BMI The Esperance Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection of BMI The Esperance Hospital on the 21/22 and 29 June 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical services, medical services and out-patient and diagnostic services as these incorporated the activity undertaken by the provider, BMI Healthcare Limited at this location.

We also made a judgement on whether the hospital had made improvements on requirement notices which had been served by CQC at a previous inspection of the service in June 2015.

We rated all three core services as good overall, and found that the hospital had mostly made the improvements required of them following requirement notices.

Are services safe at this hospital?

We found that there were sufficient numbers of medical, nursing and diagnostic staff to deliver care safely and that patient risk was assessed and responded to. However, mandatory training rates in surgery were worse than the BMI Healthcare target of 90%. This meant the hospital did not have assurance all staff had the necessary up-to-date training to keep patients safe.

Hospital infection prevention and control practices were mostly followed and these were regularly monitored, to reduce the risk of spread of infections. However, we saw some examples of poor compliance with infection control policies. This included staff not adhering to uniform policy and not being bare below the elbows. In theatres we saw staff re-using a single-use item for multiple patients.

There were a number of hand wash basins and floor surfaces that did not meet the standards required for a clinical area. We found that the hospital had not put in sufficient measures to ensure that the infection risk associated with carpeted areas had been addressed. Although we could see that some areas of the hospital carpets had been replaced and were told that this work would continue the hospital needs to address the progress and speed of these refurbishments as a priority.

In the theatre suite, it was not clearly signposted as to which doors were fire doors. Staff were unclear about fire evacuation procedures. This meant the hospital might not have been able to keep patients safe in the event of a fire. Fire signage, lighting and escape routes across the hospital did not always meet the recommended HTM 05 – 02.

The management of sharps and labelling of sharps bins in theatres did not follow best practice.

We found that staff understood and fulfilled their responsibilities to raise concerns and report incidents, we also found that the hospital fully investigated incidents and shared learning from them to help prevent recurrences. The hospital gave safeguarding sufficient priority because staff received safeguarding training to an appropriate level and staff demonstrated that they knew how to escalate safeguarding concerns. Staff were also aware of and applied the Duty of Candour regulations.

Are services effective at this hospital?

The hospital monitored consultants working under practising privileges. There were systems in place to ensure that consultants were competent to perform their roles, and records were kept and monitored to ensure that both consultants and the Resident Medical Officer (RMO) had DBS checks, appraisals, and relevant qualifications in place to perform their roles.

Summary of findings

Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice. People had comprehensive assessments of their needs. This included consideration of clinical needs, mental health, physical health, nutrition and hydration needs. The hospital routinely collected and monitored information about people's care and treatment, and their outcomes. The hospital used this information to improve care.

We found that staff obtained and recorded consent in line with relevant guidance and legislation. Staff could access the information they needed to assess, plan and deliver care to people in a timely way and were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards legislation.

There was a good multidisciplinary team approach to care and treatment. Staff had the right qualifications, skills and knowledge to do their job. However, there was a low rate of staff appraisals in theatres.

We found that agency staff records on Devonshire ward did not show that all staff had demonstrated competency in all required areas before being signed off as competent to work unsupervised. This meant the hospital might not have had assurance all agency staff had the necessary induction to enable them to work competently on the ward without direct supervision.

Are services Caring at this hospital?

We observed that patients were treated with dignity and respect and their privacy was maintained. We saw that staff offered appropriate emotional support. Patients who shared their views said they were treated well, with compassion, and that their expectations were exceeded. We saw that results of the friends and family test and other patients satisfaction surveys demonstrated that patients would recommend the hospital to others.

Are services responsive at this hospital?

Services were planned and delivered to meet the needs of the local population. Patients could be referred in a number of ways and patients could choose appointments which suited them. Cancellations were minimal and managed appropriately and services ran on time.

The service made reasonable adjustments and took action to remove barriers for people who found it hard to use or access services. Staff had access to translation services. However, Staff were not aware there was a system available to print written information such as pre-appointment information and leaflets in other languages.

We saw openness and transparency in how the service dealt with complaints. The service always took complaints and concerns seriously and responded in a timely way. We saw evidence the service learnt from complaints and made improvements to working practices where appropriate.

Are services well led at this hospital?

We found that the hospital managers may be obtaining false assurance from their audit results as we found that compliance with WHO and staffs understanding of VTE screening did not meet with the assurances that hospital audit scores conveyed.

We found that poor infection control practices were going unchallenged which could indicate that staff did not feel empowered to challenge poor practice when they saw it.

The hospital's clinical governance committee scheduled to meet every two months. However, meeting minutes showed the committee only met four times in the last year. The clinical governance committee was responsible for ensuring the hospital used appropriate systems and processes to deliver safe, high quality patient care.

We saw a comprehensive clinical audit schedule to provide quality assurance. However, we saw that the hospital missed some scheduled audits. For example, the hospital did not have results for scheduled audits in IPC in January, February or March 2016. This meant the executive team might not have had up-to-date assurance of quality in some areas.

Summary of findings

The leadership, governance and culture promoted the delivery of person-centred care. The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately. Quality received sufficient coverage in all relevant meetings. The hospital reported information on people's experiences and reviewed this alongside other performance data.

Leaders modelled and encouraged cooperative, supportive relationships among staff. Staff felt respected, valued and supported. Candour, openness, honesty and transparency were evident throughout the service.

We saw staff were focused on providing the best service for all patients, and were proud to work at the hospital. Managers encouraged staff to recognise and celebrate success.

The management team had an understanding of the Workforce Race Equality Standard (WRES) as there is a national requirement to produce key data relating to race quality in the workplace. BMI had started to collect data nationally which they currently held, for example the numbers of staff from black and ethnic minority groups. The management team was in the process of implementing reporting processes to capture the data to enable them to fully comply with WRES reporting requirements.

We saw areas of outstanding practice including:

The hospital had a chaperone policy that was followed by the outpatient staff, there was signage in all rooms and patients were aware they could ask for a chaperone if needed. Staff maintained a chaperone register which demonstrated where and when chaperones had been required.

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

Importantly, the provider must:

- Take action to ensure they are compliant with Health Technical Memorandum (HTM) 05-02: Fire Code Guidance and ensure adequate lighting and signage for fire escapes, along with ensuring fire escapes are kept free from foliage. They must also address their fire plan in theatres as a priority and ensure that signage is correct and placed to ensure that staff and visitors understand which doors are fire doors, which direction to travel in the event of a fire, and that staff understand evacuation and fire policies and procedures.
- Take urgent action to ensure staff do not reuse single-use items on more than one patient.
- Ensure that the risks associated with carpeted clinical areas and corridors areas are addressed. This should include regular cleaning and appropriate mitigation for risks associated with spillages and infection control. Although we could see that some areas of the hospital carpets had been replaced and were told that this work would continue the hospital does need to address the progress and speed of these refurbishments as a priority.

In addition the provider should:

- Take action to ensure all staff are compliant with mandatory training.
- Take action to ensure all staff have an annual performance appraisal.
- Take action to ensure they keep accurate records of all agency staff competencies on Devonshire ward.
- Ensure that staff follow BMI Healthcare corporate policy to check the pregnancy status of all female patients of potential childbearing age before surgery in line with professional guidance from NICE and the NPSA.
- Consider installing level access showers on Devonshire ward to maximise independence for wheelchair users.
- Ensure all staff are aware written information such as leaflets are available for patients in other languages, though an electronic printing system.
- Ensure that all staff follow hand hygiene best practice processes in all areas of the hospital, including being "bare below the elbow".
- Consider actions to regulate the temperature in the endoscopy suite to prevent the drying cabinet from overheating.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

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 have rated medical services at BMI The Esperance Hospital as good. This is because: • We saw there was good understanding of what constituted an incident as well as sound knowledge of how to escalate safeguarding concerns. We saw the hospital had a system in place (BMI Learn) which tracked mandatory training for all staff including when training was due, when staff had completed the training and what level staff were trained to. • We witnessed excellent care provided to cancer patients who were receiving treatment at the time of the inspection. We also saw patient feedback from both the endoscopy unit and the oncology unit, which was overwhelmingly positive. • Despite some difficulties with staff vacancies at a senior level, the management structure in place was working well to provide a service in the oncology unit that would have been in jeopardy without intervention. • There was a feeling among staff that improvements had been made although further improvements and a settled management team would have improved things further.
Surgery	Requires improvement 	Overall, we rated surgical services as requires improvement. This was because: • We found that the hospital managers may be obtaining false assurance from their audit results as we found that compliance with WHO and staffs understanding of VTE screening did not meet with the assurances that hospital audit scores conveyed. • We found that poor infection control practices were going unchallenged which could indicate that staff did not feel empowered to challenge poor practice when they saw it. • The hospital's clinical governance committee scheduled to meet every two months. However,

Summary of findings

meeting minutes showed the committee only met four times in the last year. The clinical governance committee was responsible for ensuring the hospital used appropriate systems and processes to deliver safe, high quality patient care.

- We saw a comprehensive clinical audit schedule to provide quality assurance. However, we saw that the hospital missed some scheduled audits. For example, the hospital did not have results for scheduled audits in IPC in January, February or March 2016. This meant the executive team might not have had up-to-date assurance of quality in some areas.
- Mandatory training compliance and staff appraisal rates were below BMI Healthcare targets.
- We saw examples of non-compliance with infection prevention and control (IPC) policies. This included staff in theatres re-using a single-use item for multiple patients.
- We also saw two members of staff enter the theatre, anaesthetic room and recovery area in outdoor clothes contrary to BMI Healthcare clinical uniform policy. One wore a watch and bracelets below the elbows, which can prevent effective hand washing. We also saw a consultant's briefcase on the floor inside theatre two. This risked the transfer of germs from the outside environment into the operating theatre.
- We saw a member of staff in the theatre suite with waist-length hair not tied back. This is contrary to the BMI Healthcare clinical uniform policy, which stated, "If hair is longer than collar length, it must be neatly tied back".
- Staff hand washing facilities on Devonshire ward fell below recommended standards.
- In the theatre suite, it was not clearly signposted as to which doors were fire doors. Staff were unclear about fire evacuation procedures. This meant the hospital might not have been able to keep patients safe in the event of a fire in theatres.
- We found staff knowledge around VTE assessment to be poor, with theatre staff checking a box to say that a VTE assessment

had been completed who were then unable to show inspectors how they knew his was the case. The hospital reported two cases of venous thromboembolism (VTE) for surgical inpatients between January 2015 - December 2015. The hospital consistently did not meet their NHS contracted 95% target screening rate for VTE risk assessment throughout 2015. The lowest screening rate in this period was 52.4% between July and September 2015.

- We saw staff did not fully complete all the WHO checklist processes for two procedures during our inspection.
- We saw that some of the patient bedrooms on Devonshire ward had carpets. Carpets in clinical areas prevent the effective cleaning and removal of bodily fluid spillages and therefore pose an infection control risk. The Department of Health's HBN00-09 states, "Carpets should not be used in clinical areas". We saw a risk assessment for carpets in clinical areas dated 17 May 2016. There were no control measures on the risk assessment relating to cleaning of carpets following a bodily fluid spillage. The hospital was unable to provide evidence of regular deep cleaning of carpets. This meant carpet on the ward may have posed an infection control risk to patients.
- We saw poor practice around the disposal of sharps and the labelling of sharp containers. These practices increased the risk of sharps injury (cuts from sharp objects such as needle sticks) and potential transmission of blood-borne viruses to staff.
- We saw staff did not fully complete all the WHO checklist processes for two procedures. For one of these, we saw staff completed the WHO sign-in process, but failed to complete the time out and sign out processes.
- We observed an operation in theatre two where staff placed surgical instruments outside of the laminar flow (clean air) area. This may have compromised sterility and increased the risk of infection to the patient. We reported this to staff, who repositioned the trolley under the laminar flow. We also saw poor aseptic

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technique from a nurse, who almost entered the sterile field twice. A member of the inspection team stopped her from compromising sterility on both occasions, and we reported our concerns to the theatre manager after the procedure.

However:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. The hospital fully investigated incidents and shared learning from them to help prevent recurrences.
- There was sufficient emergency resuscitation equipment available and staff checked equipment regularly to ensure it was safe.
- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice.
- People had comprehensive assessments of their needs. This included consideration of clinical needs, mental health, physical health, nutrition and hydration needs.
- The hospital participated in relevant local and national audits and contributed to national data to monitor performance such as the National Joint Registry (NJR)
- Staff obtained and recorded consent in line with relevant guidance and legislation.
- Staff treated people with dignity, respect and kindness during all interactions. Patients felt supported and cared for by staff.
- The service supported patients and those close to them to cope emotionally with their care and treatment. Staff encouraged patients and their loved ones to be partners in their care.
- Services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these appropriately.
- We saw openness and transparency in how the service dealt with complaints. The service always took complaints and concerns seriously

Summary of findings

and responded in a timely way. We saw evidence the service learnt from complaints and made improvements to working practices where appropriate.
- The leadership, governance and culture promoted the delivery of high quality person-centred care.
- The hospital reported information on people's experiences through their monthly patient satisfaction surveys and reviewed this alongside other performance data.
- Leaders modelled and encouraged cooperative, supportive relationships among staff. Staff felt respected, valued and supported.

Outpatients and diagnostic imaging

Good

Overall we rated the outpatients and diagnostic imaging service as good. This was Because:

- Patients were protected from the risk of abuse and avoidable harm. Staff knew how to escalate key risks that could affect patient safety, such as safeguarding from abuse. They took steps to prevent abuse from occurring, respond appropriately to any signs of abuse and worked effectively with others to implement protection plans. The diagnostic imaging 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.
- Staff completed mandatory training with good compliance rates. The departments were clean, and hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections. Medications were stored safely.
- The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- During the inspection we observed staff respond compassionately when people needed help and support to meet their basic personal

Summary of findings

needs as and when required. People's privacy and confidentiality was respected at all times. Patients' feedback through interviews and comments cards was entirely positive.

- Patients praised all aspects of the service with comments such as "the care, courtesy and respect was exceptional", "welcoming", "friendly", "excellent", and "nothing is too much trouble". Staff verbally offered a chaperone to all outpatients. Signs were also clearly displayed in waiting areas and clinical rooms offering a chaperone and the patient's acceptance or rejection of the offer was recorded on the chaperone register.
- Outpatient and diagnostic imaging clinics were available in the evenings with appointments made for the patients' convenience. Occasional weekend clinics would be held, depending on need. Waiting times were minimal and well managed.
- There was clear and visible leadership provided by senior management and within the departments. Staff spoke highly of their managers, who told us they were visible and approachable.

However we found:

- There were a number of hand wash basins and floor coverings that did not meet the standards required for a clinical area.
- Fire signage, lighting and escape routes in some cases did not meet the recommended HTM 05 – 02.
- Staff were not aware there was a system available to print written information such as pre-appointment information and leaflets into other languages.

Summary of findings

Contents

Requires improvement

BMI - The Esperance Hospital

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

Summary of this inspection

Background to BMI The Esperance Hospital

The Esperance Hospital is an independent hospital which is part of BMI Healthcare Limited. It is situated in Eastbourne, East Sussex. The Esperance Hospital was the first private hospital in Eastbourne. In 1917 it opened its doors as a hospital run by the Sisters of Bordeaux having previously been a private residence. The Sisters nursed the victims of war and ran the Esperance for 70 years. In 1987 the hospital was taken over by G.M. Healthcare. Many alterations and extensions took place at this time. BMI Healthcare acquired The Esperance Hospital in 1989.

The hospital has 28 bedrooms and three theatres.

We inspected this hospital as part of our national programme to inspect and rate all independent healthcare providers. We inspected three core services at the hospital which incorporated all the activity undertaken. These were Surgical services, Medical services and Outpatient and Diagnostic Services. We had previously carried out an unannounced, focused inspection at the BMI Esperance Eastbourne on the 23rd June 2015. That inspection was triggered by information of concern we had received relating to infection control arrangements, standards of cleanliness and the maintenance of the fabric of the buildings. We found some areas of concern during that inspection and subsequently served the provider with requirement notices. Therefore on this inspection we also revisited the areas of previous concern in order to judge whether improvements had been made.

The registered manager had recently retired and the hospital was being overseen by an interim manager Connie Stocker until a permanent replacement manager was employed. The provider's nominated individual for this service was Elizabeth Sharp. The controlled Drug Accountable Officer was Connie Stocker.

Our inspection team

Our inspection team was led by:

Inspection Lead: Vanessa Ward, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

- Two nurses including a theatre nurse and one with experience of managing outpatient departments in independent hospitals

How we carried out this inspection

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We placed comment boxes at the hospital prior to our inspection which enabled staff and patients to provide us with their views. We received 16 comments from patients.

We carried out an announced inspection on the 21 and 22 June 2016 and an unannounced visit on the 29 June 2016

We interviewed the management team. We spoke with a wide range of staff including nurses, resident medical officer, radiographers and administrative and support staff totalling 46 personnel.

We also spoke with19 patients who were using the hospital.

We observed care in the outpatient and imaging departments, in operating theatres and on the wards and reviewed patient records. We visited all the clinical areas at the hospital with the exception of the assisted conception unit at the hospital as this unit falls outside of our scope for inspection.

Summary of this inspection

Information about BMI The Esperance Hospital

During 2015, BMI The Esperance Hospital treated a total of 531 patients requiring overnight stays and 3120 day cases. Of the inpatient stays 25% were NHS funded as were 63% of day cases. In addition the hospital saw 11 279 outpatient attendances of which 8% were NHS funded.

In 2015 the most common surgical procedures performed were Intravitreal injection of pharmaceutical agent(503), Epidural injection lumbar (495), Phacoemulsification of lens with implant (139)

There were 82 doctors with practising privileges at the hospital, and 52% of these carried out over 100 episodes of care during 2015, 15% carried out between 10-99, and 12% between 1-9 episodes of care. This meant that 21% did not carry out any procedures during the same period. There were 42.7 full time equivalents (FTE) registered staff employed, including nurses, and 50.2 FTE support staff including care assistants and administrative staff.

Sickness rates were low at less than 10% during 2015. Moderate level of vacancies at January 2016 (between 10% and 19%) for Allied Health Professionals (hospital-wide). Whilst other staffing groups (hospital-wide) had a low level of vacancies (less than 10%). There were no vacancies for healthcare assistants.

No whistleblowing concerns have been reported to CQC in the last 12 months. CQC directly received four complaints in the reporting period (Jan 15 to Dec 15). No complaints have been received since Dec 15.The CQC completed an unannounced inspection on 26/06/2015. That inspection was triggered by information of concern we had received relating to infection control arrangements, standards of cleanliness and the maintenance of the fabric of the buildings. We found some areas of concern during that inspection and subsequently served the provider with requirement notices.

The hospital received a total of 28 complaints in 2015, an increase on the previous year. The provider has received two items of rated feedback on the NHS Choices website in the reporting period (Jan 15 to Dec 15). Both had rated as extremely likely to recommend.

During 2015 there were no serious incidents or never events at the hospital. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death. There were 149 other clinical incidents within this year. The rate of clinical incidents (per 100 inpatient discharges) has risen from the beginning of the period. No safeguarding concerns have been reported since January 2015.

In the same year there were no unexpected deaths and no were no reported cases of serious infection such as MRSA.

VTE screening had not met for all of the reporting period (Jan 15 to Dec 15).The target rate for VTE screening for NHS patients is 95%. During this period 74.1% of patients were screened between January and March 2015, 82.6% between April and June 2015, 52.4% between July and September 2015, and 67.1% between October and December 2015. There had been three incidents of hospital acquired VTE or PE in the reporting period (Jan 15 to Dec 15).

Follow Up information on previous Regulatory Breaches

CQC had previously completed an unannounced inspection of the hospital June 2015 following concerns that had been raised with us by a member of the public who had been an inpatient at the hospital. During the inspection (June2015) we found some areas of concern and served the hospital with requirement notices. The hospital provided us with action plans following the inspection. On this inspection we checked that the hospital had made the required improvements.

At the previous inspection (June 2015) we found that staff whose job role was concerned with the preparation and serving of food and drink had not received adequate training in food safety. This breached Regulation 12 (2) (c) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this Inspection: we found that staff involved in the preparation and serving of food had received adequate training.

Summary of this inspection

- We looked at both the training records for the catering staff working within the main kitchen (chefs and catering manager) as well as the staff working on the wards (hosts).
- There were three members of the catering team working in the kitchen and we saw that each member of staff had completed a level of food hygiene training commensurate with their level of responsibility as required by the Food Safety Act 1990. Chefs had completed level two in food safety and the catering manager had completed level three in food safety. They were all required to attend this training three yearly and all up to date with this training.
- There were four members of staff who work as hosts on the wards they had all received in house training on accidents and hazards, kitchen safety, manual handling, risk assessment, preparation, serving, storing food safely, personal hygiene, date label and shelf lives, food and drink temperature checks and food handling.

At our previous inspection (June 2015) we found that food safety guidance was not fully implemented. This breached Regulation 12(2)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that food was stored and regulated in a way that met with food safety guidance.

- The main kitchen dry goods store along with the main kitchen and ward refrigerators were checked for correctly labelled and dated food to ensure that it had not passed its use by or best before date. All food items were checked on the 21st June 2016 and all were labelled and in date. We asked two members of the hosting staff what they would do if they found food not labelled/dated in the refrigerator and they both said they would discard without looking for the owner of the item.
- Records for the two walk in refrigerators and one walk in freezer in the main kitchen were checked. The refrigerators were checked twice a day and the freezer once a day. The records we looked at were from 3rd June 2016 to 20th June 2016. All were within the expected range.
- We were told the temperature of the refrigerators on the wards were checked twice a day and the records we inspected substantiated this. We checked the records for March, April, May and June 2016.On Hartington ward records we saw that all temperatures for these months were within the expected range. On Devonshire ward all March records were within range.
- In April there was one instance where the temperature was out of range and in May there were four instances where the temperature was recorded as out of the expected range. These out of range temperatures were recorded from 6 degrees celsius to 14.4 degrees celsius. Actions recorded beside each of the out of range temperatures indicating that the food had been disposed of. This was checked with the host staff and both said they would discard food if the temperature was outside the expected range

At our previous inspection (June 2015) we found that Monitoring of water safety, planned preventative measures in relation to air handling in operating theatres had not been performed in line with national guidance. Flooring materials used and their maintenance did not meet national specifications. This breached Regulation 12(2)(d) of the Health & Social Care Act 2008.

At this inspection we found that water safety checks and theatre ventilation maintenance checks were completed in line with current legislation. However, we found that areas of the hospital were still carpeted and that the mitigation for the increased risk of infection related to carpets had not been addressed in an adequately robust manner.

- We checked the records for water flushing on the week commencing 6th June 2016 and checked 12 records and these showed all outlets in these rooms had been flushed a minimum of twice in the week. We checked 14 records from the week commencing 17th June 2016 and these showed all outlets in these rooms had been flushed a minimum of twice in the week which complies with the relevant legislation.
- We inspected the water temperature records for March 2016. There were 52 records and 50 were within the expected range with two being outside the expected range. Records showed that the two outside the range had actions beside them and the estates manager showed us the requisitions for work that had been raised for the actions.
- We checked a further 30 records across April 2016 and May 2016 and 21 were within the expected range. Of

the nine that were not four had actions against them and the estates manager showed us the works requisitions that had been raised for these actions. The other 5 outside of range were records as between 53.2 degrees celsius and 62.8 degrees celsius. The actions beside these were that thermostatic mixing valves (TMV) were installed. At the time of inspection had not been carried out.

- We also inspected 104 records for descaling of shower heads from September 2015 to June 2016. All shower heads were recorded as being descaled and changed every three months.
  - We were shown the regime for changing the filters and general maintenance of the theatre ventilation plant. This was evidenced by us seeing the planned preventative maintenance schedules for this plant. We also saw a report for the annual verification of theatre suite ventilation systems suite dated 18th January 2016 which showed out of ratings of poor, average and good, the theatres were rated average. We also saw a quality control report for air samples which showed results complied with limits specified. The air was sampled on 18th January 2016.
  - At this inspection we still found some areas of the hospital where carpets were in situ. We were shown a risk assessment dated 17th May 2016 which was titled "Any department with carpet in clinical areas" The risk assessments highlighted the risks of this as Cross Infection, Room out of service, unidentified spillages could cause mould formation and Diseases such a Noro virus, Hep B and C can be isolated in carpets leading to a high risk of cross contamination to patients and staff.
  - The control measures in place according to the risk assessment were, "carpets are vacuumed only, no provision for deep cleaning carpets currently in place." Control measures to be implemented, according to the risk assessment, were "identified date for removing carpets in clinical areas in order to comply with national guidance on infection prevention and control. All current guidance recommends that carpet should not be fitted in clinical areas. Replace carpets with vinyl". The timescale for these control measures to be implemented was documented as "ASAP" on the risk assessment.
  - The risk scoring for the current risk was 12 and the score following implementation of the control measures was 2. According to the risk matrix if a risk is scored at 12 – 18 "Urgent action required now to reduce and / or control the risk. Within two weeks at the latest"
  - There were no control measures on the risk assessment relating to cleaning of carpets whist they were still in situ following a spillage. We asked for the evidence to show that the carpets were regularly cleaned and this was not available. We saw five invoices for steam cleaning of carpets, net curtains and curtains from May 2016. We were told this took place following a patient with an infection being discharged.
  - After reviewing the evidence we found that the hospital had not put in sufficient measures to ensure that the risks associated with carpeted areas had been addressed. Although we could see that some areas of the hospital carpets had been replaced and were told that this work would continue the hospital needs to address the progress and speed of these refurbishments as a priority.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We found that there were sufficient numbers of medical, nursing and diagnostic staff to deliver care safely and that patient risk was assessed and responded to. However, mandatory training rates in surgery were worse than the BMI Healthcare target of 90%. This meant the hospital did not have assurance all staff had the necessary up-to-date training to keep patients safe.

Hospital infection prevention and control practices were mostly followed and these were regularly monitored, to reduce the risk of spread of infections. However, we saw some examples of poor compliance with infection control policies. This included staff not adhering to uniform policy and not being bare below the elbows. In theatres we saw staff re-using a single-use item for multiple patients.

There were a number of hand wash basins and floor surfaces that did not meet the standards required for a clinical area. We found that the hospital had not put in sufficient measures to ensure that the infection risk associated with carpeted areas had been addressed. Although we could see that some areas of the hospital carpets had been replaced and were told that this work would continue the hospital needs to address the progress and speed of these refurbishments as a priority.

In the theatre suite, it was not clearly signposted as to which doors were fire doors. Staff were unclear about fire evacuation procedures. This meant the hospital might not have been able to keep patients safe in the event of a fire. Fire signage, lighting and escape routes across the hospital did not always meet the recommended HTM 05 – 02.

The management of sharps and labelling of sharps bins in theatres did not follow best practice.

We also found that records were stored safely, were up to date, legible, and were available for staff. However, on Devonshire ward, there were no accurate records of the quantity of controlled drug prescriptions (FP10) or private prescriptions (SPF100) in stock. This meant there was the potential for blank prescriptions to go missing un-noticed.

We found that staff understood and fulfilled their responsibilities to raise concerns and report incidents, we also found that the hospital fully investigated incidents and shared learning from them to help prevent recurrences. The hospital gave safeguarding sufficient

Summary of this inspection

priority because staff received safeguarding training to an appropriate level and staff demonstrated that they knew how to escalate safeguarding concerns. Staff were also aware of and applied the Duty of Candour regulations.

Are services effective?

Good

The hospital monitored consultants working under practising privileges. There were systems in place to ensure that consultants were competent to perform their roles, and records were kept and monitored to ensure that both consultants and the Resident Medical Officer (RMO) had DBS checks, appraisals, and relevant qualifications in place to perform their roles.

Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice. People had comprehensive assessments of their needs. This included consideration of clinical needs, mental health, physical health, nutrition and hydration needs. The hospital routinely collected and monitored information about people's care and treatment, and their outcomes. The hospital used this information to improve care.

We found that staff obtained and recorded consent in line with relevant guidance and legislation. Staff could access the information they needed to assess, plan and deliver care to people in a timely way and were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards legislation.

There was a good multidisciplinary team approach to care and treatment. Staff had the right qualifications, skills and knowledge to do their job. However, there was a low rate of staff appraisals in theatres.

We found that agency staff records on Devonshire ward did not show that all staff had demonstrated competency in all required areas before being signed off as competent to work unsupervised. This meant the hospital might not have had assurance all agency staff had the necessary induction to enable them to work competently on the ward without direct supervision.

Are services caring?

Good

We observed that patients were treated with dignity and respect and their privacy was maintained. We saw that staff offered appropriate emotional support. Patients who shared their views said they were treated well, with compassion, and that their expectations were exceeded. We saw that results of the friends and family test and other patients satisfaction surveys demonstrated that patients would recommend the hospital to others.

Summary of this inspection

Are services responsive?

Good

Services were planned and delivered to meet the needs of the local population. Patients could be referred in a number of ways and patients could choose appointments which suited them. Cancellations were minimal and managed appropriately and services ran on time.

The service made reasonable adjustments and took action to remove barriers for people who found it hard to use or access services. Staff had access to translation services. However, all written information, including pre-appointment information, leaflets and signage was in English only.

We saw openness and transparency in how the service dealt with complaints. The service always took complaints and concerns seriously and responded in a timely way. We saw evidence the service learnt from complaints and made improvements to working practices where appropriate.

Are services well-led?

Requires improvement

We found that the hospital managers may be obtaining false assurance from their audit results as we found that compliance with WHO and staffs understanding of VTE screening did not meet with the assurances that hospital audit scores conveyed.

We found that poor infection control practices were going unchallenged which could indicate that staff did not feel empowered to challenge poor practice when they saw it.

The hospital's clinical governance committee scheduled to meet every two months. However, meeting minutes showed the committee only met four times in the last year. The clinical governance committee was responsible for ensuring the hospital used appropriate systems and processes to deliver safe, high quality patient care.

We saw a comprehensive clinical audit schedule to provide quality assurance. However, we saw that the hospital missed some scheduled audits. For example, the hospital did not have results for scheduled audits in IPC in January, February or March 2016. This meant the executive team might not have had up-to-date assurance of quality in some areas.

We saw from the hospital's risk management plan for 2016 that they only updated the risk register annually. This may have meant the hospital did not record new areas of risk in a timely way. It may also have meant the hospital did not monitor action against areas of risk in a timely way.

The leadership, governance and culture promoted the delivery of person-centred care. The board and other levels of governance

Summary of this inspection

within the organisation functioned effectively and interacted with each other appropriately. Quality received sufficient coverage in all relevant meetings. The hospital reported information on people's experiences and reviewed this alongside other performance data.

Leaders modelled and encouraged cooperative, supportive relationships among staff. Staff felt respected, valued and supported. Candour, openness, honesty and transparency were evident throughout the service.

We saw staff were focused on providing the best service for all patients, and were proud to work at the hospital. Managers encouraged staff to recognise and celebrate success.

The management team had an understanding of the Workforce Race Equality Standard (WRES) as there is a national requirement to produce key data relating to race quality in the workplace. BMI had started to collect data nationally which they currently held, for example the numbers of staff from black and ethnic minority groups. The management team was in the process of implementing reporting processes to capture the data to enable them to fully comply with WRES reporting requirements.

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	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Good

Medical care

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

Information about the service

The medical services provided at BMI The Esperance Hospital comprise of oncology and endoscopy. Both of these units have their own distinct areas within the hospital.

We inspected both of these areas during our inspection. The oncology unit only delivered chemotherapy on one of the days of our inspection. We spoke face to face with both of the patients receiving treatment that day.

The services provide care for adults aged eighteen and over.

The hospital had 1,118 attendances to the endoscopy unit between 1 January 2015 and 31 December 2015. We did not receive with any data for the number of patients attending the oncology unit for treatment in the same period; however, at the time of the inspection, they had seven patients who were receiving regular chemotherapy.

Summary of findings

We have rated medical services at BMI The Esperance Hospital as good. This is because;

We saw there was good understanding of what constituted an incident as well as sound knowledge of how to escalate safeguarding concerns. We saw the hospital had a system in place (BMI Learn) which tracked mandatory training for all staff including when training was due, when staff had completed the training and what level staff were trained to.

We witnessed excellent care provided to cancer patients who were receiving treatment at the time of the inspection. We also saw patient feedback from both the endoscopy unit and the oncology unit, which was overwhelmingly positive.

Despite some difficulties with staff vacancies at a senior level, the management structure in place was working well to provide a service in the oncology unit that would have been in jeopardy without intervention.

There was a feeling among staff that improvements had been made although further improvements and a settled management team would have improved things further.

Good

Medical care

Are medical care services safe?

Good

We have rated the safety of medical services at the BMI The Esperance Hospital as good. This is because;

- Safeguarding was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.
- Staff awareness of the duty of candour was good (duty of candour means that any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint had been made or a question asked about it). There were clear local and corporate expectations for all staff to be candid should anything go wrong.

However;

- Staff did not always receive feedback and associated learning when incidents had occurred.
- The environment in the endoscopy was very warm and had little ventilation to regulate the temperature.

Incidents

- All incidents were reported on an electronic reporting system (Sentinel) . BMI used this system for recording any incidents as well as complaints. We saw evidence in team meeting minutes that incident reporting was a standing item. Nurses we spoke with in the endoscopy unit had a good knowledge of the duty of candour and could clearly explain what it meant. We also saw the internal policy folder had a section devoted to duty of candour. This information was also available online.
- Two staff we spoke with from the oncology unit were able to describe how to report an incident as well as their own personal responsibilities, including where the incident report needed to be sent. However, the staff could not tell us in any detail what happened after the incident had been reported. This meant that opportunities for learning from incidents could be missed.
- Information obtained during the inspection showed there were three incidents reported between January 2015 and December 2015 that related to the endoscopy unit. All incidents were appropriately dealt with and there had been clear adherence to the duty of candour.
- Due to the nature of the service, morbidity and mortality reviews (these are meetings summarise all deaths and adverse incidents) were not carried out as a matter of course. This was in part due to the relatively low number of patients they had and the consequent low numbers of patients that would fall into these categories. We were told that any such reviews would be likely to be dealt with as an incident. Depending on the outcome of any investigation into the incident, a risk may be identified and added to the risk register.

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

- The hospital published data regarding safety that could be accessed through the BMI The Esperance Hospital website. The data regarding safety was contained within the hospital's Quality Accounts. The information in this document included, but was not limited to the Patient Led Assessment of the Care Environment (PLACE) reports, mortality rates and patient safety incidents. The information about mortality rates, and patient safety incidents was benchmarked against the national average, the highest national score and the lowest national score. Information specific to the endoscopy unit and the oncology unit were reported monthly.

Cleanliness, infection control and hygiene

- The hospital had a standard infection control precautions policy in place. This was issued in February 2016 and was due to be reviewed in February 2017. The head of infection prevention and control was the custodian of this policy.
- The hand hygiene policy was issued in May 2016 and due for review in May 2019. The head of infection prevention and control was also the custodian of this policy.
- We witnessed staff adhering to good hand hygiene practices and appropriate use of PPE (personal protective equipment).

- There had been no incidences of Meticillin-resistant Staphylococcus Aureus (MRSA), Clostridium difficile or Meticillin Sensitive Staphylococcus Aureus (MSSA) reported in the period 1 January 2015 to 31 December 2015.
- Rooms used for patients receiving chemotherapy were cleaned as soon as treatment had finished and the patient had gone. We saw there was a checklist in place for the cleaner to complete.

Environment and equipment

- We inspected the crash trolley in the oncology unit and saw all of the equipment had been regularly checked and was ready to be used when required.
- We saw a newly fitted out clean utility room, accessed by a keypad lock, which had safe storage of medication in a locked cupboard as well as a thermometer to check the ambient temperature. While it was a positive to see the thermometer was in place to check the ambient temperature, and that it was checked Monday to Friday, there was no system in place to check it at weekends. This was raised with the oncology lead who told us that they would address this issue. The clean utility room was very neat, tidy and clean. However, we found some pieces of equipment that were out of date. This was reported to the oncology lead and the out of date equipment was disposed of. We also saw the storage area for dirty linen, which was large, clean, tidy and well ordered. The room was locked and accessed by a keypad lock and linen was segregated.
- In the endoscopy unit, we saw clear demarcation of the dirty and clean scope areas. The water fill lines in the sink were correct. Chemicals to clean the scopes were automatically delivered rather than poured in by hand. Appropriate PPE was available, including gauntlet gloves, aprons and visors. Scopes were placed in the Gettinge machine to clean them. This machine was also able to carry out a leak test. Were the scope to fail the leak test, the machine notified staff of the failure. If the scope was damaged, it was sent for repair and a replacement provided until it was fixed.
- When the scope had been through the cleaning process, it was placed into the drying unit. All scopes were tracked throughout the cleaning process. If a scope was in the drying unit for more than 72 hours, an alert would be sent. If there was an alert, the scopes would need to go through the cleaning and drying process again.
- Each scope, when going through the process had a unique identification number. Two printouts of full details of the scopes were produced, one of which should have been attached to the patient records. We viewed two sets of patient records and confirmed that these had been retained appropriately.
- The environment where the scopes were initially cleaned was adequate although small, very warm, had a strong chemical smell and the reverse osmosis unit was very noisy. There was little ventilation. We asked staff about the environment in the rooms where the scopes were cleaned and dried. It was evident that these rooms were very warm. Although the day of inspection was in the summer, it was not particularly warm. There was no air conditioning in these rooms, although there was in the room where the endoscopic procedures took place. The staff explained when possible, they would open the doors of the air-conditioned room to try to regulate the temperature in the other rooms. This was only partly effective as the doors were on timers and would automatically close.
- We were also told that the only other means of cooling the room was to open the window. This was done frequently to cool the drying cabinet, as it was not supposed to go above 35 degrees. There had been one occasion where the drying cabinet over heated, released steam and set off the fire alarms. Although staff had pushed for air conditioning, this had not been installed and it was not on the risk register. The reverse osmosis unit was checked regularly by the manufacturers and 'next service due' date stickers were placed on the machine.
- The endoscopy suite had a chemical spill kit stored on top of the chemical cupboard. This was stored at around 70 centimetres from the ground rather than on top of a high cupboard and did not pose any safety risk.
- The endoscopy sister told us staff no longer needed to see occupational health on a regular basis since the change to the system of adding chemicals to water. This was because the chemicals were added automatically and not by hand, therefore the risk of exposure had diminished significantly.
- In endoscopy, patients were given their own room to change and store their belongings. There was a recovery room with curtains to protect patient's dignity. However, the next patient would have to come through the same

room as the one the patient was recovering in. Staff showed awareness of the challenges this posed but did not have a workable alternative due to the configuration of the unit.

- At the time of inspection, the endoscopy unit was going through the process of applying for Joint Advisory Group (JAG) on GI endoscopy accreditation incorporating the endoscopy global rating scale. Staff advised us they were at the early stages of this process and there was still a lot to be done in recognising that the environment may need addressing. They were hopeful that they would be able to achieve the accreditation in 2017.
- The hospital wanted to work toward achieving The Macmillan Quality Environment Mark (MQEM**).** This was a detailed quality framework used for assessing whether cancer care environments met the standards required by people living with cancer. Macmillan had provided the hospital with a self-assessment tool to work through. Once completed it would be audited by Macmillan, and if approved, would then be put to the corporate team to approve its implementation. At the time of the inspection, the hospital had started work on this but had not completed it.
- The oncology suite had two rooms, both with beds. Although both rooms had beds, the majority of patients did not need a bed to receive treatment. However, during our inspection we did see that one patient required a bed as the correct position of their arm could only be achieved lying down.

Medicines

- We observed the administration of drugs to a patient. Name and date of birth were checked and both nurses checked the drug, quantity, batch number and expiry date before administration. The time of administration was also recorded and signed by each of the nurses. We also saw that the consultant had signed the prescription. Throughout the administration process there was good interaction between the nurses and the patient and appropriate use of PPE.
- The hospital had a pharmacy on site, which was open Monday to Friday. A pharmacist and pharmacy technician staffed this. The staff we spoke with told us of a good working relationship between the separate units and the pharmacy.
- Drugs were stored appropriately in a locked cupboard inside a clean utility room, which was also locked.

Records

- Patient records in the oncology unit were kept in a locked cabinet in a locked room.
- We observed good practice from all staff that ensured that doors to rooms where records were kept remained locked when unoccupied.
- The oncology unit had an e-prescribing system. The system could be accessed from two tablet computers.
- The endoscopy unit had never needed to complete a look back exercise. A look back exercise was where something may be detected from a scope or the potential for something such as Creutzfeldt-Jakob desease (CJD). [This is a rare and fatal condition that affects the brain. It causes brain damage that worsens rapidly over time] to be detected. The hospital can then look back at all patients who had been treated with that scope, contact them and test again if necessary. The hospital retained patient records for seven years; therefore they would be able to perform a look back exercise within this timeframe.
- We reviewed the records of patients who attended the endoscopy unit on the day of inspection. The records were comprehensive, well-ordered and contained all of the relevant information including details of consent.
- Consultant medical records were stored on site and consequently, there was no reason for them to be taken away. In addition, many consultants had paperless records under secure IT systems. All applicable consultants had to be registered with the ICO and this formed part of the Practising Privileges contract.

Safeguarding

- Any safeguarding incidents would require an incident form to be completed and put on to the hospital's incident reporting database. Consequently, the director of nursing would forward this to social services. We spoke with three different members of staff, of different grades and, in different parts of the hospital who were all consistent in describing how safeguarding incidents were reported.
- We spoke with two members of staff in the endoscopy unit about safeguarding. We were given an example of how they had addressed an issue with a patient who had attended the department from a care home with an

issue that required them to make a safeguarding referral. Staff were able to evidence that they had followed correct internal procedures and had raised the matter with the relevant authorities for investigation.

Mandatory training

- All mandatory training was done online and was followed up by face-to-face sessions. Mandatory training included basic life support, infection control, fire safety and safeguarding. The progress of individual staff training was available on the internal system, BMI learn.
- Staff we spoke with confirmed that all staff in the endoscopy unit had completed 100% of their mandatory training. The staff we spoke with in the oncology unit had completed their mandatory training. The oncology lead also oversaw the training records of the staff and was able to manage the team's compliance with the mandatory training requirements.

Assessing and responding to patient risk

- The hospital had a policy detailing what staff should do in the event of a patient seriously deteriorating. Actions included calling 999 to transfer the patient to the local NHS hospital. If however the deterioration were caused by an anaphylactic reaction to medication, the patient would be treated in the enhanced recovery area in the hospital.
- The Esperance Hospital was a member of Sussex Critical Care Delivery Unit, which supported transfers to critical care providers as required.
- We looked at the notes of a patient who had rapidly become unwell. The notes were well documented and the procedures put in place kept the patient safe from harm.
- We saw that the National Early Warning Scores (NEWS) was correctly used and the appropriate action taken if needed. NEWS is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital.
- There was a local protocol for the treatment of febrile neutropenia, febrile neutropenia occurs when a patient has a fever and a significant reduction in a type of white blood cells, known as neutrophils, which are needed to fight infections. The protocol has been agreed between the oncologists and microbiologist. These medicines were available within the hospital with enough stock to treat for a minimum of 72 hours.

Nursing staffing

- The oncology unit was led by the oncology lead and employed one permanent chemotherapy nurse. There was one healthcare assistant and one member of staff providing administrative support.
- There were three doctors who could prescribe chemotherapy medication and five nurses trained to administer. There was also one nurse who could support the administration of chemotherapy.
- BMI The Esperance Hospital used the BMI staff-planning tool that calculated the required nursing hours and skill mix to provide care for the numbers of different patient types and complexities. The corporate team and clinical leads had sight of each hospitals figures on a daily basis. If the data flagged hours above or below the required number, an explanation would need to be given. This also allowed staffing trends to be identified
- The tool provided a rolling review and was valuable in reviewing staffing levels at local, management and corporate level. This tool was used to plan the appropriate number of hours required to fulfil demand and skill mix five days in advance, with continuous review on a daily basis. The actual hours worked were also entered retrospectively to understand variances from the planned hours and the reasons for these.
- Due to staff shortages, the oncology lead had brought some staff from another hospital in the BMI group to ensure that the hospital would still be able to offer cancer services. We were told nurses were rotated when delivering chemotherapy in order that patients felt comfortable with all members of staff.
- Across the endoscopy and oncology units, there was very little use of bank or agency staff. Any use of such staff was infrequent.

Medical staffing

- It was a requirement of BMI Healthcare's practising privileges (PP) policy, that consultants remained available (both by phone and, if required, in person) or arranged appropriate alternative named cover if they were unavailable at all times when they had inpatients in the hospital. In addition to clinical and consultant arrangements, the management team operated a rota for on call support out of hours.
- Consultants for oncology were on-call whenever they had a patient in the hospital, we saw consultant contact details posted clearly in the staff room, and details were

also available in patient notes. Staff told us they had no problems getting hold of consultants and that the resident medical officer (RMO) was always visible and contactable 24 hours a day.

Major incident awareness and training

- The hospital had a comprehensive suite of policies to cover a wide range of situations that could affect the care they provided. They had a set of action cards that gave information about what to do in the event of any incidents. These included, but were not limited to problems with utilities, loss of essential equipment, loss of access to internet and telecoms, loss of connection to BMI corporate IT services, support services, loss of premises and global threats such as bomb threats or suspicious packages. All of these incident cards were available to staff online.

Are medical care services effective?

Good

We rated the effectiveness of medical services at the BMI The Esperance Hospital as good. This was because;

- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet these learning needs. Staff were supported to maintain and further develop their professional skills and experience.
- The hospital had a means of ensuring staff had access to training which enabled them to undertake their role safely and effectively. The BMI learn system gave a comprehensive overview of what training staff had completed any outstanding training, as well as any training to support staff to develop in their roles.
- We saw there was good working across the teams and with other parts of the BMI group. This was particularly apparent in the oncology unit where a teleconference across the organisation had been held to exchange ideas and share learning on how to improve the unit and improve the patient experience.

Evidence-based care and treatment

- The oncology care pathway was consistent across the BMI group and did not vary from one hospital to the next.
- The hospital participated in the BMI wide collection of data that was published on their website. This showed their performance in a number of areas compared with the average scores across BMI, the lowest and highest scores. Comparisons were shown in a number of different categories, including patient safety, patient satisfaction, cleanliness and incidents.
- Nurses in endoscopy told us how they kept up to date with changes in guidance and policies. They explained how the consultants at the hospital provided updates on any changes in National Institute for Health and Care Excellence (NICE) standards and explained how they affected their work. Any changes were then updated in policies and protocols both locally and across the BMI group.

Pain relief

- Patients' pain was recorded on the National Early Warning Scores (NEWS) chart. The NEWS is a standardised chart for assessment and response to acute illness.
- Patients told us their pain was well managed and anticipated. We heard from a patient who described staff taking precautions and sending for a doctor at the first sign of difficulty with their pain. We saw this documented in the patient's notes.

Nutrition and hydration

- All patients we spoke with during the inspection told us that they had received food as and when required. They were also able to request any drinks they wanted.
- The hospital underwent a Patient Led Assessment of the Care Environment (PLACE) had a food satisfaction rating of 93.4%

Patient outcomes

- Patient outcome data was compared with all hospitals across BMI Healthcare using the corporate clinical dashboard that gathers the data from the group incident database and patients' satisfaction results. BMI Healthcare contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS .

- The hospital participated in national programmes as applicable to services. Local outcome data was audited through incident analysis: for example, unplanned readmission rates, infection rates and transfers, complaints and patient satisfaction results.
- Results were reported monthly to heads of department meetings, applicable individual monthly departmental meetings and at daily huddles. Corporate clinical governance bulletins with actions to be implemented were sent to the hospital on a monthly basis, these included patient outcomes trends, areas requiring actions, sharing of lessons learned and examples of good practice. Areas where these outcomes showed a negative deviation were subject to recommendations and actions that were monitored through the appropriate committee.

Competent staff

- We saw comprehensive records of all staff trained in delivering chemotherapy. Competence was assessed annually through a review of chemotherapy administration competence. This was an assessment supervised by a senior member of staff who would sign off the practitioner's competence. Part of this assessment included looking at the practitioners understanding of the potential complications of administering cytotoxic chemotherapy in relation to allergic or hypersensitivity reactions and what actions would need to be taken.
- The BMI learn system contained details of a staff member's training. This included mandatory training as well as other developmental training. It was categorised into learning I have to do, learning I would like to do, face-to-face bookings and record of learning. There was also a dashboard that would capture all of this information. Training records held in BMI learn were fed in to the member of staff's objectives. This was a very well designed and simple system to use to record staff training. It also allowed staff to take ownership of their own development.
- The BMI learn system also fed into the manager's balanced scorecards and monitored staff compliance with mandatory training. Ultimately, this meant that the annual appraisal of any manager, who had less than 90% of staff completing their mandatory training, could be impacted.
- There was a protocol in place for cleaning the scopes. Before staff were responsible for cleaning scopes, they would have to have completed training.
- Any new staff to the endoscopy suite were trained how to use the equipment by a member of staff from the equipment provider.
- Four staff we spoke with told us that they were given regular appraisals and that any training needs were identified through that process. Further training identified could then be booked online.
- One member of staff told us that due to recent staff shortages, they had missed a pre-booked training course, as they had been required to work.
- Staff we spoke with had completed their appraisals.

Multidisciplinary working

- Two nurses we spoke with told us of good working relationships with the consultants that worked in the endoscopy unit. There were clear channels of communication and all consultants were considered accessible.
- We were told how the staff in the oncology unit had engaged in an inter-organisational teleconference about the future shape of the oncology unit. The purpose of the meeting was to exchange ideas and share learning on how to improve the layout of unit and improve the patient experience.
- Patients' bloods were taken the day before chemotherapy treatment and sent to pathology at the local NHS hospital. The results were then e-mailed to the consultant to review. This showed that a process had been established to ensure patients received chemotherapy without delay.
- Oncology patients had access to regular physiotherapy if needed. We spoke with a patient who had accessed this service following treatment described how helpful this was to aid recovery.

Seven-day services

- Resident medical officers (RMO) provided a 24 hour service on a rotational basis. The RMO would work for seven days before handing over to the next. All RMOs working at the hospital were selected on their experience specifically to enable them to manage the hospital's mix of patients and particular requirements. All RMOs were required to be trained in Advanced Life

Support (ALS). In addition, there was always a senior nurse available at the hospital during the day as a contact point for both staff and patients, including helping resolve queries.
- During the night, an on call rota ensured the same level of service and supported the acceptance of out of hour's admissions.

Access to information

- We were shown a file that contained all relevant policies for the endoscopy suite as well as instruction manuals on how to use the various pieces of machinery including the Gettinge cleaning machine and the reverse osmosis machine. All policies were also available online.
- We were shown the full intranet site, which had a wide range of information available for staff to access. We also saw how all of the HR based systems were accessible. The systems were easy to use. There were sufficient computers to allow staff the opportunity to access any information they needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence within a patient's notes where pre-assessment had documented a mental health disorder. Staff were able to tell us about the care pathway that was put in place to provide extra support for the patient before, during and after the procedure with the help of staff, relatives and known carers.
- Two sets of patient notes that were reviewed showed that patients were appropriately consented prior to their procedure taking place.
- Staff members in oncology were aware of do not attempt cardio pulmonary resuscitation (DNACPR) but could not give an example where it had been used.

Are medical care services caring?

Good

We rated the caring in medicine, at BMI The Esperance hospital, as Good. This was because:

Staff displayed a genuine, respectful, kind, caring and compassionate approach to patient care. Patients we spoke to were overwhelmingly positive about the care they received from all staff encountered. Patients described staff that went the extra mile and the care they received exceeded their expectations. We saw a highly motivated staff who sought to make changes and help create better environment for patients and staff alike. Patients spoke enthusiastically about the hospital, staff and environment. We saw people being treated as active partners in their care and staff committed to working in partnership with the patients and their loved ones.

Compassionate care

- We looked at over 50 patient questionnaires relating to medical care, all were overwhelmingly positive about the care received. Some examples included, "excellent, just excellent." In addition, "I wouldn't change a thing, staff wonderful, rooms clean five star service."
- The Esperance Hospital participated in the national friends and family test scheme to gather patient feedback. Friends and Family test results showed results of 98% and above for the period July 2015 to December 2015. A score above 50% was considered a positive indication that patients would recommend the hospital to family and friends, with 100% being the highest possible result. Response rates were in line with or better than the national average for the same period.
- Staff treated patients with kindness and warmth. A patient we spoke with told us how she had woken up at 4am, as she was anxious about upcoming treatment. The doctor delivering the treatment was due at 7am and the nurse on duty sat with the patient for over two hours reassuring her and talking through her worries. This showed the dedication staff had towards patients and the positive impact this had on the patient's wellbeing.
- BMI used the nationally recognised '6cs' to deliver commitment, care, compassion, competence, communication and courage. These values did not feed into the appraisal system, but staff we spoke with felt they were embedded into everyday working. We witnessed staff delivering highly compassionate care.
- We observed staff delivering care discretely, shutting doors and always knocking before entering patient's rooms.
- We spoke with a patient who said all the staff were "Amazing, you can see they really care." Another described feeling, "So safe, so cared for, everyone is so kind."
- We observed staff supporting oncology patients in a caring and compassionate manner whilst administering chemotherapy. There was evidence of a good rapport

between patients and nurses and staff demonstrated professionalism and knowledge that provided reassurance and support to their patients during treatment.

Understanding and involvement of patients and those close to them

- Nurses were assigned to patients at the beginning of each shift. We saw genuine and caring staff and patient interaction. The patients we spoke with knew and referred to doctors and nurses on a first name basis.
- The oncology unit had two patients on the day of our inspection. One patient we spoke with talked about how they considered the care they received had been excellent. They were happy with the environment in which they were being treated, the consistency in the staffing and the fact they had never had to wait before being seen.
- Patients we spoke with were particularly pleased with how they felt they could ask any question, that the answers would always be given honestly and that no question was "silly." They also praised the staff for admitting that sometimes they did not have the answers to questions, but where possible, they would try to find answers for them.
- Patients told us they felt informed about their care plans and progress. A patient's relative told us they felt part of the decision-making process and was included in discussions with doctors and nurses. She spoke of the reassurance she received from all staff and described how this helped her when leaving her sister in hospital, as she could see how happy and relaxed she was and knew she would be well looked after in her absence.
- Another patient's spouse explained how they felt that they were treated as equals and they both felt well supported going through what was a sometimes challenging and difficult process.
- The majority of patients in oncology ranged in age from their early thirties to mid-eighties. Staff on the unit encouraged patients with young children to bring them to hospital throughout their treatment. Staff felt this helped the child feel included in the treatment process and increased the child's understanding alleviating any fears they may have. Although there was no policy in relation to this, staff demonstrated they understood the need to be adaptable to different circumstances.
- Oncology nurses provided patients with information on discharge, should they have had any concerns when not attending for treatment. Patients had access to a 24-hour phone line directly linking them with the oncology nurses.

Emotional support

- The hospital provided advice on counselling services that could be accessed by patients. We saw information leaflets and bedside information on services available and spoke with a patient who was aware of the availability of this service if they required it.
- Nurses referred patients to a psychologist if they felt it was beneficial.
- A patient we spoke with described feeling in control of her treatment and felt her relative was included in all discussions with doctors. We witnessed several interactions between staff members and patients in which first names were used and there was genuine warmth between the patients and staff.
- Staff referred to the importance families played in oncology treatment and how they saw the patients' family as an extension of the patient. We saw nurses talking to family members in a professional but friendly way and addressing both patient and relative when discussing treatment.

Are medical care services responsive?

Good

We rated the responsiveness of BMI The Esperance Hospital as good. This was because:

The process for reviewing and responding to complaints was well managed. We saw good discharge arrangements and good links with other BMI hospitals as well as outside agencies.

Patients' needs were identified and provisions made to ensure appropriate planning was made to meet their needs. Visitors were welcome at any time, including overnight and the hospital offered flexibility and choice centred around continuity of care.

Good

Medical care

Both oncology and endoscopy services were under improvement reviews which aimed to maximise the space available, increase numbers of patients being treated and improve patient experience and flow.

Service planning and delivery to meet the needs of local people

- We saw that the facilities in endoscopy and oncology were appropriate for the services provided. There were improvements planned in both these areas to further extend the facilities and allow a greater number of patients to access the services provided.
- GPs referred NHS-funded patients choosing to have endoscopy procedures at the hospital via the NHS "choose and book" system. This was an electronic referral system for NHS patients. The system gave patients a choice of hospital, and the date and time of their first consultation.
- The hospital did not have set visiting times, therefore patient's relatives could visit at any time convenient to them. There were facilities for relatives to stay overnight if needed. Patients we spoke with praised the flexibility of this arrangement.
- Patients' bloods were taken the day before chemotherapy treatment and sent to pathology at Eastbourne District General Hospital. The results were then e-mailed to the consultant to review. These showed processes had been established to ensure patients received chemotherapy without delay.
- Oncology nurses provided patients with information on discharge, should they have any concerns between periods of treatment. Patients had access to a 24-hour phone line, directly linking them with the oncology nurses. We heard from a patient who had accessed this service after becoming unwell. She told us she was advised to go into accident and emergency as a precaution following chemotherapy. She was told what to say on arrival to ensure she received timely treatment. The patient told us it was extremely re-assuring and helpful to know someone was at the end of the phone. We saw evidence of this documented in the patient's notes.
- There was a local protocol for the treatment of febrile neutropenia, febrile neutropenia occurs when a patient has a fever and a significant reduction in a type of white blood cells, known as neutrophils, which are needed to fight infections. The protocol had been agreed between the oncologists and microbiologist. These medicines were available within the hospital with enough stock to treat for a minimum of 72 hours.
- Patients and their relatives had access to a range of drink and snack options 24 hours a day. Staff in oncology understood the need to be flexible when patients were receiving chemotherapy as the treatment can affect patients' appetite.

Access and flow

- Pre-assessment clinics offered a choice of appointments between 7am and 6pm, Monday to Friday. The hospital also ran occasional Saturday morning pre-assessment clinics. This enabled patients to choose an early morning or evening appointment if they found it difficult to attend during the daytime, for example because of work commitments.
- Patients in endoscopy were given a private room to get changed. They were collected from their room and escorted to the theatre for the procedure. After they had spent time in recovery, they returned to this room and could stay as long as they needed to recover.
- Oncology patients were collected from the main hospital waiting area, as there was no separate waiting area available. Staff members from outside of the oncology department took patients to the room where they would be receiving treatment. One staff member we spoke with felt that that this was not ideal, as they would prefer to walk with the patient to the room as this gave more time for the patient to adjust to their surrounding and for introductions.
- Discharge planning in oncology began on the patient's arrival. Staff told us that delays were rare and patients were kept informed during all stages of discharge. Patients described feeling fully informed of any discharge delays.
- Oncology and endoscopy patients were able to access treatment through their insurance companies or fund their treatment privately. Endoscopy services also included NHS referrals. All insured patients had preauthorisation obtained for their treatment by hospital staff prior to administration of the medication. Self-pay patients had signed a self-pay agreement.
- The Esperance Hospital is a member of The Sussex Critical Care Network, ensuring good links with local hospitals should a patient's condition deteriorate. Policy states, whilst awaiting transfer a nurse patient ratio of

1:1 will be effective to ensure the patient is transferred in the safest situation possible. All transfers were recorded on a clinical incident form, which was inputted onto the Sentinel system, reported to the M.A.C. and clinical governance committee.

- We were shown a 'red book', which was provided to all oncology patients and kept with them at all times. The red book showed the patient's condition and their medicine regime as well as personal and contact details in the event that the patient needs emergency care outside of the hospital. All patients were given the number of the oncology nurse to contact between the hours of 9am and 5:30pm. Patients were also given an emergency out of hours contact number.
- Consultants for oncology were on-call whenever they had a patient in the hospital, we saw consultant contact details posted clearly in the staff room, and details were also available in patient notes. Staff told us they had no problems getting hold of consultants and that the resident medical officer (RMO) was always visible and contactable 24 hours a day.
- Referral to treatment targets were set at 90% in-line with national targets for NHS patients. This target was met for all admitted, non-admitted and incomplete patients throughout the period January to December 2015, ensuring that patients received treatment in a timely manner.

Meeting people's individual needs

- Staff were aware, prior to admission of any patients who required extra care. Endoscopy patients had a pre-assessment appointment a few days before admission. Additional needs were determined at this stage and appropriate care pathways implemented. Oncology staff were aware pre admission of people with extra care needs and services planned and delivered to cater for their extra needs accordingly.
- Dementia passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient's individual needs. Patients with learning disabilities also had individual care passports. However, we did not see any completed passports as there were no patients living with dementia or learning disabilities in endoscopy or oncology at the time of our inspection.
- However, we saw patient's health records clearly identifying a pre-existing mental health issue. Staff explained specific procedures that were taken to keep both the patient and staff safe. Detailing how they dealt with the patient's complex needs, for example, by including the relatives and carers in all decisions and allowing them to be with them at all times.
- Translation services were available via the telephone. Patients needing this service were identified on admission. A ward manager we spoke with had witnessed this working well on several occasions. Staff members informed us they would not have used a family member for any interpreting. Staff explained that this was because they could not guarantee the objectivity of a patient's relative. The policy was contained on file and was readily available online.
- A new initiative of visiting therapies was being trialled in oncology. The service invited patients to mindfulness sessions as well as other complimentary therapies such as reflexology and reiki. The first session was free, with following sessions paid for by the patient for a small fee.
- Patients in oncology had access to a range of leaflets explaining their condition and treatment. These included Macmillan Cancer Research leaflets with clinical information about types of cancers, managing signs and symptoms and other relevant subjects. These were available in large print and available to order in other languages if necessary.
- The oncology department was on the ground floor with wide corridors, doors and large private rooms, which were easily accessable if people required wheelchairs. Endoscopy was located on the first floor and could be accessed via a lift or wide staircase.
- We saw drinks machines and water dispensers available for waiting patients in waiting areas.

Learning from complaints and concerns

- Complaints were logged onto a complaints database; we saw staff use the database and they reported it to be user-friendly. Specific complaints were discussed with department heads and reported at the monthly head of departments meetings.
- The hospital aimed to respond to formal complaints within 20 days. All complaints were logged on a central database that alerted staff if the complaint had not been dealt with within this timeframe. This ensured complaints were not forgotten about or lost in the system. Informal complaints were dealt with on the ward and all patients received a follow up call 48 hours

after discharge to ensure they were happy with the outcome. This showed there were robust procedures to ensure patients were happy with the outcome of informal complaints.

- A patient told us about a complaint they had in oncology that they raised with the nurse at the time. They explained it was taken seriously and dealt with immediately. The patient's sister said "It was reassuring to be taken seriously even through it was a relatively small issue." We were told the patient received a phone call the next day from the manager to check she was happy with the outcome.
- A clinical governance committee discussed all complaints and learning points alongside any themes or trends on a monthly basis. This ensured all complaints were learnt from and themes identified early.
- We saw complaints leaflets throughout the building as well as information beside patient's beds clearly explaining how both NHS patients and private patients could complain. This showed an open culture and understanding of a patient's right to complain.
- We were told about a complaint regarding the way the oncology department had communicated with patients following the resignation of a consultant. The consultant had resigned and left within two weeks. Patients were not notified of this and one patient in particular complained because they were expecting to see their regular consultant. While these were exceptional circumstances, the oncology lead learned from this and changed policy to ensure all patients were contacted in the event of any changes to staffing personnel during their care.

Are medical care services well-led?

Good

We have rated the leadership of medical services at the BMI The Esperance Hospital as good. This was because;

- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and were taking action to address them. Performance information was used to hold management and staff to account.
- The manager of the services in the oncology unit had been seconded to the role to cover a staff vacancy. They split their responsibilities between The Esperance Hospital and another BMI hospital nearby. The appointment of the manager, albeit on a part time basis, demonstrated the commitment the executive had to ensuring the continuity of cancer care at the hospital. The manager had led and been proactive in making efforts to improve the oncology unit.
- We also saw that the endoscopy unit have begun the process in order to achieve Joint Advisory Group (JAG) on GI endoscopy accreditation.

Vision and strategy for this this core service

- The medical services provided at The Esperance Hospital were limited in that they dealt predominantly with oncology and endoscopy.
- The current executive management team had a clear vision for the oncology unit. The first aspect of this was to get a permanent lead for the team.
- Staff wanted to be able to re-shape the environment they currently worked in to improve the service they provide. They also wanted to make changes to the physical environment that could increase the number of patients they were able to treat.

Governance, risk management and quality measurement for this core service

- The oncology lead held regular team meetings with staff where standing agenda items included incidents, training and the cancer care strategy.
- The oncology lead then fed in to the director of clinical services. Immediately above the director of clinical services was the interim director of operations. The director of operations then ultimately reported in to the executive director.
- The heads of the departments and the executive team all fed in to the medical advisory committee and could have, if necessary, cascaded information back to the staff.
- A clinical governance report was prepared and discussed at the clinical governance committee, medical advisory committee and quality and risk meetings.
- The executive team at the hospital had four key priorities in terms of governance and this applied to all services including medicine. They were working towards further embedding the process for reporting incidents or

near misses, improving mandatory training compliance, identification and review of risks through the risk register and to continue with monthly feedback / learning to staff.
- The endoscopy unit, in addition to the collection of data to support JAG accreditation was working to improve the quality of service they provided by developing the corporate software and reviewing the patient pathway.
- Complaints training was delivered to the heads of departments by the group quality and risk manager.

Leadership and culture of service

- The oncology lead had been seconded part time, to BMI the Esperance Hospital in mid-March 2016 from another hospital in the BMI group and were working two days per week. The reason they were seconded was to cover the previous lead who had resigned from the hospital. The lead had been appointed to provide support for the rest of the team.
- BMI had a 6c's corporate stance (values). They were commitment, care, compassion, competence, communication and courage. However, these values did not feed into the appraisal system. This was because the appraisal system was described as being more 'self-assessment'.
- The new manager of the endoscopy unit, who was based in surgery, visited staff in the unit every day.
- Although staff were visited once a day, formal meetings that were scheduled weekly had not been taking place due to all staff being busy.
- We were also told that in some circumstances, managers tended to be reactive rather than proactive. Given the changes to the management team across the hospital this was in some way to be expected, so can be considered a neutral finding.

Public and staff engagement

- Following the results of the staff survey, BMI had revealed areas where action was needed. A draft action plan was published in June 2016. This highlighted all areas for improvement and where possible, target dates for action were provided.
- All patients attending either the oncology or endoscopy unit had the chance to feedback their thoughts on the care they received via a questionnaire. The questionnaire varied from unit to unit however both provided patients the opportunity to state what went well and where there could be improvement.
- People attending the endoscopy and oncology units were encouraged to participate in the friends and family test. This included the NHS patients who attended the endoscopy unit.

Innovation, improvement and sustainability

- The endoscopy unit was, at the time of inspection going through the process of applying for Joint Advisory Group (JAG) on GI endoscopy accreditation incorporating the endoscopy global rating scale. Staff advised us there was still a lot to do and that there were issues with the environment, which may be a barrier. Staff were hopeful that they would be able to achieve the accreditation in 2017.

Requires improvement

Surgery

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

Information about the service

Surgery is the main inpatient activity within the hospital. Surgical services cover a range of specialties including orthopaedics, ophthalmic (eye), cosmetics and general surgery. The hospital only treats adults aged 18 and over and does not provide services for children.

Between January and December 2015, there were 4,295 visits to theatre. The most common procedure in 2015 was intravitreal injection of pharmaceutical agents (injection of drugs into the eye) to treat conditions such as age-related macular degeneration (loss of central vision). Intravitreal injection of pharmaceutical agents accounted for 503, or 11.7% of, procedures. Lumbar epidural injection, to treat back pain, was the second most common procedure and accounted for 495 or 11.5% of, procedures in 2015. The NHS funded 57% of inpatient procedures in 2015. Out of 3,651 inpatient procedures, the NHS funded 2,095.

The theatre suite has three operating theatres, three recovery bays and two anaesthetic rooms.

Theatre two has a laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). General, orthopaedic, and urology surgeries take place in this theatre. Theatre one does not have laminar flow. Gynaecology, urology, maxillofacial, ophthalmology (eye), ear, nose and throat and dermatology (treatment of skin conditions such as mole removal) procedures take place in theatre one. We did not inspect theatre three as the hospital use this theatre solely for assisted conception procedures, which do not fall under Care Quality Commission's regulatory remit.

Both inpatient and day case patients recover from surgery on Devonshire ward. Devonshire ward has 16 single bedrooms, one double room and a two-bedded enhanced recovery unit. All patient bedrooms have ensuite bathroom facilities. The hospital was also a BMI Healthcare pilot site for ambulatory care. Ambulatory care is surgery on an outpatient basis without admission onto a ward. Ambulatory care patients spent a short time in a single-sex recovery area after surgery before discharge home.

We visited all clinical areas including theatres, ward areas and the preoperative assessment clinic during our inspection. We also undertook an unannounced visit the week after our announced inspection.

During our inspection, we spoke with 26 members of staff including doctors, nurses, allied health professionals, administrative staff and the executive team. We spoke with eight patients and one patient relative. We also received two patient comment cards with feedback from patients who had surgery at the hospital. We reviewed ten sets of patient records and a variety of hospital data including meeting minutes, policies and performance data.

Requires improvement

Surgery

Summary of findings

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

- We found that the hospital managers may be obtaining false assurance from their audit results as we found that compliance with WHO and staffs understanding of VTE screening did not meet with the assurances that hospital audit scores conveyed.
- We found that poor infection control practices were going unchallenged which could indicate that staff did not feel empowered to challenge poor practice when they saw it.
- The hospital's clinical governance committee scheduled to meet every two months. However, meeting minutes showed the committee only met four times in the last year. The clinical governance committee was responsible for ensuring the hospital used appropriate systems and processes to deliver safe, high quality patient care.
- We saw a comprehensive clinical audit schedule to provide quality assurance. However, we saw that the hospital missed some scheduled audits. For example, the hospital did not have results for scheduled audits in IPC in January, February or March 2016. This meant the executive team might not have had up-to-date assurance of quality in some areas.
- Mandatory training compliance and staff appraisal rates were below BMI Healthcare targets.
- We saw examples of non-compliance with infection prevention and control (IPC) policies. This included staff in theatres re-using a single-use item for multiple patients.
- We also saw two members of staff enter the theatre, anaesthetic room and recovery area in outdoor clothes contrary to BMI Healthcare clinical uniform policy. One wore a watch and bracelets below the elbows, which can prevent effective handwashing. We also saw a consultant's briefcase on the floor inside theatre two. This risked the transfer of germs from the outside environment into the operating theatre.
- We saw a member of staff in the theatre suite with waist-length hair not tied back. This is contrary to the BMI Healthcare clinical uniform policy, which stated, "If hair is longer than collar length, it must be neatly tied back".
- Staff hand washing facilities on Devonshire ward fell below recommended standards.
- In the theatre suite, it was not clearly signposted as to which doors were fire doors. Staff were unclear about fire evacuation procedures. This meant the hospital might not have been able to keep patients safe in the event of a fire in theatres.
- We found staff knowledge around VTE assessment to be poor, with theatre staff checking a box to say that a VTE assessment had been completed who were then unable to show inspectors how they knew his was the case. The hospital reported two cases of venous thromboembolism (VTE) for surgical inpatients between January 2015 - December 2015. The hospital consistently did not meet their NHS contracted 95% target screening rate for VTE risk assessment throughout 2015. The lowest screening rate in this period was 52.4% between July and September 2015.
- We saw staff did not fully complete all the WHO checklist processes for two procedures during our inspection.
- We saw that some of the patient bedrooms on Devonshire ward had carpets. Carpets in clinical areas prevent the effective cleaning and removal of bodily fluid spillages and therefore pose an infection control risk. The Department of Health's HBN00-09 states, "Carpets should not be used in clinical areas". We saw a risk assessment for carpets in clinical areas dated 17 May 2016. There were no control measures on the risk assessment relating to cleaning of carpets following a bodily fluid spillage. The hospital was unable to provide evidence of regular deep cleaning of carpets. This meant carpet on the ward may have posed an infection control risk to patients.
- We saw poor practice around the disposal of sharps and the labelling of sharp containers. These practices increased the risk of sharps injury (cuts from sharp objects such as needle sticks) and potential transmission of blood-borne viruses to staff.

Requires improvement

Surgery

- We saw staff did not fully complete all the WHO checklist processes for two procedures. For one of these, we saw staff completed the WHO sign-in process, but failed to complete the time out and sign out processes.
- We observed an operation in theatre two where staff placed surgical instruments outside of the laminar flow (clean air) area. This may have compromised sterility and increased the risk of infection to the patient. We reported this to staff, who repositioned the trolley under the laminar flow. We also saw poor aseptic technique from a nurse, who almost entered the sterile field twice. A member of the inspection team stopped her from compromising sterility on both occasions, and we reported our concerns to the theatre manager after the procedure.

However:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. The hospital fully investigated incidents and shared learning from them to help prevent recurrences.
- There was sufficient emergency resuscitation equipment available and staff checked equipment regularly to ensure it was safe.
- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice.
- People had comprehensive assessments of their needs. This included consideration of clinical needs, mental health, physical health, nutrition and hydration needs.
- The hospital participated in relevant local and national audits and contributed to national data to monitor performance such as the National Joint Registry (NJR)
- Staff obtained and recorded consent in line with relevant guidance and legislation.
- Staff treated people with dignity, respect and kindness during all interactions. Patients felt supported and cared for by staff.
- The service supported patients and those close to them to cope emotionally with their care and treatment. Staff encouraged patients and their loved ones to be partners in their care.
- Services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these appropriately.
- We saw openness and transparency in how the service dealt with complaints. The service always took complaints and concerns seriously and responded in a timely way. We saw evidence the service learnt from complaints and made improvements to working practices where appropriate.
- The leadership, governance and culture promoted the delivery of high quality person-centred care.
- The hospital reported information on people's experiences through their monthly patient satisfaction surveys and reviewed this alongside other performance data.
- Leaders modelled and encouraged cooperative, supportive relationships among staff. Staff felt respected, valued and supported.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Mandatory training compliance and staff appraisal rates were below BMI Healthcare targets.
- We saw examples of non-compliance with infection prevention and control (IPC) policies. This included staff in theatres re-using a single-use item for multiple patients.
- We also saw two members of staff enter the theatre, anaesthetic room and recovery area in outdoor clothes contrary to BMI Healthcare clinical uniform policy. One wore a watch and bracelets below the elbows, which can prevent effective hand washing. We also saw a consultant's briefcase on the floor inside theatre two. This risked the transfer of germs from the outside environment into the operating theatre.
- We saw a member of staff in the theatre suite with waist-length hair not tied back. This is contrary to the BMI Healthcare clinical uniform policy, which stated, "If hair is longer than collar length, it must be neatly tied back".
- Staff hand washing facilities on Devonshire ward fell below recommended standards.
- In the theatre suite, it was not clearly signposted as to which doors were fire doors. Staff were unclear about fire evacuation procedures. This meant the hospital might not have been able to keep patients safe in the event of a fire in theatres.
- We found staff knowledge around VTE assessment to be poor, with theatre staff checking a box to say that a VTE assessment had been completed who were then unable to show inspectors how they knew his was the case. The hospital reported two cases of venous thromboembolism (VTE) for surgical inpatients between January 2015 - December 2015. The hospital consistently did not meet their NHS contracted 95% target screening rate for VTE risk assessment throughout 2015. The lowest screening rate in this period was 52.4% between July and September 2015.
- We saw staff did not fully complete all the WHO checklist processes for two procedures during our inspection.
- We saw that some of the patient bedrooms on Devonshire ward had carpets. Carpets in clinical areas prevent the effective cleaning and removal of bodily fluid spillages and therefore pose an infection control risk. The Department of Health's HBN00-09 states, "Carpets should not be used in clinical areas". We saw a risk assessment for carpets in clinical areas dated 17 May 2016. There were no control measures on the risk assessment relating to cleaning of carpets following a bodily fluid spillage. The hospital was unable to provide evidence of regular deep cleaning of carpets. This meant carpet on the ward may have posed an infection control risk to patients.
- We saw poor practice around the disposal of sharps and the labelling of sharp containers. These practices increased the risk of sharps injury (cuts from sharp objects such as needle sticks) and potential transmission of blood-borne viruses to staff.
- We saw staff did not fully complete all the WHO checklist processes for two procedures. For one of these, we saw staff completed the WHO sign-in process, but failed to complete the time out and sign out processes.
- We observed an operation in theatre two where staff placed surgical instruments outside of the laminar flow (clean air) area. This may have compromised sterility and increased the risk of infection to the patient. We reported this to staff, who repositioned the trolley under the laminar flow. We also saw poor aseptic technique from a nurse, who almost entered the sterile field twice. A member of the inspection team stopped her from compromising sterility on both occasions, and we reported our concerns to the theatre manager after the procedure.

However:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. The hospital fully investigated incidents and shared learning from them to help prevent recurrences.
- The hospital reported no serious incidents, never events or patient deaths in 2015.
- The hospital gave safeguarding sufficient priority because staff received safeguarding training to an appropriate level. Staff knew how to escalate safeguarding concerns. There was sufficient emergency resuscitation equipment available and staff checked equipment regularly to ensure it was safe.

Requires improvement

Surgery

Incidents

- The hospital reported no never events in January 2015 - December 2015. Never events are serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- The hospital reported no expected or unexpected deaths in January 2015 - December 2015.
- The hospital reported no serious injuries in January 2015 - December 2015.
- The hospital reported no serious incidents in January 2015 - December 2015. During the same period, the hospital reported 149 clinical incidents. Of these, 37 (24.8%) related to surgery.
- The hospital used an online software system for reporting incidents. Staff completed a paper form, which they submitted to the appropriate ward or theatre manager. Managers subsequently entered data from the form onto the computer system. Staff could all describe the process for reporting incidents, and gave examples of times they had done this. All staff we spoke to had confidence in the incident reporting process and felt it was an adequate system.
- Heads of departments investigated incidents with oversight by the clinical governance committee. Staff told us the relevant ward or theatre manager fed back to the team with learning from incidents at monthly ward or theatre team meetings. We saw copies of the theatre team meeting minutes, which showed clinical governance committee feedback on incidents was a standard agenda item. We also saw evidence in the minutes that managers discussed lessons learned from incidents with the team. This included changes to the local and BMI Healthcare theatre checklists following an incident involving a prosthetic eye lens.
- Staff we spoke with were aware of the Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support. Staff knew what DoC meant and could describe their responsibilities relating to it. We also reviewed three incident forms and the patient notes relating to these and saw evidence that staff had applied DoC appropriately.
- The hospital did not carry out mortality and morbidity review meetings as a matter of course. This was in part due to the relatively low number of patients treated and the consequent low numbers of patients that would fall into these categories. For example, the hospital had no patient deaths in 2015; therefore, mortality meetings were not applicable. The director of nursing told us the hospital would likely deal with any such reviews as an incident. Depending on the incident investigation outcome, the hospital may identify a risk and add this to the risk register.

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

- The safety thermometer was a national tool used for measuring, monitoring and analysing common causes of harm to hospital inpatients. These included falls, new pressure ulcers, catheter and urinary tract infections (UTIs) and venous thromboembolism (blood clots in veins).
- In 2015, the hospital reported no pressure ulcers. In 2016 to-date, there were three cases of pressure ulcers related to surgical inpatients. We saw the results of incident investigations for all three cases. These showed that in two out of the three cases, the pressure ulcers were pre-existing conditions developed before the patient attended for surgery.
- In 2015, the hospital reported two patient falls related to surgical inpatients. In both cases, the patients sustained fractures. We saw the root cause analysis (RCA) for one of the patient falls in 2015. This identified that the cause of the fall may have been an overfull catheter bag in need of emptying. The RCA showed evidence of an action plan to reduce the falls risk to other patients, and demonstrated staff had completed their required actions.
- In 2016 to-date, the hospital reported three patient falls related to surgical inpatients. None of the three patients injured themselves when they fell.
- The hospital reported no UTIs for catheterised inpatients in January 2015 - June 2016.

- The hospital reported two cases of venous thromboembolism (VTE) for surgical inpatients between January 2015 - December 2015. There were no cases of VTE in between January 2016 - June 2016.
- The hospital treated 531 inpatients in 2015. There were two VTEs and two falls in this period. This meant there were 527 episodes of harm-free care. The rate of harm-free care in 2015 was therefore 99.3%.

Cleanliness, infection control and hygiene

- We saw copies of the BMI Healthcare group's hand hygiene policy, standard infection control precautions policy, and clinical uniform policy. All these policies were in-date and referred to national guidelines, for example the World Health Organization (WHO) Guidelines on Hand Hygiene in Health Care (2010).
- However, we saw examples of non-compliance with infection prevention and control (IPC) policies. We saw two members of staff enter the theatre, anaesthetic room and recovery area in outdoor clothes contrary to BMI Healthcare clinical uniform policy. One wore a watch and bracelets below the elbows, which can prevent effective hand washing. The policy stated, "All personnel who enter the restricted area of the theatre suite should don the attire intended for use within the surgical environment".
- We saw a consultant's briefcase on the floor inside theatre two. This risked the transfer of germs from the outside environment into the operating theatre. We also saw a member of staff in the theatre suite with waist-length hair not tied back. This is contrary to the BMI Healthcare clinical uniform policy, which stated, "If hair is longer than collar length, it must be neatly tied back".
- On Devonshire ward, we saw a doctor at the nurses' station wearing medical gloves. The WHO patient safety information leaflet: Glove Use stated healthcare workers should "remove gloves after caring for a patient". Failure to remove and discard gloves immediately after patient care may result in the spread of germs across the clinical environment, to other patients and to staff.
- We met the IPC lead, who told us a hand hygiene audit in theatres in May 2016 showed only 20% compliance with hand hygiene processes. This was much worse than the target of 100%. The IPC lead gave immediate feedback to staff, and in June 2016, the hand hygiene audit improved to 80% compliance.
- We observed an operation in theatre two where staff placed surgical instruments outside of the laminar flow (clean air) area. This may have compromised sterility and increased the risk of infection to the patient. We reported this to staff, who repositioned the trolley under the laminar flow. We also saw poor aseptic technique from a nurse, who almost entered the sterile field twice. A member of the inspection team stopped her from compromising sterility on both occasions, and we reported our concerns to the theatre manager after the procedure.
- We saw the anaesthetic room doors into the corridor left open for long periods. This reduced the efficiency of the laminar flow and meant outside air containing germs was allowed into the anaesthetic room. This could potentially increase the risk of infection to patients.
- The hospital reported three surgical site infections (SSI's) in January - December 2015. Of these, one related to hip surgery, one related to other limb surgery and one related to thoracic surgery.
- We reviewed the RCA investigations for these three incidents. In two out of the three cases, the IPC lead identified surgeons used a skin preparation agent that fell below the recommended guidelines for pre-operative skin preparation. Action plans for the RCAs showed staff attended an in-house training session on an alternative skin preparation product that met the guidelines. A member of theatre staff told us the hospital changed their skin preparation agent to one that met the relevant guidelines, and we observed this in use.
- The BMI Healthcare group also updated their corporate policy for skin preparation in 2015 and obtained a corporate contract for purchasing of a skin preparation agent that met the relevant guidelines. These actions showed the hospital used appropriate measures to prevent similar events recurring.
- Two of the RCAs also identified incomplete documentation of preoperative advice given to patients. NICE guideline CG74 stated, "advise patients to shower or have a bath (or help patients to shower, bath or bed bath) using soap, either the day before, or on the day of, surgery". Action plans from the RCAs included reminding staff of the need for accurate documentation to provide assurances they acted appropriately to minimise the risk of surgical site infections.
- On Devonshire ward, we saw there were no dedicated hand hygiene sinks in patient bedrooms. Staff told us

they washed their hands before and after patient contact in the sinks in the ensuite bathrooms. This is contrary to the Department of Health's Health Building Note 00-09, which states, "healthcare providers should have policies in place ensuring that clinical wash-hand basins are not used for other purposes". The BMI Healthcare hand hygiene policy also stated, "Basins in patients' bathrooms/ensuite must never be used for hand washing by clinical staff as these sinks carry high levels of bacterial contamination due to their design and general usage".

- Furthermore, we saw that the ensuite bathroom sinks were not suitable for the purpose of hand hygiene. This was because they had plugs and overflows contrary to the Department of Health's Health Building Note 00-09: Infection control in the built environment. This states clinical wash-hand basins "should not have a plug or a recess capable of taking a plug", and "clinical wash-hand basins should not have overflows, as these are difficult to clean and become contaminated".
- The taps on the ensuite bathroom sinks in Devonshire ward were not lever or sensor-operated and staff needed to twist them on and off with their hands. This risked re-contamination of hands when turning the taps off after hand washing. It is contrary to the Department of Health's Health Building Note 00-09, which states "taps can be lever or sensor-operated and should be easy to turn on and off without contaminating the hands". However, we asked the ward's infection prevention and control link nurse how staff operated the taps after hand washing. She described how staff used a clean paper towel to cover the tap while turning it off to reduce the risk or re-contamination. We saw paper towels available in dispensers in the three ensuite bathrooms we inspected. We also saw a poster on the wall in the enhanced recovery area describing the process for reducing the risk of contamination when switching off taps that twisted on and off. However, we did not see any posters next to patient bathroom sinks to remind staff of this procedure.
- The sink in the enhanced recovery area on Devonshire ward was also unsuitable for hand washing. This was because it had an overflow, a recess capable of taking a plug, and discharged directly into the drain hole. The Department of Health's Health Building Note 00-09 stated, "Taps discharging directly into a drain hole can cause splashing, which could disperse contaminated droplets".
- However, the hospital reported no infections of MRSA, Clostridium difficile or methicillin sensitive Staphylococcus aureus between January and December 2015. We spoke to a pre-assessment nurse, who told us the hospital screened patients at risk of carrying MRSA, for example patients recently admitted to an NHS hospital, at the pre-assessment clinic.
- On Devonshire ward, all areas we inspected were visibly clean and tidy. We saw "I am clean" labels on the toilets in two patient bathrooms. This showed the housekeeping team had cleaned toilets ready for the next patients.
- We saw a single-use bougie in an opened package on an airway trolley. A bougie is a device used placed into a patient's trachea (windpipe) to keep the airway open following a general anaesthetic. This may have compromised the sterility of this device.

Environment and equipment

- We saw there were doors that appeared to be fire doors within the theatre suite. Electromagnetic retainers held these doors back. These doors automatically close in the event of a fire alarm. They were not marked as fire doors, had no fire rating on them and no intumescent strips. Intumescent strips around the edges of doors or doorframes expand under high temperatures to seal the gap between the door and the doorframe, keeping out fire and smoke.
- We asked two members of staff how they would evacuate patients. One member of staff said that once the patient was stable and safe, they would ensure the patient was behind the first set of fire doors that were away from the fire. The other member of staff said they would completely evacuate, once the patient was safe and stable, to the outside. We asked the theatre manager what was their interpretation of what should happen in the event of a fire in theatres. They asked the group fire officer who said, "Theatre complex in its entirety is the fire zone. It is inherently difficult to compartmentalise theatres in old buildings such as ours. I understand this is common practice." If this was the case, staff needed to understand the correct evacuation procedure as in a fire situation, confusion could potentially put lives at risk.
- Health Technical Memorandum 05-02: 2.1 Fire Code Guidance in support of functional provisions stated that in healthcare buildings, particularly in patient access areas, the immediate and total evacuation of the

building in the event of fire would be a major logistics exercise and, from a patient safety perspective, not desirable. Patients with restricted mobility, patients who use wheelchairs, and patients confined to bed cannot negotiate escape routes, particularly stairways, unaided. Patients under medication may require staff assistance, and patients who are dependent on electrical/ mechanical equipment for their survival cannot always be disconnected and moved rapidly without serious consequences.

- During the unannounced part of our inspection, we returned to theatres to check the information provided to us by the hospital following concerns around fire compartmentalisation in theatres. The executive team told us that the theatre as a whole was a fire compartment. We found one door between the rest of the hospital and the theatre complex labelled as a fire door that had the required intumescent strips to ensure that the door sealed in the event of a fire. This door did not have signage to show staff how long the door would hold fire back from theatres. The other two external doors, which would have sealed the whole compartment, did not have intumescent strips and only one was marked as a fire door.
- Staff we spoke with on our return visit were clear that they would evacuate theatres in the event of a fire. However, they were still under the impression that if a patient were under anaesthetic a skeleton staff number would stay with the patient until they were safe to evacuate the building. Staff were unaware that the doors around the theatre rooms did not have intumescent strips and would not seal in the event of a fire. Only 86.7% of theatre staff attended mandatory fire training in 2015. This was worse than the BMI Healthcare target of 90%.
- We saw that some of the patient bedrooms on Devonshire ward had carpets. Carpets in clinical areas prevent the effective cleaning and removal of bodily fluid spillages and therefore pose an infection control risk. The Department of Health's HBN00-09 states, "Carpets should not be used in clinical areas".
- We saw a risk assessment for carpets in clinical areas dated 17 May 2016. There were no control measures on the risk assessment relating to cleaning of carpets following a bodily fluid spillage. The hospital was unable to provide evidence of regular deep cleaning of carpets. This meant carpet on the ward may have posed an infection control risk to patients.
- We saw staff in theatres reusing items designed for single use on multiple patients. For example, we saw staff in theatre one used the same single-use transfer sheet to move four patients from the operating table to a recovery bed. This could have resulted in the transfer of bacteria and viruses between patients and posed an infection control risk. The transfer sheet may also weaken after multiple uses, causing risk of patient injury.
- We saw inappropriate use of two sharps bins. On Devonshire ward, we saw an unlabelled sharps bin that was overfull in the enhanced recovery area. We saw non-sharp items, such as gloves, discarded into the sharps bin. This contributed to over-filling. We saw another unlabelled sharps bin in theatre two. Failing to label sharps bins with the location and dates prevented the tracking of clinical waste. On one occasion, we saw a surgeon not immediately discarding sharps after use but leaving them for another staff member to discard. These practices increased the risk of sharps injury (cuts from sharp objects such as needle sticks) and potential transmission of blood-borne viruses to staff.
- We saw a broken handle on the first aid box in the theatre sluice with sharp edges. This could injure staff if grabbed in a hurry.
- Nurses told us some of the smaller rooms on Devonshire ward were difficult for wheelchair users to access due to the room size. Staff therefore allocated larger rooms to wheelchair users to enable easier access.
- However, we saw that patient baths and showers on Devonshire ward were not accessible for wheelchair users. This was because there were no level access showers. Nurses told us they helped patients with physical disabilities to wash, and we saw hoists available on the ward. However, level access showers would maximise independence for this group of patients.
- We checked 15 items on the difficult airway trolley in theatres and found all 15 were in-date. However, there was no checklist located with the trolley to provide assurance of regular checks. The hospital told us they kept records in theatres, however we did not see evidence of these on our visit.
- On Devonshire ward, we checked two emergency trolleys in the enhanced recovery area. We checked 22

items on one trolley and all were in-date. On the other trolley, we checked 20 items and only one item was out-of-date. We reported this to the senior nurse, who arranged a replacement.

- On Devonshire ward, we saw the cardiac arrest trolley clearly signposted. This served to remind staff, especially those less familiar with the ward layout, of its location in an emergency. We checked the suction unit on the cardiac arrest trolley and saw it worked. However, the suction unit did not have a sticker to show the hospital had performed portable appliance testing (PAT). The hospital told us all equipment was tested as per policy timeframes and that evidence of testing and details of when the next test was due was held centrally. However, we did not see this on inspection.
- We checked nine electrical items on Devonshire ward, and saw evidence of PAT testing for only two. The hospital told us all equipment was tested as per policy timeframes and that evidence of testing and details of when the next test was due was held centrally. However, we did not see this on inspection.
- In theatres, we checked 14 electrical items for evidence of PAT testing. We saw that all items were PAT tested; however, the PAT certificate had expired for two out of the 14 items. We saw that the hospital had not tested the forced-air warming blanket machine in theatre two, used to maintain body temperature during surgery, since 1 February 2012. In theatre one, the hospital had not checked the forced-air warming blanket machine since 2011. This meant the hospital did not have assurances about the electrical safety of these items. We highlighted this to a member of staff, who told us an external contractor performed PAT testing and the theatre team did not manage service contracts. However, staff provided evidence of an equipment list, which showed the dates of the last PAT tests so that the hospital could identify items due for testing.
- In theatres, we checked the anaesthetic machine logbooks for four anaesthetic machines. We saw staff had fully completed both logbooks with evidence of daily pre-use checks in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. This provided assurance that the anaesthetic machines worked safely.
- We checked the cardiac arrest trolley in the theatre recovery area. We saw staff had fully completed the trolley checklist throughout May and June 2016 to provide evidence they had checked items. We checked 14 items on the trolley, and all 14 were in-date. All emergency drugs were tamper-evident.
- In theatre two, we observed an orthopaedic list with two patients. We saw staff checked all surgical instruments and gauze swabs before, during, and at the end of both patients' operations. This was in line with the Association for Perioperative Practice (AfPP) guidelines.

Medicines

- On Devonshire ward, there were no accurate records of the quantity of controlled drug prescriptions (FP10) or private prescriptions (SPF100) in stock. The hospital told us the pharmacy department provided the RMO with controlled drug prescriptions on a restricted amount and recorded these. The RMO recorded the use of these individually. However, a nurse we spoke with on Devonshire Ward was not aware of any processes for recording the quantity of prescriptions in stock.
- On Devonshire ward, the temperature-monitoring checklist for the drugs fridge showed that on 10 occasions in the last month, staff had not recorded the fridge temperature. We saw that there was also a checklist for monitoring the ambient temperature of the medicines storage room. This was to ensure that drugs stored at room temperature remained within the manufacturer's indicated temperature range. We saw that on 11 occasions in the past month, staff did not record the temperature of the room. We confirmed these findings with a senior nurse, who was disappointed to find staff had not regularly monitored temperatures to ensure drug safety. However, we saw the temperature of the drugs fridge on Devonshire ward was within the expected range. We asked two members of staff, and both knew the safe temperature ranges for the fridge and at what temperatures they should take action.
- However, we saw medicines stored safely and securely on Devonshire Ward in line with relevant legislation for the safe storage of medicines. The medicines storage room had key code entry to ensure that only authorised staff could access medicines. We saw the last month's records, which showed staff had checked the level of drugs every day.
- We checked the controlled drugs (CD) cupboard on Devonshire ward. Controlled drugs were medicines liable for misuse that required special management. We

saw the CD cupboard was locked, and only authorised staff with a key could access CDs. We checked the stock levels of two CDs. We saw the correct quantities in stock according to the stock list, and that all were in-date.

- In theatre two, we saw staff check CDs appropriately. We saw accurate records of Midazolam, (a sedative) entered in the CD book showing how much the patient used and the amount wasted. However, we saw incomplete records of the amount of Midazolam used in the theatre one anaesthetic room. This was because staff blanket-signed for the drug rather than signing for individual doses. However, the daily checking process of CDs in theatres was otherwise robust.
- We found emergency drugs in the anaesthetic room fridge that staff had drawn up 15 days earlier. Leaving drugs drawn up for this length of time risked bacterial contamination and possible absorption of the drug into the plastic material of the syringe, which might reduce its effectiveness. We reported this to the theatre manager, who safely discarded the drugs immediately.
- We checked temperature monitoring charts for the drug fridges in anaesthetic room one, theatre two and recovery. The records showed staff had monitored the temperature of both fridges daily in the last month. All temperatures fell within the safe ranges, and staff had not missed any checks. This provided assurances the theatre team stored refrigerated drugs within the correct temperature range to maintain their function and safety.
- We reviewed three prescription charts on Devonshire ward and found them legible and mostly completed appropriately. However, we saw that for one patient, staff had not signed and dated for two out of 11 prescriptions. We saw evidence of antibiotic assessment for all three patients. The hospital did not prescribe antibiotics for any of the three patients whose records we saw in line with their antibiotic assessment policy. We saw evidence of prescribing in line with national guidance. For example, we saw VTE prophylaxis indicated and prescribed for two out of the three patients following VTE assessment in line with National Institute for Health and Care Excellence (NICE) guideline CG92: "Venous thromboembolism: reducing the risk for patients in hospital".
- Staff recorded patient allergies on the patient's prescription chart. One of the patients had an allergy, and we saw the patient wearing a wristband that alerted staff of this.
- Pre-packed to take out (TTO) medicines were available on Devonshire ward. Nurses told us medical staff prescribed TTO medicines and the hospital pharmacy team dispensed them from a central cupboard. We saw patient labels attached to TTO medicines, with the prescribed dose and frequency documented on the label. We saw a nurse check TTO medication to ensure it was correct. Nurses told us they confirmed the patient's personal details with them and counselled the patient on the dosage and possible side effects of the medicine before discharge.
- Staff told us porters checked the oxygen cylinder levels in theatres every two hours throughout the working day and replaced any empty cylinders. However, there was no checklist to provide any assurance of checking.
- There was an oxygen leak on the pipework in theatre recovery This made it even more important to have assurance staff checked the oxygen cylinders, as empty cylinders would have resulted in a disruption in the supply of therapeutic oxygen. The hospital told us they had installed new pipework; however, this was not connected at the time of our visit. The hospital told us they had arranged for an external company to connect this on 3 July 2016.

Records

- We spoke with a member of the administration team, who explained the arrangements for the transfer of NHS notes to and from the hospital. She explained that The Esperance Hospital porters transferred NHS notes between the local NHS hospital and The Esperance Hospital The porters transported the notes inside sealed, tamper-evident envelopes to maintain security and prevent unauthorised access to patient notes. We saw the envelopes used. We saw the electronic spreadsheet completed by the administration team to track the movement of NHS notes in and out of the hospital. The administration team assured us that notes never left the hospital by any other route to ensure data security in line with the Data Protection Act 1998.
- We examined the records for four patients on Devonshire ward. Staff stored notes securely in the nurses' office to prevent unauthorised access to confidential patient data. We saw a good standard of documentation in some areas. For example, all four patients had care plans that identified all their care needs. We saw staff had fully completed all four care plans. We saw some patients followed standardised

pathways, such as a general surgery pathway. This was personalised through individual risk assessments and notes made in the care plans. We saw thorough evidence of pre-assessment in all four sets of notes.

- However, we saw that although patients and staff had fully completed surgical consent forms, in three sets of patient notes staff had not securely filed the consents. We also saw loose pathology results in three sets of patient notes. Failure to effectively file paperwork risked confidential patient data falling out. This risked unauthorised access to confidential data and accidental loss of essential medical information.
- In one set of notes, we saw a dietary requirements form filed incorrectly for the wrong patient. Poor record keeping such as this risks staff giving a patient food or fluids that is unsuitable for their needs. We reported this to a nurse, who took it out immediately and found the correct set of notes for re-filing.

Safeguarding

- All ward and theatre staff received level two training in safeguarding vulnerable adults and safeguarding children. Overall hospital compliance in mandatory safeguarding training in 2015 was 97.62%. This was better than the BMI Healthcare target of 90%. On Devonshire ward, 100% of ward staff received safeguarding level two training in 2015. In theatres, all except one member of staff (94%) completed level two safeguarding training in 2015.The hospital did not treat children under 18 years of age. Therefore, theatre and ward staff received an appropriate level of training to enable them to identify and escalate safeguarding concerns.
- Additionally, the sister on Devonshire ward attended internal and external level three safeguarding training. The director of clinical services was the safeguarding lead for the hospital. She had also trained to level three. Again, this was an appropriate level of training for the services the hospital provided.
- Staff could identify the safeguarding lead and described how to report safeguarding concerns. We saw a poster describing the safeguarding reporting process displayed on a wall in the corridor outside theatres. This served to remind staff of the correct reporting processes.
- The safeguarding lead told us she felt staff knew the process for raising safeguarding concerns in the hospital, and gave us an example of a time they had done this. The hospital reported two safeguarding concerns between January and December 2015. Neither of these related to surgery.

Mandatory training

- Overall mandatory training rates for surgical staff were 86.7% in 2015. This was worse than the BMI Healthcare target of 90%. The theatre team meeting minutes from 6 June 2016 stated the hospital was the third worst hospital in the BMI Healthcare group for mandatory training compliance.
- There were 27 mandatory training courses for surgical staff. This was a combination of online and classroom-based training. Staff completed the appropriate number and type of courses from this list relevant to their role. For example, managers completed an additional equality and diversity module as well as the one completed by all staff groups.
- Mandatory training courses covered the following areas: Acute illness management; blood transfusion; pain assessment and management; adult advanced life support, adult basic life support; adult immediate life support; control of substances hazardous to health; data protection; display screen information; documentation and legal aspects; equality and diversity; fire safety; infection prevention and control; information security; the Mental Capacity Act and deprivation of liberty safeguards (DoLS); medical gases; moving and handling; safeguarding vulnerable adults; safeguarding children; safety, health and the environment and Prevent. (Prevent training was the Government's response to help counter the extreme ideologies that recruit vulnerable people and to offer guidance and support to those who are drawn to them).
- In 13 out of 27 mandatory training courses, theatre staff achieved compliance rates better than the 90% target in 2015. However, for the remaining 14 courses, completion rates were worse than the 90% target. The worst performing areas were acute illness management for registered nurses (0% compliance), adult basic life support for non-clinical staff (50% compliance), and medical gases- practical (64.7% compliance).

Assessing and responding to patient risk

- We observed theatre staff carrying out the WHO Surgical Safety Checklist for four procedures. The WHO checklist was a national core set of safety checks for use in any

operating theatre environment. The checklist consisted of five steps to safer surgery. These were team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre), and debrief. For two procedures, we saw staff fully completed all the required checks.

- We observed staff using specific WHO checklists for different procedures, for example for eye surgery. This ensured staff checked the most important safety factors relating to a specific procedure.
- The hospital performed monthly World Health Organization (WHO) checklist audits on ten sets of patient notes each month. The purpose of this was to check staff compliance with the WHO Surgical Safety Checklist. Audits assessed completion of 18 out of the 28 questions on the WHO checklist. We saw audit data for the five months before our inspection. This showed 100% completion of all applicable areas of the checklist assessed between February and June 2016
- However, we saw staff did not fully complete all the WHO checklist processes for two procedures. For one of these, we saw staff completed the WHO sign-in process, but failed to complete the time out and sign out processes. For another procedure, we saw staff ticked the box on the WHO checklist to confirm VTE assessment/prophylaxis where applicable. However, when we asked staff where they had seen evidence of VTE assessment, they were unable to show us and seemed unsure of where to find this. Following further investigation, the inspection team found the patient's VTE assessment with their medication chart. We reported the lack of staff awareness around checking for VTE assessment to the theatre manager. The manager told us she would address this issue with staff.
- The hospital consistently did not meet their NHS contracted 95% target screening rate for VTE risk assessment throughout 2015. The lowest screening rate in this period was 52.4% between July and September 2015.
- However, during our inspection, we checked four sets of patient notes on Devonshire ward and found all four had a complete VTE risk assessment. We also saw patients wearing compression stockings to help prevent VTE post-surgery where the risk assessment indicated this.
- Theatre staff told us they checked the pregnancy status of female patients of potential childbearing age on the morning of planned surgery by asking them for the date of their last menstrual period (LMP). We saw a space on the hospital's pre-operation checklist to record this. However, guidance from the National Patient Safety Agency in their 2010 Rapid Response Report: Checking pregnancy before surgery highlights "the unreliability of LMP as a sole indicator for potential for pregnancy". Staff told us they did not routinely perform a urine test for pregnancy on female patients before surgery. We saw a patient in theatres who was unable to remember her last LMP pre-operatively. Staff subsequently asked her to provide a urine sample for pregnancy testing. This delayed her operation to later on in the list, as she could not immediately provide a urine sample before surgery.
- We reviewed four sets of patient notes on Devonshire ward, and saw evidence of thorough pre-assessment of risk for surgery in all four files. This included falls risk assessment, dementia screening, infection prevention and control risk assessment, risk assessment for pressure ulcers and assessment of nutritional status. These assessments were vital to assess a patient's suitability for surgery and to enable staff to make any necessary adjustments to ensure safe care. For example, staff allocated patients at increased risk of falls to bedrooms closest to the nurses' station where possible.
- The hospital used the National Early Warning System (NEWS) track and trigger flow charts. NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. We reviewed three patients' NEWS charts. Staff had completed all three accurately and fully. We saw evidence of increased monitoring and intervention when clinically indicated in line with national guidance.
- The hospital's resident medical officers (RMOs) provided medical cover 24 hours a day, seven days a week. This ensured nurses could always quickly escalate any issues concerning a deteriorating patient. The RMO also informed the patient's consultant in an emergency so that they could provide consultant-level care.
- The hospital did not have any level two or three critical care beds. To mitigate this risk, the hospital only operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.

- The hospital had a service-level agreement with a local NHS hospital. This enabled them to transfer any patients who became unwell after surgery and needed critical care support. We saw evidence of agreed standards for the transfer of critically ill patients with local NHS ambulance services and NHS hospitals. We also saw the BMI Healthcare group policy used by the hospital for the emergency transfer of patients to specialist units outside of BMI Healthcare. However, this policy had been due for review since January 2016. The hospital told us BMI Healthcare had a process according to the development and management of procedural documents policy that allowed documents that had exceeded the planned review date to remain in use until superseded.
- We saw a hospital report on patient transfers to the local NHS hospital. This showed the hospital transferred 15 patients to the local NHS hospital between January 2015 and June 2016. Of these, 12 patient transfers related to surgery.
- Staff told us any patients who developed complications following discharge could contact the nurses on Devonshire ward any time, day or night. We saw a copy of the discharge pack given to patients, and this included a 24-hour contact number direct to the ward. We also saw a nurse give this information to a patient she discharged.

Nursing staffing

- The theatre department had 15.1 whole time equivalent (WTE) staff on 1 January 2016. The team consisted of one WTE nurse manager, three WTE nurse team leaders, 2.6 WTE nurses, 2.7 WTE care assistants and 5.9 WTE operating department practitioners (ODPs).
- The theatre department had the full establishment of care assistants and operating department practitioners, with no staff vacancies in these areas. However, the hospital reported a 15% vacancy rate for registered theatre nurses on 1 January 2016.
- On the day of our visit, we saw staffing levels met the AfPP guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. We saw there were three scrub practitioners in theatre two, which exceeded the minimum recommended standards.
- However, theatre staff told us staffing levels in theatres sometimes fell below AfPP guidelines. This meant staff were sometimes unable to take a break during a busy list. We asked the hospital how many times staffing levels fell below AfPP guidelines in the three months before our visit. The hospital told us that on average, staff numbers fell below the recommended level on 14% of operating lists. This was usually because agency staff decided not to attend for their shift at the last minute. However, managers risk assessed all operating lists where this happened and the theatre manager carried out clinical shifts to help make up the numbers. We asked theatre staff, who confirmed the theatre manager provided clinical cover when needed. The hospital told us if the outcome of risk assessment indicated it was unsafe to continue, managers would cancel the operating list.
- On Devonshire ward, we saw the actual versus the planned numbers of staff for the morning of our visit and the day before. We saw that the expected number of staff was two nurses and two healthcare assistants (HCAs) on all shifts. We saw that actual staffing levels met the expected numbers on all shifts.
- The hospital used the BMI staff planning tool. The planning tool calculated the nursing hours and skill mix needed for the planned patient numbers and acuity levels. The hospital told us they used the tool to plan the appropriate number of hours and skill mix needed to meet demand five days in advance, with continuous review on a daily basis. The hospital told us they also entered the actual hours staff worked retrospectively to understand variances from the planned hours and the reasons for these.
- The hospital told us a senior nurse was a nominated contact for both staff and patients each day. During the night, the hospital had an on-call senior nurse rota to ensure the same level of service and to accept out of hours admissions.
- In all except three months of 2015, the hospital did not use any agency theatre staff. In the months of June, November and December 2015, the hospital used a small number of agency theatre nurses. Agency nurses represented only 2% of total nursing staff in theatres in June 2015, 2% in November 2015 and 8% in December 2015. Theatre departments did not use any agency care assistants or ODPs in 2015.

- However, the hospital reported an average of 36% use of bank and agency nurses on Devonshire ward between January 2015 and June 2016.
- We saw a nursing handover on Devonshire ward. We saw clear and concise information sharing. However, there was no safety briefing to highlight patients who may have needed additional nursing care, such as those at risk of falls or pressure ulcers. Staff coming in and out of the room caused constant interruptions during the handover.

Surgical staffing

- The hospital used an international agency to provide 24-hour, seven days a week RMO cover on a rotational basis. This ensured a doctor was on-site at all times of the day and night should an emergency arise. The RMO we spoke to worked a shift pattern of three weeks on followed by two weeks off.
- The RMO conducted regular ward rounds to ensure patients were safe. We saw the RMO providing medical cover on Devonshire Ward. The RMO reported any changes in a patient's condition to their followed the consultant's advice regarding further treatment.
- Staff told us most consultants were approachable and reacted quickly in emergencies. However, a member of staff told us two consultants were often uncontactable and did not make themselves available in these situations. This behaviour was contrary to BMI Healthcare's practising privileges policy, which required that consultants remained available, both by telephone and, if necessary, in person, at all times when they had inpatients in the hospital. The policy also stated a consultant must arrange appropriate alternative named cover for their patients if they were unavailable. A member of staff gave us an example of a time they transferred a deteriorating patient to a local NHS hospital. The patient's consultant was uncontactable and disinterested once they did eventually make contact. A member of staff reported this as a clinical incident, but told us they had not yet received feedback from the hospital.
- Anaesthetists were available for the first 24 hours after a patient's operation. This ensured availability of anaesthetic cover should a return to surgery become necessary. The RMO told us anaesthetists were contactable and approachable when needed.
- Staff told us RMOs carried out a formal handover. However, we did not see this as there was no change over during our visit

Major incident awareness and training

- The hospital provided scenario-based training exercises for major incidents. We saw evidence that nursing staff completed a major haemorrhage training scenario on 2 May 2016. Nursing staff told us they found this a useful exercise. The RMO also told us they took part to help keep their skills up-to-date.
- We saw the hospital's business continuity policy. The policy was in-date and produced with reference to the NHS England Core Standards for Emergency Preparedness, Resilience and Response (May 2015) and ISO 22301 Business Continuity Management Systems Requirements. The policy set out clear roles and responsibilities to ensure service continuity in the event of a business continuity incident.
- The hospital had a back-up generator to ensure services could continue in the event of a disruption to the main power supply. We saw weekly generator checking records for the eight months before our inspection. These showed staff checked the generator, including the oil, water and diesel levels, each week. Staff also ran the generator for one hour every month to test that it worked. We saw monthly generator testing records for the three months before our inspection. Generator testing records provided the hospital with assurance that the generator would provide back-up power and enable services to continue in the event of a power failure.

Are surgery services effective?

Good

We rated effective as good because:

- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice.
- People had comprehensive assessments of their needs. This included consideration of clinical needs, mental health, physical health, nutrition and hydration needs.

- The hospital routinely collected and monitored information about people's care and treatment, and their outcomes. The hospital used this information to improve care.
- The hospital participated in relevant local and national audits and contributed to national data to monitor performance such as the national joint registry.
- Staff obtained and recorded consent in line with relevant guidance and legislation.
- Staff could access the information they needed to assess, plan and deliver care to people in a timely way.

However:

- There was a low rate of staff appraisals in theatres, although we saw evidence the theatre manager was taking action to address this.
- Agency staff records on Devonshire ward did not show that all staff had demonstrated competency in all required areas before being signed off as competent to work unsupervised. This meant the hospital might not have had assurance all agency staff had the necessary induction to enable them to work competently on the ward without direct supervision.

Evidence-based care and treatment

- All protocols we saw were in-date and referred to national guidance. For example, we saw that the policy for "provision of blood components in a massive haemorrhage" referred to relevant guidance from the National Patient Safety Agency (NPSA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI).
- We saw the BMI "Safety Alerts Management Policy" used by the hospital. This set out the processes for communication of NPSA and Medicines and Healthcare Regulations Authority alerts to all relevant staff. Staff told us managers effectively communicated updates to policies and practices at team meetings following any revisions to national guidance. For example, staff told us that last year; the theatre team changed the skin preparation agent they used on patients before surgery to bring this in line with NPSA guidance.
- In theatres, and in the patient notes, we saw evidence of the hospital providing surgery in line local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, we saw evidence of antibiotic assessment in four sets of patient notes, along with prescription (or non-prescription) or prophylactic antibiotics in line with the guidance.
- We reviewed three patient records, which all showed, evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient's health post-surgery. Staff had completed all three observation charts in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.
- We observed patient care carried out in accordance with national guidelines and best practice recommendations. This included enhanced recovery after surgery (ERAS) following knee and hip replacement. The enhanced recovery programme aimed to speed a patient's recovery after surgery and improve patient outcomes by reducing the risk of complications associated with a longer hospital stay. The interim lead nurse told us ERAS data from hospitals across the BMI Healthcare group was benchmarked nationally against other independent healthcare providers.
- There were specialist clinical pathways and protocols for the care of patients undergoing different surgical procedures. We reviewed two patient pathways- the hip and knee replacement pathway and the general surgery pathway. Both were fully completed and easy to understand.
- The hospital provided data to the National Joint Registry (NJR). The NJR collected information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor the performance of joint replacement implants.
- The service provided breast enlargement surgery. The hospital signed up to contribute information for inclusion in the national Breast and Cosmetic Implant Registry (BCIR). Similar to the NJR, the purpose of the BCIR was to monitor the performance of implants, specifically breast implants. National implementation of the BCIR had not yet taken place at the time of our inspection. However, the hospital showed us a local register they kept in preparation for transfer of records to the BCIR once this was launched. This was in line with best practice guidance.
- Staff told us the service referred all cosmetic breast surgery patients to the breast care nurse pre-surgery. This was in line with the Royal College of Surgeons (RCS)

professional standards for surgery 2016. This helped identify any psychologically vulnerable patients for further support before cosmetic surgery. However, we checked three sets of cosmetic breast surgery notes and found no confirmation of input from the breast care nurse. We asked a senior member of staff, who was unsure of where staff recorded this information.

Pain relief

- We spoke to two patients who had recently undergone surgery. Both told us their pain was well controlled and said nurses responded quickly when they requested additional pain relief.
- Nurses on Devonshire ward asked patients whether they had any pain as part of their hourly ward rounds. We reviewed three sets of patient notes, which showed evidence of pain assessment as part of hourly ward rounds.
- We saw the use of a pain assessment tool and analgesia ladder in four sets of patient notes we reviewed. Staff asked patients to rate their pain between one and 10, one meaning no pain and 10 being extreme pain. The analgesia ladder set out guidelines for the management of pain
- There was no dedicated pain team at the hospital. However, consultant anaesthetists with an interest in pain relief gave advice on pain management.

Nutrition and hydration

- The hospital used the Malnutrition Universal Screening Tool (MUST) as part of pre-assessment screening. The MUST tool enabled staff to identify patients at risk of malnutrition and make adjustments to mitigate any risk where appropriate. We reviewed four sets of patients notes, which all provided evidence of MUST assessment.
- All four patient sets of notes included a "dietary requirements record" completed as part of pre-assessment. This allowed staff to identify any special dietary requirements, such as gluten intolerance, before admission so they could advise the catering staff to prepare a suitable meal for the patient.
- An external contractor provided pre-cooked food for the hospital. We reviewed patient menus and saw a balanced variety of choices. This included options for vegetarians. The hospital also catered for other cultural needs, such as halal and kosher, on request. One patient we spoke to, who was unhappy with the choice of food, told us the catering staff cooked alternative meals for her that were not on the menu.
- Patients told us nurses offered them drinks as part of their hourly ward rounds. We also saw patients had access to a water jug at their bedside to enable them to stay hydrated.

Patient outcomes

- The hospital provided data to national Patient Reportable Outcomes Measures (PROMS). PROMS used patient questionnaires to assess the quality of care and outcome measures following surgery. The hospital provided PROMS data from three areas: hip replacements (Oxford Hip Score), knee replacements (Oxford Knee Score) and groin hernia (EQ-5D and EQ VAS indexes).
- However, the hospital did not have enough data available to calculate average health adjusted scores for PROMS in any of the three areas in 2014-15. This was because PROMS was an NHS programme, and therefore providers could only collect PROMS data for NHS-funded patients.
- The hospital's PROMs data showed seven out of seven patients reported health improvements under the Oxford Knee Score criteria following primary knee replacement between April 2014 and March 2015. This was the most recent confirmed data available at the time of inspection.
- In the same period, six out of six patients reported health improvements following primary hip replacement under the Oxford Hip Score criteria.
- For the 15 NHS-funded patients treated for groin hernia in 2014-15, nine reported their health had improved following surgery, two felt their health had worsened, and four reported no change in their health under the EQ-5D criteria. Under EQ VAS measures for the same 15 patients during the same reporting period, the health of nine patients had improved, three had worsened, and three were unchanged following groin hernia repair. The EQ-5D profile, asked patients to report on their health based on self-assessed levels of problems ("no", "some"," extreme"). The EQ-VAS questionnaire asked patients to describe their overall health on a scale that ranged from "worst possible" to "best possible" health.

- Due to the small numbers of patients involved, these findings cannot be compared to national data. The PROMs programme required at least 30 patients in each category to calculate average health adjusted scores and compare these outcomes to other hospitals.
- The hospital told is it compared patient outcome data with all hospitals across BMI Healthcare group using the corporate clinical dashboard. BMI Healthcare also contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS.
- The hospital reported seven unplanned returns to theatre between January and December 2015. There were 4,295 total visits to theatre during the same period. The rate of unplanned returns to theatre varied between 0.1% and 0.3% during 2015. The highest rate of unplanned returns (0.3%) was in October 2015 - December 2015.
- We reviewed incident forms for six out of the seven unplanned returns to theatre. For three of these, we also reviewed the patient notes. In one case, the patient returned to theatre for an additional pain relief procedure. For the other five, post-operative complications were the reason for further surgery, although we saw there were no common themes. In all cases, we saw evidence staff treated patients with post-operative complications appropriately. All patients had good outcomes following further surgery.

Competent staff

- We saw staff give an agency operating department practitioner (ODP) a thorough orientation to theatres on their first day at the hospital. This included a tour of the department, including the location of emergency equipment and fire exits. We saw a comprehensive introductory check sheet in use to demonstrate the competency of new agency staff.
- We reviewed induction records for staff on Devonshire ward. We saw that agency and bank staff completed a comprehensive induction alongside a member of permanent staff to assess their competencies in areas including local policies and controlled drugs.
- We reviewed induction records for 14 members of agency staff who had started working on Devonshire ward in 2016. For six of these, we saw agency staff had demonstrated competence in all required areas and a member of permanent staff has signed the person off as competent to practice unsupervised.
- However, for eight out of the 14 records, we saw an assessor had signed off the “induction check sheet for agency/bank staff” but the agency staff member had not demonstrated competence in all areas. Areas where agency staff had not fully completed the checklist included medical devices on the ward; the bleep system; Duty of Candour; location of medical/ emergency equipment; incident reporting; departmental policies and evidence of mandatory training record. This meant the hospital might not have had assurance all agency staff had the necessary induction to enable them to work competently on the ward without direct supervision.
- We saw that all theatre staff had a competency folder containing evidence of continuing professional development (CPD), such as certificates. These showed that staff kept their knowledge current through continuous learning, which is required to maintain professional registration with the Health and Care Professions Council or the Nursing and Midwifery Council.
- The hospital reported all ODPs and all registered nurses working in inpatient departments had validation of professional registration on 1 January 2016.
- We saw competency records for a surgical first assistant/ lead surgery practitioner. These showed that the first assistant was competent to assist consultants during surgery.
- No theatre staff received an appraisal in 2015. In 2014, only 37% of theatre nurses, 33% of ODPs and 33% of care assistants in theatres received an appraisal. Lack of appraisals for theatre staff may have meant the service did not address any potential staff performance issues.
- However, the theatre manager showed us evidence that eight members of theatre staff had an up-to-date appraisal. She also showed us evidence she was taking action to address the poor appraisal rate. We saw a document showing that nine further members of the theatre team had appraisal dates booked between the time of our visit and the end of July 2016. This accounted for all members of the team who were not on long-term leave, except one.
- Hospital data showed that over half of all doctors with practicing privileges (52%) carried out over 100 episodes of care between January and December 2015. A further 15% of doctors with practicing privileges carried out between 10 and 99 episodes of care in the same period.

This showed that over three-quarters of doctors (78%) worked at the hospital regularly and were therefore more likely to be familiar with hospital policies and procedures.

- As part of consultant re-validation, the hospital told us it completed a standard form for submission as part of consultants' annual appraisals at their normal place of work. The chair of the hospital's medical advisory committee raised specific issues relating to consultant practice directly with the consultant's responsible officer.
- We saw thorough and robust records of consultants' competencies. This included the following data on all practising consultants: Profile, proof of identity, reference, CV, qualifications and CPD, responsible officer, right to live and work in the UK, self-declaration of fitness to practice, signed practicing privileges and general correspondence. We also saw a copy of the application form for the granting of practising privileges. It was comprehensive and included a 14-point checklist for documentation consultants had to supply. A member of staff gave us an example of a consultant who was not awarded practicing privileges because they were unable to supply all the necessary evidence.
- The interim director of clinical services was not aware of any issues where the hospital had revoked a consultant's practicing privileges. However, she demonstrated awareness of the process for dealing with any competency or behavioural issues involving consultants with practicing privileges.
- The interim director of clinical services told us the hospital compared outcome data for individual consultants. However, she was unsure of how the hospital fed this information back to consultants.
- The hospital told us they selected RMOs based on their experience to manage the mix of patients and their particular requirements. An international agency provided RMOs to the hospital. The agency required all new doctors to attend a one-week UK based induction programme followed by further skills checking at a one-to-one induction day before they started a new rotation. New RMOs were also required to attend a three-day work shadow period at the hospital with an experienced RMO.
- The agency provided RMOs with up-to-date advanced life support training (ALS). We spoke to an RMO who confirmed they had annual BLS training and ALS training every four years. This was in line with current guidance from the Resuscitation Council (UK).
- The hospital had verification of registration status for 100% of doctors and dentists working under practicing privileges who had worked at the hospital for more than one year. Where DBS checks or MDU certificates had passed their date the hospital chased staff members for up to date certificates. We saw evidence of two consultants who had been sent a warning letter to supply an up to date DBS check. They were given two weeks to supply this or their practising privileges would be revoked.

Multidisciplinary working (in relation to this core service only)

- Care planning took place at pre-assessment with input from the multidisciplinary team. We reviewed four sets of patient notes, which showed involvement from consultants, nurses and allied healthcare professionals such as physiotherapists.
- We saw copies of the pre-assessment questionnaire patients completed before coming to pre-assessment clinic. Part of the questionnaire asked questions to help identify a patient's needs for after discharge. For example, it identified whether the patient had someone at home to support them and whether they had access to a downstairs toilet. This enabled the hospital to arrange additional support if needed.
- The hospital liaised with district nurses to arrange ongoing care for patients post-discharge where appropriate. Staff on Devonshire ward were able to describe the process for arranging district nursing care. Staff completed and sent a specific form to local community services to arrange post-discharge care. A nurse told us staff always made a follow-up telephone call to the district nurses to check care was in place before they discharged a patient.
- We saw a nurse on Devonshire ward discharge a patient. We saw the nurse give the patient a discharge pack. This included detail of ongoing care the surgery team had arranged, for example, outpatient follow-up appointments and physiotherapy. The nurse discussed the next steps with the patient and their partner. This allowed them to leave the hospital fully informed about the patient's ongoing care.

- The multidisciplinary theatre team met monthly, and we saw minutes from the last two meetings.
- The theatre manager met with other heads of departments within the hospital. We saw meeting minutes that showed heads of departments met once a month.
- We saw good multidisciplinary working between consultants, anaesthetists, nurses and ODPs in theatres. We also saw good team working between theatre staff and a radiographer.
- We observed effective multi-disciplinary working between the RMO and nurses on Devonshire ward during the RMO's ward round.

Seven-day services

- Theatre lists in theatres one and two ran Monday to Friday, 8.30am to 12:30pm and 2pm to 5.30pm. The hospital told us occasional Saturday sessions ran between 8.30am and 12.30pm, although staff agreed these as needed.
- Although there were no scheduled operations at the weekend, theatre staff participated in an on-call rota. The on-call rotas covered the hours of 8pm to 8am on weekday nights, and 24 hours on Saturdays and Sundays. This ensured staff were available should a patient need to return to theatre out-of-hours. As very few patients needed to return to theatre (the hospital had seven unplanned returns to theatre in 2015), staff told us they rarely needed to come into work when they were on-call.
- We saw the BMI Healthcare practicing privileges policy for consultants. The policy required consultants to be available by telephone, and in person if required, 24 hours a day whenever they had a patient in the hospital. This ensured inpatients recovering from surgery over the weekend had 24-hour access to consultant input if needed. If a consultant was not available, the policy required them to arrange for another consultant to provide 24-hour cover.
- Anaesthetists were available for the first 24 hours after a patient's operation. This ensured availability of anaesthetic cover should a return to surgery become necessary.
- Devonshire ward was open seven days a week to care for patients after surgery that needed to stay in hospital over the weekend.
- The diagnostic imaging department provided a 24-hour a day, seven day a week service for urgent examination requests. This allowed staff to access diagnostic services in a timely way to support clinical decision-making.
- The hospital pharmacy team provided cover Monday to Friday, 8.30am - 5pm. Outside these hours; staff told us the resident medical offer (RMO) could dispense urgent prescriptions. We saw a copy of the out-of-hours pharmacy policy, which reflected this.
- Pre-assessment clinics ran between 7am and 6pm Monday to Friday. We spoke to a pre-assessment nurse, who told us they occasionally ran Saturday morning clinics when needed.

Access to information

- We saw a learning room available in the theatre suite where staff could readily access folders containing local policies and procedures. This information was also available to staff on Devonshire ward in the nurses' office. We saw computers available where staff could access national guidance via the internet.
- The hospital held patient notes on-site. As well as keeping confidential patient data safe, this ensured timely access to information needed for patient care. We reviewed four sets of patient notes. All four contained sufficient information to enable staff to provide appropriate patient care. This included diagnostic test results, care plans and risk assessments.
- We spoke with a ward clerk on Devonshire ward, who told us the nurses completed a discharge summary for every patient. The nurses passed this form onto the ward clerks to update the computer system with details of the patient's discharge. The ward clerks sent a copy of the discharge form to the patient administration office to communicate to the consultant's secretary when a patient left the hospital. The consultant secretaries subsequently sent a letter dictated by the consultant to the patient's GP informing them of the patient's surgery. This ensured continuity of care within the patient's community.
- For NHS patients, the hospital transferred the patient's NHS notes from the local NHS hospital. The hospital held the NHS notes on-site while the patient was under the care of The Esperance Hospital. This enabled staff to access to all relevant medical information to enable continuity of care. After staff discharged NHS patients, the hospital transferred their NHS records back to the local NHS hospital to enable ongoing care.

Requires improvement

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 14 consent forms for surgery. Patients and staff had fully completed, signed and dated the consents to ensure they were valid. Consent forms contained no abbreviations so that the patient could fully understand what they were consenting to. We also saw examples of consent forms with the percentage rate of different complications relating to the patient's procedure. This showed staff had fully informed patients of the possible risks and obtained informed consent.
- We saw that staff obtained patient consent in advance of the day of the procedure. This was in line with guidance from the RCS Good Surgical Practice 2014, which states staff should "obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision".
- However, as part of our unannounced inspection, we reviewed three files of patients who had cosmetic breast surgery. We saw that in all three cases, staff obtained consent on the day of surgery. This did not comply with the guidance stated above.
- We saw a copy of the hospital's "Consent form four- statement of healthcare professional for adults who are unable to consent to investigation or treatment". This documented the best interests' decision-making of staff for patients who lacked capacity in accordance with the Mental Capacity Act 2005.
- Hospital mandatory training records showed 87.5% of surgical staff received training in the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS). This was worse than the target rate of 90%.
- Staff on Devonshire ward were aware of DoLS for patients who lacked capacity. However, a longstanding member of staff on the ward told us they had never needed to apply for a standard authorisation from the local authority. A standard authorisation gave permission for hospital staff to restrict a patient's liberty who lacked mental capacity when this was necessary and proportionate to keep the patient safe from avoidable harm.
- We asked a senior nurse what action they would take if a patient who lacked mental capacity needed bed rails because of being at high-risk of falls. The nurse told us they would perform a bed rails risk assessment. They were not aware that the hospital should apply for a standard authorisation under the Mental Capacity Act 2005 in these circumstances as bed rails would deprive the patient of their liberty to move freely out of bed.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback from people who used the service and those who are close to them was positive about the way staff treated people.
- Staff treated people with dignity, respect and kindness during all interactions. Patients felt supported and cared for by staff.
- Staff encouraged patients and their loved ones to be partners in their care.
- Staff respected people's privacy and confidentiality at all times.
- The service helped people and those close to them cope emotionally with their care and treatment.

Compassionate care

- Between July and December 2015, friends and family test scores ranged between 98.4% and 100%. This showed that the vast majority of patients would recommend The Esperance Hospital to their family and friends. Survey response rates varied throughout this period, with the lowest response rate of 24.8% recorded in September 2015 and the highest response rate of 64.0% in October 2015. However, in every month during this period, response rates were the same as, or better than, the average England response rates for NHS patients.
- We saw BMI Healthcare patient satisfaction survey reports for the six months before our visit. Each month, the BMI group collated and analysed responses from questionnaires given to patients. The survey compared the performance of different hospitals in the BMI group. This allowed Esperance to benchmark its performance.
- BMI Healthcare patient satisfaction reports showed the vast majority of patients were happy with the care they received from hospital staff. The most recent data from

117 patients treated between March and May 2016 showed 100% of patients were happy with the care they received from theatre staff. This was better than the BMI average of 98.2% for the same period.

- We saw patients received compassionate care from staff in theatres. For example, we saw staff checking that patients were comfortably warm.
- We also saw theatre staff arrange for a member of the team who spoke the same first language as the patient to care for her in recovery after her surgery. Although the patient spoke English and did not require an interpreter, this allowed her feel more comfortable and relaxed communicating in her first language while she recovered from a general anaesthetic. We saw warm, caring interactions between the nurse and the patient. We also saw that the same nurse had collected the patient from the ward before her operation to provide continuity of care.
- We spoke to three surgical patients on Devonshire ward, who all told us they were very happy with care from nursing staff. One patient told us the nurses were "first rate". Another said the staff were "wonderful".
- There was a board inside the entrance to Devonshire ward displaying comments from patients about their experiences of care. We saw eight patient comments, which were all very positive. These included "staff are all nice and friendly"; "all staff are lovely- great service and the best healthcare I have ever had"; and "staff are all very helpful, kind, caring and conscientious".
- We received two patient comment cards from patients who recently had surgery at the hospital. Both were very positive about the care they received. One described the care as "first class all the way". The other, from a patient who had undergone several operations at the hospital, said they had always received very good care.
- We saw that staff always respected patients' privacy and dignity. We saw staff in theatres closing the curtains around patients in recovery to protect their privacy when they needed to open the recovery door. We saw that staff on Devonshire ward always knocked on patients' bedroom doors to check the patient was happy for them to come in before they entered.
- Two inpatients we spoke with on Devonshire ward were dressed in their own clothes and out of bed. This showed staff encouraged patients to mobilise and feel as normal as possible while staying in hospital.

Understanding and involvement of patients and those close to them

- A BMI Healthcare patient satisfaction report showed 100% of patients at the hospital felt they were involved in decisions about their treatment between March and May 2016. This was better than the BMI Healthcare average of 99.7% for the same period. The hospital received survey responses from 117 patients during this period.
- We spoke to three patients, who all told us their consultants kept them well informed at every stage. A patient who had stayed on the ward for one week told us her consultant had visited her every day. This allowed patients to be partners in their care.
- However, during our visit, staff in theatres identified that a patient needed a urine pregnancy test to rule out the possibility of pregnancy before surgery. This resulted in a delay in the patient's operation until later the same day. We spoke to the patient and her relative, who told us that although staff apologised for the delay, they did not fully explain the reasons behind it. This prevented the patient from being fully informed and involved in her own care.
- On Devonshire ward, there were two teams of nurses and healthcare assistants- a green team and a blue team. Each team covered eight patient beds. Although patients did not have a named nurse, this enabled patients to become familiar with a small number of staff. This allowed continuity of care for patients and their relatives.
- The service involved patients' relatives and people close to them in their care. Patients told us, and we saw for ourselves, that staff provided their visitors with hot and cold drinks. We saw staff involved patients' relatives in their treatment at all stages of their hospital visit, from admission to discharge.
- In a BMI Healthcare patient satisfaction survey, 98.5% of patients at the hospital said their family and people close to them were able to talk to a doctor if they wanted to between March and May 2016. This was about the same as the BMI average of 98.4% for the same period. In the same survey, 94.6% of patients were satisfied with the hospital's care of their visitors. This was better than the BMI Healthcare average of 93.7% for the same period.
- We saw a copy of the hospital's "Consent form four- statement of healthcare professional for adults who are

unable to consent to investigation or treatment". This form, for patients who lacked capacity to consent to treatment, had a section documenting the involvement of the patients' family and others close to them. The form recognised that while relatives and friends cannot provide consent on the patient's behalf, it was important to involve them in the patient's care. However, we did not see any completed examples of this form, as there were no patients who lacked capacity at the time of our visit.

- We saw the notes of a patient whose consultant advised them to give up smoking before having surgery. This demonstrated the consultant encouraged the patient to manage her own health. The patient subsequently gave up smoking and later returned to the same consultant for surgery.
- In most cases, the hospital provided self-paying patients with a fixed price treatment package. This gave patients peace of mind that the hospital would not add any unexpected costs to their bill. Written information given to self-paying patients was very clear of the requirement to pay their bill before treatment started.

Emotional support

- We saw staff in theatres providing emotional support to patients who were worried or anxious. For example, we saw a member of staff holding a patient's hand during a procedure to provide comfort and reassurance.
- The hospital provided counselling services for patients. We saw counselling leaflets available for patients, which contained details of how to book an appointment. Trained counsellors provided this service five days a week, Monday to Friday. The service was available to patients before, during and after their diagnosis and treatment to help them cope emotionally. Patients' family and friends could also access the counselling service.
- A specialist breast care nurse provided support to patients undergoing cosmetic breast surgery.
- Inpatients told us their family and friends could visit them any time during their stay. Patients also had telephones in their bedrooms. This allowed patients to receive emotional support from their loved ones while they recovered from surgery.
- Staff on Devonshire ward telephoned all patients 48 hours after discharge to check on their recovery. This enabled patients to feel supported by staff after they left the hospital.
- The BMI Healthcare patient satisfaction survey showed 98.6% of patients treated between March and May 2016 felt they were able to discuss any worries or fears about their treatment with hospital staff. This was about the same as the BMI Healthcare average of 98.8% during the same period.

Are surgery services responsive?

Good

We rated responsive as good. This was because:

- The hospital planned and delivered surgical services in a way that met the needs of the local population.
- Services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these appropriately.
- The service made reasonable adjustments and took action to remove barriers for people who found it hard to use or access services.
- We saw openness and transparency in how the service dealt with complaints. The service always took complaints and concerns seriously and responded in a timely way. We saw evidence the service learnt from complaints and made improvements to working practices where appropriate.

Service planning and delivery to meet the needs of local people

- Services provided reflected the needs of the local population. The most recent census data showed there was a higher percentage of people aged 60 and over living in the local area compared to the England average. For example, 8.1% of people in Eastbourne were age 75 to 84, which was higher than the England average of 5.5%. The hospital subsequently offered a range of surgeries to treat age-related conditions. This included eye surgery to treat age-related conditions such as macular degeneration (loss of central vision) and cataracts. The hospital also provided a high proportion of joint replacements, and orthopaedic surgery accounted for 26% of all work at the hospital.
- Patients having surgery attended for elective procedures such as hip and knee replacements and eye injections. Due to the elective nature of surgery at the hospital, service planning was relatively straightforward because the workload was predictable.

Requires improvement

Surgery

- Between January and December 2015, NHS care commissioning groups (CCGs) funded 2,095 inpatient/ day case procedures at the hospital. This accounted for 57% of all inpatient/day case procedures. GPs referred NHS-funded patients choosing to have surgery at the hospital via the NHS "choose and book" system. This was an electronic referral system for NHS patients. The system gave patients a choice of hospital, and the date and time of their first consultation.
- The theatre manager reviewed operating lists in advance. This ensured there was sufficient time to arrange all necessary staff and equipment.
- The hospital used the BMI Healthcare staff planning tool to plan appropriate staffing ratios based on the planned number of patients. However, staff told us they occasionally took later breaks or shorter breaks on particularly busy days. Staff told us they were sometimes able to take extra breaks on quiet days to make up for this. This ensured the service maintained a consistent level of patient care regardless of how busy it was.
- We saw that the facilities in theatres were appropriate for the services provided. For example, there were sufficient operating theatres and recovery space for the number and type of operations.

Access and flow

- On arrival at the hospital, staff showed surgical patients to their rooms on Devonshire ward. Patients changed and prepared for surgery in their room. Staff then escorted patients to the theatre suite for their operation. Immediately after surgery, staff cared for patients in the recovery room. Once patients were stable and pain-free, staff took them back to the ward to continue recovering. Patients designated a responsible adult to collect and escort them home from the ward after discharge. Day case patients went home the same day, and inpatients stayed on the ward for one or more nights after surgery.
- Patients having some day case procedures, such as some types of eye surgery used the ambulatory care pathway and did not go onto the ward. Ambulatory care patients waited in a designated waiting room with other patients of the same sex. The hospital told us they ran separate male and female operating lists. These ensured patients did not have to share the waiting room with patients of the opposite sex. These patients went home following assessment in the recovery room after their procedure.
- The hospital cancelled only five out of 4,295 procedures on the day of planned surgery for non-clinical reasons in 2015. The hospital cancelled procedures for four of these patients due to consultant sickness. The hospital cancelled the fifth due to over-running of a theatre list.
- Throughout our visit, theatre lists generally ran on time. Staff delayed one patient's operation until later in the list. This was because the patient needed to provide a urine sample to rule out the possibility of pregnancy before her surgery started. The patient told us staff apologised for the delay. She said staff regularly checked she was ok while she waited to go to theatre.
- Referral to treatment waiting times (RTTs) for NHS-funded patients having inpatient surgery at the hospital showed that, on average, 93% of patients received treatment within 18 weeks of referral in 2015. This was better than the national target of 90%.
- The hospital met the RTT target for inpatient surgery in every month of 2015. Although NHS England abolished the national target in June 2015, the hospital continued to treat 90% of more of its inpatients within 18 weeks of referral for the rest of the year. The worst months in this period were May and September, where 90% of patients received treatment within 18 weeks of referral. The best months were March, April and August, where 97% of patients received treatment within 18 weeks.
- Pre-assessment clinics offered a choice of appointments between 7am and 6pm, Monday to Friday. The hospital also ran occasional Saturday morning pre-assessment clinics. This enabled patients to choose an early morning or evening appointment if they found it difficult to attend during the daytime, for example because of work commitments.
- Theatre staff participated in an on-call rota. Consultants were on-call whenever they had a patient in the hospital. Anaesthetists were on-call for the first 24 hours after a patients operation. This system ensured staff were available should a patient need to return to theatre at night or at a weekend.
- At discharge, nurses gave patients a direct telephone number to the ward in their discharge pack. Patients could call this number to speak to a nurse anytime of the day or night if they had any concerns. We saw a discharge pack and observed a nurse give this information to a patient at discharge.

Meeting people's individual needs

Requires improvement

Surgery

- We reviewed four sets of patient notes and all provided evidence of dementia screening. A pre-assessment nurse told us all patients aged 75 and over completed a dementia-screening questionnaire as part of pre-assessment for surgery. This enabled staff to identify patients who may lack capacity and provide them with appropriate care to meet their needs.
- A pre-assessment nurse told us patients living with dementia and their carers completed a "dementia passport" as part of the pre-assessment process. Staff on Devonshire ward told us all patients living with dementia attended for surgery with their dementia passport. Dementia passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient's individual needs. Patients with learning disabilities also had individual care passports. However, we did not see any completed passports as there were no patients living with dementia or learning disabilities on the ward at the time of our visit.
- The hospital told us all clinical staff completed a one-off dementia awareness course. This gave staff an awareness of dementia to enable them to provide responsive care to people living with dementia.
- A pre-assessment nurse told us staff in the pre-assessment clinic created an alert form for patients living with dementia or learning disabilities. The purpose of this was to alert clinical staff to the patient's individual needs. This allowed staff to plan effectively, for example by arranging theatre lists in a way that lessened anxiety for patients with learning disabilities.
- Staff told us the hospital could book interpreters for both NHS and private patients. A pre-assessment nurse told us staff identified any language requirements at the pre-assessment stage. This allowed administrative staff to arrange interpreters in advance of surgery. However, as the service treated very few patients who did not speak English, staff told us they rarely needed to use interpreters. A nurse on Devonshire ward told us only two or three patients had used interpreters in the last year.

Learning from complaints and concerns

- The hospital's website provided clear information on how to make a formal complaint. Printed information was also available throughout the hospital.
- The hospital received 28 formal complaints in 2015. Of these, only three related to surgery. This suggested that surgical patients were generally happy with the treatment they received, or that the surgery team managed to resolve patient concerns informally. Themes for all three complaints were clinical treatment.
- We saw complaint responses for the last six complaints relating to surgery. In four out of the six complaints, we saw the hospital sent a formal response within 20 working days in accordance with its complaints policy. If the hospital was unable to provide a full response within this timeframe, they told us they aimed to send a "holding letter" explaining this to the complainant.
- From complaint responses, we saw the hospital fully investigated patient complaints. We saw complaints were a standard agenda item on the hospital's clinical governance committee meetings.
- We saw the hospital was open and honest in its responses. In one complaint we reviewed, the hospital apologised for an anaesthetic error. This was in line with the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014.
- We saw evidence of learning from a complaint involving a wrong-site anaesthetic block. This included displaying "stop before you block" posters prominently in theatres. The posters served to remind staff to perform all necessary checks before setting up an anaesthetic injection. We saw the posters were clearly visible during our visit.
- In four out of the six complaint responses we reviewed, the hospital gave details of how the complainant could escalate their complaint for further independent investigation if they did not feel the response fully addressed their concerns.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement. This was because:

- We found that the hospital managers may be obtaining false assurance from their audit results as we found that compliance with WHO and staffs understanding of VTE screening did not meet with the assurances that hospital audit scores conveyed.

Requires improvement

Surgery

- We found that poor infection control practices were going unchallenged which could indicate that staff did not feel empowered to challenge poor practice when they saw it.
- The hospital's clinical governance committee scheduled to meet every two months. However, meeting minutes showed the committee only met four times in the last year. The clinical governance committee was responsible for ensuring the hospital used appropriate systems and processes to deliver safe, high quality patient care.
- We saw a comprehensive clinical audit schedule to provide quality assurance. Audits related to surgery included IPC, hand hygiene, venous thromboembolism (VTE) screening, theatres, and the WHO checklist for safer surgery. However, we saw that the hospital missed some scheduled audits. For example, the hospital did not have results for scheduled audits in IPC in January, February or March 2016. This meant the executive team might not have had up-to-date assurance of quality in some areas.

However

- The leadership, governance and culture promoted the delivery of person-centred care.
- The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately.
- Quality received sufficient coverage in all relevant meetings.
- The hospital reported information on people's experiences and reviewed this alongside other performance data.
- Leaders modelled and encouraged cooperative, supportive relationships among staff. Staff felt respected, valued and supported.
- Candour, openness, honesty and transparency were evident throughout the service.

Vision and strategy for this this core service

- The service shared the BMI Healthcare vision. This was to provide the best outcomes, the best patient experience and the most cost-effective care.
- However, we asked two members of staff and neither could tell us what the vision was. This meant the vision might not have been fully embedded with staff.
- The strategy for 2016 consisted of eight strategic priorities. These were the governance framework; superior patient care; people, performance and culture; business growth; maximising efficiency and cost management; facilities and sustainability; improving internal and external communications; and information management.
- The executive team told us about areas they were working to improve. Those related to surgery were improvements to facilities, including sinks and flooring; governance, including mandatory training compliance; and staff recruitment and retention. We saw evidence of progress against these objectives. For example, the hospital had recently approved funding for new flooring in theatres.

Governance, risk management and quality measurement for this core service

- We saw a diagram of the hospital's governance structure. Surgery staff reported to either the theatre manager or ward sister. Managers met with other heads of departments monthly and reported to the executive team. The hospital's clinical governance and medical advisory committees also provided quality and safety assurances to the executive team. The theatre manager and ward sister represented surgery on the hospital's clinical governance committee. Consultant surgeons represented surgery on the medical advisory committee (MAC). The hospital also had a quality and risk manager to oversee hospital-wide quality and risk, who reported to the executive director.
- The executive team consisted of the executive director, the director of clinical services and the operations director. Following staff departures and sickness, all three executives held interim positions at the time of our inspection.
- We found that the hospital managers may be obtaining false assurance from their audit results as we found that compliance with WHO and staffs understanding of VTE screening did not meet with the assurances that hospital audit scores conveyed.
- We saw the hospital's risk register, although there was no local risk register for surgery. We saw that some of the areas of risk we identified, such as infection prevention and control (IPC) and reliance on agency staff, were on the risk register. The risk register also aligned with areas the executive team told us they were working to improve. This showed the executive team understood the areas of risk relating to surgery.

- We saw a comprehensive clinical audit schedule to provide quality assurance. Audits related to surgery included IPC, hand hygiene, venous thromboembolism (VTE) screening, theatres, and the WHO checklist for safer surgery. However, we saw that the hospital missed some scheduled audits. For example, the hospital did not have results for scheduled audits in IPC in January, February or March 2016. This meant the executive team might not have had up-to-date assurance of quality in some areas.
- The hospital's clinical governance committee scheduled to meet every two months. However, meeting minutes showed the committee only met four times in the last year. The clinical governance committee was responsible for ensuring the hospital used appropriate systems and processes to deliver safe, high quality patient care. We saw from meeting minutes that standard agenda items included incidents, infection prevention and control, complaints, the risk register, external/national guidance and new legislation, and clinical performance/compliance. We also saw that the clinical governance committee ratified new policies at these meetings. We saw that the theatre manager and the ward manager represented surgery on the committee.
- The BMI Healthcare group produced a monthly group clinical governance bulletin. This contained details of incidents, never events, and internal quality inspection visits from hospitals across the BMI Healthcare group. The purpose of the newsletter was to share learning from governance issues in all hospitals across the group. The interim director of nursing explained how the executive team cascaded learning to heads of departments, and sought assurances departmental leads had made clinical staff aware of any learning points or changes to practice.
- We saw the clinical governance bulletin was a standard agenda item on the hospital's clinical governance committee minutes. We saw from the minutes that the theatre manager provided assurances and made changes to practice because of learning from the group clinical governance bulletins. An example of this was thorough checking of consumables (disposable items that were used regularly), such as syringes, in theatres to ensure that no items that had passed their expiry date remained in stock.
- The hospital's MAC provided the formal organisational structure through which consultants communicated. The MAC advised the executive team and worked to maintain high standards and improve the quality of services. The MAC met every two months.
- We saw from the MAC minutes that the committee reviewed consultant's practicing privileges. This provided the executive team with assurance that consultants were competent to perform surgery at the hospital. We saw from the November 2015 MAC minutes that the hospital suspended the practicing privileges of two consultants. This was because they did not provide the hospital with medical defence updates giving assurances of their fitness to practice. We also saw from the July 2015 MAC minutes that the MAC refused to award practicing privileges to one consultant until he provided evidence of valid professional indemnity insurance.
- The hospital told us no staff reported whistleblowing concerns in 2015. No staff reported whistleblowing concerns to the Care Quality Commission in the same period. This suggested staff had no significant concerns about clinical practices in the hospital, or that managers adequately addressed any concerns.

Leadership / culture of service related to this core service

- We saw leaders valued and respected staff. The executive director told us one of the things she was most proud of was the team. The director of clinical services also told us the "very willing nursing team" was one of the best things at the hospital. We saw an email from the director of clinical services praising staff on Devonshire ward for the high standard of patient satisfaction responses in May 2016 and thanking them for their hard work.
- Following staff departures and sickness, all three members of the executive team held interim positions at the time of our inspection. The hospital was actively seeking to recruit a permanent executive director. Despite not having permanent leadership, staff felt supported by the executive team. All staff could identify the executive team and told us members of the executive team visited their areas. Staff told us morale had improved since the new interim executive team came in. For example, a nurse told us the previous executive team were not visible and described the previous leadership as "weak".

- We found that poor infection control practices were going unchallenged which could indicate that staff did not feel empowered to challenge poor practice when they saw it.
- We saw good local leadership from the theatre manager. A new theatre manager had worked at the hospital for four months at the time of our inspection. All staff we spoke to were very positive about her leadership and gave us examples positive changes since her arrival. These included implementation of different coloured anaesthetic sheets to alert staff of patients with individual needs, such as dementia. The theatre manager also told us about positive changes she had made. These included gaining funding for new showers and washbasins in the theatre changing rooms.
- Staff told us one of the best things about working at the hospital was their colleagues. We saw that staff worked well together and respected each other in their behaviours. Staff told us they felt supported by their managers and colleagues.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents. We asked three members of staff about Duty of Candour. All three could describe what this meant and gave examples of when it might be used.
- There were high levels of staff stability within theatre teams, with no staff turnover in any staff group in 2015. On 1 January 2016, all the care assistants based in theatres had been in post for longer than one year. On the same date, 83% of operating department practitioners (ODPs) and 77% of theatre nurses had more than one years' service at the hospital. Three members of the theatre team left the hospital in 2016. We saw exit interviews, which showed staff all left for different reasons and there were no common themes.
- Theatre departments reported low rates of staff sickness, with less than 10% sickness rates across all staff groups in 2015. The lowest sickness rate in theatres was 0% amongst theatre nurses in August 2015, and the highest was 7% amongst healthcare assistants in January 2015. In the months of February, March and June 2015, there was no sickness amongst ODPs.

Public and staff engagement

- The hospital actively engaged to seek the views of patients and their relatives. We saw patient satisfaction questionnaires available throughout the hospital for patient feedback. Staff on Devonshire ward told us they gave all patients a satisfaction questionnaire with their discharge pack. We saw this for ourselves when we observed a patient discharge. The hospital also sought feedback through the NHS choices website and the NHS friends and family test. We saw two positive responses related to the hospital on NHS Choices at the time of our inspection. The hospital also told us they ran regular patient focus groups to engage with patients.
- The hospital told us they engaged with the local community. They did this by participating in career fairs at local schools and supporting local business and charitable events. They also provided mandatory training for local GP surgeries.
- The hospital's website provided a range of information about the services provided. It also provided details of consultants who worked at the hospital and their credentials. Members of the public could use this information to help them decide whether they wanted to receive treatment at the hospital before booking a consultation.
- The hospital engaged with staff, seeking their views through the annual staff survey, BMI Say. However, the 2016 staff survey identified a lack of staff engagement. The executive team had an action plan to address this. The action plan included holding staff forums to discuss BMI Say results. This showed the hospital took the views of staff seriously.

Innovation, improvement and sustainability

- The hospital took part in BMI Healthcare provider visits. This was where staff from other BMI Healthcare hospitals carried out internal quality inspections. Provider visits gave the hospital feedback to enable a continuous cycle of improvement. We saw evidence of learning from provider visits in the clinical governance committee and team meeting minutes we reviewed.
- The BMI Healthcare group had a patient satisfaction league table. The group collated patient satisfaction data from all hospitals and ranked hospitals on their results each month. Staff told us hospitals were very competitive over their place in the league table, and this made the hospital strive to improve the quality of patient care every month.
- We reviewed patient satisfaction reports for the six months before our inspection. These showed the hospital's highest rank was ninth out of 55 hospitals in February 2016 and its lowest was 30th in May 2016.

While this suggested a decline in patient satisfaction, we saw the hospital took action to improve in areas where patients were less happy. For example, in 2016, we saw patients at the hospital were consistently less satisfied with their accommodation than the BMI Healthcare average. The hospital told us they were refreshing patient areas to improve the patient environment.

- The hospital had an awards system to recognise staff that went "above and beyond". This helped motivate staff to continually improve and develop the services they provided. Staff on Devonshire ward told us they nominated the ward sister for the high level of care she gave patients and staff. Staff told us they were motivated by the above and beyond awards.
- The hospital was a BMI Healthcare pilot site for ambulatory care. Ambulatory patients did not transfer to the ward after minor procedures and instead spent a short time in recovery before early discharge. The benefits of ambulatory care included helping the patient feel more normal after surgery, reduced costs to patients and commissioners, and ease of scheduling.
- The executive team told us one of the things they were most proud of was their enhanced recovery programme. The hospital developed this in line with national best practice guidelines to enable patients to recover from surgery quicker and with lower risk of complications.
- However, staff told us there was sometimes a slow pace of change in making improvements. For example, two members of staff separately told us of an on-going challenge to obtain bladder scanners for Devonshire ward. Staff described how this equipment was important to reduce unnecessary catheterisation, but felt the hospital ignored their requests. In theatres, we saw a newly decorated staff room, which the team told us they decorated and funded themselves. Staff felt the hospital should have funded improvements to staff areas.

Good

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at BMI The Esperance Hospital cover a wide range of specialities, including dermatology, cardiology, gynaecology, gastroenterology ophthalmology, orthopaedics, dietetics, haematology, nephrology, oncology, respiratory and cosmetic, general, vascular and reconstructive surgery. From March 2015 to May 2016 the outpatient department provided 985 new patients appointments and 2888 follow up appointments.

The diagnostic and imaging department carries out routine x-rays, magnetic-resonance imaging (MRI), computerised tomography (CT), mammography, dexa and ultrasound scans. In the last year the department x-rayed 1584 patients. On average 22 patients a month had MRI, 3 patients had CT over the same period.

The outpatient department runs clinics from 8am to 8pm Monday to Friday, with occasional Saturday clinics between 8am and 3pm. The diagnostic imaging department provides a 24 hour a day, seven day a week service for urgent examination requests. The outpatient department is in a separate building to the rest of the hospital, called Esperance House, and is over three floors. There are eight consulting rooms in the outpatient department with three treatment rooms. No minor operations are carried out in the department. Physiotherapy and phlebotomy services are located in the main hospital. During our inspection we visited the outpatient department, diagnostic imaging, physiotherapy and pathology.

We spoke with nine patients and 14 members of staff including, nurses, radiographers, physiotherapists, pathology staff, health care assistants, radiology assistant, administrators and managers. As part of our inspection we looked at hospital policies and procedures, staff training records, and audits. We looked at six sets of notes, the environment and equipment staff used.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatients and diagnostic imaging service as good for safe, caring, responsive and well led. We did not rate effective as we do not currently collect sufficient evidence to rate this.

Patients were protected from the risk of abuse and avoidable harm. Staff knew how to escalate key risks that could affect patient safety, such as safeguarding from abuse. They took steps to prevent abuse from occurring, respond appropriately to any signs of abuse and worked effectively with others to implement protection plans. The diagnostic imaging 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.

Staff completed mandatory training with good compliance rates. The departments were clean, and hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections. Medications were stored safely.

The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

During the inspection we observed staff respond compassionately when people needed help and support to meet their basic personal needs as and when required. People's privacy and confidentiality was respected at all times. Patients' feedback through interviews and comments cards was entirely positive. Patients praised all aspects of the service with comments such as "the care, courtesy and respect was exceptional", "welcoming", "friendly", "excellent", and "nothing is too much trouble". Staff verbally offered a chaperone to all outpatients. Signs were also clearly displayed in waiting areas and clinical rooms offering a chaperone and the patient's acceptance or rejection of the offer was recorded on the chaperone register.

Outpatient and diagnostic imaging clinics were available in the evenings with appointments made for the patients' convenience. Occasional weekend clinics would be held, depending on need. Waiting times were minimal and well managed.

There was clear and visible leadership provided by senior management and within the departments. Staff spoke highly of their managers, who told us they were visible and approachable.

However we found:

There were a number of hand wash basins and floor coverings that did not meet the standards required for a clinical area.

Fire signage, lighting and escape routes in some cases did not meet the recommended HTM 05 – 02.

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

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safe in outpatients and diagnostic imaging as good because:

- There were effective systems in place to report incidents. Staff were aware how to report incidents, safeguarding issues and were aware of the Mental Capacity Act 2005 and the Duty of Candour processes
- Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections.
- Records were stored safely, up to date, legible, and were available for staff. Emergency equipment was in place. Medicines were well managed within the department.
- There were sufficient numbers of medical, nursing and diagnostic staff to deliver care safely. Patient risk was assessed and responded to. There was a major incident plan in place, and a recent exercise had been undertaken.

However:

- We observed that not all staff were "bare below the elbow" during inspection.
- There were a number of floor surfaces that did not meet the standards required for a clinical area.
- There were a number of hand wash basins that did not meet the standards required for a clinical area.
- Fire signage, lighting and escape routes in some cases did not meet the recommended HTM 05 – 02.

Incidents

- There were no "never events" reported by the hospital between January and December 2015. "Never events" are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented.
- The hospital followed their corporate "Incident Policy Including Serious Incidents" (dated February 2016), and used a combination of a paper based and electronic systems. However, staff told us the hospital was changing to an electronic system, and that some staff were waiting to undertake their training and receive a password for the new system.
- Staff in the outpatient departments had a good understanding of the reporting system and could access it. They were aware of the type of incidents they needed to escalate and report. Staff told us they made time to report incidents. We were told of a recent incident where a patient had become unwell in the diagnostic imaging department, and was transferred to the local NHS hospital. Staff told us the process they followed, including how they had followed up with the local hospital for an update on the patient after transfer.
- Staff in the diagnostic imaging department used a paper based system to report incidents. They were confident in what to report and gave us an example of shared learning.
- From January 2015 to May 2016, the outpatients department reported nine incidents. We saw four of these, and found an investigation had taken place. Staff gave us examples of learning from incidents.
- The outpatient manager and staff told us feedback and learning from incidents occurred during the monthly team meetings. We looked at team meeting minutes and saw feedback from incidents had taken place.
- We saw minutes of the Clinical Governance Committee and Heads of Department meetings which indicated staff/managers discussed incidents and outcomes every month.
- The diagnostic imaging department had never reported an incident to the Care Quality Commission in line with ionising radiation (medical exposure) regulations (IR (ME) R, 2000). Staff gave us explanations of what was a reportable incident and understood the process of reporting. A radiation protection supervisor (RPS) was available in the department for diagnostic imaging staff to discuss incidents relating to radiation with. In addition to this, staff told us that the radiation protection advisor, although not on site, was easily contactable should advice be required for reportable incidents required in the Ionising Radiation (medical exposure) Regulations (IR(ME)R, 2000.
- Staff described the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of 'certain

notifiable safety incidents' and provide reasonable support to that person. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. We saw three examples where the hospital had followed the duty of candour and compliant response process.

Cleanliness, infection control and hygiene

- We saw diagnostic imaging waiting areas and examination rooms were clean, tidy and well presented. In the diagnostic imaging areas, we saw cleaning checklists completed each day that the examination rooms were in use.
- We saw in both outpatients and where blood tests took place, the waiting areas, consultation and treatment rooms were clean, tidy and well presented.
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations.
- We found equipment was clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection prevention and control. Some equipment had 'I am clean' stickers on them which indicated the date the equipment had been cleaned.
- We saw personal protective equipment, hand washing basins and hand sanitising gel was available in consultation and treatment rooms or areas. Posters were positioned near hand washing basins which explained "5 moments for hand hygiene" in line with World Health Organisation guidance.
- The hospital followed their corporate "Clinical Uniform Policy" (for review June 2016) and their "Hand hygiene policy" (dated May 2016), which says, all wrist and hand jewellery must be removed at the beginning of each clinical shift (with the exception of a plain wedding band). We saw, overall, staff who delivered direct patient care were 'bare below the elbows'. However, we saw four members of staff wore wrist watches. Staff should be "bare below the elbow", and remove hand and wrist jewellery in order to ensure that hands can be easily cleaned.
- We saw staff in clean uniforms and observed them washing their hands or using the hand sanitising gel in line with this guidance before and after interacting with patients. We saw hand hygiene audits for the department from, March, April and May 2016, where the score was consistently high, with a score of 100%.
- Staff signed a label on the sharps bins which indicated the date it had been constructed and by who. This was in line with health and safety regulation 5 (1) d, which requires staff to place secure containers and instruction for safe disposal of medical sharps close to the work area.
- The hospital followed their corporate "Standard Infection Control Precautions Policy" dated (February 2016), which says sharps bins should not be in use for longer than one calendar month. On the arrest trolleys in the outpatients department we found sharps bins which had been assembled and dated 6 February 2016. Additional labels with dates were on the sharps bin, showing the sharps bins had been checked monthly. The Environment and sustainability Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste says "If the sharps receptacle is seldom used, it should be collected after a maximum of three months, regardless of the filled capacity". We spoke with the Infection Control Lead Nurse, who told us it had been agreed that sharps bins on the arrest trolleys can remain in place, provided they are empty and checked monthly, this is not written in the policy. However, we found used sharps in the sharps bin on the arrest trolley on the first floor.
- There was a dedicated infection control link nurse for the department. Link nurses are members of the department, with an expressed interest in a specialty; they act as link between their own clinical area and the infection control team. Their role is to increase awareness of infection control issues in their department and to motivate staff to improve practice. The link nurse for outpatient department had recently taken up the role, and was undergoing further training.
- We saw ultrasound probes were cleaned between each use with a triple cleaning system. At the end of each of the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff had used. The records showed each time a probe was cleaned with the three stages completed. We saw records were complete.

- The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipeable materials. This meant that the couches could easily be cleaned between patients.
- The hospitals Patient Led Assessment of the Care Environment (PLACE) audit for 2015 showed the hospital scored the same or better than the England national average for cleanliness, condition, appearance and maintenance. In all the consulting and treatment rooms we visited, disposable curtains were used. They were all labelled with the date on which they were put up, which in all cases was within the last month. Staff were aware they needed to be changed every six months or sooner if they became visibly dirty.
- We saw carpets in the consulting rooms and were told that some clinical procedures occurred in theses rooms. This did not comply with the Department of Health HTM Health Building Note 00-09: Infection control in the built environment Hospital building note (3.82) which states that carpets should not be used as this area has a high probability of body fluid contamination. However, the hospital is aware, and we were told there is a planned programme of works to change the flooring in these areas. However, staff told us that most clinical procedures took place in the designated treatment rooms, which were not carpeted.
- We saw sinks throughout the outpatients department which were non-compliant with the Department of Health HTM Health Building Note 00-09: Infection control in the built environment Hospital building note, (3.31-3.32) which says clinical hand-wash basins should not have plugs or overflows (a plug may allow the basin to be used to soak and clean equipment, and overflows are hard to clean). However, staff told us this has been highlighted as a risk, and the hospital informed us there is a programme of work to replace the sinks in the outpatients department.

Environment and equipment

- We saw three resuscitation trolleys in diagnostic imaging and outpatient areas. All trolleys were locked. Records indicated that the trolleys were checked daily on days when clinics operated. All drawers had correct consumables and medicines in accordance with the check list. We saw consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator worked and suction equipment was in order.
- We saw equipment in diagnostic imaging was serviced regularly and service records were completed and in date for all diagnostic imaging equipment. There was also quality assurance of the machines being tested regularly; we saw examples of these tests. This indicated that the machines were working as they should. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations IR (ME) R 2000).
- We saw stickers on equipment which indicated it had been serviced regularly.
- Lead aprons were available in the diagnostic imaging departments. We saw staff use them. The effectiveness of their protection was checked with regular audits. We saw copies of the audits.
- The department had changing cubicles available for patients to prepare for an examination. Two cubicles had lockable doors. We saw lockers available for patients to use to store their belongings in whilst they had an examination.
- In all examination rooms visited we saw consumables stored were in date.
- We noted that the fridge in the first floor treatment room portable appliance testing (PAT) was out of date and was last PAT tested in 2010. Portable appliance testing (PAT) is a process by which electrical appliances are routinely checked for safety once a year. This meant the hospital could not give assurance that the fridge was safe to use. The hospital told us all equipment is tested as per policy timeframes and the evidence of testing and when next due is held centrally, however we did not see this on inspection.
- Within the outpatient department, the left hand side ground floor fire escape opened on to the grounds. There was a wooden threshold and two concrete steps leading on to a partially gravelled path, the other part of the construction of the pathway was earth. Bushes over grew the pathway in parts.
- Health Technical Memorandum (HTM) 05-02: Fire code Guidance in support of functional provisions states: 3.60 Final exit doors should not be provided with a step and should open onto an area which is level for a distance of at least 1 metre. Therefore the service has failed to meet this regulation. This would mean potentially patients and staff with mobility problems may find using this escape route problematic and therefore find it difficult to escape from a fire.

- In the same area for approximately half the length of the pathway there was lighting, but there was none for the last ten metres approximately. The final escape was through a gate which potentially would have been difficult to see in the dark.
- HTM 05 – 02 3.62 states: The following points should be considered when designing external escape routes: the provision of adequate artificial lighting. The service had failed to meet this regulation. Without artificial lighting in this area people using the fire escape were at risk of not seeing their exit clearly and therefore unable to escape safely.
- Signage for this escape route was not clear. There was no directional green running man when the door was opened. The purpose of a green running man signage is to show persons escaping a fire the direction of travel in order to escape. Because the service had not installed the correct signage people could be confused as to their direction of escape in the event of a fire.
- Emergency call bells had been introduced into all clinical areas and consulting rooms, in the outpatient department to alert staff to a medical emergency.

Medicines

- The hospital had safe systems and processed in place for the management of medicines in the outpatient department. We saw medicines were kept in a secure cupboard and the keys for those cupboards were kept in an electronically secured room.
- In the diagnostic imaging department, we saw medicines stored in a locked trolley in an examination room. The key to the trolley was held by a registered health professional. The temperature of the room was monitored and we saw staff recorded maximum and minimum temperatures, which meant the hospital had assurance that medications were kept at the correct temperature.
- In computerised tomography (CT), staff stored medicines in a locked cupboard in a locked room with keypad access. Only authorised staff had the access code to the room and a registered health professional held the key to the drug cupboard. All drugs were in date.
- We reviewed the hospitals prescription pad records and these were recorded correctly. All prescription pads were kept in a locked cupboard. We saw evidence of the prescribing pad log which was up to date, showing serial number, date and time when the prescription pads were last used.
- Patient Group Directives (PGDs) provide a legal framework that allows the supply and/or administration of a specific medicine by name, authorised, registered professional. We saw PGDs from medicines administered in diagnostic imaging had been updated in May 2016. PGDs were not required in the outpatients department.
- We saw that when applicable medicines were stored in dedicated medicines fridges. We saw records which showed that daily checks were undertaken. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range. However, we found the portable appliance testing (PAT) on one medicine fridge was out of date. Portable appliance testing is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. This meant that the hospital could not give assurance that the fridge was safe to use.
- Patients were given information for medication in a way they could understand. We saw the information of the medicine given to patients prior to gastric investigations.

Records

- The hospital followed their corporate Policy for the "Retention of Records (includes guidance for All Business Documentation and Healthcare Records)" (dated April 2014, for review February 2017).
- At the time of inspection we saw patient personal information and medical records were managed safely and securely. During clinics, all medical records were kept in a locked office and transferred to the consultant when the patient arrived. Staff told us that they had no difficulty in retrieving medical records for clinic appointments.
- Medical records were held securely on site in the medical records room. There was an archive facility for patient notes, which would be stored on site for six months, and then transferred off site to a secure location. There was a tracker system in place, which we saw, this meant staff knew where notes where at all times. Consultant secretaries, who held some medical records in their offices, would ensure they closed and locked the doors when leaving the rooms.

Good

Outpatients and diagnostic imaging

- On the whole medical records in the diagnostic imaging department were on computer systems. The computer systems were secure and accessed by staff with individual login details. We saw some patient records stored in a locked cupboard, in a lockable room. This provided assurance that records were kept safely and securely.
- We saw the medical records of six patients. All medical records were tidy with no loose filing, legible, dated and signed, which was in accordance with the hospitals documentation policy.
- All of the staff that we spoke with told us, that obtaining medical records for clinics has never caused an issue in the department. However, currently the outpatient department did not audit availability of medical records for clinics.

Safeguarding

- There have been no safeguarding concerns raised by the hospital since December 2015
- The hospital followed their corporate "Safeguarding Adults Policy Incorporating Mental Capacity and Deprivation of Liberties and PREVENT for England and Wales" (dated May 2015), this was accessible to staff in both outpatients and diagnostic imaging.
- Staff in the outpatient department knew how to identify safeguarding issues, gave us an example of a safeguarding concern and how it was dealt with in line with the safeguarding policy. A member of staff told us where they had identified safeguarding need for patient during a routine appointment, and the support and access and help given to the patients relative.
- Staff we spoke with in diagnostic imaging and pathology could not give us an example of a safeguarding concern raised in the past. They told us if they encountered a concern they would escalate to their line manager.
- Staff completed a combination of on-line electronic learning module and face to face workshops as part of their mandatory training for safeguarding.
- Safeguarding vulnerable adults training was undertaken every two years for levels one and two. Data indicated, 92% of required staff had completed Safeguarding Vulnerable Adults (Level 1); 100% of required staff had completed Safeguarding Vulnerable Adults (Level 2)
- Safeguarding vulnerable adults Level 3 was undertaken every three years. Data indicated 100% of required staff had completed Safeguarding Vulnerable Adults (level 3).
- As this hospital only sees adult patients, this is an appropriate level of training.
- Staff also complete an on-line learning module for PREVENT, (protecting people at risk of radicalisation) training. The prevent strategy is the Government's response to help counter the extreme ideologies that recruit vulnerable people and to offer guidance and support to those who are drawn to them. The data request showed 90% of the required staff had completed this training. PREVENT training was undertaken every three years.

Mandatory training

- Staff received mandatory training. The training was a mixture of face-to-face and online training via the BMILearn system. The online training sessions were easy to access and staff found the sessions met their needs.
- We saw records which indicated more than 90% of staff in the diagnostic imaging departments had completed mandatory training which was better than the target of 90%. We saw examples of mandatory training certificates.
- We saw records which indicated 90% of staff in the outpatient department had completed their mandatory training, which was equal to the target.
- Staff we spoke with told us they felt their training was good, however, staff told us they did not always get the time to complete their mandatory training while at work and often had to complete the training at home, in their own time.

Assessing and responding to patient risk

- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in the areas we visited. We saw appropriate warning signs and lights outside of rooms in accordance with ionising radiation (medical exposure) regulations IR (ME) R 2000.
- Staff in radiology told us they would first check with a patient if they had previous scans and x-rays. They told us they were able to access any previous scan which enabled them to ensure a patient wasn't over irradiated, in accordance with IR (ME) R regulations.
- We saw signs prompting women to inform staff if there was a possibility they could be pregnant. In addition, staff asked women if they could be pregnant and recorded this on the electronic records system. We saw

electronic records which indicated this had been done. In addition, the radiology manager audited this and we saw results of the audit which indicated this question was always documented in the patient record.
- Comprehensive policies and procedures were available and in place in the imaging department. This was in accordance with the radiation protection advisor audit which concluded that the overall management of radiation protection in the department was found to be at a high level.
- We saw the department had completed a number of risk assessments for the diagnostic imaging areas and equipment. This indicated patients and staff were being kept from harm.
- The manager gave us an example of a finding something unexpected on a patient examination. Staff contacted the local emergency department and the patient was transferred for on-going management. This was in line with the standards for the communication of critical, urgent and unexpected significant radiological findings.
- We saw 'stop and check' signs in every examination room. This prompted staff to double check patient identification details to ensure they had the right patient in the examination room.
- We saw evidence of a clear process in place for patients who had become critically unwell in the outpatients department and required admission to hospital. The hospital followed the corporate "Adult Resuscitation Policy" (dated March 2015).
- Staff we spoke with gave us an example of a recent incident where a patient had become unwell in the department, and had to be transferred to the local NHS hospital. Staff told us the process they followed, including how they had followed up with the local hospital for an update on the patient after transfer.
- We saw three emergency trolleys, on each of the floors of the outpatient department. This meant that in the event of an emergency or patient collapse, that staff would be able to obtain emergency equipment without delay.

Nursing staffing

- There are no set guidelines on safe staffing levels for outpatient department. Outpatient department staffing levels and skill mix were planned and reviewed on a daily basis to ensure the correct number or staff required to be on duty to ensure safe care and treatment of patients at all times.
- However, some staff told us if a member of staff goes on holiday or is off sick, this could lead to additional pressure on the workload.
- The sickness rate for all staff groups working in outpatients for the period of January to December 2015, was less than 10%, except for November 2015, where care assistant sickness rates rose to between 10% and 19%.
- The outpatients reported that they had occasional use of agency staff for the period January to December 2015. In the same period, there were no vacancies for nurses and care assistants in OPD.
- Staff told us they had daily meeting at the beginning of the day to discuss any concerns that may affect delivery of safe care and treatment to patients, such as updates, planned clinics or staffing for the day.

Medical staffing

- We were unable to speak with any consultants during our inspections. However, all staff we spoke with told us that they had very good relationships with clinicians.
- Eighty two doctors had been granted practising privileges at the hospital. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The hospital had a "Practising Privileges Policy Consultant Medical and Dental Practitioners" (dated November 2015).
- We saw four sets of minutes from the Medical Advisory Committee and saw Practising privileges were discussed, including new applications, appraisals, and training requirements.
- The hospital has a resident medical officer (RMO) onsite 24 hours a day, seven days a week to support the clinical team in the event of an emergency or with patients requiring additional medical support.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics.
- Staff in the outpatient department told us they rarely had any issues with clinicians not arriving for clinic. They told us in the event a clinic had to be cancelled at the last minute, the outpatient staff would ring every patient and where possible stop them from attending. They would rebook them into a new appointment.

Radiology staffing

- The hospital contracted under practising privileges four out of a possible eight radiologists. Two radiologists could access patient examinations remotely and the

hospital was working to offer this to the other consultants. If an examination report was required urgently, but none of the radiologists were available, the manager would request assistance from another BMI hospital.
- The manager told us the department was trying to recruit two more radiographers to work at the hospital. A bank member of staff worked regularly at the hospital and had undertaken all the mandatory training which a permanent member of staff was required to do.

Major incident awareness and training

- The hospital has a Business Continuity Policy (amended February 2016), which was approved by the Governance Committee. The policy had associated "action cards" and covered major incidents such as loss of power, loss of staffing, adverse weather and passenger lift failure.
- Staff had a good understanding of what would happen in the event of a major or untoward incident. This was in line with the business continuity plan. We saw the major incident process with action cards and this was accessible to all staff.
- Staff told us about a recent evacuation exercise that had taken place in the hospital.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

We inspected but did not rate effectiveness in outpatients and diagnostic imaging as we do not currently collect sufficient evidence to rate this.

We found:

- Patient care and treatment reflected relevant research and guidance, including National Institute for Health and Care Excellent (NICE) guidance.
- Staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards legislation.
- There was a good multidisciplinary team approach to care and treatment. Staff had the right qualifications, skills and knowledge to do their job.
- The department undertook a variety of local based audits.
- Consent to care and treatment was obtained in line with legislation and guidance.

However:

- Staff felt there was limited time for undertaking further study, and were encouraged to undertake the training in their own time.

Evidence-based care and treatment

- We saw minutes of the Clinical Governance Committee, which reviewed recent NICE guidance monthly.
- We saw NICE guidelines NCG45 for pre operatives tests was being adhered to, by the pre assessment nurses.
- Staff in outpatients, diagnostic imaging, phlebotomy and physiotherapy had a good awareness of and had read local policies. They were able to give us examples of how to find policies and when they had used them.
- The diagnostic imaging department had comprehensive policies and procedures in place. We saw these were in date, in line with regulations under IR (ME) R and in accordance with the Royal College of Radiographers standards.
- The department undertook a variety of local audits. They were to check equipment, medicines management, electronic records, hand hygiene and monthly spot check audits. We saw examples of these audits, along with action plans arising from them.

Pain relief

- The Physiotherapy department offered low level LASER therapy and acupuncture to provide pain relief for patients.

Patient outcomes

- Physiotherapy staff asked all patients to complete a patient reported outcome measure (PROM). This enabled staff to measure the effect of treatment on each patient.
- All NHS patients having hip or knee replacements, varicose vein surgery or groin hernia surgery are being invited to fill in Patient Reported Outcome Measures (PROMs) questionnaires. The PROMs questionnaires ask patients about their health and quality of life before they have an operation, and about their health and the

effectiveness of the operation afterwards. The hospital provided data for hip replacements (Oxford hip score) and knee replacements (Oxford knee score), along with groin hernia surgery.

- Between March 2014 and April 2015 the hospitals PROM data showed six out of six patients reported improvements in health following primary hip replacement, under the Oxford hip score. Seven out of seven patients reported health improvements under the Oxford knee score. This was the most recent data available at the time of inspection.
- However, the hospital did not have enough data available to calculate the average adjusted health score for PROMs for March 2014 to April 2015, as PROMs collects data from NHS funded patients only.
- The hospital took part in the Patient Led Assessment of the Care Environment audit (PLACE) audit 2015, which showed the hospital score the same or higher than the England average for cleanliness, condition, appearance and maintenance, food and organisational food. However, the hospital score for dementia, privacy, dignity and wellbeing was lower than the England average.

Competent staff

- We saw that all allied health professionals working in the radiography department had registration with the Health Care Professions Council (HCPC). We saw copies of their registration certificates. Staff told us they had the opportunity to attend a variety of courses, which were required to maintain registration.
- One hundred percent, of nurses who worked in the outpatient department for 12 months or more had validation of professional registration. This meant the hospital conducted annual checks to make sure all the nurses are registered with the Nursing and Midwifery Council (NMC) and is considered good practice.
- The outpatient staff had to complete two appraisals using an electronic training system every year. Staff told us that a face to face appraisal was available if required. Staff training needs were identified at appraisal. Some staff told us that when a training need is identified, staff often had to undertake the training in their own time.
- Staff in the diagnostic imaging department had annual competency checks. We saw certificates had been completed within the last year.
- Physiotherapy staff told us they could access around 30 different courses to develop their skills further.
- Physiotherapy staff who performed acupuncture attended a specialist interest group, which was in line with best practice.
- There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen during the inspection.

Multidisciplinary working (related to this core service)

- There was a strong multi-disciplinary team (MDT) approach across all of the areas we visited. We observed good collaborative working and communication amongst all members of the MDT. Staff reported that they worked well as a team.
- Staff told us that they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another.
- The hospital had a service level agreement with the consultant microbiologist at a local hospital for 24 hour access to an infection control doctor
- The hospital had a small on site pathology laboratory, but most pathology tests and microbiology was provided through a service level agreement with a local hospital.

Seven-day services

- The outpatient department ran clinics between 8am and 8pm, Monday to Friday. Staff cover was provided between these times. When required, additional Saturday clinics were provided from 8am and 3pm. Dermatology clinics ran once a month on a Saturday.
- The diagnostic imaging department provided a 24 hour a day, seven day a week service for urgent examination requests.
- Phlebotomy services were available at the hospital. We observed there was little waiting time for patients who required any tests following an outpatient consultation.
- There was a pharmacy service available at the hospital, Monday to Friday from 08.30am until 5pm.

Access to information

- Images from other hospitals could be accessed via a secure computer network in the diagnostic imaging department. Staff could see what previous scans or tests had been undertaken. This enabled staff to ensure patients did not receive greater doses of radiation than required.

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- Staff accessed patient information via a secure computer system. Those requiring access had individual passcodes.
- Two radiologists could access patient examinations remotely, which enabled them to provide a report if they were not at the hospital.
- Staff told us access to diagnostic tests, including blood results, from the local health care provider were readily available and that they have a good working relationship with the local hospital. This meant that access to diagnostic test results for patients could be accessed in a timely manner and assisted staff to make appropriate decisions about patient care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital followed their corporate "Safeguarding Adults Policy Incorporating the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs) and PREVENT For England and Wales" (dated May 2015). Staff had knowledge of these policies and how to use them.
- We saw six sets of notes during our inspection. We saw evidence of staff following the consent policy and seeking written consent from patients prior to procedure, and on the day of procedure. This meant staff were working in line with the General Medical Council guidance for consent and the hospital policy which meant patients are involved and understand the reason for the procedure.
- Staff had received training in consent, the Mental Capacity Act and DoLs. Staff told us if there were concerns over a patient's capacity to consent, they would be pre assessed by a particular consultant anaesthetist. For example, the pre assessment nurses told us if the patient had learning difficulties or was living with dementia they would be seen by the consultant anaesthetist at pre assessment and a care passport commenced. An alert form would be sent to theatre and the ward prior to admission.
- We were told the consultant anaesthetist, had provided additional training on consent and the Mental Capacity Act to staff. All staff we spoke with were very complementary about the consultant anaesthetist and described them as "absolutely marvellous". All staff told us that the additional training was "excellent" and "informative".

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Patients and relatives feedback constantly very positively about the care provided from all of the outpatient and diagnostic imaging staff.
- Patients felt supported and said staff cared about them, and that "nothing was too much trouble".
- Staff were highly motivated to provide good quality care
- Staff respond compassionately when patients needed help and supported them to meet their basic personal needs as and when required. Staff were highly motivated to offer care that promotes people's privacy and confidentiality was respected at all times.
- Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- Interactions between staff and patients were welcoming, caring and supportive.

Compassionate care

- Staff treated patients with kindness, dignity and respect. Staff interacted with patients in a positive, professional and informative manner. This was in line with National Institute for Health and Care Excellence (NICE), QS 15.
- All patients we spoke with said the care they received was of a very good standard. One patient told us "treatment from the physio team has been fantastic. The ladies I have met here have all been attentive, patient and caring". Another patient said "the care, courtesy and respect was exceptional".
- We observed many positive interactions between staff and patients during out inspection. We witnessed staff approach people rather than waiting for requests for assistance. Staff introduced themselves with "my name is" and we observed consultants introduce themselves and shake patients hands when they were called in for their appointments. A patient told us, "all staff are extremely polite and pleasant to deal with". Patients we

spoke with were very positive about the way staff treated them. Patients told us staff were "excellent", "friendly", "welcoming" and "nothing was too much trouble"

- Staff were expected to keep patients informed of waiting times and reasons for delays. We observed during our inspection the majority of clinics were running on time. However, we did witness one clinic was running twenty minutes late. The patient who was waiting was informed of the delay and a reason was given, the patient was offered a hot or cold drink and a biscuit.
- We saw that chaperones were available. The hospital followed their corporate "provision of chaperones during examination, treatment and care" policy (dated September 2015), including a chaperoning register. We reviewed the chaperoning register and it was up to date and in line with the hospitals policy.
- We saw posters informing patients that chaperones were available on display in the waiting areas and in all the consulting and treatment rooms. Patients were given the opportunity to accept or decline a chaperone during their appointment with a consultant. The decision to accept or decline was recorded in the chaperoning register.

Understanding and involvement of patients and those close to them

- We saw staff introduced themselves to patients, explained their role and the examination that was about to be performed. Staff sent detailed information about the examination patients were booked in for with the appointment letter. We saw examples of this information and it was in clear, simple language.
- All patients we spoke with told us that their care was discussed in detail with them. Patients told us they were given time and were able to ask questions, and felt included in the decisions that were made about their care. One patient told us, "appointments run on time and my concerns and questions were answered".
- Clear and concise information was provided to patients prior to their appointment. They told us the reception staff treated them with kindness.
- We observed consultants behaving in a friendly and respectful manner towards the patients in their care. Most of the consultants came out to the waiting area to greet and show patients to their consulting room.

Emotional support

- All treatment and consultation rooms were private and could be used to deliver any bad news which may adversely affect a patient's future. Staff told us the consultants would inform them if they were about to break bad news to a patient so they would be available to support them. They spent as much time as was needed with the patient and those close to them. They provided support and gave them guidance on where to get further help and support.
- Staff gave us an example where a patient had received bad news; they were able to use another consultation room which was not being used, where the patient and relative could be alone. The staff told us they made sure the patient and relative knew they were available if they wanted further information, and were offered a hot or cold drink.

Are outpatients and diagnostic imaging services responsive?

Good

We have rated responsive in outpatients and diagnostic imaging as good because:

- Services were planned and delivered to meet the needs of the local population.
- Patients could be referred in a number of ways.
- Patients could choose appointments which suited them.
- Cancellations were minimal and managed appropriately and services ran on time.
- Staff had access to translation services

However we found:

- Staff were not aware there was a system available to print written information such as pre-appointment information and leaflets into other languages.

Service planning and delivery to meet the needs of local people

- The diagnostic imaging department was open for routine examinations from 9 am to 5 pm from Monday to Friday. This did not offer a wide variety of appointment times for patients.

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- The manager told us they booked patients in for specific examinations on or near days when the specialist radiologist was in attendance. A report on the examination could then be provided quickly.
- There were no waiting times for physiotherapy treatment and staff saw NHS as well as private patients.
- Patients could access hydrotherapy and exercise classes as part of their physiotherapy management plan.
- The outpatient department was open from 8am until 8pm Monday to Friday, and at times of high demand, ran clinics on a Saturday between 8am and 2pm. Evening appointments allowed patients who work Monday to Friday 9am to 5pm to access healthcare at a time that suited their needs.
- Both patients and staff told us that car parking was a problem on the hospital site. The hospital told us they had applied to extend the car parking facilities, but the hospital was situated in a conservation area, and therefore have not been able to add extra spaces.
- There was a free hospital car park but it did not have enough spaces in it to manage the amount of patients requiring a parking space for their cars. Patients and visitors were able to park in the roads around the hospital however most of this was metered parking.
- The waiting areas were comfortable and not crowded.
- Signage around the outpatient department was clear. We saw staff stopping to ask patients and visitors if they required assistance or direction, if they saw them appearing to be lost.

Access and flow

- Access to outpatient appointments was fast and patients told us they were more than satisfied with the amount of time it had taken, to get the appointment. Patients also told us they were able to get appointments at times that suited them.
- The target time for providing a diagnostic imaging report was 48 hours, which, we were told, was met overall. However, this was not documented or recorded anywhere.
- From May 2015 to April 2016, 99% of patients received an MRI or CT scan within 6 weeks. Which was better than the national average. Although this was worse than the operational standard of less than 1% of patients waiting more than six weeks for a diagnostic examination, however, it only equated to three patients. All three of these patients had delayed scan dates as consultants had requested a delay due to the patients' medical condition and did not constitute a delayed diagnosis.
- Private patient's appointments were arranged through the consultant's individual secretaries along with the booking office and the outpatient's manager.
- NHS patients who used Choose & Book, and were subject to NHS waiting time criteria, were managed by the hospital's own administration team.
- The hospital had very low 'did not attend' (DNA) rates. All patients who missed their appointment were followed up and offered a second appointment. If they DNA on the second appointment the hospital would contact the referrer who would be notified of the non-attendance, and would need to re-refer the patient.
- One administrator explained the process of receiving referrals from the General Practitioners (GP) and other healthcare organisations and told us the average wait for an appointment is about four to five days
- We were told outpatient department did not routinely monitor clinic delays. The clinics we observed mostly ran to schedule. However, we did witness one clinic was running twenty minutes late. The patient who was waiting was informed of the delay and a reason was given, the patient was offered a hot or cold drink and a biscuit.

Meeting people's individual needs

- Patients had access to a variety of information leaflets in diagnostic imaging and outpatient departments. We noted that leaflets were not available in other languages. The hospital told us written patient information can be provided through an electronic system, which is available in multiple languages and can be printed as required. However, staff we spoke with were not aware of this system.
- Staff told us they had access to a translation service. Staff gave us an example, where translation services were required for a pre assessment appointment, the translation services were then booked for the patients admission to the hospital and for the duration of their stay.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 73% for dementia which was lower than the England average of 81%. However, the pre assessment nurses told us if patient had learning difficulties or was

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living with dementia they would be seen by the consultant anaesthetist at pre assessment and a care passport commenced, an alert form would be sent to theatre and the ward prior to admission.
- There were procedures in place to make sure patients who were self-funding were aware of fees payable. Staff told us they would provide quotes and costs, and ensure that patients understood the costs involved,
- There were leaflets available that explained the payment options, and procedure and gave advice of who to contact if there were any queries. The hospital website also clearly described the different payment options available.
- We were told of examples where consultants had seen patients at short notice at the patient's request. During our inspection we observed a patient who had arrived for their appointment on the wrong day, we saw the staff speak with the consultant and the patient was seen during that day.
- Staff treated patients with kindness, dignity and respect. Staff interacted with patients in a positive, professional and informative manner. This was in line with National Institute for Health and Care Excellence (NICE), QS 15. One example given by staff was the support plan the hospital has in place for deaf and blind patients. The patient had a buddy (a designated member of staff) throughout their care pathway.

Learning from complaints and concerns

- The hospital had clear processes in place for dealing with complaints, including, an up to date "complaints policy" (October 2015). Staff we spoke to were aware of the complaints procedure, but were unable to give us an example of where practice had changed in the department following a complaint. We saw complaints leaflets in the reception area and saw the hospital website had a section detailing how to make a complaint
- We saw the minutes for the monthly clinical governance committee meetings and Head of Department meeting and saw that complaints and actions were a regular agenda item. We also saw complaints were discussed at the bi-monthly Medical Advisory Committee.
- The Interim Executive Director had overall responsibility for responding to all written complaints. The hospital acknowledged complaints within 48 hours of receiving the complaint with an aim to have the complaint reviewed and completed within 20 days. During our inspection we saw the outpatients department had four complaints between January to December 2015. We saw three of the complaints had been answered within the specified timeframe. However one complaint had been assigned a stage two complaint and was still ongoing.
- Staff told us complaints were discussed at the team meetings. We saw evidence in the minutes of team meetings that complaints were a regular agenda item.

Are outpatients and diagnostic imaging services well-led?

Good

We have rated well-led in outpatients and diagnostic imaging as good because:

- The leadership, governance and culture promoted the delivery of high quality person centred care.
- We saw staff were focused on providing the best service for all patients, and were proud to work at the hospital
- Managers encouraged staff to recognise and celebrate success
- Staff told us that senior managers and team leaders were visible and approachable.
- Staff morale was high.
- The hospital had clear governance arrangements that ensured any issues affecting safety and quality of patient care were known, disseminated, managed and monitored.

However:

Some staff felt they were not as connected to the department as other staff

Vision and strategy for this this core service

- Hospital staff knew about the "BMI Vision", although not all staff were able to explain to us what the values were. Staff told us they tried to provide best quality care, by making sure they listened to patients, stayed up to date with current practice, and ensured they learned from feedback.
- The radiology imaging manager was developing a business plan for new equipment to be installed in the department. This was to be developed in line with the needs of the hospital.

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- All staff in the outpatient and diagnostic imaging departments knew about the executive team plans for developing their services. The plans included refurbishment of the consulting rooms in the outpatient department.

Governance, risk management and quality measurement for this core service

- The hospital had clear governance in place. The hospital held meetings thorough which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Heads of Department (HOD) meeting, Radiation Protection, Infection Control and Medicines Management.
- The MAC met bi-monthly and the minutes of the last four meetings were reviewed. The minutes showed the key governance areas such as complaints, incidents, health and safety and feedback from the clinical governance committee were discussed.
- The HOD met monthly and the minutes of the last four meetings were seen. The minutes showed items discussed included infection control, hospital activity, complaints and incidents.
- The Clinical Governance Committee met alternate months and discussed incidents, complaints, infection control issues and risk register review. There was also a standing agenda item to review NICE guidance, to ensure the hospital implemented and maintained best practice, that ensured any issues affecting safety and quality of patient care were known, disseminated, managed and monitored. During our inspection we saw the minutes of Clinical Governance Committee meetings held in May and July 2015 and January and April 2016.
- The outpatient department had a governance framework and reporting system in place. Regular monthly team meeting were planned and we saw evidence of these. However, these meetings did not always take place as planned. During our inspection we saw minutes of team meetings held in January, February and June 2016.
- The diagnostic imaging department carried out a variety of regular local audits to measure the quality of documentation and we saw the results of these.
- Regular quality assurance tests were carried out on equipment to test the output of machines
- The physiotherapy department used Patient Reported Outcome Measures (PROM's) to measure the quality of treatment interventions.
- During our inspection we were told that the hospital had introduced a new departmental risk register and this new risk register was shown to us. The outpatient manager was aware of the risks within their departments and were managing them appropriately. For example we saw the carpets in the outpatient department we on the register, and will be replaced during the refurbishment programme.

Leadership / culture of service

- The low staff turnover reflected the positive attitude staff with which held the services they delivered and their colleagues. There were high levels of staff stability of equal to or greater than 80% for nurses and between 60% and 79% for care assistants working within the outpatient department. This provided continuity of care.
- Staff morale was good with some staff we spoke with told us they had been at the hospital for many years. Other staff told us it felt like a "family" working at the hospital and it is a supportive place to work. One example, a staff member had recently been off sick and had received flowers and calls from their colleague, they felt very supported during this time
- Staff told us that they enjoyed working for the organisation because the culture of the organisation focused on meeting the needs of the patients.
- The staff we spoke with were extremely proud to work for the organisation and felt that the care they provided was excellent.
- Some staff told us the uncertainty of not having a permanent Executive Director (ED) had affected morale. However, since the temporary ED had been in place, a member of staff told us "things are beginning to feel a bit more stable".
- Staff told us the new management team, were visible and approachable and felt they could discuss issues and concerns with them; this was clear during the inspection as the staff were able to name the interim ED, and director of nursing. One member of staff told us they felt things are now no longer "long winded" and are "much more dynamic". Another member of staff told us "there is a buzz around the place now".

Good

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- The Director of Clinical Services, visited outpatient and diagnostic imaging department daily to ensure everything was going well and to help with any potential problems.
- The outpatients department was a part of the hospitals daily "huddle". The daily "huddle" was a meeting with all the heads of department to discuss the day's activities and any staffing or other concerns that may affect hospital services.
- Staff told us they enjoyed working at the hospital and felt they had sufficient time to spend with each patient. They told us it was a good place to work and everyone was very friendly.
- We spoke with the outpatients manager who told us she was proud of the staff working within the whole of the outpatients department, they felt the staff took time to get know patients, especially those who returned often.
- Overall staff told us they felt their immediate managers were approachable and supportive; however, some staff told us they felt remote from others in the team and their issues were not well understood, for example cover when a member of staff is off sick, which can have a negative impact on their workload.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data for all patients between July and December 2015 showed the hospital had consistently high scores (greater than 98%) and the response rates varied between 24.8% and 64%. However the response rates for this period were the same as, or better than the average England response rates for NHS patients. This showed that most patients were positive about recommending the hospital to their friends and family
- Staff told us, they always encouraged patients to leave feedback, so they can try to continually improve, services and standards of care.
- During out inspection we saw twelve compliment letters and cards to the staff from patients, expressing their gratitude for the "wonderful" care and treatment they received during their visit to the department.
- The hospital told us they regularly held focus groups, and staff told us the hospital held coffee mornings and had recently taken part in the world record attempt for largest cream tea event. However, staff could not tell us about any feedback because of this event relating to the outpatients department.
- Results of the latest patient survey (May 2016) showed high levels of satisfaction with 100% of patients recommending the outpatient department.

Innovation, improvement and sustainability

- Staff were encouraged to recognise and celebrate success. There was an 'Above and Beyond' award scheme in place, where staff could nominate colleagues or patients could nominate a member of staff member. Successes were awarded in categories such as; outstanding care, innovative thinking, amazing support, true inspiration, brilliant leadership. We were told of a member of staff who had been nominated, as they were always an excellent team member who was always willing to be flexible and put the needs of the patients first. We were told the staff member received a letter from the Executive Director, along with a prize.

Outstanding practice and areas for improvement

Outstanding practice

The hospital had a chaperone policy that was followed by the outpatient staff, there was signage in all rooms and patients were aware they could ask for a chaperone if needed. Staff maintained a chaperone register which demonstrated where and when chaperones had been required.

Areas for improvement

Action the provider MUST take to improve
Action the hospital MUST take to improve

- Take action to ensure they are compliant with Health Technical Memorandum (HTM) 05-02: Fire Code Guidance and ensure adequate lighting and signage for fire escapes, along with ensuring fire escapes are kept free from foliage. They must also address their fire plan in theatres as a priority and ensure that signage is correct and placed to ensure that staff and visitors understand which doors are fire doors, which direction to travel in the event of a fire, and that staff understand evacuation and fire policies and procedures.
- Take urgent action to ensure staff do not reuse single-use items on more than one patient.
- Ensure that the risks associated with carpeted clinical areas and corridors areas are addressed. This should include regular cleaning and appropriate mitigation for risks associated with spillages and infection control. Although we could see that some areas of the hospital carpets had been replaced and were told that this work would continue the hospital does need to address the progress and speed of these refurbishments as a priority.

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

- Take action to ensure all staff are compliant with mandatory training.
- Take action to ensure all staff have an annual performance appraisal.
- Take action to ensure they keep accurate records of all agency staff competencies on Devonshire ward.
- Ensure that staff follow BMI Healthcare corporate policy to check the pregnancy status of all female patients of potential childbearing age before surgery in line with professional guidance from NICE and the NPSA.
- Consider installing level access showers on Devonshire ward to maximise independence for wheelchair users.
- Ensure all staff are aware written information such as leaflets are available for patients in other languages through an electronic printing system.
- Ensure that all staff follow hand hygiene best practice processes in all areas of the hospital, including being “bare below the elbow”.
- Consider actions to regulate the temperature in the endoscopy suite to prevent the drying cabinet from overheating.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control 12.— Care and treatment must be provided in a safe way for service users. b. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; We found staff reusing single-use items on more than one patient. The Provider had carpets in clinical areas and were unable to evidence regular cleaning and appropriate mitigation for risks associated with spillages and infection control.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.— Care and treatment must be provided in a safe way for service users. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a) assessing the risks to the health and safety of service users of receiving the care or treatment; c)ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

This section is primarily information for the provider

Requirement notices

The provider was not compliant with Health Technical Memorandum (HTM) 05-02: Fire Code Guidance and ensure adequate lighting and signage for fire escapes, along with ensuring fire escapes are kept free from foliage. They must also address their fire plan in theatres as a priority and ensure that signage is correct and placed to ensure that staff and visitors understand which doors are fire doors, which direction to travel in the event of a fire, and that staff understand evacuation and fire policies and procedures.