suitably maintained environment. Patient records were well structured but we found staff did not complete all sections of the patient record and did not record reasons why sections were not completed. Staffing levels were sufficient to meet the needs of patients. The service had competent staff who worked well as a team to care for patients. Doctors were available to provide care for patients 24 hours a day. Staff were up to date with their mandatory training and staff were aware of safeguarding policies and procedures for adults and children.

The service had policies and guidance to ensure staff provided care and treatment in line with evidence based standards and procedures. The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals in the company.

Staff supported and treated patients with dignity and respect. Patients and their carers were satisfied with the care they received.

Services were planned and delivered to meet the needs of the local population. There was daily planning by staff to ensure that patients were admitted and discharged in a timely manner with the right level of care and support. Patients told us their pain was managed effectively. The service had identified concerns with the management of pain and had set up a pain group to review and improve the management of

Good

Surgery

pain for patients. The hospital had access to interpreters for patients whose first language was not English. Information leaflets were available about the services were available in all areas we visited

There were clear governance structures in place with committees for clinical governance, health and safety, infection control and medication.

Are surgery services safe?

Good

We rated safe as good because:

- Patient safety was monitored, incidents were investigated, and learning was shared to improve care.
- Patients received care in a visibly clean and suitably maintained environment. Medicines were stored appropriately and checked according to guidance.
- Staff were aware of safeguarding policies and procedures for adults.
- Equipment was available and staff would arrange for faulty equipment to be repaired or replaced. Resuscitation equipment was well organised and available for use in an emergency.
- Staffing levels were sufficient to meet the needs of the patients. Staff were up to date with their mandatory training.

However:

- We found staff did not complete all sections of the patient record and did not record reasons why sections were not completed.

Incidents

- There were no never events or serious incidents reported between July 2014 and June 2015. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- All incidents were recorded on paper records and then transferred onto an electronic incident reporting system. Staff were aware of how to report incidents.
- A governance lead and an appropriate manager reviewed and investigated incidents and identified improvements. We saw action plans that had been developed following incidents.
- Incidents were discussed during a daily communication cell meeting and at monthly meetings with staff.
- Each area had a communication cell notice board, which displayed incident information and actions taken.
- Staff told us they received feedback directly if they were involved in an incident to learn lessons and improve

practice. Staff told us about an incident when a patient got a pressure ulcer on their heel. Staff had training in the use of risk assessments to improve the identification of a patient at risk of developing a pressure ulcer.

- We looked at the minutes of the sisters meetings in August and September 2015 and the minutes of the Medical Advisory Committee (MAC). We saw evidence of discussions about incidents reported in all BMI hospitals. For example, another hospital in the group re-admitted a patient because they had an infection and needed the wound cleaning.
- We saw four never events from other BMI hospitals had been discussed at the MAC and learning shared with medical staff. For example, a number of consultants at another BMI hospital had been identified as not site marking patients correctly for theatre and that staff should not use biro but a correct marker pen. As a result, the hospital had an action plan to reduce the risk of not marking a patient correctly. MAC had agreed that surgeons got one warning for not marking a patient correctly and if they did not comply a second time they would have their practising privileges revoked.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and urine infections to be measured on a monthly basis.
- Staff carried out risk assessments before they admitted patients to surgery to identify patients at risk of falls and acquiring pressure ulcers and venous thromboembolism (VTE). The hospital had a Commissioning for Quality and Innovation (CQUIN) for VTE and had consistently achieved above its 95% target for completed VTE assessments. NHS commissioners offer a CQUIN to providers of healthcare services commissioned under an NHS Standard Contract to encourage care providers to share and continually improve how care is delivered.
- Patients identified at risk were placed on an appropriate care plan and were monitored more closely by staff. For example, if a patient was at risk of developing pressure ulcers the hospital would provide a special mattress for them, which would help stop pressure ulcers occurring.

Cleanliness, infection control and hygiene

- Between July 2014 and June 2015 there had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium difficile infections at the hospital.
- All patients underwent MRSA screening prior to being admitted to the hospital.
- However, in April 2015 it was reported at the sisters meeting that two MRSA screening samples had been left on a ward and not sent to the lab. The service had reviewed practice to ensure that all samples were sent to the lab for testing.
- Patients identified with an infection could be isolated in their rooms.
- We found there had been an incident recorded for a hip replacement patient who had been re-admitted due to an infection and needed a wound washout. The service had reviewed the incident and implemented actions to reduce the risk of recurrence.
- The pre-assessment area, wards and theatres were visibly clean. The flooring in theatres were worn but were visibly clean. There were plans for the flooring in theatres to be replaced with the first phase of replacement scheduled for December 2015 and the second phase of replacement scheduled for January 2016.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- We observed staff following hand hygiene and washing their hands before and after looking after a patient. Staff also followed bare below the elbow guidance. The ''bare below the elbows'' guidance is an attempt to reduce infection rates. Doctors and nurses must have their shirtsleeves rolled up to their elbows, with no watches or other jewellery to help stop the spread of infections.
- The service completed monthly hand hygiene audits. We reviewed hand hygiene audits for August, September and October 2015 and the service achieved 100% compliance.
- Personal protective equipment was available for all staff. Personal protective equipment is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.

- We observed staff wearing personal protective equipment such as gloves and aprons. On one ward, a patient was barrier nursed because of a risk of infection. Staff wore aprons and gloves while delivering care.
- Gowning procedures were adhered to in the theatre areas.

Environment and equipment

- Equipment was visibly clean and well maintained. Staff told us equipment was available and any faulty equipment was repaired or replaced.
- Theatre staff carried out daily, weekly and monthly checks of equipment in theatres.
- Reusable surgical equipment was sterilised by an external contractor. Staff told us they were always able to access the sterilised equipment when required.
- Single use sterile equipment was stored appropriately and kept within their expiry dates.
- Emergency resuscitation equipment was available and was checked daily. The adult emergency resuscitation equipment contained all appropriate equipment.

Medicines

- The hospital had two pharmacists and two pharmacy technicians who worked Monday to Friday 9:00am to 17:00pm. The hospital had an on-site pharmacy so medicines were available for patients. The hospital had an arrangement with a local pharmacy to provide medicines out of hours and at weekends.
- Medicines, including controlled drugs, were stored securely. The senior nurse in charge of the ward kept keys to the medicines cabinets.
- Staff carried out daily checks on controlled drugs and medication stocks to ensure medicines were reconciled correctly. The pharmacist had worked with the staff to improve medicine reconciliation. The pharmacist was new in post and planned to carry out further audits to monitor improvement.
- Staff recorded daily medication fridge temperatures to ensure medicines were stored at the correct temperature. The fridge temperatures were within the recommended levels for storing medicines in the fridge.
- We looked at the medication charts for 23 patients. Staff had completed all these medication charts without gaps and allergies were clearly recorded. Staff carried out medication audits and no gaps in the completion of medication charts were identified.

The pharmacist completed a controlled drug audit. The September 2015 audit showed that a part dose had been destroyed and the amount destroyed had been overwritten. This meant that it was not clear how much had been destroyed. This was raised with staff and an action plan was developed to prevent recurrence of the error.

Records

- The service used paper based patient records, which were securely stored in each area we inspected.
- The hospital used printed booklets for recording patient care for different care pathways.
- The booklets included prompts to record key information about patients, including their past medical history and medication as well as details of their pre-operative risk assessments, nutrition, pressure ulcer and falls risks.
- We looked at the records for 23 adult patients. All records were well structured. The service used generic pathways and we found that sections of the patient records we reviewed were not completed and that staff had drawn a line through uncompleted sections without a reason to explain why it was not completed or signed. Staff told us that this was because some sections of the pathway were not relevant. We did not have any concerns that the incomplete records posed a risk to patient safety.
- The hospital carried out a medical record audit in October 2015 and found that nursing records were completed but there was only minimal evidence of daily reviews by the consultant. The results from the audits were discussed at the Medical Advisory Committee. The hospital planned to six month re-audit for the completion of medical records by consultants.

Safeguarding

- BMI Thornbury Hospital's Director of Clinical Services was Level 3 trained for the safeguarding of children and vulnerable adults. The Director of Clinical Services was the named safeguarding lead for the location.
- Staff received mandatory training in safeguarding of vulnerable adults as part of their inductions and had annual safeguarding updates. All staff were required to undertake Safeguarding Children and Vulnerable Adults training by completing a mandatory e-learning module. 100% of theatre and ward staff had completed safeguarding children and adult training.

- Staff caring for adults had received appropriate training in safeguarding adults. Staff were aware of how to identify potential abuse and how to report adult safeguarding concerns.

Mandatory training

- Staff were up to date with mandatory training. Staff explained they received mandatory training through e-learning and some on-site training, for example manual handling. Staff described topics included information security, care of the patient and infection control.
- Theatre and ward staff had an overall compliance rate of 98%. There had been a focus by the hospital on completing mandatory training and the hospital recognised individuals achieving 100%.

Assessing and responding to patient risk

- The hospital had admission guidelines and only accepted patients who were at low risk of complications. There was a resident medical officer (RMO) on site 24 hours a day. Nursing staff told us RMO cover was sufficient to meet patient needs because patients were assessed as low risk and did not have complex health needs.
- Consultants were responsible for the care and treatment of their patients at all times. Consultants were accessible by telephone 24 hours a day. Consultants would visit their patients at weekends and out of hours if required. There were arrangements in place for the treating consultant to name a consultant to provide cover for them if they were going to be unavailable.
- Staff knew how to escalate if a patient was deteriorating and needed input from the RMO or consultant**.**
- We were told compulsory intentional rounding had started in June 2015 and these were every two hours. Intentional rounding is a process of making rounds of an area of a service to check at regular intervals that patient care needs are being met.
- The hospital had a transfer agreement with the local NHS acute trust so a deteriorating patient could be transferred if more specialised care was needed. Medical staff supported nursing staff to stabilise the patient prior to transfer.
- The service used the World Health Organisation (WHO) surgical checklist. The checklist was completed before, during and after surgery. Staff had a good understanding of the WHO checklist. The hospital had an escalation policy in place and staff we spoke with knew how to escalate any concerns.
- A monthly audit was undertaken to monitor adherence to the WHO checklist and theatres had achieved 98% WHO checklists completed appropriately. We looked at the audits for the completion of the WHO checklist. We observed staff completing the WHO checklist.The hospital used the national early warning scores (NEWS) for monitoring any deterioration in adult patients. We looked at the 23 patient records and found NEWS charts were completed for all patients.

Nursing staffing

- There were appropriate numbers of qualified and non-qualified nursing staff to meet the needs of the patients. It was recorded in the sisters meeting in April 2015 that staff used and populated a ward labour tool 5 days in advance. At Thornbury Hospital, the skill mix target for the nursing staff was 65% qualified and 35% non-qualified for wards.. The current ratio on the wards was 67% qualified and 33% non-qualified.
- The hospital used the BMI Healthcare Nursing Dependency and skill mix to plan staffing levels. Staffing was discussed at daily communication cell meetings and any risks identified were addressed.
- Staff told us staffing levels on the wards was three qualified and two unqualified staff during the day and two qualified and one unqualified staff at night. Staff also told us the staffing levels were increased if a patient required additional support during their pre-operative assessment or if it was identified during their inpatient stay. We looked at staffing rotas during the inspection and we found Planned and actual levels matched,
- The planned and actual staffing levels were displayed on a notice board at the entrance to Mappin ward. During our inspection, we saw that actual staffing levels matched the planned levels.
- There were a low number of vacancies for theatre department nurses and no vacancies for theatre department care assistants and operating department practitioners.
- Staffing levels were maintained with regular bank staff who filled extra shifts.

Surgical staffing

Good

Surgery

- Most medical staff worked for the NHS and worked at the hospital via practising privileges. The term practising privileges refers to doctors being granted the right to practise in a hospital.
- There was an RMO on site 24 hours a day. RMOs were supplied by another company and provided a 24 hour 7 day a week service on a rotational basis. The RMO was on duty 7:30am to 22:00pm daily and was on call out of hours. We reviewed RMO rotas between 30 July 2015 and 26 November 2015 and they confirmed this arrangement. All staff told us they had good links with the consultants and RMOs. They confirmed the RMOs worked for two-week periods and stayed on site for call outs.
- It was a requirement of BMI Healthcare's practising privileges policy, that consultants remained available (both by phone and if required, in person) or arranged appropriate alternative named cover if they would be unavailable at any time when they had inpatients in the hospital.
- Consultants were responsible for the care and treatment of their patients at all times. Consultants were accessible by telephone 24 hours a day. Consultants would visit their patients at weekends and out of hours if required.
- Anaesthetists would remain at the hospital until the patient had recovered from their surgery. There was an on call team for theatres for emergencies out of hours.

Major incident awareness and training

- There was a business continuity plan, which identified keys risks that could affect the provision of care and treatment. Staff were aware of the business continuity plan and knew where information was kept at the nurse's station.
- The hospital had local and corporate business continuity plans with supporting action cards for use in the event of a major incident. For example, there were action cards for the loss/failure of operating Theatre Air Handling.

Are surgery services effective?

Good

We rated effective as good because:

- The service had policies and guidance to ensure staff provided care and treatment in line with evidence based standards and procedures. The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals within the BMI group.
- Patients reported their pain was managed effectively. The service had identified concerns with the management of pain and had set up a pain group to review and improve the management of pain for patients.
- The hospital had looked at the food provided to patients and changed catering companies to improve the patient menus and catering.
- The service had competent staff who worked well as a team to care for patients. Staff told us training was available and they were given time to attend and complete training.
- Information was available for patients about the care and treatment given. Consultants gained consent from patients during the initial consultation and again on the day of surgery. The hospital gave discharge information to patients when they went home and sent it to their GPs within 48 hours of discharge.

Evidence-based care and treatment

- Patients received care according to national guidelines developed by the National Institute of Health and Care Excellence (NICE), the Royal College of Surgeons and the Royal College of Anaesthetists.
- The hospital followed surgical protocols based on best practice and guidance.
- Patients were assessed for venous thromboembolism (VTE) and staff took steps to minimise the risk where appropriate, in line with NICE guidelines on reducing the risk for patients in hospital. Over 98% of patients had been assessed for VTE between July 2014 and June 2015.
- The hospital followed NICE guidance for preventing and treating surgical site infections (SSI). Following discharge, the hospital had implemented a 48-hour follow up call for all hip and knee patients as part of the 30-day surgical site infection audits. The hospital had called patients within 48 hours 77% of the time in the period July-September 2015.
- Best practice guidance for patients undergoing surgery published by the Royal Colleges of Anaesthetists,

Surgeons and GPs advised the use of enhanced recovery programmes (ERP) for hip and knee surgery. ERPs were in place within the care pathways used on the wards for knee and hip replacement.

Pain relief

- Staff told us anaesthetists would prescribe regular and 'as required' pain relief medication to be used post operatively to manage pain relief and we saw evidence of this in patient medication charts. We looked at 23 patient records and there were pain-scoring forms in the patient record and staff had completed pain scoring forms for all patients.
- Anaesthetists, recovery theatre staff and nurses monitored patients' pain. Staff would liaise with the RMO on duty if pain control issues occurred.
- Patients said they had been given clear information about pain control and pain relief had been given promptly.
- However, the hospital had identified through audits and patient feedback that patients did not always receive pain relief in a timely manner. In response to the feedback, the hospital had established a pain group to review and improve pain management for surgical patients. An anaesthetist, medical and nursing staff and the risk and quality manager attended the meetings.

Nutrition and hydration

- Pre-assessment questionnaires asked patients if they had any special dietary requirements or allergies.
- Patients were asked if they needed assistance with eating, if they had experienced weight changes or swallowing problems. This information was used to inform a nutritional risk assessment.
- Patients were advised of fasting times prior to surgery at pre-assessment.
- Inpatients had a choice of meals and were offered additional snacks. They could request meals outside of the designated meal times, and they could change their orders if they preferred something different.
- The hospital had recently changed their catering provider following low patient satisfaction with the quality of the meals provided. Staff told us the meals and patient satisfaction had improved since the introduction of new menus. Patients we spoke with during the visit told us food was good and there was plenty of choice.

Patient outcomes

- There had been no patient deaths reported at the hospital in the last 12 months.
- The service participated in national audit programmes such as the Patient Reported Outcome Measures (PROMs). PROMs measure the health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery. PROMs for hip replacement were within the England average for organisations carrying out the procedure.
- They also participated in the National Joint Registry (NJR). The National Joint Registry (NJR) was set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole
- The hospital reviewed audit findings from PROMs and NJR and action plans were developed at the monthly Medical Advisory Committee (MAC) and the Clinical Governance Committee.
- The hospital also collected data for unplanned returns to theatres. There were 20 unplanned returns to theatres between July 2014 and June 2015. The rate of returns had fallen and returns remained low since October 2014.
- We looked at unplanned re-admissions with 29 days of discharge and found they were similar to other independent hospitals. Between July 2014 and June 2015 there had been 19 cases of unplanned readmissions.
- There were 14 cases of unplanned transfer of an inpatient to another hospital in the reporting period (July 2014 to June 2015).
- For the time period July to September 2014 (six cases of an unplanned transfer), CQC has assessed the proportion of unplanned transfers to be 'similar to expected' compared to the other independent acute hospitals we hold this type of data for.

Competent staff

- The Medical Advisory Committee reviewed practising privileges. Doctors with practising privileges were

reviewed biennially unless they were over 65 years then they were reviewed annually. All doctors signed a self-declaration of fitness to practice prior to their review.
- Concerns about staff performance were reviewed and discussed at clinical governance meetings and the Medical Advisory Committee. We looked at minutes for joint quality meetings and found concerns about poor performance were discussed and actions taken to prevent recurrence.
- There were moderate levels of staff appraisal for nurse staff groups in 2014. Only 52% of nursing staff had received an appraisal. However, the ward manager had a timetable for completing appraisals for nursing staff by the end of January 2016.
- There were high levels of staff appraisal in theatres (equal or greater than 75%) for nurses, care assistants and operating department practitioners in 2014. 88% of theatre staff had received an appraisal.
- In June 2015 there was 100% verification of registration for all staff groups working in inpatient departments. All nurses working in the UK have to register with the nursing and midwifery council (NMC). Employers have the duty to ensure that staff are registered with the NMC.
- Newly appointed staff completed an induction, which included working supernumerary for two weeks. Their competency was assessed at the end of the process before they worked independently. We told us they had completed an induction.
- All staff told us there was on-the-job learning and training available and they felt well supported by their line managers.
- The hospital told us all RMOs had Advanced Life Support (ALS) Support (PALS). We looked at RMO records and found that all RMOs had Advanced Life Support (ALS).

Multidisciplinary working

- There was daily communication between the staff on the wards and theatres. Nursing staff told us they worked well with consultants and the RMO.
- Staff carried out daily communication handovers to ensure all staff had up to date information about the services. We observed communication meetings with the heads of service and ward managers where information was shared.
- Pre-assessment staff, ward staff and theatre staff worked together to ensure patient care was co-ordinated and delivered effectively. An example of this was the pre-assessment team liaising with the ward to re-appoint a patient around a relative's care.
- Physiotherapy services were planned to support recovery and rehabilitation.

Seven-day services

- The service only undertook elective surgery, with patient lists planned in advance for children and adults. Mappin ward nursed patients seven days per week and staffing levels were appropriately maintained during out of hours and at weekends.
- Consultants were available 24 hours a day for patients in their care. Consultants we spoke with confirmed this. Staff told us consultants were contactable by phone and would visit the wards during the day or at night if they had concerns about patient.
- There was 24-hour RMO cover in the hospital to provide clinical support to consultants, nursing staff and patients.
- During out of hours a RMO could access the pharmacy with a nurse present if a prescribed medicine was not available on the ward.
- There was an on call rota operated by pharmacy, radiology and the theatre team for out of hour's emergencies. The hospital also had arrangements with a local pharmacy if they required medicine out of hours.

Access to information

- Information was displayed at the entrance to the ward, which showed the planned and actual nurse staffing numbers for the ward.
- Patient leaflets were available on the pre- assessment ward and inpatient wards. Information was only available in English.
- Patients told us they had been given detailed information about planned treatment as well as written information.
- Patients discharged home were given a discharge letter and this was sent to their GP within 48 hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy and staff we spoke with knew how to access the policy on the intranet.

Good

Surgery

- Consultants gained consent from patients during the initial consultation and again on the day of surgery. Patient records documented verbal or written consent had been obtained for care and treatment. We looked at 17 consent forms for adults and these had been completed, signed and dated by the consultant and the patient.
- Consent forms showed the risks and benefits of surgery were discussed with the patient prior to procedure being carried out.
- Staff were aware of the legal requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DOLS). Staff had training on the Mental Capacity Act and DOLs.
- Staff told us the majority of patients admitted had the capacity to make their own decisions.

Are surgery services caring?

Good

We rated caring as good because:

- Staff supported and treated patients with dignity and respect.
- Patients were involved in the planning of their care.

Patients and their carers were satisfied with the care they received. Patients told us they received enough information about their care and treatment.

Compassionate care

- Patients were treated with dignity, compassion and empathy.
- We spoke with 15 patients and their relatives who told us they were treated with respect and dignity. We observed staff providing care in a respectful manner.
- We observed nurses, doctors and allied health professionals introducing themselves to patients.
- We observed staff knocking before entering rooms and staff introducing themselves before entering the room.
- The friends and family test on NHS choices showed 98% of patients reported being satisfied with the overall care they received and 99% said they would recommend the hospital to friends and family. The hospital's patients were highly complementary of the care provided, which was perceived as a good mix of professional, personal and friendly service.

Understanding and involvement of patients and those close to them

- Patients told us they had been provided with sufficient information about their care and treatment both at pre-assessment and on the day of surgery.
- Patients reported they understood what to expect after surgery and what their care needs would be on discharge.
- The ward manager was available to speak with patients and their relatives. Patients told us staff were available to answer questions and they kept them informed what was happening. Patients felt they could ask the staff questions to clarify issues and help them understand their treatment better.
- We observed positive interactions between staff and patients and their relatives.

Emotional support

- Staff told us they had time to spend with patients to provide emotional support.
- Staff told us they understood the importance providing support to patients. We observed staff providing reassurance to patients who were anxious about their operation on their way to theatre.
- The pre-admission documentation included consideration of a patient's wellbeing. We reviewed patient records and saw that this documentation had been completed.

Are surgery services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered to meet the needs of the local population. There was daily planning by staff to ensure patients were admitted and discharged in a timely manner with the right level of care and support. The hospital was meeting their referral to treatment targets for patient admissions.
- The hospital had access to interpreters for patients whose first language was not English. Information leaflets were available about the services were available in all areas we visited.

- There was a complaints system in place. The hospital investigated and responded to complaints within the designated timescales.

Service planning and delivery to meet the needs of local people

- The hospital treated NHS funded patients who were referred to the hospital via the NHS choose and book system.
- The CCG met with the hospital at monthly contract quality monitoring meetings to review the procedures provided to NHS patients.
- All admissions were pre-planned so staff could assess patients' needs prior to admission. This enabled staff to plan for any language, physical or mental needs.
- There was sufficient staff on the wards and theatres. Admissions were discussed at the daily communication cell meetings and this ensured patients admitted received the right level of care.

Access and flow

- There were clear admissions criteria in place. Patients were assessed in a nurse led pre-assessment clinic prior to being admitted for surgery. NICE pathways for preoperative tests were used to assess the patient's anaesthetic risk for a general anaesthetic in the clinic.
- Some patients who were undergoing a procedure and identified as low risk had a telephone pre-assessment. This meant patients were identified as being safe for surgery and unnecessary cancellations were avoided.
- Bed capacity was discussed at daily communication cell meetings and any risks identified were addressed.
- We were told if a patient's operation was cancelled then it would be rescheduled within 28 days. At the inspection, staff told us that told no patient had had their operation cancelled in the previous three months.
- The hospital had an average length of stay of 2.6 days for hip surgery and 3.2 days for knee surgery, which was better for these types of surgery than other hospitals.
- The hospital met the target of 90% of admitted adjusted patients beginning treatment within 18 weeks of referral for each month in the reporting period (July 2014 to June 2015).
- The hospital met the target of 92% of incomplete admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period (July 2014 to June 2015).

Meeting people's individual needs

- Staff could access a language interpreter if needed. Patients' special needs such as specific dietary requirements, or access to a profiling mattress were identified at pre-assessment**.**
- Patients' discharge planning began in pre-assessment. Staff gained an understanding of the patient's home circumstances and likely care needs.
- Information leaflets about the services were available in all areas we visited.
- We saw information was displayed in all areas we inspected. Each area had a communication cell board which displayed information about incidents, audits, performance information and complaints.
- All areas were accessible to patients and relatives who had reduced mobility.
- Staff told us about a relative who had stayed with a patient who was living with dementia and the service had provided a reclining chair in the patient's room so the relative could stay.

Learning from complaints and concerns

- The hospital used the BMI Complaints Policy. The CQC had not received any complaints about the hospital between July 2014 and July 2015. We found the hospital had investigated the complaints and the patients had received an apology.
- Complaints were discussed daily at the Management "Comms Cell", attended by the hospital's senior management team and heads of department, and monthly at a Senior Management Team Complaints Meeting.
- A common theme for the clinical complaints received related to patients feeling that some staff were not as engaging or as informative as they should have been and in some cases, poor attitude was cited. The hospital had implemented staff training to improve communication and staff attitude.
- If a complaint was clinical in nature, it was discussed at the hospital's Clinical Governance Committee meetings. Complaints were also reported to the Medical Advisory Committee (MAC) at their bimonthly MAC meetings.

Good

Surgery

Are surgery services well-led?

Good

We rated well led as good because:

- There was a vision for the services provided at the hospital. There were clear governance structures in place with committees for clinical governance, health and safety, infection control and medication. Staff were positive about the culture and the support they received from managers.
- There were daily communication meetings to discuss what was happening in the hospital. Patients were encouraged to complete patient surveys.
- There was a monthly BMI Patient Survey Report and in May 2015 98.6% of patients would recommend the hospital.

Vision and strategy for this this core service

- The corporate vision for the hospital was that they are serious about health, passionate about care. They had a quality strategy in which they endeavour to provide the best possible care and continual improvement. The quality strategy had four core themes – safety, clinical effectiveness, patient experience and quality assurance. We observed these themes were discussed at the daily communication cells by all staff.
- Staff at the hospital told us adult surgical services was well established Staff were able to articulate the vision for the services which was to provide high quality care and increase activity levels.

Governance, risk management and quality measurement for this core service

- Theatre and ward staff attended governance meetings and committees such as infection prevention and control meetings.
- There was a clinical governance committee, which met monthly to discuss governance issues such as complaints, incidents and risks.
- The ward and theatre managers told us staff logged risks on a risk register and the risk and quality manager within the hospital maintained this.
- We looked at the risk register and it recorded surgical risks for example the service had identified the theatre doors did not lock and was a security risk. The service had put controls in place to reduce the risk until the new access control system was in place. Controls implemented included staff manning the reception desk at the entrance of the theatre at all times and staff challenging visitors trying to access theatres. The hospital had plans to improve security by fitting a new access controlled system to the doors.
- At the daily communication cell board meetings staff discussed risks and concerns. For example, they discussed staff sickness and absence and how staffing would be managed.
- The service had a yearly audit plan which included the WHO checklist, VTE, infection control and care bundles.
- There were staff meetings to discuss issues and share information on complaints, incidents and audit results.
- Feedback from hospital wide meetings was disseminated to theatre and ward staff by e-emails and team meetings. Feedback was also displayed on the communication cell boards in each area we visited.
- The Medical Advisory Committee (MAC) met monthly and was attended by consultants. The MAC had terms of reference and it had standing agenda items, which included regulatory compliance, practicing privileges, quality assurance and proposed new clinical services and techniques.

Leadership / culture of service related to this core service

- There was a daily communication cell board meeting attended by the executive director of the hospital and the senior management team. This ensured the senior management team were aware of significant occurrences and issues, which had occurred in the hospital.
- Patient's medical care was overseen and provided by their consultant.
- Ward and theatre staff told us they felt managers and consultants were approachable. However, ward managers told us they did not have dedicated management and planning time separate from patient care.
- Staff told us senior managers such as the hospital director, Director of Clinical Services and the governance lead were visible and approachable.

Public and staff engagement

- Patients were encouraged to provide feedback through the Family and Friends Test and the BMI patient survey.

Good

Surgery

- There was a monthly BMI Patient Survey Report and a quarterly report for October 2015 collated information and showed 100% of patients would recommend the hospital for treatment. Comments included very efficient and professional service by the consultant and the anaesthetist. The nursing care was excellent.
- A Patient Satisfaction Group Meeting looked at the results from the Family and Friends Test and Patient Survey. The group would agree actions to continue to improve the response rates and satisfaction scores. For example, patients and staff had highlighted signage as an issue. It had been agreed a company would be invited to review signage throughout the hospital; this work had taken place during the summer 2015.
- The Patient Satisfaction Group also had an action to seek a patient representative to attend the group.
- There was a weekly staff update, which included information from all BMI hospitals. There were monthly team meetings in theatres.

Requires improvement

Critical care

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

Information about the service

The BMI Thornbury hospital had a four bedded critical care unit which was located in the middle of Mappin ward near the nurses station. It was divided in to two areas with a small clinical room in between the two. Generally the patients cared for were level two patients (who required extended post-operative care or single organ support). In addition there were two rooms on Mappin ward which had wall mounted cardiac monitors which could be used as additional high dependency beds.

91% of admissions from January 2015 to August 2015 were planned elective admissions. Patients were also admitted if they deteriorated and required closer observation and monitoring. There were 14 unplanned admissions following elective surgery between January 2015 and August 2015, and a total of 156 admissions in to the critical care unit over this period.

Patients were admitted to the critical care unit under the direct care of their consultant. The anaesthetist would also review the patients. The consultant and anaesthetist were available by telephone and would come and review the patient if staff had any concerns. Patients' medical care was supported by 24/7 cover from the resident medical officer (RMO).

There were three core critical care staff nurses and two sisters that worked on the unit. One of the sisters was the clinical lead. When there were no patients the staff worked on Mappin ward.

We visited the unit on the announced and unannounced inspection and observed the environment.

We spoke with the nurse manager, the clinical lead, four staff nurses, a consultant, two pharmacists, two pharmacy technicians and three patients. We observed care and treatment and reviewed 13 sets of patient records.

Requires improvement

Critical care

Summary of findings

We rated this service as requires improvement. This was because of practice we observed in relation the administration of controlled drugs and storage of record books. We also had concerns over some of the environmental factors in the unit. For example, the lack of patient call bells and the ability to access a patient in an emergency situation as this could result in a delay in attending to a patient. Early warning scores were not recorded for patients in the critical care unit; this could mean deteriorating patients were not identified at an early stage.

Two of the five staff we spoke with had not had their annual appraisal. We also saw that pain scores were not routinely recorded in the critical care unit and that some policies we reviewed were out of date.

Care was evidence based and staff were appropriately trained. Staffing levels were in line with the core standards for intensive care. There was an ongoing programme of audit with results collated in a dashboard, and actions taken as a result if needed.

A care pathway had been developed for deteriorating patients in response to information gathered about patients who had been transferred from the unit. Patients were treated with dignity and respect and involved in their care, and individual care needs were identified at pre-assessment.

The unit was responsive to the needs of patients and additional beds and appropriate staffing could be arranged at short notice.

The critical care unit had a clear vision and strategy and the governance arrangements enabled clear identification of risk and sharing of information.

Are critical care services safe?

Requires improvement

We rated safe as requires improvement because:

- Patients did not have access to a call bell.
- One of the rooms did not allow access to the bathroom or one of the beds in an emergency without having to remove the other bed from the room. This could cause a delay in attending to a patient.
- Early warning scores were not recorded for patients in critical care; this could mean deteriorating patients were not identified at an early stage.
- We observed practice which was not in line with local policy when a controlled drug was being administered and there were some gaps in the checking of controlled drug stock balances.
- We observed that infection prevention and control best practice was not always followed and hand wash facilities were not available in patient's rooms.

However:

- Staffing levels were appropriate on the unit.
- There were robust systems in place to feedback learning from incidents.

Incidents

- There have been no never events reported in 2014/2015. Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken.
- Hospital policies for reporting incidents were embedded and staff could describe the process for reporting an incident. Incidents were reported on paper records, pink for clinical incidents and blue if it related to equipment. They were then transferred onto an electronic system.
- We reviewed data on incidents from January 2015 to November 2015, during this time there were 14 incidents reported from the critical care unit. Five of these related to personal injury (the dashboard didn't specify if this was to patients or staff), eight were about communication and one related to administration.
- There was a communication cell board in the office which displayed information about incidents and any actions from these. We were given an example of the pathway for deteriorating patients being changed

following review of clinical incidents to try and reduce unnecessary transfers to NHS hospitals. We were told this had reduced the number of transfers from the unit to NHS hospitals. Data supported this as from January 2015 to August 2015 there had only been one patient who required transfer to an NHS critical care facility.

- The hospital manager led daily communication cell meetings with a representative from each area of the hospital, any incidents were discussed at this meeting. We observed one of these meetings where a patient who returned to the ward late following surgery was discussed.
- Incidents were also discussed at the monthly critical care delivery group meeting.
- Staff told us they would be given feedback directly if it was an incident they were involved with.
- The duty of candour legislation requires an organisation to disclose and investigate mistakes and offer an apology. The sister described a working environment in which any mistakes in patient's care or treatment would be investigated. They would also be discussed with the patient and their relatives and an apology given.
- The staff we spoke with had some understanding of the duty of candour but they could not provide us with any examples of where it had been applied.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and urine infections to be measured on a monthly basis.
- This data was not collected specifically for critical care, however a random selection of patients were audited on a set day each month. Overall figures from September to November 2015 showed safety thermometer percentages to be 99-100% which demonstrates good performance.
- The hospital carried out venous thromboembolism (VTE) risk assessments for all patients. The hospital had a Commissioning for Quality and Innovation (CQUIN) for VTE and had consistently achieved above its 95% target for completed VTE assessments. A CQUIN is offered by NHS commissioners to providers of healthcare services commissioned under an NHS Standard Contract to encourage care providers to share and continually improve how care is delivered.
- From incident data reviewed there had been no falls or pressure ulcers reported in the critical care unit from January 2015 to November 2015.

Cleanliness, infection control and hygiene

- There had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium difficile (c.diff) infections at the hospital from July 2014 to June 2015The hospital had policies and procedure in place to manage infection prevention and control. These were kept in a file in the office, it was noted several of them were out of date, for example the 'single use items' policy was due for review in February 2014 but had not been reviewed. The management team were aware of this but we were given no time frame in which they would be reviewed.
- The unit was visibly clean and personal protective equipment (PPE) was available in wall mounted units in each of the areas in the unit. We observed staff using PPE during our inspection.
- Housekeepers completed mattress audits. We checked under the cover of two mattresses and they were clean and in good condition.
- Alcohol gel was not available at each bed space but was available on the wall in each room.
- There were no hand wash facilities within the patient areas, however a hand wash sink was in the clinical room attached to the unit. This meant staff had to leave the room to wash their hands. We observed staff working on the unit washing their hands and using alcohol gel appropriately. However were observed two other staff visit the unit to review patients and no hand washing or use of alcohol gel was seen. If a patient required isolating we were told only one bed space in an area would be used, alternatively they would be moved to a single room on the ward.
- Hand hygiene audits were conducted each month. We reviewed data which showed compliance with hand hygiene. In September 2015 they were 93% compliant and in the following two months they had improved to 95%.

- The unit had wall mounted sharps bins with labels completed indicating when they had started being used and who had assembled them. We were told they contained powder in the bottom to absorb any wasted medication.
- We observed a member of staff who was not bare below the elbows in the department and a member of staff was seen collecting bags of clinical waste and putting them on a bed before disposing of them.

Environment and equipment

- The equipment available in the unit such as ventilators and monitoring equipment meant patients from level one to level three could be cared for safely.
- There was a central monitoring screen on the desk in critical care which meant any patient being monitored could have their heart rhythm and oxygen levels viewed from one screen.
- The beds were electric profiling beds and could accommodate patients up to 180kgs. A bariatric hoist and chair was available.
- Staff told us there were systems in place to maintain and repair equipment.
- We saw that a daily checklist of equipment was completed when the unit was open.
- We checked equipment for evidence of portable appliance testing **(**PAT**);** this is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. We looked at all equipment in the critical care unit and all had in date PAT.
- The bed areas in critical care were cramped. We expressed concerns to staff about access to patients in an emergency situation in this area of the unit. Staff told us that to access the bed next to the window or the bathroom in an emergency, the other bed would have to be removed as there was not enough space for equipment to be brought in. We asked staff if they had simulated an evacuation or emergency in this room and they told us that they had not. Senior staff told us they would conduct a risk assessment of the area.
- On the unannounced inspection a risk assessment form had been completed and included a patient collapsing in the bathroom, slips, trips and accessibility to the bathroom. We reviewed the risk assessment relating to managing a deteriorating patient, which stated the other bed would have to be removed to enable the patient to be attended too. It also stated to keep equipment to a minimum in the critical care unit to reduce clutter. The porters were also identified to assist with moving equipment in an emergency to allow easier access. However, the corridor outside the critical care unit was obstructed with blood pressure machines. No scenario for managing a deteriorating patient had taken place and the agency induction form made no reference to challenge in accessing a patient in this area in an emergency. There was no record of this issue on the hospital's risk register.
- We expressed concerns over the lack of call bells for patients. In one room there was a cord hanging between the beds for patient use but they could not be reached if patient was in bed. In the other room there were no patient call bells. In the bathroom the call bell was on the wall by door and could not be reached from the shower or toilet. We were told this was not an issue as staff would always be present in the unit. However we observed two patients in one room and the nurse caring for them was sitting in the other room writing up their notes for 45 minutes. They had no direct line of sight, the patients were not receiving monitoring so the central monitor was not being used. Neither patient had access to a call bell. On a separate occasion a patient was sitting in a chair with no means of summoning assistance and during a 20 minute observation the nurse left the room 3 times. It was the first time the patient had been out of bed since having a surgical procedure.

Medicines

- The hospital had two pharmacists and two pharmacy technicians who worked Monday to Friday 9:00 to 17:00. The hospital had an arrangement with a local pharmacy out of hours and at weekends. The hospital had an on-site pharmacy and secure systems for accessing medication out of hours.
- All medicines were prescribed by the patient's consultant or anaesthetist. The RMO was also available to prescribe medication.
- Guidelines and resources were available for medications, including, Medusa online for injectable medicines and the British National Formulary online.
- We reviewed 13 medication charts that were completed in line with hospital policy and national guidance.
- The BMI policy stated controlled drug stock balances should checked when the unit was open. We found staff

missed daily checks when the unit was open, for example in September the unit was closed for seven days but there were 15 days when the stock check was not done.
- We randomly selected two drugs and found the balance and record keeping was correct.
- During our inspection we observed practice not in line with the hospital policy (Administration of controlled drugs within BMI Thornbury Hospital) as both staff did not remain present throughout the whole procedure of checking, preparation and administration of the drug (morphine). Throughout the inspection, whilst on the unit the controlled drug record books were not locked away. They were left on the work counter. This was not in line with BMI pharmacy professional local operating practices and National Institute for health and Care Excellence (NICE) guidance on the safe use and management of controlled drugs. We reviewed an action plan following a controlled drug audit from September 2015, which recommended three monthly audits and further training to be done by the pharmacy team. The findings of the audit were to be discussed at the nurse handover.
- On our unannounced inspection we did not observe any controlled drugs being administered. We discussed the process for administering controlled drugs with two staff and they described correct practice in line with hospital policy. The controlled drug record books were locked in the cupboard.
- We observed a fridge in the critical care unit which contained actrapid (a type of insulin), the key to the fridge was in the door and it was unlocked. Minimum and maximum fridge temperatures were recorded which were within the appropriate range, but not the actual temperature. This meant that medications may not have been stored at the correct temperature. There were days when it was not checked due to the unit being closed.

Records

- The hospital used a paper based record system for recording patients' care and treatment.
- We reviewed 13 sets of in patient records. Information was easy to access with each episode of care divided into separate sections to allow staff to access the most recent and relevant information about the patient.
- Risk assessments were completed for each set of notes we reviewed, such as moving and handling and Malnutrition universal screening tools (MUST).
- The records contained details of the patient's journey through the hospital including pre-assessment, investigations, results and treatment provided. There were different pathways for each speciality or procedure.
- A clear plan was documented for all patients who were admitted to the critical care unit so staff were aware when to contact the consultant or anaesthetist. For example, parameters for observations.
- We reviewed documentation of resuscitation equipment checks and found they had been completed when the unit was open in line with local policy.

Safeguarding

- BMI Thornbury Hospital's Director of Clinical Services was Level 3 trained for the safeguarding of children and vulnerable adults. The director of clinical services was the named safeguarding lead for the location. The adult access team could also be contacted for advice.
- The hospital had a policy for safeguarding and staff could easily access this.
- Staff received mandatory training in safeguarding of vulnerable adults as part of their inductions and had annual safeguarding updates. All staff were required to undertake Safeguarding Children and Vulnerable Adults training by completing a mandatory e-learning module.
- We reviewed mandatory training figures for safeguarding from September 2015. Adult safeguarding compliance was 96% and children's safeguarding was 97%. These figures were not specific to critical care.
- In the critical care unit we observed a safeguarding adults flow chart on the wall and information from Sheffield safeguarding children's board on how to make a referral.
- None of the staff we spoke with had had to make a safeguarding referral but they were aware of the process and how to escalate concerns.

Mandatory training

- Staff explained they received mandatory training to provide safe care. Some of this was completed through e-learning and some through on-site training, for example, manual handling. Staff described a range of topics included in their training such as information security and basic life support.

- Overall mandatory training compliance figures were reviewed for critical care and they were 90% in September 2015.

Assessing and responding to patient risk

- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. They needed to be available to attend within an appropriate timescale if there was an emergency or significant deterioration in their patient's condition. There were arrangements in place to provide additional cover if the consultant was unavailable.
- The RMO was on site 24 hours a day.
- There was a formal arrangement for patients to be transferred to the local NHS hospital if their clinical condition could not be safely managed at BMI Thornbury.
- There was a deteriorating patient pathway and a clinical escalation policy which covered who to contact if the patient's consultant could not be contacted.
- Staff told us about when patients had to be transferred to NHS hospitals and reported the system had worked well.
- There was an emergency cord which was tested each Monday. Staff on the ward would attend as well as RMO if they were on the ward. If the RMO was not on the ward they would be bleeped by the ward staff.
- The National Early Warning System (NEWS) tool is a way of identify deteriorating patients. This scoring system was not used in the critical care unit. We questioned why this was not used as the deteriorating patient pathway was triggered by a high NEWS score. We were told that because patients were monitored they would use that information or look at trends.
- Two of the patients we saw were not cardiac monitored but NEWS scores were still not recorded. This made recognising any deterioration in their clinical condition more difficult. We were concerned that not using NEWS could mean deteriorating patients were not identified at the earliest possible stage. We saw an example of a patient who became unwell and required transfer to an NHS intensive care unit. This decision was made on the second post-operative day, NEWS scoring was not done for this patient. NICE guidance recommends the use of NEWS to recognise and respond to deterioration in a patient's condition.
- The observation charts used on the ward were different to critical care and did include a NEWS score. This meant any trends would not be as obvious as a separate chart was used to record observations when a patient was transferred from one area to another.
- There was no outreach team. However the critical care staff worked on the ward when there were no patients in the unit so would routinely ask if there were any ward patients causing concern and would review patients who were transferred from critical care to the ward.
- The hospital did not have a pathway for the management of suspected sepsis. Sepsis is a potentially life threatening complication from an infection. There are national guidelines and care bundles on early recognition and management of sepsis.

Nursing staffing

- Nurse staffing met the core standards for intensive care (2013) requirements of one nurse to two level two patients.
- There were five staff who worked in the critical care unit, two sisters and three staff nurses. If additional staffing was required the hospital had regular agency staff that they would use. The agency staff were critical care trained and an induction checklist was completed.
- Average staff turnover figures for the hospital from July 2014 to June 2015 were 5%. Sickness rates for the same period were 2% for each month. The vacancy rate as of July 2015 was 6%. This figure was not specific to critical care.
- Most of the admissions to critical care were planned so the sister would ensure the appropriate number of critical care trained staff were on duty. The ratio of 1:2 was achieved for level two patients.
- If only one member of staff was on duty in the critical care unit there was no formal process to cover breaks. Staff told us they would go into the kitchen opposite to have a drink. Whist on inspection we observed a nurse who had been on duty all morning and at 14.00 had not had a break.
- We were told a situation can arise where one nurse is caring for two level two patients and there is no other member of staff with critical care experience to cover breaks.
- We were provided with a risk assessment in relation to staff breaks. It outlined various ways of ensuring support and breaks if staff are working alone. For example, staff working flexibly and taking breaks before patients arrive

from theatre. The staff we spoke with did not express concerns over cover for breaks it had become custom and practice to either have long periods of time without a break or have a short break without any cover.
- A comprehensive handover sheet was completed and a verbal handover given when a patient transferred from critical care to the ward.

Medical staffing

- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. They had overall responsibility for the patients.
- Medical cover was provided by a RMO who worked two week shifts. During this time they were on site and available 24 hours a day.

Major incident awareness and training

- There was a business continuity plan which identified keys risks that could affect the provision of care and treatment.
- There were robust escalation plans in place if a consultant could not be contacted in an emergency, which included a flow chart of who else to contact.

Are critical care services effective?

Requires improvement

We rated effective as requires improvement because:

- Two of the five critical care staff we spoke with had not had their annual appraisal.
- Pain scores were not routinely recorded on the critical care unit.
- Some of the polices we viewed were out of date.
- The hospital was not submitting data to the Intensive Care National Audit and Research Centre (ICNARC) at the time of inspection, although there were corporate plans to do this in early 2016.

However:

- There were polices and guidelines specific to critical care which were taken from the local NHS trust.
- We saw good multidisciplinary working.
- Staff on the unit were experienced and appropriately trained.
- There was a robust audit programme with data collated on a dashboard to monitor progress.

Evidence-based care and treatment

- Policies were accessible on the hospital intranet and paper copies were kept in files in the sister's office. Policies were based on professional guidance such as National Institute of Health and Care Excellence (NICE) and Royal College guidelines.
- The policies specific to critical care were taken from the local NHS Teaching Hospital.
- Not all policies were up to date. For example, the management of chest pain policy was out of date in 2012. The management team were aware that some of the BMI policies were due for renewal and the BMI governance team were addressing this.

Pain relief

- Anaesthetists would prescribe post-operative patient relief for patients and could be contacted if effective pain control was not achieved.
- The RMO could also be contacted to prescribe additional or alternative pain relief.
- Patient controlled epidural pumps and epidural catheters were used for pain management post operatively.
- We saw no evidence of pain scores being routinely recorded in the 13 sets of records we reviewed. There were some references to pain scores within the nursing documentation. Staff told us there was space on the bottom of observation chart to add in pain scores, but we saw no evidence of this being done.
- Through the hospital audit tracker and patient feedback it had been identified that patients did not always receive pain relief in a timely manner. In response to this the hospital had recently established a pain group to review and improve pain management for surgical patients. The meeting was attended by an anaesthetist, medical and nursing staff and the risk and quality manager.

Nutrition and hydration

- In the records we reviewed all patients had a completed MUST assessment.
- Patients were offered a choice of meals and additional snacks. Specific dietary requirements could be catered for.

- Intravenous fluids were prescribed as appropriate and recorded according to hospital policy. We observed that fluid balance charts were used to monitor patients' hydration status.
- The PLACE score for food for the same time period was 94.30% this was higher than the national average of 88.49%
- Patients who were able to have fluids had drinks available and assistance was offered.
- Patients spoke positively about the food they were provided with.

Patient outcomes

- The BMI Thornbury hospital did not submit data to the Intensive Care National Audit and Research Centre (ICNARC) as the information collected was not applicable to the patients they cared for. However there was minimal data collected on some local data sets and there were corporate action plans in place to begin submitting data in January 2016.
- The hospital had a monthly audit programme which we reviewed. This included audits such as VTE assessments and medical records. This information was collated on a dashboard. We were provided with information on current progress of audits which was 63.8% this was RAG (red, amber, green) rated as green. This was not specific to critical care.
- We reviewed audit data from October 2015 in relation to central line insertion and peripheral insertion care bundles. Compliance with set standards was seen in all of the cases reviewed.

Competent staff

- All patients were cared for by their admitting consultant and anaesthetist. Doctors with practising privileges were reviewed biennially unless they were over 65 years then they were reviewed annually. All doctors signed a self-declaration of fitness to practice prior to their review.
- The introduction of a new technique or procedure for a consultant had to have the support of the Medical Advisory Committee (MAC) which may take specialist advice such as that of the National Institute for Health and Care Excellence. The practitioner was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure.
- The unit had a dedicated lead nurse in line with the core standards for intensive care units. The lead nurse was also the clinical educator and had 10 hours per week contracted for this.
- The staff who worked on the unit had critical care experience and training. Intermediate life support was mandatory for all nursing and healthcare staff.
- 95% of nursing staff had completed a recognised course in recognising and managing the deteriorating patient.
- There was an induction checklist for new staff and agency staff which covered areas such as what to do in the event of a fire.
- We were not provided with appraisal rates specific to critical care however two of the staff we spoke with had not had their annual appraisal. Dates had been arranged for these to take place.
- The hospital had a web page about revalidation and it has been discussed at the end of training sessions and communication cell meetings.

Multidisciplinary working

- Staff told us they had good working relationships with the consultants and anaesthetists and would not hesitate to contact them if they had any concerns about a patient.
- They also had good relationships with their local NHS hospitals.
- We observed effective team working among managers, administrative, clinical, nursing and ancillary staff during our inspection for example, when patients were ready to be moved from critical care to the ward.
- We saw patients being reviewed by physiotherapists and an informal handover being given before and after they were seen.
- As the staff worked on the ward when the unit was closed they had good relations with the ward staff who would contact them if they were concerned about a patient.
- Discharge letters were sent to the patient's general practitioner (GP) with details of the treatment provided, follow up arrangements and medicines provided on the day of discharge.

Seven-day services

- The hospital undertook elective surgery with theatre lists planned in advance. There were facilities to accommodate an emergency return to theatre if it was assessed as safe to do so.

Requires improvement

Critical care

- Consultants were on call 24 hours a day for patients in their care.
- There was 24 hour RMO cover in the hospital to provide clinical support to surgeons, staff and patients.
- The hospital had on-call arrangements for theatres, radiology and physiotherapy services.
- During out of hours, if a prescribed medicine was not available on the ward, the RMO could access the pharmacy with a nurse present.
- There was always a senior nurse available at the hospital as a contact point for both staff and patients, to help resolve patient queries and to accept out of hours admissions and they were available via bleep or telephone.

Access to information

- A critical care to ward handover sheet was completed by the staff nurses when the patient was ready to transfer back to the ward, this included things such as what procedure they had undergone and what their current observations were. This was in line with National Institute for Health and Care Excellence (NICE) guideline CG50.
- Policies and guidelines were accessed in folders in an office and BMI policies could be accessed on the intranet.

Consent and Mental Capacity Act

- Compliance figures for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was 83% in September 2015, these were not specific to critical care. Staff were aware of the legal requirements related to this but said they had not had a patient which this had been applicable to.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people.
- Consultants gained consent from patients discussing the risk and benefits of surgery.
- The patient records we reviewed documented verbal or written consent had been obtained for care and treatment.

Are critical care services caring?

Not sufficient evidence to rate

We inspected the caring domain but did not rate. However, we saw that:

- Patients were treated with dignity and respect, were involved in their care and spoke positively about the staff looking after them.
- Patients felt able to ask questions and the staff to patient ratio on the unit meant staff had time to attend to any needs their patients may have.

Compassionate care

- BMI Thornbury's patient satisfaction survey showed 98% of patients reported being satisfied with the overall care they received at and 99% said they would recommend the hospital to friends and family. This information is not specific to the critical care service.
- The Patient Led Assessment of the Environment (PLACE) score for the hospital in 2015 for privacy, dignity and well-being was 86.36% this was marginally higher than the national average of 86.06%.
- The three patients we spoke to were positive about staff. They told us that staff were there when they were needed without being intrusive. They said their pain was well managed and staff introduced themselves.
- Patients stated their procedure and post-operative care was explained to them, and they felt able to ask questions.
- The three patients we spoke with were aware that they would be coming to the critical care unit following their surgery and were prepared for this.
- Staff told us they liked having time to spend with patients and felt they provided high levels of patient care.

Understanding and involvement of patients and those close to them

- The three patients we spoke with were fully informed of the procedure they underwent and told us the consultant had clearly explained any risks associated with the procedure.
- The patients we spoke with were involved in all aspects of their care.

- We were not able to speak with any relatives as there were none on the unit at the time of our inspection.

Emotional support

- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.
- Pre admission assessments included consideration of patient's emotional well -being. This was seen in the medical noted we reviewed.

Are critical care services responsive?

Good

We rated responsive as good because:

- The critical care unit was available for patients when required and additional staff could be obtained at short notice.
- We saw evidence of service improvement in the pathway for deteriorating patients which aimed to help the management of these patients and prevent unnecessary transfers.
- Any individual needs were identified at pre-assessment to allow planning of the patient's care prior to admission.

Service planning and delivery to meet the needs of local people

- The hospital planned services to meet the needs of private and NHS patients.
- All admissions were planned and patients assessed before admission to enable their needs to be met. This included identifying those who would require high dependency care post operatively.
- We observed the morning daily communication cell meeting. This was attended by representatives from all departments. Any potential issues with either clinical care or number of admissions were identified to enable swift resolution, for example getting additional staff or moving staff from one area to another.
- We were told the clinical lead for the unit had reviewed the last 20 patients who had transferred from the unit to an NHS hospital and they had looked at any themes. As a result of this the deteriorating pathway was developed and implemented in January 2015 to provide support and guidance for staff and reduce unnecessary transfers out of the hospital. We were told the introduction of this pathway had reduced the number of patient transfers. Data reviewed from January 2015 to August 2015 showed there had only been one transfer from the unit to NHS care.
- We were told if an unexpected admission came in to the unit there were critical care trained staff 'on call'. Alternatively they were agency staff who could be contacted.

Meeting people's individual needs

- Staff told us they could access interpreting services however they tended to use family members to translate. This is not considered to be best practice, however this was whilst they were on the critical care unit and consent for their procedure would have already taken place.
- Mandatory training did not include dementia awareness or caring for those with a learning difficulty. However we were provided with examples of when staff had cared for a patient with a learning difficulty and reasonable adjustments were made to make the experience less stressful, for example having the patient's mum present throughout their in-patient stay.
- Due to the lack of space and the location of the bathroom, the bathroom would be difficult to access if someone had mobility problems and used a walking aid, for example.
- Discharge planning began at pre-assessment where patient's social circumstances and any anticipated care needs would be discussed and plans made for them.
- Much of the equipment for patients could be used for bariatric patients. All patients undergoing gastric band/ sleeve operations were routinely admitted to critical care for post-operative monitoring. The equipment on the unit could accommodate these patients. For example, the beds could take patients up to 180kgs in weight. We were told if additional equipment was required this would be identified at pre-operative assessment and arrangements made to ensure it was available at the time of admission.

Access and flow

- Patients requiring high dependency care were identified at pre-assessment. We were told there had been no

instances of surgery being cancelled due to no critical care beds being available. All bariatric patients or those with sleep apnoea were routinely admitted to critical care.

- We were told if an additional bed was required there were two beds on Mappin ward which had cardiac monitors which could be used for level two patients.
- Additional staff could be sought as needed as there were staff on call or regular agency staff would be contacted. The staff we spoke with told us they may be asked to alter their shift patterns to accommodate admissions to critical care but they were happy to do this.
- Most patients were admitted post operatively from theatre following an elective procedure.
- Patients were not moved from critical care until they have been de-classified by the consultant responsible for their care or the anaesthetist involved in their procedure. Patients were usually seen in the morning, given the plan for the day and transferred to the ward later the same day. The ward staff would not accept a patient that had not been declassified.
- If a patient deteriorated on the ward they would be moved to critical care and stabilised and either remain on the unit or transferred to NHS care as appropriate.
- Between January 2015 and August 2015 there were 14 unplanned admissions to critical care. There was one readmission to the unit and one patient required transfer to NHS critical care facilities. There could not be compared to other units as there was no ICNARC data for comparison.

Learning from complaints and concerns

- The complaints data that we were provided did not identify which complaints, if any, were about critical care. The Care Quality Commission had received no complaints about the hospital during 2014- 2015.
- Any complaint the hospital received was discussed at the communication cell meeting and then shared with each team and department.
- The hospital used the BMI complaints policy.
- From January 2015 to October 2015 the hospital had received 47 complaints. A common theme for the clinical complaints received related to patients feeling that some staff were not as engaging or as informative as they should have been and in some cases poor attitude was cited. The hospital had implemented staff training to improve communication and staff attitude.

Are critical care services well-led?

Requires improvement

We rated well led as requires improvement because:

- We were concerned that the environmental risks within the critical care unit had not been identified prior to our inspection. Although a risk assessment had been competed once concerns were raised, an emergency situation simulation had not taken place to test the hospital procedure.
- We were not assured that deteriorating patients would be identified at an early stage as national early warning scores (NEWS) were not being recorded in the unit. The deteriorating patient pathway was triggered by a raised NEWS score, so we were not assured this pathway would be implemented at the earliest opportunity.
- We observed medicines administration not in line with hospital policy and gaps in the checking of controlled drug stock levels.
- Not all staff within the critical care unit had undergone their annual appraisal.

However:

- The hospital and critical care lead had a vision of further developing the department and this was supported by the annual plan and quality strategy.
- Management were visible and approachable.

Vision and strategy for this this core service

- Management recognised the need to continually improve services. The hospital's annual plan focused on effective marketing, good news stories, quality improvement and constant learning.
- The hospital had a quality strategy which aimed to provide the best possible care and for continual improvement. It had four core themes – safety, clinical effectiveness, patient experience and quality assurance. Within critical care this meant increasing audit activity to evidence changes in practice were having a positive impact.
- We were told staff would like to see more major surgery taking place and that the unit had the equipment and staff to be able to support this.

Requires improvement

Critical care

- The critical care unit was exploring plans to support NHS trusts in terms of winter pressures by providing a high dependency 'step down' service.
- There was an ongoing refurbishment plan but staff were not aware of any plans specific to critical care.

Governance, risk management and quality measurement for this core service

- There was a clinical governance committee which met monthly to discuss governance issues such as complaints, incidents and risks. Any risks were discussed at the daily communication cell meeting.
- The critical care delivery group led by the lead anaesthetist/intensivist tried to meet monthly to discuss any specific issues.
- The Medical Advisory Committee (MAC) met monthly. The MAC had terms of reference and it had standing agenda items which included regulatory compliance, practicing privileges, quality assurance and proposed new clinical services and techniques. The critical care lead told us they did not attend every meeting, but would attend if there was a need to. We were told the MAC were very engaged and committed.
- There was a communication cell board in each area which displayed information about any incidents or risks.
- We reviewed the hospital's risk register which outlined seven risks. There was evidence of review and actions associated with these risks. For example staffing in clinical areas was being managed with daily meetings, review of admissions and ongoing recruitment.
- The environment within the critical care unit had not been identified as a risk. We lacked assurance that bed spaces and bathrooms could be accessed in an emergency situation due to the space available.

Leadership / culture of service

- Heads of departments were engaged in management/ performance training to support their development.
- Staff told us senior management were very visible and approachable and if they had a concern they would feel able to ask for help and support.
- Ward managers told us they did not have dedicated time to complete administrative and management duties which presented a challenge. Staff were not aware of any plans to address this.

Public and staff engagement

- Patients were encouraged to provide feedback through the Family and Friends Test and the BMI patient survey.
- There was a monthly BMI Patient Survey Report and in May 2015 98.6% of patients would recommend the hospital.
- Daily communication cell meetings were attended by a representative from each department, any information was then cascaded to the team by the team leader. Staff we spoke with were aware of any current issues in the hospital.

Innovation, improvement and sustainability

- The critical care team had developed a pathway for the deteriorating patient which aimed to support staff when a patient became unwell. It also hoped to reduce the number of unnecessary transfers from critical care. Since its implementation in January 2015 and up to August 2015 there had only been one patient transferred from critical care to an NHS critical care facility.
- The critical care unit was planning to collect outcome data in the future to submit to the Intensive Care National Audit and Research Centre (ICNARC).
- The critical care staff had the equipment and experience to care for more complex cases if the hospital chose to undertake more major surgery.
- The clinical lead was exploring the possibility of supporting NHS trusts in the winter pressure period by providing a 'step down' service.

Requires improvement

Services for children and young people

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

Information about the service

Thornbury Hospital offered a limited paediatric service. This service was available only to self-funding and privately insured paediatric patients. Once a month, the hospital carried out non-complex day case surgery, such as endoscopy, dental and podiatry operations on children over the age of three years on dedicated paediatric theatre lists.

Between July 2014 and June 2015, 48 children (aged three to 15 years) and 18 children (aged 16 and 17 years) attended the hospital as day cases. There were 11 children who were inpatients. All operations were elective cases only and children did not access the hospital's critical care unit.

The outpatients department offered services for children of all ages, with the exception of neonates. The radiology service did not provide CT scanning to young people under 16 years of age or MRI scanning for children below six years of age.

We spoke with members of staff including consultants, ward managers, nurses, health care assistants, theatre staff and porters. We looked at 10 sets of children's notes. We talked with two patients and four carers.

Summary of findings

We rated this service as requires improvement overall.

We rated the safe and effective domains as requires improvement. We rated the service as good for the caring, responsive and well-led domains.

The resuscitation equipment for children on the ward was not well organised to allow staff to find equipment quickly in the event of an emergency. Three staff did not know the procedure for using the resuscitation masks. A children's nurse was not routinely available on site when children attended for outpatient appointments, as required by corporate policy. A lead children's nurse was in place and was contactable by telephone off site.

Although patient records were well structured, we found staff did not complete all sections of the patient record.

The hospital did not complete audits for children and young people because the service had only had small numbers of children admitted for surgery and no data was collected on the outcomes for children and young people following surgery. Staff in theatres had not all completed Paediatric Intermediate Life Support Training as required.

The service did not have robust performance monitoring systems in place to allow assurance that all risks were managed effectively.

The service had incident reporting systems in place and there had been no serious incidents reported between July 2014 and June 2015.

Requires improvement

Services for children and young people

Staff supported and treated patients with dignity and respect. Patients were involved in the planning of their care. Patients and their carers were satisfied with the care they received. Patients told us they received enough information about their care and treatment.

Services were planned and delivered to meet the needs of the local population. There was planning by staff to ensure patients were admitted and discharged in a timely manner with the right level of care and support. There was a complaints system in place. The hospital investigated and responded to complaints within the designated timescales

The hospital had access to interpreters for patients whose first language was not English. Information leaflets were available about the services were available in all areas we visited. However, there were no child-friendly or easy-to-read information leaflets available throughout the hospital.

There was a vision for the services provided at the hospital. There were clear governance structures in place with committees for clinical governance, health and safety, infection control and medication. Staff were positive about the culture and the support they received from managers.

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Staff in outpatients did not have an awareness of the potential safeguarding concerns arising due to children not attending planned appointments.
- Although patient records were well structured, we found staff did not complete all sections of the patient record so there was a risk that patients would not receive care in a timely manner.
- Mandatory training was delivered via e-learning and some face to face training. Paediatric nursing staff worked one day per month for the hospital. Staff provided certificates and documentary evidence of training completed with their NHS employer. We found evidence that training was not up to date and we did not see evidence that paediatric nurses had up to date level three safeguarding training, although the hospital subsequently confirmed that this was in place.
- We looked at children's emergency resuscitation equipment on Fulwood ward and in theatres. We found staff used the children's resuscitation trolley on the Fulwood ward as a workstation and the trolley was not locked to ensure security of the equipment. The equipment drawers were not well organised to allow staff to find equipment quickly in the event of an emergency. Three staff did not know the procedure for using the resuscitation masks.
- The corporate policy on care of children specified that a registered children's nurse should be available on site for children under three years old undergoing consultation, and for children aged three to sixteen for children undergoing local anaesthetic. Staff told us a children's nurse was not routinely available on site in line with this policy. A lead children's nurse was in place and was contactable by telephone off site.

However

- Staff were aware of how to report an incident and there had been no serious incidents reported between July 2014 and June 2015.

- All areas we visited were visibly clean. We observed staff following hand hygiene and washing their hands before and after looking after a patient.

Incidents

- Between July 2014 and June 2015 there had been no never events or serious incidents reported that involved children or young people. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- All incidents were recorded on paper records and then transferred onto an electronic incident reporting system. Incidents were reviewed and investigated by a governance lead and a ward or a theatre manager in the service to look for improvements.
- Incidents were discussed during a daily communication cell meeting and at monthly meetings with staff.

Cleanliness, infection control and hygiene

- The service had an infection prevention and control policy and there was a lead nurse for infection prevention and control.
- All areas we visited were visibly clean. We observed staff following hand hygiene and washing their hands before and after looking after a patient. Staff also followed bare below the elbow guidance. The ''bare below the elbows'' guidance is an attempt to reduce infection rates.
- The service completed monthly hand hygiene audits. We reviewed hand hygiene audits for August, September and October 2015 and the service achieved 100% compliance.
- Personal protective equipment was available for all staff. Personal protective equipment is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.
- We observed staff wearing personal protective equipment such as gloves and aprons. Staff wore aprons and gloves while delivering care.
- Gowning procedures were adhered to in the theatre areas.

Environment and equipment

- Theatre staff carried out daily, weekly and monthly checks of equipment in Theatres.
- Equipment was visibly clean and well maintained. Staff told us equipment was available and any faulty equipment was repaired or replaced.
- Reusable surgical equipment was sterilised by an external contractor. Staff told us they were always able to access the sterilised equipment when required.
- Single use sterile equipment was stored appropriately and kept within their expiry dates.
- Emergency resuscitation equipment was available.
- We reviewed children's emergency resuscitation equipment on Fulwood ward and in theatres. We found the resuscitation trolley on the Fulwood ward was used as a work station by staff and it was not locked to ensure security of the equipment. The trolley contained stationary and tabards for nursing staff to wear in two drawers. The trolley was not organised in the same way as other resuscitation trollies, therefore there was a risk that staff would not be able to find equipment quickly in an emergency.
- We found items were not immediately ready for use. For example, there were no straight blades for the laryngoscope in the trolley and items could not be accessed immediately because they were stored with elastic bands around them. In addition, the nasogastric tubes and the suction tubes were not stored separately. There was a risk the wrong tube would be used in an emergency.
- We brought the resuscitation trolley on Fulwood ward to the attention of senior managers at the time of the inspection who removed the stationary and tabards. They also arranged for the trolley to be re-organised to allow staff to find equipment easily in an emergency and for the trolley to be secured.
- The paediatric resuscitation masks needed a syringe to inflate them prior to use.

However, syringes were not available in the paediatric resus trolley on Fulwood ward or the resus grab bags in the consulting suite and physiotherapy area of the hospital. We brought this to the attention of hospital managers who arranged for syringes to be added to the equipment.

- We looked at the children's resuscitation equipment again at a further announced inspection on 4 December 2015. We found the resuscitation trolley on Fulwood had been re-organised and syringes were available with the masks. However, we found the trolley had not been

tagged correctly and the drawers were unsecure. Staff told us they had checked the trolley the day before the inspection and on the day of the inspection but we could not find documentation to support this.

- The trolley in theatres and outpatients had syringes available with the masks. However, there were no instructions on the need to inflate the masks prior to use. Three staff did not know the procedure for using the resuscitation masks.
- The hospital's clinical educator carried out regular resuscitation scenario training. Following the concerns raised by the inspection team about the paediatric resuscitation trolley, the scenario was carried out again to allow learning to be shared and improvements implemented. In addition, training had taken place and there was a debriefing for staff.
- Children were cared for in private rooms in the same wards area as adults. The ward did not group children together in to a specific area of the ward. On the day of our inspection, the ward looked after adults in private rooms opposite rooms used for children. There was a risk that adults could access the children's rooms without being observed.
- The ward was not secure and the areas where children were cared for was next to an unsecure staircase, which was not visible from the nurse station. Carers we spoke with told us they did not tell the nursing staff if they left the room.
- The main outpatient waiting area on the first floor had a children's toy box that contained a small number of children's books and a toy. There was no separate waiting area or activity area for children.

Medicines

- The hospital had two pharmacists and two pharmacy technicians who worked Monday to Friday 9:00am to 17:00pm. The hospital had an on-site pharmacy so medicines were available for patients. The hospital had an arrangement with a local pharmacy to provide medicines out of hours and at weekends.
- Medicines including controlled drugs were stored securely. The senior nurse in charge of the ward kept keys to medicines cabinets.
- Staff carried out daily checks on controlled drugs and medication stocks to ensure medicines were reconciled correctly. The pharmacist had worked with the staff to improve medicine reconciliation. The pharmacist was new in post and planned to carry out further audits to monitor improvement.
- Staff recorded daily medication fridge temperatures to ensure medicines were stored at the correct temperature. The fridge temperatures were within the recommended levels for storing medicines in the fridge.
- We looked at the medication charts 10 child patients. Staff had completed all these medication charts without gaps. Allergies were documented on medication charts. The service had not completed any audits for children's medication charts.

Records

- The hospital used a paper-based paediatric day case booklet which started with pre-admission documentation and ended with the patient's discharge. The booklet documented the patient journey. There were checklists, risk assessments and observations including the paediatric early warning system (PEWS), consent and medication charts.
- We reviewed ten sets of records. In every record we reviewed there were gaps in documentation. Pre-assessments and risk assessments were not always completed and PEWS were not recorded. Staff told us this was because they considered the patients were relatively low risk and therefore did not require this monitoring.
- We looked at ten set of records. In all the records we looked at there was no evidence that the child's view about the procedure was discussed in the medical record and that the child's view was taken into account.
- We did not see any evidence that the paediatric records had been audited to monitor if they were completed appropriately.

Safeguarding

- There were no safeguarding concerns reported to us in the reporting period from July 2014 to the time of our inspection. BMI Thornbury Hospital's Director of Clinical Services was Level 3 trained for the safeguarding of children and vulnerable adults. The Director of Clinical Services was the named safeguarding lead for the location.
- All staff were required to undertake safeguarding children and vulnerable adults training by completing a mandatory e-learning module. 100% of theatre and

ward staff had completed safeguarding children level 1 and 2 training. There was 100% compliance with safeguarding training children level 1 and 2 within the diagnostic imaging, radiology and physiotherapy departments. There was 90% compliance with training in the outpatient department against a target of 100%.

- We looked at two paediatric nurse files and saw evidence they had completed level two safeguarding children training with their NHS employer. We found no evidence to show these staff had completed level three training. The Intercollegiate Document on Safeguarding Children (2014) states that all nurses staff providing direct care to children are required to have completed level three safeguarding training. The hospital has subsequently confirmed that this training was in place at the time of inspection.
- Staff working with children who had undergone surgery had limited understanding of abuse for children in a private health care setting. We spoke with two paediatric nursing staff and the ward manager. There was no understanding of the risk of abduction and abuse in an unsecure environment on the ward. Staff had not identified steps to reduce the possibility of abuse and prevent abuse from happening.
- In outpatients and diagnostic imaging staff we spoke with did not have an awareness of the potential safeguarding concerns arising due to children not attending planned appointments. This was not covered in any corporate or hospital policy provided to us at the time of our inspection.

Mandatory training

- Mandatory training was delivered via e-learning and some face to face training.
- Paediatric nursing staff worked one day per month for the hospital. The nursing staff were employed by local NHS services. Staff provided certificates and documentary evidence of training completed with their NHS employer.
- We looked at three staff files for paediatric nursing staff. We found training was not up to date. In one file we found medicines training was out of date and had not been reviewed since 2013. We did not see any evidence that this had been discussed with the member of staff.

Assessing and responding to patient risk

- The hospital had admission guidelines and only accepted patients who were low risk of complications.
- The WHO checklist was used and we saw evidence that this was completed.
- Consultants were responsible for the care and treatment of their patients at all times. Consultants were accessible by telephone 24 hours a day. Consultants would visit their patients at weekends and out of hours if required.
- Staff knew how to escalate if a patient was deteriorating and needed input from the RMO or consultant. However we looked at 10 sets of children's notes and found the Paediatric Early Warning Score (PEWs) was not being used consistently. Paediatric Early Warning Score is a simple, physiological score and its primary purpose is to prevent delay in intervention or transfer of patients who become more unwell.
- Staff explained that if a paediatric patient were to become acutely unwell then they would call an emergency ambulance. The hospital also provided us with information on the local 'Embrace' service operated by Sheffield Children's NHS Foundation Trust. This is a 'pick and retrieve' system for acutely unwell children. There was no formal agreement in place to use this service, but the hospital told us that this arrangement was under review.

Nursing staffing

- The hospital used bank paediatric nurses to cover the ward based activities for children attending for day case. There was a minimum of two registered children's nurses on duty for the surgical list.
- The lead for children told us that the children's list was planned and co-ordinated with the paediatric nurses to ensure there were be at least two registered children's nurses available to cover the wards. If two nurses were not available the hospital would cancel the surgery.
- There was no staff in theatres with paediatric training. Theatres would allocate a theatre nurse to look after children in recovery. There was a risk that staff did not have appropriate training for looking after children.
- The corporate policy on care of children specified that a registered children's nurse should be available on site for children under three years old undergoing consultation, and for children aged three to sixteen for children undergoing local anaesthetic. Staff told us a children's nurse was not routinely available on site in line with this policy. A lead children's nurse was in place and was contactable by telephone off site. This meant the hospital was not following its own policy.

Requires improvement

Services for children and young people

Medical staffing

- Most medical staff worked for the NHS and worked at the hospital via practising privileges. The term practising privileges refers to doctors being granted the right to practise in a hospital.
- There was an RMO on site 24 hours a day. RMOs were supplied by RMO International and provided a 24 hour 7 day a week service on rotational basis. The RMO was on duty 7.30am to 10pm daily and was on call out of hours. We reviewed RMO rotas between 30 July 2015 and 26 November 2015 and they confirmed this arrangement. All staff told us they had good links with the consultants and RMOs. They confirmed the RMOs worked for two-week periods and stayed on site for call outs.
- It was a requirement of BMI Healthcare's practising privileges policy, that consultants remained available (both by phone and if required, in person) or arranged appropriate alternative named cover if they would be unavailable at any time when they had inpatients in the hospital.
- Consultants were responsible for the care and treatment of their patients at all times. Consultants were accessible by telephone 24 hours a day. Consultants would visit their patients at weekends and out of hours if required.
- Children were seen and treated as day cases and an anaesthetist would not leave the hospital until the last child was discharged. Operations were scheduled for the morning so children were ready to be discharged home in the afternoon.

Major incident awareness and training

- There was a business continuity plan, which identified keys risks that could affect the provision of care and treatment. Staff were aware of the business continuity plan and knew where information was kept at the nurse's station.
- The hospital had local and corporate business continuity plans with supporting action cards for use in the event of a major incident. For example, there were action cards for the loss/failure of operating Theatre Air Handling.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement because:

- The hospital did not complete audits for children and young people because the service had only had small numbers of children admitted for surgery.
- There was no data collected on the outcomes for children and young people following surgery.
- Staff in theatres had not all completed Paediatric Intermediate Life Support Training as required.

However:

- There had been no readmissions of children to the service.
- The paediatric nurses provided evidence of their paediatric qualifications and training.
- The hospital told us RMOs must have Advanced Life Support (ALS) and Paediatric Advanced Life Support (PALS). The hospital organised the RMO rota to ensure that an appropriately trained RMO was on duty during any paediatric list.
- Patient records documented verbal or written consent had been obtained for care and treatment. Consent forms showed the risks and benefits of surgery were discussed with the patient prior to procedure being carried out.

Evidence-based care and treatment

- Children and young people were under the care of a paediatric consultant surgeon who saw them in outpatients and then on the ward for the surgical procedure.
- The provider had a corporate care of the child policy which was available to staff. Policies and procedures including NICE guidance were available on the intranet. Staff told us they were able to access the information easily.
- The service had only had small numbers of children admitted for surgery. It had not collected enough information to carry out formal audits and had not been able to learn from audits and improve services.

Pain relief

- There was a pain management chart in the day surgery documentation. The pain assessment tool used smiley faces for the child to choose to describe their pain. We looked at ten records and saw that this was being used.
- The service had a pain management policy. Children and their carers told us nurses asked them about their pain and managed pain well and provided advice.

Nutrition and hydration

- Full nutritional screening and assessment was not completed because the children were day case patients.
- Children were always first on the surgical list so pre-operative fasting times were not a concern.
- Patients were supported to eat and drink following surgery prior to discharge.

Patient outcomes

- There was no data collected on the outcomes for children and young people following surgery.
- There had been no readmissions of children to the service.

Competent staff

- We confirmed that consultants had a children's practice in the NHS. Consultants provided evidence of their NHS practice before they were granted practising privileges.
- The Medical Advisory Committee reviewed practising privileges. Doctors with practising privileges were reviewed biennially unless they were over 65 years then they were reviewed annually. All doctors signed a self-declaration of fitness to practice prior to their review.
- The hospital used paediatric nursing staff from local NHS trusts. The bank nurses provided the specialist care, treatment and advice for children and young people.
- During the inspection nursing staff who cared for adult patients told us they did not provide care and treatment to children on the ward because the paediatric nurses would look after them.
- There was a lead paediatric nurse who worked at the hospital two days per month who performed a clinical educator role.
- The hospital told us RMOs must have Advanced Life Support (ALS) and Paediatric Advanced Life Support (PALS). At the time of our inspection, two of the six RMO's had this in place. During the inspection we spoke with RMO on duty who told us they had not completed PALS training. The hospital organised the RMO rota to ensure that an appropriately trained RMO was on duty during any paediatric list.
- In outpatients and diagnostic imaging compliance with paediatric life support training varied across the departments. Diagnostic imaging and radiology was 100% compliant with this training; physiotherapy was 83% compliant with paediatric life support training; and outpatients was 86% compliant for paediatric life support training.100% of the paediatric nursing staff on the wards had completed paediatric life support training.
- For theatres, not all recovery staff had completed paediatric intermediate life support training as required. However anaesthetists working with children were trained in the management of the paediatric airway and had completed paediatric life support training.

Multidisciplinary working

- The hospital provided information to GPs about the care and treatment to patients.
- Nursing staff and consultants worked together on the wards. We observed nursing staff, anaesthetists and consultants discussing patient care on the ward.

Seven-day services

- The service only undertook elective surgery, one day per month with patient lists planned in advance for children.
- Staff in outpatients and diagnostic imaging told us that there was not sufficient demand on the service to provide seven day working at the time of our inspection.

Access to information

- Information was displayed at the entrance to the ward, which showed the planned and actual nurse staffing numbers for the ward.
- Patients told us they had been given detailed information about planned treatment as well as written information.
- Patients discharged home were given a discharge letter and this was sent to their GP within 48 hours.

Consent

Requires improvement

Services for children and young people

- Patient records documented verbal or written consent had been obtained for care and treatment. Consent forms showed the risks and benefits of surgery were discussed with the patient prior to procedure being carried out.
- The hospital's care of children policy identified Gillick competencies, which assesses whether a child under 16 had the maturity to make their own decisions. Gillick competency is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge.
- Children must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions. Ward and theatre staff were aware of these guidelines.
- Staff in outpatients and diagnostic imaging had some knowledge of Gillick competencies. Staff were able to provide a limited description of the issues around consent in a child. However, most staff referred to this only being a consideration in young people aged 16-18 years old. Staff we spoke with did not describe recognition of competency arising in a younger child.
- We looked at 10 consent forms for children and they were signed and dated by the consultant and the patient's carer and for three consent forms the child patient had also signed the form.
- Staff were aware of the legal requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DOLS). Staff had training on the Mental Capacity Act and DOLs.

Are services for children and young people caring?

Good

We rated caring as good because:

- Staff supported and treated patients with dignity and respect. Patients were involved in the planning of their care.
- Patients and their carers were satisfied with the care they received. Patients told us they received enough information about their care and treatment.
- Staff told us they had time to spend with patients to provide emotional support

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- We observed nurses, doctors and allied health professionals introducing themselves to patients.
- The friends and family test on NHS choices showed 98% of patients reported being satisfied with the overall care they received and 99% said they would recommend the hospital to friends and family. This information was not available at children's service level. The hospital's patients were complementary of the care provided, which was perceived as a good mix of professional, personal and friendly service.

Understanding and involvement of patients and those close to them

- We spoke to three carers who told us they had been provided with sufficient information about their care and treatment both at pre-assessment and on the day of surgery.
- All patients we spoke to and their carers reported they understood what to expect after surgery and what their care needs would be on discharge.

Emotional support

- Staff told us they had time to spend with patients to provide emotional support.
- The pre-admission documentation included consideration of a patient's wellbeing.
- We looked 10 children's patient notes and only one set of notes had completed pre-admission documentation with information about the emotional care and support required.

Are services for children and young people responsive?

Good

We rated responsive as good because:

Requires improvement

Services for children and young people

- Services were planned and delivered to meet the needs of the local population. There was planning by staff to ensure patients were admitted and discharged in a timely manner with the right level of care and support.
- Patient's individual needs were met. The hospital had access to interpreters for patients whose first language was not English. Information leaflets were available about the services were available in all areas we visited.
- There was a complaints system in place. The hospital investigated and responded to complaints within the designated timescales.

However,

- There were no child-friendly or easy-to-read information leaflets available throughout the hospital
- Children were cared for in adult rooms and the rooms did not have age appropriate equipment

Service planning and delivery to meet the needs of local people

- Children were only admitted for surgery one day per month when there were two registered children's nurses on the ward to provide care and support for patients and their families. The patient's consultant and the anaesthetist stayed on-site until all children had been discharged.
- The outpatients department offered services for children of all ages, with the exception of neonates. The radiology service did not provide CT scanning to young people under 16 years of age or MRI scanning for children below six years of age. Staff told us paediatric radiologists carried out and reviewed any radiological exposure on children. The physiotherapy department did not see children or young people under the age of 16.
- Based on feedback from local GP services, the outpatient department provided services which were not always available to patients at their local GP practice. For example, meningitis B vaccines for infants outside of the cohort being treated by GPs in the community

Access and flow

- Between June 2014 and July 2015 there had been 42 day cases.
- The paediatric nurses co-ordinated the admission and stay of children on the ward until discharge.
- Children's surgery was scheduled in the morning to minimise worry and fasting times.

Meeting people's individual needs

- There was a children's pathway in place but we did not see evidence that it was followed. For example, according to the pathway children and young people were assessed in outpatients prior to admission to ensure the hospital could meet their needs. Staff told us this happened, however we did not see evidence of this assessment in the records we reviewed. It was unclear how ward staff would tailor care to any needs identified in pre-assessment when the patient was subsequently admitted.
- Patient leaflets were available on the pre- assessment ward and inpatient wards. Information was only available in English. There were no child friendly leaflets available.
- Staff could access a language interpreter if needed. Patients' special needs such as specific dietary requirements were identified at pre-assessment.
- Patients' discharge planning began in pre-assessment. Staff gained an understanding of the patient's home circumstances and likely care needs.
- Information leaflets about the services were available in all areas we visited. However, there were no child-friendly or easy-to-read information leaflets available throughout the hospital.
- All areas were accessible to patients and relatives who had reduced mobility.
- Children were cared for in adult rooms and the rooms did not have age appropriate equipment. There were no toys available for children to play with. Parents were told they could bring in toys for the children to play with.
- Carers were encouraged to stay with the children on the ward.
- An information pack advising staff about paediatric patients ('More than just little adults') was displayed on the notice board in the outpatient sister's office. This provided staff with specific information about assisting paediatric patients.
- Staff provided an example of a paediatric patient with complex needs attending the outpatient department for a procedure. Staff recognised that the situation was too distressing, and with the support of the RMO, agreed with the family that the patient should instead attend

the local NHS children's hospital. Staff identified that this would provide sedation and a more suitable environment for the patient, to make the experience less distressing.

Learning from complaints and concerns

- The hospital used the BMI Complaints Policy. The CQC had not received any complaints about the hospital between July 2014 and July 2015. We found the hospital had not had any complaints relating to children's services.
- Complaints were discussed daily at the "communication cell" meetings, attended by the hospital's senior management team and heads of department, and also monthly at a Senior Management Team Complaints Meeting.
- If a complaint was clinical in nature, it was discussed at the hospital's Clinical Governance Committee meetings. Complaints were also reported to the Medical Advisory Committee (MAC) at their bimonthly MAC meetings.

Are services for children and young people well-led?

Good

We rated well-led as good because:

- There was a vision for the services provided at the hospital.
- There were clear governance structures in place with committees for clinical governance, health and safety, infection control and medication.
- Staff were positive about the culture and the support they received from managers.

However:

- There had not been any auditing of the services provided for children.
- The service did not have risk management systems in place to allow assurance that all risks were managed effectively.

Vision and strategy for this this core service

- The corporate vision for the hospital was that they are serious about health, passionate about care. They had a quality strategy in which they endeavour to provide the best possible care and continual improvement. The quality strategy had four core themes – safety, clinical effectiveness, patient experience and quality assurance. We observed these themes were discussed at the daily communication cells by all staff.
- Staff at the hospital told us adult surgical services was well established and they were reintroducing children's surgical services. The vision for both services was to provide high quality care and increase activity levels.

Governance, risk management and quality measurement for this core service

- Theatre and ward staff attended governance meetings and committees such as infection prevention and control meetings.
- There was a clinical governance committee, which met monthly to discuss governance issues such as complaints, incidents and risks. Managers had limited knowledge of the risks and concerns within the service. For example they had not identified the risk of the resuscitation equipment not being stored appropriately and staff did not know how to use the equipment.
- There had not been any auditing of the services provided for children. Without audits it was not possible to have assurance that any form of quality measurement was being reviewed and monitored.
- The ward and theatre managers told us staff logged risks on a risk register and the risk and quality manager within the hospital maintained this. We looked at the risk register and it recorded the theatre doors did not lock and was a security risk. The hospital had plans to improve security by fitting a new access controlled system to the doors.
- At the daily communication cell board meetings staff discussed risks and concerns. For example, they discussed staff sickness and absence and how staffing would be managed.
- The service did not have robust performance monitoring systems in place to allow assurance that all risks were managed effectively.
- There were staff meetings to discuss issues and share information on complaints, incidents and audit results.
- Feedback from hospital wide meetings was disseminated to theatre and ward staff by e-emails and team meetings. Feedback was also displayed on the communication cell boards in each area we visited.
- The Medical Advisory Committee (MAC) met monthly. The MAC had terms of reference and it had standing

agenda items, which included regulatory compliance, practicing privileges, quality assurance and proposed new clinical services and techniques. Consultants attended it.

Leadership / culture of service

- There was a daily communication cell board meeting attended by the executive director of the hospital and the senior management team. This ensured the senior management team were aware of significant occurrences and issues, which had occurred in the hospital.
- Patient's medical care was overseen and provided by their consultant.
- Ward and theatre staff told us they felt managers and consultants were approachable.
- Staff told us senior managers such as the hospital director, head of clinical services and the governance lead were visible and approachable.

Public and staff engagement

- Patients were encouraged to provide feedback through the Family and Friends Test and the BMI patient survey. There was no method for collecting the views of children to inform service delivery.
- A Patient Satisfaction Group Meeting looked at the results from the Family and Friends Test and Patient Survey. The group would agree actions to continue to improve the response rates and satisfaction scores. For example, patients and staff had highlighted signage as an issue. It had been agreed a company would be invited to review signage throughout the hospital; this work had taken place during the summer 2015.
- There was a weekly staff update, which included information from all BMI hospitals

Good

Outpatients and diagnostic imaging

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

Information about the service

BMI Thornbury Hospital provided outpatient consultations and minor surgical procedures (such as colposcopy and endrovenous laser therapy (EVLT)). Outpatient clinics covered a range of specialties including gynaecology, ophthalmology, bariatric surgery, cosmetic surgery and orthopaedics. The hospital provided services for patients of all ages. The outpatient department consisted of 19 clinic rooms and two treatment rooms over two floors. The hospital provided outpatient physiotherapy services in a dedicated department and gym on a separate floor. The physiotherapy service saw patients over 16 years of age.

The hospital had a range of diagnostic imaging services. The main hospital building housed X-ray, ultrasound and a new digital mammography unit. A CT scanner with a cardiac package and a new MRI scanner with breast coil package were located in a separate building in the hospital grounds. Third party contractors provided pathology and histopathology offsite.

Between July 2014 and June 2015, the hospital saw 37,224 outpatients in clinic. The hospital treated fee-paying patients and accepted referrals via choose and book and from a number of local NHS trusts including Chesterfield, Rotherham, Doncaster and Sheffield.

During our inspection, we spoke with twenty staff members and 12 patients. We also observed the outpatient and diagnostic imaging environments, reviewed 19 sets of medical records and checked eight pieces of equipment.

Summary of findings

We rated this service as good. There were clear systems embedded for reporting risk and safeguarding patients from abuse. All staff had received appropriate training in adult safeguarding. Staff were aware of how to raise incidents and we saw evidence of incidents being appropriately investigated and learning being shared. The radiology service took appropriate steps to screen patients before exposing them to radiation and clear signage was in place to warn patients when entering designated areas. The departments were clean and medications were stored safely.

Staffing levels were safe and were generally appropriate, but management in the outpatient department identified a shortage of staff and were recruiting to these posts.

Although below the hospital target of 100%, compliance with mandatory training was high. There were variable rates of compliance with annual appraisal and this had been flagged as an issue by the hospital.

The services provided varying levels of cover, from five to six-day services dependent on the department involved. Appropriate access was available to multidisciplinary meetings within the local NHS trusts.

The service was exceeding referral to treatment targets for patients due to be seen in outpatients and physiotherapy. Although not formally monitored, staff explained most patients could be seen within one week of making an appointment. Radiology imaging was available on site and reports were routinely made available to staff within 24 hours of imaging. Patients we

Good

Outpatients and diagnostic imaging

spoke with raised no concerns about timely access to services being available. Some 'one stop' clinics were available to reduce the number of visits a patient needed to make to the hospital.

The service used evidence based guidance to inform practice and we saw that appropriate guidance from NICE and the royal colleges was in use. Systems were in place to ensure that medical staff had competencies regularly assessed once being granted practising privileges, although we found that these were not consistently applied. In the main, appropriate systems were in place to ensure that deteriorating patients could access emergency care.

Staff had a broad understanding of capacity and consent. All staff had undergone appropriate training in the mental capacity act and deprivation of liberty.

All patients we spoke with told us that staff had treated them well and the majority felt that they had received timely and informative care. The service had measures in place to protect the privacy and dignity of patients. Staff provided emotional support to patients and gave examples of when this had been necessary. Signage in the departments and the patient information provided also helped to ensure that patients and their families understood relevant information about their care and their visit to the hospital.

An appropriate system was in place to log and investigate complaints and we saw complaints about the wider hospital being discussed in staff meetings to share learning.

Appropriate governance systems were in place and the majority of staff spoke highly of their immediate line managers and colleagues. However, there had previously been cultural challenges within the outpatient department. This resulted in an abrupt change in management within the past six months and staff reported feeling under pressure and unsupported during this period. The new management team were addressing the issues and staff told us things were improving.

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- There were clear systems embedded for reporting risk and safeguarding patients from abuse. All staff had received appropriate training in adult safeguarding.
- Staff were aware of how to raise incidents and we saw evidence of incidents being appropriately investigated and learning being shared. The radiology service took appropriate steps to screen patients before exposing them to radiation and clear signage was in place to warn patients when entering designated areas.
- The departments were clean and medications were stored safely. Although below the hospital target of 100%, compliance with mandatory training was high.
- Staffing levels were safe and were generally appropriate, but management in the outpatient department identified a shortage of staff and were recruiting to these posts. In the main, appropriate systems were in place to ensure that deteriorating patients could access emergency care.

Incidents

- The hospital had an incident reporting policy in place. This included guidance on how to report incidents and how to investigate concerns. It also directed staff to an accompanying 'Being Open' policy concerning discussing incidents with patients. This policy dated from 2010 and it was not clear whether this was now overdue for review.
- Staff we spoke with understood how to report incidents on paper based IR1 forms. They were confident about reporting issues and raising concerns with senior staff.
- The services reported no Never Events between July 2014 and the time of our inspection. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The outpatient and diagnostic imaging services reported no serious incidents for the period between July 2014 and June 2015.
- The hospital provided us with a breakdown on the number and type of incidents recorded in the services

between January 2015 and November 2015. This did not include details on the classification of the seriousness of the incidents reported. In this period, there were 42 reported incidents in outpatients and 55 reported incidents in diagnostic imaging. The most commonly reported incident was coded as 'admin'.

- Data submitted by the hospital showed that there had been a wrong site radiological exposure in January 2015. The service made the patient aware and the correct X-ray was undertaken. The report identified that all departmental documentation would be reviewed. This was to ensure it was explicit that all radiographers undertake a six point check prior to any imaging and that the checks are only undertaken by the person undertaking the exposure. This hospital reported the incident to the CQC in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). We reviewed documents which confirmed this during the inspection.
- We saw evidence that staff discussed clinical and non-clinical incidents at meetings of the hospital's Clinical Governance and Medical Advisory Committees (MAC). Incidents were also discussed at the hospital's 'comms cells' which were held on a daily basis within departments and with heads of department. Staff also discussed issues and activity at the daily meetings.

Duty of Candour

- Staff we spoke with were broadly aware of the principles behind the duty of candour. This is a statutory duty for healthcare providers to inform patients of incidents when certain harm thresholds are met.
- All staff could describe the principles of being open and honest with patients. All staff we spoke to said that they would be happy to speak to patients and their families if an incident had occurred.
- Staff we spoke with were not aware of the regulatory steps and requirements that needed to be met when the duty of candour was engaged.

Cleanliness, infection control and hygiene

- The departments we visited were visibly clean and cleaning schedules were visible within the departments. At the time of our inspection, staff recorded daily cleaning and we saw no gaps in these schedules.
- The departments conducted monthly infection control audits to monitor aseptic technique and hand hygiene. The latest audit data from diagnostic imaging and physiotherapy was from October 2015 and showed 100% compliance. The latest audit data we saw in outpatients was from November 2015 and showed 100% compliance.
- An audit of compliance with clinical waste disposal in July 2015 identified that medical waste and instruments were not disposed of in the correct bins in the outpatient department. The audit report did not identify any steps to address this issue. During our inspection, we saw that waste was being disposed of appropriately. Guidance posters on waste were displayed in the dirty utility area to inform staff of the correct disposal processes.
- The hospital had appointed hand hygiene champions; this included an outpatient sister and an outpatient staff nurse. A member of staff from another BMI facility was seconded to the hospital for two days per week to act as the infection control lead.
- We saw 'I am clean' labels were in use to show when equipment was clean and was ready for use.
- We observed staff using sharps bins appropriately and these were stored safely. Personal protective equipment was available for staff in the treatment rooms. We observed staff wearing appropriate personal protective equipment in clinical settings.
- Hand gel was available in the main outpatient waiting area. Hand gel dispensers were located by the reception and on a link corridor to Mappin ward. No posters were displayed within the department to ask patients to sanitize their hands. However, the hospital did display signage in the main entrance to encourage hand hygiene.

Environment and equipment

- Patient led assessment of the care environment (PLACE) is the new system used by NHS England for assessing the quality of the patient environment. The hospital identified that it had been incorrectly categorised as a treatment centre for the purposes of PLACE data being collected and should have instead been categorised as a general acute hospital.
- When this is taken in to account, the 2015 results showed that the hospital performed in line with the national average scores for all sites for privacy and dignity (86.4% versus 86%), better than the national

average for food and hydration (94% versus 88.3%), and below the national average for cleanliness (92.5% versus 97.6%) and the condition and appearance of premises (82.2% versus 90.1%).

- Records were displayed in each of the services showing weekly water flushing of water supplies. These were all fully completed.
- Resuscitation equipment was available on the first floor outpatient clinics, in the MRI/CT scanning centre and in physiotherapy outpatients. In outpatients and physiotherapy, we checked the equipment and found staff had completed daily and weekly checks of the adult resuscitation equipment. In the MRI/CT scanning suite, we could not see that full daily and weekly checks had been completed. The checklists available on the trolley identified equipment had only been checked on three days in November 2015.
- We checked eight pieces of equipment during our inspection. This was appropriately tested and checked. The hospital provided evidence to show that equipment logs were kept showing the date of testing to identify when further testing was due.
- Hot and cold drinks were available for patients and visitors in the main outpatient waiting areas. Other areas offered cold water for patients.
- Staff told us that they were encouraged to view the hospital from a patient's perspective and carried out 'walk arounds' to identify issues in the hospital. A member of staff told us feedback they had provided on clinic chairs marking walls had resulted in estates installing protective strips.
- The hospital fluoroscopy room was not in use at the time of our inspection after being 'condemned'. The hospital recognised the need to make repairs and upgrade the facility. This was in discussion at the time of our visit.
- Appropriate protective equipment was available for staff and patients in radiology. There were also appropriate metal checks and warnings for patients entering the MRI area.
- Appropriate environmental measures, including signage, was in place to identify areas where radiological exposures were taking place in line with Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. This ensured visitors or staff could not accidentally enter a controlled area.
- The hospital had contracts in place for the servicing of radiology equipment by the supplier and the radiation protection adviser at appropriate intervals.

Medicines

- Medicines in the departments were stored and monitored appropriately. Medicines were kept in locked cabinets and we saw evidence that daily temperature checks of medication fridges and the ambient room temperature were recorded. These were all in appropriate temperature ranges. The department did not store controlled drugs.
- Consultant staff in the outpatient department provided private prescriptions for patients. These were taken to the onsite pharmacy for medications to be dispensed. We checked the private prescription book in the outpatient department. This was stored in a locked room and prescription sheets were logged out to show the dispensing clinician.
- Staff in the outpatient department did not use patient group directives. These are written instructions for the supply or administration of medicines to groups of patients. These were used in diagnostic imaging to cover a range of contrast media and medicines to assist in achieving accurate imaging. We found these were in date and appropriately completed.
- The hospital did not undertake any formal prescription audits. Instead, hospital staff told us the pharmacy team reviewed prescriptions on a daily basis and when necessary, changes were made or discussions were held with the prescriber.
- The hospital pharmacy did not routinely monitor the waiting times for dispensing patient medication by the hospital pharmacy. This meant that the hospital could not be certain how long patients who had attended outpatients may be waiting to receive prescribed medications before being able to go home.

Records

- We reviewed 19 sets of medical records across the outpatient and physiotherapy departments.
- We saw that records were appropriately stored within the departments we visited. The outpatient and physiotherapy departments used paper records. These were stored in the management office in lockable cabinets. For outpatients, consultants attended the office to collect records for their clinic and returned them when clinic was completed.

Good

Outpatients and diagnostic imaging

- The hospital reported that it saw 36% of patients in outpatient clinics without a full medical record being available. Staff told us all patients attending an outpatient appointment would have either an accompanying GP referral letter, or their current records from a previous appointment or admission to the hospital available.
- Staff told us that if patient information or paperwork were missing, then depending on the nature of the missing details, this would be obtained from either the patient or consultant in advance of an appointment.
- The hospital conducted monthly audits of medical records. This included sampling ten sets of records and checking these against a list of fourteen requirements (including consent, nursing and medical entries, and risk assessments). The latest audit available at the time of our visit was for October 2015. This showed 94% compliance. The audit identified issues about individual pages in outpatient notes not containing patient identification stickers.
- The records we checked were appropriate and did contain patient identification stickers within outpatient records. Outpatient records contained a pro-forma sheet and any consultation notes; these were appropriately completed and legible. Two of the nine records did not contain copies of consultant correspondence to the patient or their GP. The physiotherapy records we reviewed were comprehensive and contained detailed explanations about the care and treatment patients received.
- The hospital discouraged the removal of hospital medical records from the hospital. If a consultant wished to take the hospital's records off-site then advance permission was sought in writing and granted by the Director of Operations. The hospital told us consultants holding practising privileges with the hospital must also be registered as independent data controllers with the Office of the Information Commissioner (ICO). The hospital was is in the process of requesting all consultants to provide evidence of ICO registration at the time of our inspection.
- The hospital completed an audit of radiology request cards in August 2015. This identified some issues in relation to the completion of request cards received in July 2015. Consultant staff were not recording the patient address and hospital number. An action plan identified that this would be raised with consultant staff and that the service would create new requisition forms. We reviewed the referral form in use at the time of our inspection. This was appropriate and included areas for address and hospital number to be completed.
- The hospital completed an audit of the World Health Organisation 'safer steps to surgery' form in October 2015. This identified issues with radiology staff signing the WHO form. This issue was due to be discussed at the next departmental meeting to ensure that staff signed these forms. At the time of our inspection, we saw that the checklist was being completed appropriately.

Safeguarding

- There were no safeguarding concerns reported to us in the reporting period from July 2014 to the time of our inspection.
- All staff were required to undertake safeguarding children and vulnerable adults training by completing a mandatory e-learning module. There was 100% compliance with safeguarding training within the diagnostic imaging, radiology and physiotherapy departments. There was 90% compliance with training in the outpatient department against a target of 100%.
- The Director of Clinical Services acted as the hospital's safeguarding lead. They were level three trained in the safeguarding of children and vulnerable adults.
- Staff we spoke with were aware of the safeguarding policy and were confident in reporting safeguarding concerns. Staff gave an example of a patient who had reported suicidal thoughts. Staff discussed the incident with the safeguarding lead and followed the appropriate process.
- Staff we spoke with had an awareness of the BMI corporate whistleblowing policy. Staff said that they would feel comfortable in raising issues under the policy.
- A safeguarding policy was in place for vulnerable adults and children. This provided guidance on safeguarding procedures and details of escalations processes within the hospital.

Mandatory training

- The provider had set a target for all staff to achieve 100% compliance with mandatory training by the end of October 2015. Those that had not achieved this had a

one-month grace period to complete training in November 2015. Members of staff that had not achieved 100% training compliance by this point did not receive a pay award.

- Mandatory topics included areas such as infection prevention and control, safeguarding, life support and 'Prevent'. Prevent was a special module looking at the risk posed to individuals at risk of radicalisation.
- The hospital provided figures from September 2015 to show the current level of compliance with mandatory training. In the outpatient department, overall compliance was 96%. For imaging services, this was broken down into diagnostic imaging (91%) and radiology (92%). Physiotherapy compliance was 91%. The hospital provided us with a chart to show the change in compliance at the time of our inspection. This showed that the outpatient department was 81%; diagnostic imaging was 98%; radiology was 91%; and physiotherapy was 99%.
- Staff told us that mandatory training was delivered via a mix of online and face-to-face training sessions. The majority of staff told us that they did not receive specific time in their rota to complete training and this was done around their rostered duties.
- The management office in the outpatient department had notices displayed for staff about training. This included reminders to check the status of mandatory training every month and a monthly learning log sheet which staff were to complete.

Assessing and responding to patient risk

- Resident medical officers (RMO's) provided a 24 hour, seven day a week service.
- It was a requirement of BMI Healthcare's practicing privileges policy, that consultants remain available (both by phone and if required, in person) or arrange appropriate alternative named cover if they will be unavailable at any time when they had inpatients in the hospital. In addition to clinical and consultant arrangements, the senior management team operated a rota for on call support during out of hours.
- The hospital had an on-site level two critical care facility that patients could be transferred to if their condition deteriorated. The hospital was also able to transfer patients to Sheffield Teaching Hospitals NHS Foundation Trust in the event of an emergency or a deteriorating patient that could not be cared for within their own critical care unit.
- The hospital had a standard operating procedure in place for the management of unplanned admissions. This included provision for a consultant review by the on-call consultant. The operating procedure was out of date and was due for review in January 2015.
- The service displayed emergency cardiac bleep number on posters in clinic rooms. This included details on what room a person was making the call from. Some staff raised concerns that the bleep number was quite long (222 2222) and that this could cause delays while the automated system responded. Information showing first aiders and the RMO bleep was displayed in reception areas.
- We saw appropriate safety checks were in place when accepting referrals for imaging. This included ensuring that patients also complete health-screening questionnaires when entering and leaving the MRI/CT scanning clinical areas.
- We saw checks were in place to ensure the service identified women who may be pregnant and that they understood the risks of radiation exposure. This included guidance posters, prompts on referral forms, and specific questioning from staff. We saw that staff observed the '28 day rule' concerning when it was safe to perform scans during a woman's menstrual cycle. We also saw staff discussing possible pregnancy with visitors before allowing them access to the MRI and CT imaging area.
- Training data provided by the hospital from September 2015 showed that compliance with adult and paediatric life support training varied across the departments. Diagnostic imaging was 100% compliant with this training; physiotherapy was 100% compliant with adult life support training; radiology was 67% compliant with adult life support training; and outpatients was 75% compliant for adult life support training.
- Clinic rooms in the outpatient department did not have emergency call buzzers in place should there be a patient incident. Instead, staff called '222 2222' and gave details of their location. Posters displaying this information were in each clinic room we visited. We saw a treatment room had an emergency buzzer in place, as did bays in the physiotherapy gym.

Nursing and care assistant staffing

- The hospital used the BMI Healthcare Nursing Dependency and skill mix tool as a guide to assist staff to assess required staffing levels. The tool was used to

plan the skill mix required five days in advance, with continuous review on a daily basis. The actual hours worked were entered retrospectively to understand the variances from the planned hours and the reasons behind these.

- Data submitted by the hospital identified that the outpatient department employed 13.9 whole time equivalent (WTE) care staff. This consisted of a 7.4 WTE nursing staff and 6.5 WTE health care assistants. At the time of our inspection, the outpatient department managers told us there was only the ward sister and four part time registered nurses in the department, whilst a further nurse was on long-term sickness absence. This is less than the 13.9 WTE staff referred to in the data that the hospital submitted to us.
- Staff in the outpatient department told us that they were busy and that more staff were required. The nurse manager and sister had identified this need and were in the process of recruiting a further full time nurse and 37.5 hours of health care assistant support (split between two part time posts).
- There was reported sickness absence of between 10% and 19% for nurses working in the outpatient departments and lower levels of staff sickness (less than 10%) for care assistants working in the outpatient department.
- There were varying levels of staff stability with regard to staff who had been in post more than 12 months in the reporting period between July 2014 to June 2015. For care assistants, between 60% and 79% working in the outpatient department had been in post for more than 12 months. This figure was less than 60% for nurses working in the outpatient department. In 2014, 20% of nursing staff and 18% of care assistants left their post.
- The outpatient department reported no use of agency staff in the reporting period between July 2014 and June 2015. It had used dedicated bank staff in this period as and when required, from the hospital's own pool of bank staff.

Medical staffing

- There were 247 doctors and dentists operating under practising privileges at the hospital. Between July 2014 and June 2015, of the doctors and dentists that had been practising at the hospital for more than 12 months: 96 recorded no episodes of care, 38 recorded between one and nine episodes of care, 89 recorded between ten and 99 episodes of care, and 30 recorded 100 or more episodes of care.
- The hospital outsourced the provision of its resident medical officer (RMO) to an external company. The RMO was on site 24 hours a day.
- There were five radiographers and 23 sessional radiologists within the diagnostic imaging department. A specialist neuroradiologist was on site during weekdays. The radiology service also operated an on call system during evenings and weekends for X-ray imaging.

Major incident awareness and training

- The hospital had an overarching business continuity policy put in place by the wider BMI group.
- The hospital had a range of 'action cards' available for staff specifying local useful contact details and the actions to be taken in a range of circumstances, including loss of utilities, loss of computer systems, adverse weather and security risks.
- Staff we spoke with were aware of the major incident policy and could describe how they would access this in an emergency.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate effective, in line with our approach in regard to outpatient and diagnostic imaging services.

- The service used evidence based guidance to inform practice and we saw that appropriate guidance from NICE and the Royal Colleges was in use. There were variable rates of compliance with annual appraisal and this had been flagged as an issue by the hospital.
- Systems were in place to ensure that medical staff had competencies regularly assessed once being granted practising privileges, although we found that these were not consistently applied.
- The services provided varying levels of cover, from five to six-day services dependent on the department involved. Appropriate access was available to

multidisciplinary meetings within the local NHS trusts. Staff had a broad understanding of capacity and consent. All staff had undergone appropriate training in the mental capacity act and deprivation of liberty.

Evidence-based care and treatment

- The hospital operated within up to date guidance (June 2015) provided by Sheffield CCG concerning commissioned treatments and the appropriate link to NICE guidance. The hospital explained that the Clinical Director and Risk Manager reviewed this information, before passing this to relevant consultants. If the guidance was applicable to treatment provided in the hospital, then this was added to the agenda for approval and implementation at MAC.
- We saw that the radiology services made use of the 'iRefer' guidance tool from the Royal College of Radiologists. Guidance was available in hard copy in the staff office and online.
- The radiology department was not accredited by the Imaging Services Accreditation Service (ISAS). We understood from staff that this was due to the wider BMI group not seeking accreditation for imaging services.
- The radiology department operated a 'stop, check' process before carrying out procedures. This involved checking patient identification, whether the correct records were being viewed, and questioning whether the procedure was appropriate. This process was set out for staff in a one-page poster for ease of reference.
- The physiotherapy service used a number of BMI group-wide clinical pathways for hand therapy. These documents contained reference to relevant literature and guidance.
- The service considered national guidance from the Department of Health in regard to setting diagnostic reference levels in practice to consider the amount radiation patients were exposed to. The RPA had requested that these be embedded in local protocols. At the time of our inspection, the service was waiting for a directive from the RPA to put this in place. Staff told us that the RPA also audited radiation exposure levels and we saw that these levels were appropriate during our inspection.
- We saw examples of policies 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) and the safeguarding policy referred to national guidance (Safeguarding Adults: The role of Health Services, Department of Health, 2011).

Pain relief

- The outpatient department hosted a pain clinic. This provided guidance and treatment for patients with chronic and acute pain issues.
- Staff described how they would offer support to patients who reported being in pain. Staff said that they would contact the RMO to request assistance and pain relief.
- Some of the minor procedures that took place in the outpatient department were performed under local anaesthetic. A consultant was present for the procedure and administered the pain relief.
- Consultants were able to provide private prescriptions for pain relief to patients in outpatient settings. Patients could collect medications on site from the hospital pharmacy.

Patient outcomes

- The radiology department conducted imaging audits to monitor that staff were providing appropriate advice and clinical outcomes.
- Management staff told us that no specific audits took place concerning clinic cancellations. Staff were aware of some concerns about clinics being cancelled at short notice and were encouraged to log details of these of these so that this could be escalated to senior staff.
- The hospital did not audit specific waiting times for patients to receive an appointment, or the length of wait when they attended for their appointment. The hospital told us it could routinely see patients within seven days of them requesting an appointment. None of the patients we spoke with raised any concerns about being able to access appointments in a timely manner or delays in clinic.
- The hospital compared survey results and activity with other locations within the region and other regions across BMI Healthcare. This was through BMI's corporate clinical dashboard. This collated data from the hospital's risk reporting database and allowed this data to be compared to hospitals of a similar size within BMI Healthcare.
- At the time of our inspection, the hospital told us that BMI Healthcare was working with the Private Healthcare

Information Network to look at better reporting of patient outcomes across the independent healthcare sector. This work was not complete at the time of our inspection.

Competent staff

- In 2014, 88% of nursing staff and 55% of care staff in the outpatient department received an annual appraisal. In 2014, 96% of allied health professionals working hospital wide (including physiotherapists working within the outpatient department) had received an annual appraisal.
- At the time of our inspection, hospital management told us a target had been set for all appraisals to be completed by December 2015. However, we saw some appraisals in the outpatient department were not scheduled to be completed until January 2016. The hospital had identified that low staff appraisal rates were a concern and this had been flagged as a priority with Heads of Department.
- The hospital told us the MAC chair was in regular contact with the NHS employers of medical staff. The hospital management team discussed any consultant concerns with the MAC Chair, and if considered serious enough, the hospital management team shared these with the consultant's responsible officer within their NHS employment.
- For a consultant to maintain their practising privileges at the hospital, there were certain minimum data requirements with which a consultant must comply. These included (but were not limited to) registration with the General Medical Council (GMC), evidence of insurance/indemnity from a medical defence organisation or insurer, and a current performance appraisal/revalidation certificate.
- A BMI group-wide policy was in place to assist the hospital in granting and renewing practising privileges. This included two yearly reviews of the grant of practising privileges (except for RMOs and clinicians over 65 who were reviewed annually).
- During the inspection we found that these procedures were not being consistently applied. The hospital was aware of this and we saw evidence that files were in the process of being updated.
- The hospital had checked the registration status of allied health professionals, all doctors and dentists, and all nurses in the outpatient department in post for 12 months or over.
- The hospital did not have a formalised process of clinical supervision for clinical and nursing staff. However, the hospital told us any issues in regard to practice were discussed in one to one meetings with staff.
- Physiotherapy staff used a peer review process and had created documentation to record discussions and outcomes from review. Staff completed this once a year and staff told us that they had requested that this be done every six months as they found it to be a useful tool.
- The policy was out of date and had been due for renewal in March 2014.
- The hospital told us that, if the hospital suspended an NHS consultant holding practising privileges then the Executive Director, with the support of the MAC Chairman, would inform that consultant's responsible officer at the NHS organisation. If the hospital was aware that the consultant held practising privileges at another private facility, they would also inform the appropriate person at that facility, with the knowledge of the consultant. Any consultant who was suspended was also reported to BMI's Medical Officer and Responsible Officer, who in turn would inform the General Medical Council.
- We spoke to new staff within the services we visited. They described their corporate induction process and the local induction process. This included guided learning and a checklist of activities they had to complete. Staff felt the induction process supported them in their role.
- Staff providing EVL had undergone training and we saw evidence of qualification certificates kept on file to show staff competency.
- Nursing staff told us that they had been supported in receiving information and support around revalidation. This included the Royal College of Nursing attending to deliver talks on revalidation to staff.
- We saw that staff administering radiation were appropriately trained to do so; only qualified radiographers practiced at the hospital. Staff who may be involved in entering radiation-controlled areas received appropriate training, for example cleaners entering the MRI suite watched an MRI safety induction video and signed safety forms.

Multidisciplinary working

Good

Outpatients and diagnostic imaging

- The hospital explained that patients were referred to a Multi-Disciplinary Team (MDT) when needed and that these patients were reviewed in a number of ways.
- Medical patients could access services for the local NHS trust's MDT, or through MDT meetings within outsourced services. The hospital provided us with copies of invoices from the local trust to show where MDT services had been provided for the hospital's patients.
- In radiology, staff worked closely with the gamma knife service to provide a smooth patient pathway. The gamma knife service operated from the BMI Thornbury site and shared a management team. However, this service was separately registered with the CQC and was not inspection on this visit. MDT meetings regularly took place concerning these patients and staff worked together closely, with the radiology manager also having management responsibility for this facility.
- There were some 'one stop shop' clinics available for patients. This involved staff in outpatient, physiotherapy, and diagnostic imaging working together to ensure patients were seen on the same day for a number of appointments.

Seven-day services

- The outpatient department was open between 08:00 and 22:00, Monday to Friday, and 08:00 to 13:00 on Saturday.
- The physiotherapy outpatient department was open 08:00-18:00 on Monday, 08:00-20:00 on Tuesday, 08:00-15:30 on Wednesday, 08:00-17:00 on Thursday, and 08:00-16:00 on Friday. The department did not routinely open on Saturday, but could open if there was a need to see patients.
- The X-ray department was open 08:00 to 20:30, Monday to Friday. The MRI/CT imaging centre opened 08:00-18:00, Monday to Thursday, and 08:00-17:30 on Friday. A radiologist was on call between 09:00-17:00 on Saturday and Sunday.
- The hospital had access to laboratory support from specialist offsite companies for pathology and histopathology. There was also 24-hour access to a microbiologist or an infection control doctor via another offsite provider.
- The RMO was on site 24 hours a day, seven days a week.
- Staff told us that there was not sufficient demand on the service to provide seven day working at the time of our inspection.

Access to information

- Staff reported no concerns about accessing relevant patient information from the local NHS organisations.
- Staff told us that electronic copies of policies and guidance was stored on the hospital computer system. Staff said that this was easy to access and that they encountered no issues in doing so.
- We saw hard copies of policy and guidance located in management offices. This provided back up should electronic systems fail.
- Information on radiological procedures was accessible to medical staff via an electronic reporting system.

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

- Staff across all departments had completed training in the Mental Capacity Act and DoLS. In outpatient, diagnostic imaging and physiotherapy there was 100% compliance with training.
- The medical record audits carried out by the hospital included specific questions about patient consent (whether a consent form was present and whether this contained a legible description of risks and benefits of a procedure). The latest audit available from October 2015 showed 100% compliance.
- A policy was in place concerning cardiopulmonary resuscitation. This included guidance on do not attempt cardiopulmonary resuscitation orders and the steps clinicians must take to make and record this in the record. The policy that was provided to us was not signed or ratified and stated that it had been due for review in March 2015.
- The hospital used BMI group-wide policies concerning the use of the Mental Capacity and Deprivation of Liberty Safeguards (DoLS). The DoLS policy we were provided with was past its date for review (March 2014) and the local CCG had highlighted that this did not reflect up to date case law.
- Staff we spoke with had a broad understanding of issues in relation to capacity and the impact on patient consent. Staff explained that if they had any concerns about capacity then they would raise these with consultant staff or the safeguarding lead for advice.

Are outpatients and diagnostic imaging services caring?

Good

Outpatients and diagnostic imaging

Good

We rated caring as good because:

- All patients we spoke with told us that staff had treated them well and the majority felt that they had received timely and informative care. The service had measures in place to protect the privacy and dignity of patients and we observed that chaperones were freely available to patients who needed them.
- Staff provided emotional support to patients and gave examples of when this had been necessary. Signage in the departments and the patient information provided also helped to ensure that patients and their families understood relevant information about their care and their visit to the hospital.

Compassionate care

- All 12 patients we spoke with told us staff had treated them well. They told us that staff had respected their privacy and dignity when delivering care.
- We observed staff interacting with patients in a professional and compassionate manner in clinic and in the waiting areas. This included staff visiting the patient waiting area to check on the status of patients waiting for appointments.
- We observed staff communicating with patients and their families in a respectful and considerate manner.
- The hospital had a policy in place concerning the use of chaperones. This provided guidance on chaperones, their availability to patients, and that the patient would have the option to reschedule an appointment if a chaperone was not available. Notices on display also advertised the chaperone service to patients. However, the policy was out of date and had been due for review in January 2015.
- We saw chaperones were available in the departments we visited. The outpatient department kept a chaperone log to record in which clinic appointments a chaperone had been present.
- Consulting rooms displayed 'free/engaged' signs on the door. We saw that staff used these to show when rooms were engaged to protect patient privacy and dignity.
- We observed staff in the MRI/CT suite discussing sensitive information with visitors in a quiet and confidential manner about the answers provided to the health screening questions completed when entering the area.
- Staff told us that they would be confident in raising any issues about disrespectful or discriminatory behaviour towards patients or visitors. Staff we spoke with could not recall an occasion when this had been necessary.
- The MRI/CT imaging centre was located in the hospital grounds, but was not connected to the hospital. This meant patients had to exit the hospital via the main entrance and walk across the car park to access the facility. Staff we spoke with reflected that in the case of patients requiring urgent scans (for example, an inpatient with a suspected bleed) then they would have to be transported via this route to access scanning. This meant that there could be challenges in maintaining a patient's privacy and dignity.
- At the time of our inspection, the latest survey data available from the hospital patient survey showed that 98.9% of patients reported being satisfied with the overall care they received, with 99% saying that they would recommend the hospital to friends and family. No specific data for the Outpatients and Diagnostics service was available.
- Friends and family test data was collected by the hospital about its NHS patients. This showed that between January 2015 and June 2015 the hospital routinely scored above 85% based on patient feedback. No service level data was available. The response rate from patients was low, with less than 30% of patients completing the friends and family test.
- The main outpatient reception area displayed a poster showing patient satisfaction scores concerning hospital services. The poster related to information collected between January and December 2014. The service did not display up to date patient feedback data.

Understanding and involvement of patients and those close to them

- The majority of patients we spoke with told us they had received appropriate information about their care and treatment. Patients described staff making every effort to explain the care and treatment options available to them.

Good

Outpatients and diagnostic imaging

- All patients felt they had received appropriate information in clinic in advance of surgical procedures taking place. Two patients told us that they did not receive information in clinic about what to expect after surgery.
- A majority of patients told us that they were seen in a timely way in outpatient clinics. Two patients told us that they had encountered lengthy waits in clinic when consultants had been late for clinic appointments.
- The majority of patients told us that they understood when test results would be returned to them. Two patients described waiting longer than they expected for information about tests, including one patient who was waiting for the result of a biopsy.
- Signage in the outpatient department identified to fee paying patients that they would receive separate invoices for the services they received from consultants, the hospital, and laboratory testing.
- An information board in the first floor outpatient area showed the role and name of staff on duty.
- Staff in physiotherapy explained that they routinely engaged with family members during appointments. This was to ensure that the patient and their family understood the timetable for rehabilitation. This also allowed staff to account for the needs of any family members (for example, such as physical disability) when considering patient treatment options.

Emotional support

- Staff we spoke with had an understanding of the emotional impact care and treatment could have on patients. An example of this included phlebotomy staff describing the steps they would go to in order to reduce anxiety and provide support for patients who were needle phobic.
- Staff were responsive to emotional needs expressed by patients. Staff in physiotherapy provided an example of providing daily phone calls to a patient who was struggling with rehabilitation following family difficulties. The phone calls were to provide emotional support and to check on the patient's wellbeing.
- The majority of patients we spoke with felt they did receive emotional support from staff, or that this would be available if they needed it.
- Staff in outpatients and physiotherapy described how they were able to call on the skills of specialist oncology nurses for assistance in breaking bad news to patients. As a result of a patient being diagnosed with cancer following a physiotherapy session, staff in physiotherapy were planning to spend time with oncology staff to learn more about supporting these patients.
- Staff were able to signpost patients to a variety of support groups within the locality, such as local or national support groups (for example, the Samaritans).
- The hospital had access to a consultant psychologist who could see patients by prior arrangement.
- The hospital told us it was in the process of linking in with organisations such as the Alzheimer's Society to improve the support available to patients. The hospital did not provide any further information on these links during our inspection.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- The service was exceeding referral to treatment targets for patients due to be seen in outpatients and physiotherapy. Although not formally monitored, staff explained most patients could be seen within one week of making an appointment.
- Radiology imaging was available on site and reports were routinely made available to staff within 24 hours of imaging. Patients we spoke with raised no concerns about timely access to services being available. Some 'one stop' clinics were available to reduce the number of visits a patient needed to make to the hospital. However, there were no plans at present to coordinate opening times across all services.
- A high proportion of staff had completed equality and diversity training and could explain the reasonable adjustments they could make for people with differing physical, mental and cultural needs.
- There was an awareness of interpreter services being available, although there was some confusion amongst staff we spoke with about how this was accessed. An appropriate system was in place to log and investigate complaints and we saw complaints about the wider hospital being discussed in staff meetings to share learning.

Good

Outpatients and diagnostic imaging

Service planning and delivery to meet the needs of local people

- There was a range of outpatient clinics offered (around 24 specialities) including services such as a variety of surgical specialties, dermatology, neurology and oncology. Minor procedures such as colposcopies and EVL laser treatment were available.
- Outpatient services were provided for people of all ages, from children aged below two years old (257 attendances in 2014/2015) to people aged over 75 (4,481 attendances in 2014/2015).
- The hospital engaged with the local Clinical Commissioning Group to plan and deliver contracted services based on local commissioning requirements. Recent examples of this provided by the hospital included:
  - Group physiotherapy (in development through a new contract with the local trust)
  - A post-menopausal bleeding clinic
- Based on feedback from local GP services, the outpatient department provided services, which were not always available to patients at their local GP practice. This included medical visa tests and vaccinations, health screening and medicals for HGV drivers.
- Staff told us that the demand for phlebotomy services had increased. Staff were keeping a log of increased requests for phlebotomy services. In response, the department had employed an additional bank member of staff to provide phlebotomy support. Staff were intending to use the log to identify the feasibility of employing a further substantive phlebotomist. Plans were also in place to change the use of one of the outpatient treatment rooms to provide a specialist phlebotomy treatment room.
- Patients and staff identified a lack of available car parking as an issue. Staff reported having to park offsite and walk to work.
- Seating was available in outpatient areas and this was appropriate for the number of patients present in clinic. Chairs were all the same height and style.
- Magazines and newspapers were available for patients in all patient waiting areas. In the main outpatient waiting area, a television was also on and showing programmes. Two additional smaller television screens advertised BMI services.

Access and flow

- Between July 2014 and June 2015, the hospital saw 37,224 outpatients in clinic.
- The hospital accepted referrals from a number of local NHS trusts including Chesterfield, Rotherham, Doncaster and Sheffield. The referrals related to a number of different specialities.
- Referral to treatment times for admitted patients (90% target), non-admitted patients (92% target) and incomplete patient pathways (95% target) routinely exceeded target. Only admitted patient waiting times in August 2014 (88%) failed to meet target. Non-admitted and admitted patient waiting times routinely achieved 100% success against target.
- The hospital told us that no specific 'do not attend' (DNA) policy was in place to manage patients who may not attend their appointment. During our inspection, staff understood a DNA policy was in place, but when asked to provide or show copies of this to us they were unable to. Staff in physiotherapy did provide a flow chart they had developed within the department to direct staff on what to do when patients did not attend.
- The hospital told us that no audit of DNA appointments took place, but that they routinely logged details of NHS patients who did not attend for appointments. We saw that the hospital discussed DNA rates per speciality with the CCG at quarterly review meetings.
- Notices on the wall told patients to enquire at the reception desk if their appointment had been delayed for more than 20 minutes. A notice board also displayed details of which clinics were delayed. We saw this being updated during our visit.
- Average turnaround times for outpatient diagnostic imaging appointments was two days. Staff told us that reports were routinely completed within 24 hours of imaging taking place. The only exception to this was specialist-imaging reports, such as paediatric imaging which staff told us could take a little longer owing to the availability of specialised staff.
- Staff in outpatient clinics told us that there was no cap on appointment numbers within the department and no minimum number of patients required for a clinic to run. This did allow patients to access clinic in a timely manner and avoided cancellations. Staff did reflect that this meant that some clinics could be very busy and delays could occur on these occasions.
- There were no plans in place to coordinate opening times between the outpatient, physiotherapy and diagnostic imaging departments. This meant some

patients seen in outpatients during evenings or weekends would have to return on a different date for imaging or physiotherapy support. Staff in radiology felt that there would not be demand for such a services, whereas staff in outpatients thought that this would be helpful.
- There were some 'one stop shop' clinics available for patients. Staff told us that the spinal clinic involved a physiotherapy appointment, imaging, discussion amongst the physiotherapist and neurosurgeon, and then a clinic appointment on the same day.

Meeting people's individual needs

- The hospital used a BMI group-wide equality and diversity policy. The policy described BMI's commitment to ensuring compliance with the Equality Act 2010 and meeting the needs of staff, patients and service users.
- Data provided by the hospital from September 2015 showed that 100% of staff in radiology, diagnostic imaging, and physiotherapy had completed equality and diversity training. In outpatients, 89% of staff had completed this training.
- Staff told us that interpreter services were available for patients. Staff expected the referral or appointment booking team to identify the need for interpreter services. Staff we spoke with provided varying information on how they would access translation services if it had not been booked in advance. Some staff were aware of access to telephone translation services, some staff said they would raise this issue with managers for guidance, while others confirmed they would consider allowing accompanying visitors to translate. Staff told us they would be conscious of the nature of the clinical information being communicated if a person accompanying the patient translated. They said they would be confident in rescheduling appointments with translator services available if they had any concerns about the information being translated correctly.
- The hospital did not display foreign language leaflets for patients. Staff told us they could order these in advance of appointments. Some staff told us that orders had to be for a large number of leaflets, so leaflets were not routinely ordered. Staff said there was little demand for foreign language leaflets.
- An information poster displayed by X-ray reception encouraged female patients to tell staff if they felt they could be pregnant. This message was displayed in 21 languages.
- The outpatient department had nominated a member of staff to act as a lead dementia nurse. However, at the time of our inspection they had not yet undergone any training or development in the role.
- Staff described the steps they would take if patients with complex needs attended services. This included allowing patients the opportunity to visit services in advance of their appointments, making use of private clinic space, and engaging family and carers to find out what personal adjustments could be made to facilitate the appointment.
- Staff told us that they did have access to bariatric equipment from other areas of the hospital when this was required. This included bariatric chairs and wheelchairs.
- Staff in physiotherapy told us that patients with specific cultural or religious needs could use a smaller treatment room, away from the main gym. This provided a private setting in which patients could be seen and treated if they preferred.

Learning from complaints and concerns

- The hospital has seen complaint numbers increase, with 90 complaints recorded in 2012, 75 recorded in 2013, and 139 recorded in 2014. The data provided to us by the hospital did not allow a breakdown of complaints by clinical area. Instead, complaints were classed as clinical, non-clinical, mixed and financial.
- The hospital had a complaint policy in place. Patient complaints followed a three-stage process, with each stage having set timeframes for responses. Stage 1 involved an investigation and response by the hospital within 20 days; Stage 2 was a regional or corporate investigation and response within 20 days; Stage 3 provided for an independent, external adjudication by the Independent Sector Complaints Adjudication Service (ISCAS), for fee-paying patients, or the Parliamentary and Health Service Ombudsman for NHS patients. The policy was out of date and had been due for review in February 2015.
- The hospital told us a patient information guide, which included a section outlining the formal complaints procedure and copies of BMI leaflet entitled 'Please tell us...' were available in the outpatients department to

inform patients, relatives and carers of how they could highlight any concerns. During our inspection, we found it hard to locate these leaflets. There was no other information on display to provide patients with details of how they could make a complaint about their care or treatment.

- Staff were encouraged to identify and address any concerns or issues whilst the patient or relative was still on site. The hospital asked staff to escalate all complaints to their Head of Department, so that issues could be resolved promptly to avoid the issue developing into a formal complaint where this was appropriate.
- The hospital logged all complaints into a central complaint database where they could be monitored and tracked for completion. In addition to discussion at the 'comms cells' and weekly management team meetings, all complaints were discussed every two months at meetings of the Hospital Clinical Governance Committee, Health & Safety/Risk Management Committee and Medical Advisory Committee (as appropriate) to share findings with service leads and consultants.
- Radiology staff provided an example of learning from a concern. A consultant had been unable to confirm the outcome of a patient scan at their appointment due to the scan not being confirmed as validated on the report. This left the patient and consultant frustrated. Staff in radiology explained the timescale for validation checks (where staff checked that the scan had been marked as validated) was every seven to 10 days. As a result of this concern, the timescale has been reduced to every three days to ensure a more timely check is taken.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well led as good because:

- Appropriate governance systems were in place via meetings and the Comms Cells system.
- Staff in the outpatient and diagnostic imaging departments spoke positively about the impact of new leadership on the services.
- Staff in therapy services spoke highly of their management and were encouraged to develop and innovate.
- There were examples of staff and public engagement taking place.
-
- New management teams were in place for both the outpatient and radiology services. This meant that there had been little time for a formal vision or strategy to be embedded in these services.
- There had been no staff survey since 2014.
- There had previously been cultural challenges within the outpatient department. This resulted in an abrupt change in management within the past six months and staff reported feeling under pressure and unsupported during this period. The new management team were addressing the issues and staff told us things were improving.

Vision and strategy for this this core service

- A BMI group-wide corporate vision was in place and focused on providing 'the highest quality outcomes, the best patient care and the most convenient choice for our patients'.
- We saw senior staff had delivered a presentation to staff on the hospital's vision and clinical strategy in March 2014. There was an action plan in place detailing further actions to be taken up to 2016 to continue to engage staff and provide ongoing training in line with the vision and strategy. This was in line with the wider corporate vision and values.
- Staff we spoke with within the departments could not articulate the wider BMI or hospital vision to us. Staff were also unclear on what the vision was for the services we visited in outpatients, physiotherapy and diagnostic imaging.
- In both outpatients and diagnostic imaging, new management teams were in place and were in the process of consolidating practice before considering how to move forward. This meant there had been limited consideration of forward planning or a vision for the future of these services.
- In physiotherapy, staff did seek opportunities to develop their service and improve the range of care available for patients. However, there was not a formal vision or plan

in place to show how services should grow and develop. We found there was a more 'ad hoc' approach, where staff identified opportunities and sought support from senior leaders to develop these.

Governance, risk management and quality measurement for this core service

- The hospital utilised a 'comms cell' system in every department. These boards displayed information which was updated daily with a range of information, including, patient throughput, availability of medical records, and incidents logged within the department. The board also displayed incident feedback from other areas of the hospital, the department risk register and staff messages.
- 'Comms cell' meetings took place every morning in the outpatient and radiology departments, before a sister's meeting and a head of department 'comms cell' escalated information up to senior staff. This was attended by the outpatient and radiology department managers.
- We witnessed messages from the heads of department 'comms cell' being cascaded to staff at departmental level on the same day.
- The hospital's clinical governance committee met monthly. included senior staff, the Director of Clinical Services and an Executive Director.. The radiology manager and nursing sisters represented staff from the departments.
- The hospital had a risk management policy in place. This provided guidance to staff in assessing and responding to operational risks, including guidance on how risk was to be graded and who to whom to escalate issues. The policy was out of date and was due for review in March 2014. This meant that there was a risk that the policy did not accurately reflect current practice.
- Nottingham University provided the hospital's radiation protection advisor services under a service level agreement. This ensured independent scrutiny of whether the hospital was complying with IRMER.
- An appropriate radiation protection supervisor was in place to ensure local compliance. During a period of maternity leave, the radiology department had appointed an appropriate deputy.
- We saw evidence of monthly team meetings taking place within the departments. Minutes of these meetings showed that governance issues were discussed, including complaints, information security, and learning from incidents within the wider BMI group.
- Staff discussed patient satisfaction scores at meetings of the hospital's Clinical Governance and Medical Advisory Committees (MAC) and at Quality Health local review meetings. Quality Health was the independent external body BMI Healthcare used to receive and analyse its patient surveys. Discussion also took place at the hospital's 'comms cells'.

Leadership / culture of service

- The hospital reported that it had recognised improvements were required in the clinical leadership in outpatients. The hospital appointed a new nurse manager in September 2015. A new outpatient sister had been in post for four weeks at the time of our inspection.
- The new outpatient management had conducted a 'baseline' audit of services and carried out SWOT (strength, weakness, opportunity, threat) analysis with staff to identify the challenges and opportunities available within the department. At the time of our inspection, this work was ongoing and had not had time to develop fully.
- Staff told us there had been an abrupt change in leadership in the outpatient department. Staff told us they had been left without appropriate support and leadership during this period. Staff also told us that they had felt criticised by senior management during this time and they did not feel senior hospital staff understood the pressures of their role. Staff provided examples of how this had manifested, including staff being on long-term sickness absence and low staff morale.
- Staff told us the appointment of the new nurse manager and sister had begun to improve the culture and leadership within the department. However, staff felt there was still some way to go before they felt fully supported in their work. All staff told us they felt the new nurse manager and sister were approachable and supportive. Some staff told us that they did not feel that the new management provided the clinical skills to assist fully in the range of activities carried out in the outpatient department. The new management staff also reflected on this.

Good

Outpatients and diagnostic imaging

- In diagnostic imaging, the service manager had only been in place for one year and its new clinical lead for five weeks. This meant that there had been limited opportunities for the leadership team to embed at the time of our inspection. Staff we spoke with told us they were happy with their experience of the leadership team to date and spoke positively about the support available to them.
- In physiotherapy, the clinical lead had been in place for a number of years. Staff spoke enthusiastically about the support and development opportunities they received.
- Most staff told us they found senior leaders in the hospital to be visible and approachable. A few staff told us senior leaders had only recently been more visible within the past six to eight weeks prior to our inspection.
- All staff we spoke with told us they found their immediate teams to be supportive. Many staff told us the support and friendship of the staff they worked with was the best part of their jobs.

Public and staff engagement

- Patients were encouraged to complete a patient satisfaction survey during or after their admission or outpatient visit. Posters were displayed on walls asking patients to complete 'how are we doing' cards. There were collection boxes for patient satisfaction surveys throughout the hospital or they could be returned by post. The results from surveys were analysed by an independent third party and communicated back to the hospital on a monthly basis for learning and action.
- Fifteen step challenges had been completed in the outpatient, physiotherapy and imaging areas. This was in line with one of the hospitals CQUIN targets from its commissioner. The 15 step challenge is a toolkit to help staff and patients consider their first impressions of the care being provided. The latest data from October 2015 showed that information was collected about how welcoming, safe, caring and involving these areas were. Feedback was largely positive and any concerns were placed into an action plan with appropriate timescale (for example, the removal of a chair which was located in front of a fire door was actioned immediately, and action to source information leaflets about post-operative infection was due by 31 December 2015).
- Staff within the outpatient area had undergone a group 'SWOT' analysis session. As a result of this, suggestions on opportunities to improve the outpatient department had been acted on. An example we were given was in regard to signs being introduced asking patients to contact the reception desk if they had been waiting more than 20 minutes for their appointment.
- The latest staff survey had been scheduled to take place in February 2015. However, no staff survey information had been collected at that time or up to the point of our inspection. This meant we were unable to review the views of all of the staff working at the hospital.

Innovation, improvement and sustainability

- The diagnostic imaging department had recently upgraded a number of pieces of equipment, including upgrading its MRI and CT scanners in 2014. The hospital had also recently invested in a new digital mammography scanner.
- The physiotherapy service was continually adapting to offer new services to its patients. This had included providing women and men's health services, and planned work around antenatal pilates and falls prevention. Staff told us the hospital supported this work.

Outstanding practice and areas for improvement

Outstanding practice

We observed outstanding practice in the hospital's daily "comms cell" meetings which were held between the hospital's senior management team and the heads of department. Comms cell meetings were used to discuss matters such as patient admissions, staffing, risk and incidents. Information from comms cell meetings was then cascaded to staff through departmental meetings. Comms cell meetings were supported by comms cell boards in the main staff areas that displayed information on incidents, audit outcomes, clinical audit data and staffing. Comms cells ensured there was a robust system of communication within the hospital.

Areas for improvement

Action the provider MUST take to improve

- Ensure that comprehensive patient records are maintained, particularly in relation to recording pre-assessment, risk assessment, consent and early warning scores.
- Ensure that paediatric resuscitation equipment is stored appropriately, all required equipment is immediately accessible and staff know how to use paediatric resuscitation masks.
- Ensure that all staff adhere to the hospital policy for the administration of controlled drugs.
- Ensure that patients in the critical care unit have access to call bells.
- Ensure that staff follow infection prevention and control practices.
- Ensure that, in relation to the service for children and young people, there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified, assessed and managed.
- Ensure that there is a robust process for ensuring that medical and nursing staff have the skills, competency, professional registration and good character to practise in the hospital, including evidence of current professional registration, up-to-date appraisal and Disclosure and Barring Service checks (DBS).
- Ensure that staff have the correct level of safeguarding children training, in accordance with the Intercollegiate Document on Safeguarding Children, 2014.
- Ensure that theatre staff involved in the care and treatment of children have child-specific training, as recommended by the Royal College of Anaesthetists.

Action the provider SHOULD take to improve

- The hospital should ensure that daily controlled drug stock checks are done when the critical care unit is open.
- The hospital should run a simulation of a patient collapsing in the bathroom in the critical care unit.
- The hospital should ensure that a system of pain scoring is used in the critical care unit.
- The hospital should ensure that cover is available for staff working in the critical care unit to have a break.
- The hospital should review and formalise arrangements for paediatric transfer.
- The hospital should ensure that the BMI corporate policy is adhered to concerning children's nurse staffing in outpatients.
- The hospital should consider formally monitoring and auditing waiting times, clinic cancellation and patients that do not attend for outpatient appointments.
- The hospital should consider developing a suitable 'did not attend' policy concerning outpatient appointments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) The provider must ensure that comprehensive patient records are maintained, particularly in relation to recording pre-assessment, risk assessment, consent and early warning scores. The provider must ensure that paediatric resuscitation equipment is stored appropriately, all required equipment is immediately accessible and staff know how to use paediatric resuscitation masks. The provider must ensure that all staff adhere to the hospital policy for the administration of controlled drugs. The provider must ensure that there are appropriate arrangements in place to manage the risks associated with the critical care environment, including ensuring patients have access to call bells and managing emergency situations in the critical care unit. The provider must ensure that staff follow infection prevention and control practices.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Good Governance, Health and Social Care Act (Regulated Activities) Regulations 2014 (Good Governance) The provider must ensure that, in relation to the service for children and young people, there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified, assessed and managed. The provider must ensure that there is a robust process for ensuring that medical and nursing staff have the skills, competency, professional registration and good character to practise in the hospital, including evidence of current professional registration, up-to-date appraisal and training and Disclosure and Barring Service checks (DBS).
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing) The provider must ensure that theatre staff involved in the care and treatment of children have child-specific training, as recommended by the Royal College of Anaesthetists.