BMI The Meriden 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Meriden Hospital is operated by BMI Healthcare. The hospital is registered for 52 beds, 48 of which are on the inpatient ward, with a further four beds in the endoscopy suite. Facilities include three operating theatres, all with laminar flow, a dedicated endoscopy suite, cardiac catheter laboratory and outpatient and diagnostic facilities.

The hospital provides surgery, outpatients and diagnostic imaging. We inspected surgery, outpatients and diagnostic imaging.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 24 and 25 April 2018, along with an unannounced visit to the hospital on 2 May 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

See the surgery section for main findings.

Services we rate

We rated this hospital as **good** overall because:

- The hospital had systems and processes in place to protect patients from avoidable harm and abuse.
- The processes for reporting, investigating and learning from incidents were well established and implemented. This was an improvement from the last inspection in May 2016.
- Infection prevention and control practices were performed well, and staff followed hospital policies. The environment was clean and fit for purpose.
- Medicines were managed and stored correctly. This was an improvement from the last inspection in May 2016.
- Staff assessed risk to patients and responded appropriately when individual patient's risks increased.
- The hospital participated in national audits where applicable. The hospital was fully engaged in the Private Healthcare Information Network (PHIN) work to develop outcome measures for independent healthcare patients.
- The hospital had a comprehensive internal audit programmes in place to monitor services and identify areas for improvement.
- Staff treated patients with care, kindness and compassion.
- Complaints and concerns were taken seriously, responded to in a timely way and managed with face to face meetings with the complainant where needed.
- Managers were visible, approachable and performed well.
- Staff we spoke with, enjoyed their work and were proud to work at the hospital. They described an open culture and felt supported and listened to by their immediate managers.

Summary of findings

We found areas of **good** practice in relation to **surgery**:

- Patients had access to care and treatment in a timely way and cancellations to surgery were minimal.
- Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care.
- Comprehensive risk assessments were carried out for specific patient groups and risk management plans were developed in line with national guidance.

And some areas for **improvement**:

- During one medicines round a nurse did not follow one standard for administering medicines.
- Not all patient outcomes were measured for patients undergoing colonoscopies.
- There was only one toilet in the endoscopy unit, and patients were admitted in the cubicles where some information could be over heard by other patients.
- We found areas of **good** practice in relation to **outpatient care**:
- There were robust systems in place to ensure that patients and staff were protected by adherence to national guidelines relating to ionising radiation and diagnostic imaging.
- Patient care and treatment was delivered in line with national guidance.

And some areas for **improvement**:

- There were no patient leaflets in the diagnostic imaging department.

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

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients and diagnostic imaging	Good 	We rated this service as good because it was safe, caring, responsive and well-led. We did not rate the service for being effective.

Summary of findings

Contents

Good

BMI The Meriden Hospital

Services we looked at
Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The Meriden Hospital

BMI The Meriden Hospital was opened in February 2006 and was purpose built. The hospital primarily serves the communities of Coventry and Warwickshire. It also accepts patient referrals from outside this area. The hospital is on the site of the local NHS trust. The hospital was developed on NHS land following agreement between BMI Healthcare and the local NHS trust. BMI retained the rights to complete all private work on the NHS site for 30 years and holds a 125-year lease on the land.

The hospital undertakes a range of surgical procedures, to patients aged eighteen years and over. They also provide outpatient consultations to patients aged eighteen years and over.

There are three theatres all with laminar flow, an endoscopy suite and a dedicated cardiac catheter laboratory.

There are 16 consulting rooms situated on the ground floor which include one dedicated ear, nose and throat room, two ophthalmology rooms, one cardiology room, one minor procedures room and one treatment room. There is a physiotherapy department and imaging diagnostics department. Radiography, ultrasound and fluoroscopy are provided by BMI The Meriden hospital staff with MRI and CT services provided by Meriden Advanced Imaging Service which is run by United Medical Enterprises (UME).

There are administration and management staff on site.

The hospital has a registered manager who has been in post since January 2017.

The registered manager is the accountable officer for controlled drugs.

The hospital offers services to NHS patients, self-pay funded patients and privately insured patients.

Our inspection team

The team that inspected the provider comprised of a CQC lead inspector, two other inspectors and five specialist advisors, with expertise in surgery, endoscopy, outpatients and governance. The inspection team was overseen by Bernadette Hanney, Head of Hospital inspection.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 24 and 25 April 2018, along with an unannounced visit to the hospital on 2 May 2018. Before visiting, we reviewed a range of information we held about the hospital and both core services.

During the inspection, we visited all departments within the hospital. We spoke with 30 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 17 patients and five relatives. We also received 39 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed 30 sets of patient records.

Summary of this inspection

Information about BMI The Meriden Hospital

BMI The Meriden Hospital provides an inpatient and outpatient service for various specialities to both private and NHS patients. This includes, but is not limited to, orthopaedics, urology, neurosurgery, gynaecology, general surgery, endoscopy, ear, nose and throat (ENT), cosmetic and oral maxillofacial. No persons under the age of 18 are seen and/or treated at the hospital.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital had been inspected in May 2016, with an unannounced inspection in June 2016, which found that the hospital was not meeting all standards of quality and safety it was inspected against. The hospital was previously served requirement notices against Regulation 12; safe care and treatment and Regulation 17; good governance of the Health and Social Care Act Regulations 2014.

Activity (February 2017 to January 2018):

- In the reporting period February 2017 to January 2018, there were 2,098 inpatient and 3,306 day case episodes of care recorded at the hospital; of these 38% were NHS-funded, and 40% were other funded.
- There were 33,973 outpatient total attendances in the reporting period; of these 45% were NHS-funded and 55% were other funded.

As of November 2017, 206 doctors worked at the hospital under practising privileges. An agency provided four regular resident medical officers (RMOs) who worked on a weekly rota. The hospital employed 28.5 full-time equivalent (FTE) registered nurses, 25.9 FTE care assistants, as well as having its own bank staff.

Track record on safety (February 2017 to January 2018):

- Zero never events.
- 212 clinical incidents; 123 no harm, 73 low harm, 17 moderate harm, zero severe, zero death
- Zero incidences of hospital acquired Methicillin-resistant staphylococcus aureus (MRSA).
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- Zero incidences of hospital acquired Clostridium difficile (C.difficile).
- Zero incidences of hospital acquired E-Coli.
- 131 complaints, one of which was referred to the ombudsman or independent healthcare sector complaints adjudication service (ISCAS).

Services accredited by a national body:

- Clinical and or non-clinical waste removal.
- Pathology and histopathology.
- Magnetic resonance imaging (MRI) and computerised tomography (CT).
- Blood transfusion.
- Interpreting services.
- Laundry.
- Maintenance of medical equipment.
- Resident medical officer provision.
- Catering.

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?

Good

We rated safe as good because:

- There was evidence of learning from incidents and complaints, and effective processes were in place to reduce risk.
- Staff were encouraged to report incidents and the duty of candour regulation was applied when things went wrong.
- Controlled medicines were safely stored and the keys were secure. This was an improvement since the inspection in May 2016.
- The management of medicine prescription pads in outpatients was robust, and there was an audit trail meaning that the risk of possible loss of, or inappropriate use of prescriptions, was minimised.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. All staff had been trained to the required level.
- Clinic rooms had been refurbished which meant that they were compliant with current Health and Building Note regulations 2013.
- The environment was visibly clean and there were systems in place to maintain the safety of equipment used across clinical areas.
- There were reliable systems in place to prevent and protect people from a healthcare associated infection.
- The wards, endoscopy unit and theatres were visibly clean and tidy.
- There were effective arrangements for the receipt, storage, dispensing and disposal of unwanted medicines.
- Patients' individual care records were accurate, complete, legible, up-to-date, and stored securely.
- Comprehensive risk assessments were carried out for specific patient groups and risk management plans were developed in line with national guidance.
- There were arrangements in place with a local acute NHS trust to provide 24 hour emergency support should patients require high dependency nursing or urgent diagnostics.

However;

- We found medicine administration standards were not followed during one medicine round. During the unannounced inspection the senior management team had mitigated the risk and further medicines rounds we observed were compliant.

Summary of this inspection

- Some equipment in the imaging and cardiac catheter laboratory was nearing the end of its life span however; this was monitored and recorded on the department's risk register.

Are services effective?

Good

We rated effective as good because:

- Care was provided in line with best practice guidelines.
- Patients we spoke with said they had been offered pain relief and felt their pain was being managed appropriately. Patient outcomes were audited and showed results in line with those nationally.
- Patient Led Assessment of the Care Environment (PLACE) audit from March to June 2017 showed the hospital scored 98% for organisational food, which was significantly better than the England national average of 88%.
- BMI the Meriden was one of the first to submit to the Private Healthcare Information Network (PHIN) system as recommended by the Competition and Markets Authority.
- Staff had access to information needed to deliver effective care and treatment to patients.
- Patients at risk of venous thromboembolism (VTE) were prescribed VTE prophylaxis in accordance with NICE guidelines.
- Practising privileges for consultants were reviewed annually and included all aspects of a consultant's performance.
- Patients said they had been given clear information about the benefits and risks of their surgery in a way they could understand prior to signing the consent form.
- The hospital monitored adherence to policies with the use of local audits.
- Patient outcomes were audited in outpatients and services adapted to improve outcomes for patients.
- Outpatient and imaging staff provided patient appointments over weekends according to clinical needs. On call provision for MRI and CT emergencies out of hours was provided by the local NHS trust.
- There were arrangements to ensure staff could access all necessary information to provide effective care.
- Most staff we spoke with were clear about what actions they would take if they had concerns about a patient's capacity to understand information and consent to treatment
- Staff had received training on the Mental Capacity Act and Deprivation of Liberty although had limited exposure to patients requiring mental capacity assessments.

Summary of this inspection

- Multi-disciplinary teams worked well together to provide effective care. Multi-disciplinary team working included hospital staff, local NHS trusts, clinical commissioning groups and general practitioners.
- Staff had received an up to date appraisal to identify individual training needs. Staff were supported to engage with specialised training to improve care and treatment within their modality.

However;

- Not all patient outcomes were measured for endoscopy patients undergoing colonoscopies. However, following our unannounced inspection, we saw evidence that senior staff had acted to ensure compliance.
- Not all corporate policies were up to date.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with dignity and respect and provided emotional support throughout their treatment. Staff helped patients to understand their condition or treatment by giving written information after their treatment and allowing time to ask questions.
- All outpatient services offered patients a chaperone and departments clearly displayed signs in waiting areas and consulting rooms.
- We saw examples of staff taking measures to ensure patients' privacy and dignity were respected.
- Patients understood their care and treatment and had opportunities to ask questions.
- Patient satisfaction scores results from January to December 2017 showed 98% of all patients said the quality of the care was very good.
- The Patient Led Assessment of the Care Environment for the period of March to June 2017 showed the hospital scored 87% for privacy, dignity, and well-being, which was higher than the England average of 84%.
- Patients told us that staff had enough time to provide them with adequate emotional support.

Are services responsive?

Good

We rated responsive as good because:

- The hospital had an admissions policy which detailed criteria for NHS patients who could be safely treated at the hospital.
- Patients were admitted on a planned basis for elective surgery, this included self-funded patients and NHS patients.

Summary of this inspection

- Theatre list for elective surgery were planned and ensured all aspects of patient's. requirements were checked and considered before booking a patient.
- Patients had timely access to initial assessment and treatment. At the time of the May 2016 inspection, hospital data showed that 95% of patients started non-admitted treatment within 18 weeks of their referral from January to December 2015. This was above the England average of 92%.
- Patient Led Assessment of the Care Environment showed the hospital scored 84% for dementia, which was better than the England average of 77%.
- There were arrangements for patients to be seen promptly by a doctor if they became unwell.
- Waiting times, delays and cancellations were monitored and were managed appropriately.
- Cancellations were minimal and managed appropriately.
- The OPD and diagnostic imaging department provided services in an environment that met people's needs.
- Patients could access the majority of services in a timely way for initial assessments, diagnoses or treatment.
- The service had good working relationships with the local clinical commissioning group to manage services for NHS patients.
- Complaints were always responded to in a timely manner.
- Patients could book appointments at a time to suit themselves. Clinics were made available at weekends to meet individual needs.
- The hospital had very low 'did not attend' (DNA) rates. All patients who missed their appointment were followed up and offered a second appointment within 28 days.
- The physiotherapy service had extended the department's opening times to enable patients to access the service during evenings and at weekends. A seven day a week service was available.

However;

- Staff admitted and discharged patients in cubicles within the endoscopy unit. Other patients in adjacent cubicles could overhear confidential information. We could not be assured that patient confidentiality was being maintained. This was raised with senior staff at the time of our inspection who had taken actions to mitigate risk by the time of our unannounced inspection.

Summary of this inspection

- We were not assured that toilet facilities were adequate in the endoscopy suite to meet the needs of patients who were administered bowel preparation. However, this concern was rectified once highlighted to the senior management team.
- There were no radiology patient information leaflets however, corporate information leaflets were being adapted and would be available once approved.

Are services well-led?

Good

We rated well-led as good because:

- The hospital's senior management team were visible, approachable, and supportive. Staff could raise concerns or share ideas and felt that they were listened to.
- Audit results were discussed at governance meetings, with findings cascaded to staff through team meetings and via email.
- The provider had a five-year vision from 2015 to 2020, with eight strategic objectives to drive positive change and further improve the quality of service provision.
- Training and development was a focus for 2018 as reflected in the 'BMI Say' action plan. Heads of departments identified training needs of staff through appraisal.
- Clinical leads were visible, approachable and integral to daily functioning of the service.
- Service level agreements were reviewed regularly to ensure they were still fit for purpose
- Patients were actively encouraged to give feedback through patient satisfaction questionnaires, Friends & Family Test and via the hospital's complaint process.
- Staff had equal opportunities for accessing training and development.
- There was good working relationships between staff, their managers and senior staff and their managers and staff morale was generally good.
- Staff were aware of the department's vision and strategy and posters were displayed in offices.
- There was a robust governance process in place to manage risks.
- The department had taken action to ensure risks identified during the May 2016 inspection, were actioned.
- There was a culture of learning and improvement across the service.

However;

Summary of this inspection

- We were not assured of effective communication of concerns between the endoscopy staff and the senior management team.
- There was no effective governance system in place to monitor, interrogate, and collate colonoscopy outcomes. The hospital used a gastrointestinal reporting tool to measure colonoscopy outcomes. However, the system was not interrogated to monitor colonoscopy outcomes including individual consultant outcomes to drive improvement. Following our inspection, we saw evidence that senior staff had taken action to ensure compliance.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Good

Surgery

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

Are surgery services safe?

Good

The main service provided by this hospital was surgery. Where our findings on surgery - for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

In this section, we also cover hospital-wide arrangements such as how they deal with risks that might affect the hospital's ability to provide services (such as staffing problems, power cuts, fire and flood), the management of medicines and incidents, in the relevant sub-headings within the safety section. The information applies to all services unless we mention an exception.

We rated safe as **good.**

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. There was an incident reporting policy dated November 2017 in place. Heads of departments and clinical leads had completed root cause analysis and human factors training.
- The hospital had introduced a new electronic incident reporting system, had updated policies to closely mirror the serious incident-reporting framework, and had completed a full review of incidents to gain assurance that incidents had been graded and reported correctly. Staff were comfortable with using the reporting system and gave examples of incidents that they had raised.
- All staff had received training to report incidents on the electronic reporting system however, not all staff had been required to report an incident. We observed refresher training to update staff on the use of the electronic reporting system was planned at the time of our inspection.
- Where incidents had been reported within theatres, staff were encouraged to complete a reflective writing. This reflection was saved within the staff file and helped towards revalidation of their professional registrations and learning.
- There had been 168 incidents reported from February 2017 to January 2018 within surgery. A total of 124 incidents were reported within the ward area, 42 incidents within theatres and two incidents had been reported in endoscopy. Of the 168 incidents reported, 11 were classified as clinical incident with moderate harm, 43 with low harm and 95 with no harm. One of the incidents reported was an accidental injury sustained by a patient during an elective surgery. This injury was a recognised complication of surgery and had been explained as a potential risk when the patient was consented. We saw that a root cause analysis had been undertaken and the incident had been fully investigated and there was evidence of actions taken.
- During our inspection in 2016, we reviewed six incidents at random and found that three of these had not been graded correctly. During this inspection, we reviewed three incidents and found that all had been graded correctly. We spoke with senior staff who said a new form had been implemented following our last inspection to guide staff on classification of incidents. Staff had been advised to refer to this classification form when classifying incidents.

- All serious incidents were analysed at clinical governance meetings to ensure that lessons were learnt. This information was disseminated to staff via head of department meetings through ward handovers, meetings, and safety briefings.
- The hospital did not report any 'never events' from February 2017 to January 2018. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- From November 2014, all providers were required to comply with the Duty of Candour Regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were fully aware their responsibilities under the duty of candour (to be open and honest) regulation, ensuring patients always received a timely apology when there had been a defined notifiable safety incident. We saw examples of where duty of candour had been applied with regards to incidents and complaints.
- Staff told us they were encouraged to report incidents and received direct feedback when they had been involved in an incident. Staff also told us they received feedback about incidents that had occurred within the hospital and other hospitals within the BMI Healthcare group. Information was cascaded in a variety of means including the daily 'communication cell', which was a meeting held every morning to review hospital activity and raise any concerns, staffing brief, emails, governance and team meetings, newsletters and noticeboards. We observed this during our inspection.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes. We did not see this displayed in the hospital. However, information provided by the hospital showed clear information about overall incidence of methicillin-resistant staphylococcus aureus (MRSA) which is a bacterium which causes infections in different parts of the body, and clostridium difficile toxin (C. Difficile) which is a bacterium that is one of the most common causes of infection of the colon.
- From February 2017 to January 2018, there had been no incidents of MRSA, Escherichia coli (a type of bacteria that normally live in the intestines of people and animals) or C. Difficile.
- Staff carried out risk assessment for venous thromboembolism (VTE) in accordance with National Institute for Health and Care Excellence (NICE) guidelines. Data provided by the hospital showed 99% of patients had been risk assessed in the reporting period from February 2017 to January 2018. This exceeded their target of 95%. VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients. There was no incidence of VTE or pulmonary embolism in the reporting period.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare associated infection.
- The wards, endoscopy unit and theatres were visibly clean and tidy.
- The hospital had policies and procedures in place to manage infection prevention and control. Staff accessed policies via the hospital intranet and could demonstrate how these policies were easily available.
- Staff followed the hospital's policy on infection control, for example, we observed staff complying with 'arms bare below the elbow' and not wearing jewellery.
- The hospital had an infection prevention and control lead nurse and link nurses in clinical areas. Link nurses were responsible for collating audit data of cleaning schedules and producing actions to address compliance when necessary. For example, they were involved in hand hygiene audits.
- Infection control audits were carried out monthly, such as environmental cleaning and hand hygiene. From November 2017 to February 2018, overall compliance to hand hygiene was 97%. The hospital had an infection prevention and control annual programme action plan

for 2017/2018. The hospital had systems in place to manage and monitor the prevention and control of infection and was reviewed by the infection prevention and control committee.

- During our last inspection in 2016, we observed a lack of clinical hand washing facilities within the ward area. Clinical hand basins were provided in utility areas but not inpatient rooms. This meant that at the point of care, staff were washing their hands in patient's private bathrooms. Although the sinks in patient bathrooms had wrist operated taps, best practice would be to have dedicated clinical sinks within each ensuite rooms. Department of Health Guidelines 2013 HBN00-09 state that 'ensuite single bed rooms should have a general wash-hand basin for personal hygiene in the ensuite facility in addition to the clinical wash-basin in the patient's room'. Therefore, the hospital was not compliant with infection prevention and control guidelines. The hospital was aware of the issue and it was recorded in the risk register in 2016.
- We observed good practice with regards to hand washing and the use of hand gel, particularly in patient bedrooms, where clinical sinks were not available yet.
- MRSA screening was done prior to admission when required, for example for patients undergoing orthopaedic surgery. This involved taking a swab from the patient's skin or their nose to test for MRSA. This followed the national guidelines.
- Within the endoscopy department, there was a decontamination process and defined cleaning pathway for endoscopes after use. All endoscopes were electronically tracked. This meant that in event of a failure in the decontamination cycle/process or for infection control reasons they were traceable.
- The hospital had a service level agreement with the local NHS trust for infection control services. This included the consultant microbiologist attending the infection control committee to review infection control incidents, audits, water testing results as well as offering advice on antibiotic prescribing and any new building works in the hospital.
- The hospital had carried out a total of 422 primary hip and knee arthroplasty procedures from quarter one to quarter four in 2017. Incidents of surgical site infections were monitored and reported to the clinical governance committee and there had been three surgical site infections in the reporting period from February 2017 to January 2018. The three infections were acquired following a primary knee arthroplasty and hip arthroplasty.
- The hospitals Patient Led Assessments of the Care Environment (PLACE) 2017 indicators were better than the England average. Cleanliness scored 100% across all areas.
- The hospital had a service level agreement (SLA) for microbiology support and infection control advice with a third party. We saw evidence that the microbiologist attended alternate infection control meetings, and they were available to offer telephone advice as needed.
- The hospital held infection prevention meetings monthly. Representatives from theatre and the ward attended, they then cascaded information to their respective teams.

Environment and equipment

- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- Resuscitation equipment, for use in an emergency in operating theatres and the ward area were regularly checked and documented as complete and ready for use. The resuscitation trolleys were secured with tags, which were removed daily to check the trolleys and that their contents were in date. There was no paediatric resuscitation equipment available and no evidence that this had been risk assessed.
- There were systems to maintain and service equipment as required. Equipment had undergone safety testing to ensure they are safe to use. The hospital engineer carried out general maintenance in the hospital and there was a specific maintenance contract for specialist equipment for example the endoscopy washers and anaesthetic machine. There was a dedicated electronic system to manage the maintenance programmes and alert staff when specific equipment required maintenance.

- The hospital had a service level agreement (SLA) with the local NHS trust for the maintenance and breakdown of equipment such as the electrocardiogram machine (ECG). We were informed these were generally repaired on the same day.
- We found some equipment in endoscopy and cardiac catheter laboratory was nearing the end of its life span. In mitigation, this was included in the department's risk register and under regular review to monitor faulty equipment and timeliness of repair to minimise impact to service continuity. Staff told us this was escalated to senior managers as required who reviewed funding for replacement equipment.
- The Patient Led Assessment of the Care Environment (PLACE) for the period of March to June 2017, which showed the hospital, scored 96%, for condition, appearance, and maintenance, which was better than the England average 94%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.
- Lead aprons were checked annually and evidence was documented in a folder.
- We saw hazard warning lights with controlled area sign notices in place outside the cardiac catheter laboratory.
- We found the suction filters in the endoscopy procedure room had not been changed since February 2012. We raised this with senior staff in endoscopy who took immediate action to replace the filters while we were still within the department.

Medicines

- There were effective arrangements for the receipt, storage, dispensing and disposal of unwanted medicines. Staff ensured any drug alerts received were responded to and reported outcomes at the clinical governance meetings.
- The hospital had a service level agreement with the local NHS trust who provided all pharmacy services. This included providing all medicines for use in departments, providing medical alerts, recalls and an emergency duty service. The trust also provided training for the hospital staff.
- The pharmacist visited the hospital daily from Monday to Friday and reviewed all patient prescription charts, and provided advice to medical and nursing staff on clinical safety issues. In addition, a pharmacy technician was allocated for three hours a week to the hospital. They were responsible for ensuring stock orders of medicines were completed. There was a pharmacist on call, for when they were not onsite.
- During our inspection in May 2016 we found that the medicine fridge in the endoscopy unit was unlocked and the lock was broken. This meant there was a risk of medicines being left unattended in an unlocked fridge when the unit was unstaffed and not in use. During this inspection, the endoscopy fridge lock had been repaired, a medicines management policy had been reviewed re-issued to staff. Staff held medicines governance meetings and fed into the clinical governance.
- Controlled drugs (medicines controlled under the misuse of drugs legislation) were stored and reconciled correctly.
- Contrast agents and medicines were stored in locked cupboards within the cardiac catheter laboratory.
- We saw that medications on the ward were kept within locked cupboards, inside a locked store room. The temperature of the room was monitored daily to ensure it kept within correct temperatures, to ensure the efficacy of the medicines. There were separate locked cupboards for intravenous fluids, medicines, topical creams and controlled drugs, to ensure that these were not mixed up. The cupboards were neat and tidy. Medications requiring refrigeration were kept within a locked fridge in the store room.
- Each theatre used a key cupboard system to store all keys required for the theatre to be operational. We saw that keys were signed out daily.
- Data provided by the hospital showed that 95% of staff were up-to-date on the medicines management training which was above the hospital target of 90%.

- We observed the administration of medicines during our inspection and found staff pulled out a strip from a ripped paracetamol (used for pain relief) box and did not check the drug name and expiry date. This medicine was stored next to an ibuprofen (used for pain relief) box. There was a risk that a wrong medication could be picked up and administered in error. This was not in line with the Nursing and Midwifery (NMC) standards for medicines management which states that 'you must check that the prescription or the label on medicine dispensed is clearly written and unambiguous, you must check the expiry date (where it exists) of the medicine to be administered'. We raised this with senior staff at the time of our inspection. During the unannounced inspection, we observed another medicine round and staff adhered to the NMC standards. During our unannounced inspection, senior staff told us they had recorded it as an incident and had discussed with the nurse we observed who had done a personal reflection about the incident. They had issued the NMC standards for medicines administrations and the BMI corporate policy on administration of medicines. Senior staff had also implemented a medicines management assessment for all agency nurses attending the ward and undertaking drug rounds and no agency nurse would administer medicines to patients until a medicines assessment had been completed.
- The ward had a stock of regular discharge medicines. There were checked and signed out by two nurses. Discharge medicines were also provided by the local trust pharmacy. The hospital could fax "take home" prescriptions through to the pharmacy initially with the original prescriptions being delivered by the hospital porters to the trust. Staff confirmed this process and told us that medicines were generally received in a timely manner.
- We reviewed nine medicine charts and saw that all entries were signed for and all allergies were documented.
- Room and fridge temperatures were checked and recorded daily to ensure stored medicines were kept at a safe level and were safe for use.
- The management of medicines was audited. We saw an example where a patient had been prescribed a patient's own drug and did not take the correct dose. Staff involved received support from the director of clinical services and reflected on their actions.
- BMI Healthcare held monthly pharmacy teleconference meetings, where medicine incidents reported across the BMI group were discussed and learning was shared. The teleconference meetings were repeated three times during the month to enable pharmacy staff to attend when they were available.
- Medicines management was a standard agenda item on the quarterly hospital clinical governance meetings. We saw evidence of this from the meeting minutes we reviewed, which included information regarding medication incidents, national guidance updates, and drug safety alerts.
- The director of clinical services submitted a quarterly controlled drugs occurrence report to the local intelligence network (LIN). This was in accordance with national requirements (Department of Health, The Controlled Drugs (Supervision of management and use) Regulations 2013, February 2013).
- There were local microbiology protocols for the administration of antibiotics and prescribers used them. The hospital had adopted the local NHS trust's guidelines regarding the use of antibiotics and reported strong links with the local NHS pharmacy team.

Records

- Patients' individual care records were accurate, complete, legible, up-to-date, and stored securely. There was a corporate retention of records policy, which stated that information has most value when it is accurate, up-to-date, and accessible when required.
- The hospital used a paper based record system for recording patients care and treatment. Records were clear and stored safely.
- We reviewed 23 sets of patient records. Information was easy to access and the records contained information on the patient's journey through the hospital including pre-assessment, investigations, results, and treatment provided. There were pathway booklets for different

types of procedures. These pathways ensured that the progress was made and any deviation from the prescribed pathway could be identified and an appropriate intervention made swiftly.

- Patient's records were stored in the nursing office on the ward. The door to the office was lockable with a keypad system.
- Theatre records included the five steps to safer surgery checklist. We saw that these were completed fully and appropriately.
- When changes were made to the theatre lists, the list was reprinted on different coloured paper so that staff could easily see that it was a newer version.
- When patients were discharged, their notes were placed in a locked box and collected by the medical records team to be stored according to hospital policy.
- Discharge letters were sent to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided.

Safeguarding

- There were processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements.
- The hospital had an up-to-date corporate safeguarding adults policy. This incorporated mental capacity, deprivation of liberties and protecting people at risk of radicalisation (PREVENT) for England and Wales which defined responsibilities at national, regional and hospital level. This was available to staff on the intranet and staff knew how to gain access.
- Data provided by the hospital showed 96% of required staff had completed safeguarding of vulnerable adults, level one training, 91% had completed level two training and this was better than the BMI Healthcare target of 90%. Level three safeguarding of vulnerable adults indicated 100% of required staff had completed this training. Staff had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children. They were able to explain how to respond to and escalate a concern.
- During the May/June 2016 inspection, nursing staff did not have access to a registered children's nurse or had not received level three safeguarding children's training. This was not in line with national guidelines. Since this inspection, the hospital had reviewed service provision and no longer provided a children's and young person's service.During this inspection we found the hospital had also strengthened safeguarding training and processes. Training was delivered in line with the BMI safeguarding children and the intercollegiate document safeguarding adults policy. We were told clinical staff were required to complete safeguarding adults and children training at level three, which exceeded national requirements as persons under the age of 18 were no longer seen and/or treated at the hospital. Non-clinical staff were required to complete safeguarding training at level two.
- The director of clinical services (DCS) was the hospital safeguarding lead for both vulnerable adults and children, and trained to level three. The DCS had access to the BMI regional safeguarding lead trained to level four. This was in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.
- There were hospital guidelines in place concerning chaperones, which were offered to all patients, undergoing intimate examinations or procedures of the genitalia, breast, or peri-anal areas. This helped to ensure that patients felt comfortable, were safeguarded from abuse and staff were protected from potential allegations of abuse.
- The hospital had recently rolled out a chaperoning training and 50% of staff had received this training at the time of our inspection.
- The safeguarding policy included information on female genital mutilation (FGM). This training had been recently introduced and 98% of staff had completed the training. Staff were aware that they had a mandatory reporting duty to report any cases of FGM.
- The hospital had recently introduced PREVENT as a mandatory training. Mandatory training data provided by the hospital showed 96% of staff had received training. Theduty is the duty in the Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways topeople from being drawn into terrorism.

Mandatory training

- The hospital had effective processes in place to ensure staff received mandatory training in safety systems, processes and practices.
- The hospital had a mandatory training programme, which included topics such as infection prevention and control, moving and handling, fire safety, conflict resolution, safety, health and the environment, and information governance. The mandatory training programme was tailored to staff's individual needs and relevance to their role. For example, clinical staff were required to complete adult immediate life support and medicine management training, and non-clinical staff completed basic adult life support training.
- Staff explained they received mandatory training to provide safe care. Some of this was completed through e-learning and some through face-to-face training, for example, manual handling. Staff described a range of topics included in their training such as information governance and infection prevention and control.
- Mandatory training sessions could be accessed on the corporate intranet via 'BMI Learn'; an online resource of training modules. Sessions included: adult basic and immediate life support, equality and diversity, control of substances hazardous to health, fire safety, infection prevention and control, moving and handling awareness, blood transfusion, safeguarding adults and children and PREVENT (protecting people at risk of radicalisation), information governance and waste management.
- Hospital staff had an overall mandatory training compliance rate of 91%, which was better than the hospital target of 90%. Heads of departments were encouraged to support staff to attend sessions to ensure compliance. Data provided by the hospital showed that 93% of clinical staff were up-to-date on adult basic life support training and 93% of clinical staff had received adult immediate life support training which was above the hospital's target of 90%.
- The hospital provided medical gases and blood transfusion training as mandatory modules. We found compliance rate for registered practitioners was 84% for medical gases training and 91% for blood transfusion.
- The hospital had recently introduced information governance, care and communication of the deteriorating patient, chaperoning and female genital mutilation as mandatory training modules. Data provided by the provider showed that staff were up-to-date on these training modules.
- Resident medical officers (RMOs) were trained in advanced life support (ALS). Some senior nursing staff and operating department practitioners were also trained in ALS.
- The compliance co-ordinator monitored staff compliance with mandatory training and sent monthly reports to heads of department. The employee compliance co-ordinator also monitored non-attendance and re-scheduled staff onto sessions they had missed to promote compliance.
- Mandatory training was discussed at the induction day for all new starters. Staff signed an agreement on appointment about their responsibility to ensure they undertook the mandatory training relevant to their role.
- Staff held induction sessions regularly for new starters followed by a customer care course. The Executive Director was involved in the induction to discuss the hospital's vision and values.
- The organisation had a sepsis policy. Nursing and theatre staff we spoke with had received training as e-learning and data showed compliance was at 92%.
- All theatre and endoscopy staff had competency and mandatory training files. We looked at staff files, found they were all up-to-date, and provided evidence of completion of mandatory training.
- The senior management team and heads of department had oversight of training compliance. The director of clinical services received a weekly training compliance report, which was shared with the heads of department. Mandatory training compliance was also discussed at various meetings, including the clinical governance and departmental meetings, and the daily 'communication cell' staff brief.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

Good

Surgery

- Comprehensive risk assessments were carried out for specific patient groups and risk management plans were developed in line with national guidance.
- There were arrangements in place with a local acute trust to provide 24 hour emergency support should patients require high dependency nursing or urgent diagnostics.
- The hospital had a 'massive blood loss' protocol and staff were aware of where the emergency blood was stored and how to obtain it. Further blood for transfusion was obtained through the local NHS trust blood bank and the details of how they were contacted were included within the flow chart attached to the blood loss protocol.
- Where patients were transferred from theatre to a recovery area, we observed the anaesthetist, surgeon and scrub nurse verbally handed over the care and treatment carried out in theatre and discussed medication which had been prescribed for both recovery and the ward.
- All 'accountable items' were checked by two members of the theatre team using an instrument sheet. Accountable items are reusable or disposable which by nature are at risk of being retained in a patient. Disposable items such as swabs and needles were documented on a count board in the patient care plan. This was checked pre and post operation and staff signed to confirm this had been undertaken.
- If a patient deteriorated the consultant would plan for transfer to the local NHS trust. There was a policy to support this process and a SLA between the hospital and the local NHS trust. There had been 10 unplanned patient transfers to the local NHS trust from February 2017 to January 2018.
- Preoperative assessment is a clinical risk assessment where the health of a patient is considered to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. It also gives an opportunity to ensure that patients are fully informed about the surgical procedure and the post-operative recovery period and can arrange for post-operative care at home. We reviewed eight preoperative assessment forms and saw that they were completed appropriately to ensure patients were ready for their surgical procedures.
- All patients who were having major planned surgery, involving the insertion of a prosthesis; such as knee or hip replacement, attended the preoperative assessment clinic. Preoperative assessments were carried out in line with National Institute of Health and Care Excellence guidelines.
- The theatre team used the World Health Organisation (WHO) Five Steps to Safer Surgery checklist, which was designed to prevent avoidable mistakes; this was an established process within the team. This included checks such as patient identify, allergies and ensuring the consent form had been signed. We observed staff using the checklist prior to surgery during the inspection. A programme was in place for the theatre five steps to safer surgery checklist audit. We reviewed the audit and saw the compliance of 98% had been achieved.
- The national early warning score (NEWS) was used to identify deteriorating patients. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate, all of which were scored according to pre-determined parameters. The NEWS tool was used to identify the deteriorating condition of patients. This system alerted nursing staff to escalate, according to a written protocol, any patient whose routine vital signs fell out of safe parameters. There were clear directions for actions to take when a patient's score increased. There were appropriate triggers in place to escalate care, which members of staff were aware of. We reviewed 23 sets of patient notes and found that scores were added up correctly and escalation was carried out appropriately. This meant that patients who were deteriorating or at risk of deteriorating were recognised and treated appropriately.
- Staff within the cardiac catheter laboratory had amended the NEWS assessment tool to be more patient specific. Staff gave an example where a patient living with a cardiac condition scored high on the NEWS based on their condition. This prompted them to make a patient specific scoring system to enable accurate scoring and escalation.
- Patients were swabbed to assess if they had any colonisation of MRSA at the pre-assessment clinic. When

results were found to be positive the admission date, if necessary, was deferred and the patient provided with a treatment protocol to use at home, according to the hospital's MRSA policy.

- Risk assessments were completed using nationally recognised tools, such as the Waterlow score to assess patients risk related to pressure ulcers. Other risks assessed were those of mobility and moving and handling and venous thromboembolism (VTE). We saw that these were documented in the patient's records and included actions to mitigate any risks identified.
- Each patient room and bathroom had emergency call bells to be used to alert staff when urgent assistance was required, these were routinely tested to ensure they were fit for purpose.
- Risk assessments were completed using nationally recognised tools, for example the Waterlow score, to assess patients' risk of developing pressure ulcers.
- The service had a sepsis screening tool and sepsis care pathway for staff to use if they suspected a patient had sepsis. Nursing staff were aware of the screening tool and pathway and told us they would escalate any patients displaying these symptoms to the resident medical officer (RMO).
- The practising privileges agreement required surgeons to be contactable at all times when they had patients in the hospital. They needed to be able to attend the hospital within 30 minutes, according to the level of risk to the patient. They had a responsibility to ensure suitable arrangements were made with another approved practitioner to provide cover if they were not available, for example when they were on holiday.
- If a patient's health deteriorated, staff were supported by medical staff and a resident medical officer (RMO). The RMO was a registrar level doctor who was on duty 24 hours a day and was available on site to attend any emergencies. The hospital had a transfer agreement in place with the local acute trust should a patient require a higher level of care. Staff could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care.

Nursing and support staffing

- At the time of our May 2016 inspection, there was no baseline staffing tool used in the outpatient's department to monitor staff levels. During this inspection, we saw the hospital had introduced a nursing dependency and skill mix planning tool to support the management of a safe staffing level and mix.
- Staffing to patient activity levels has been a continued focus for the hospital. Labour tools had been implemented by heads of departments to effectively support safe staffing.
- The service used the theatre utilisation tool (TUT) in the theatre department and across BMI Healthcare. The tool was designed to automate analysis of a number of key theatre department process measures. The TUT increases the efficiency of the department by refining staff allocation to patient numbers and procedure mix and therefore reducing staffing costs, creating capacity for additional caseload, improving patient safety and ultimately increasing satisfaction for patients, consultants and staff.
- Patient admissions were known in advance and staffing levels calculated using an electronic labour monitoring tool, this ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs.
- We saw that staff rotas were planned four weeks in advance. Bed occupancy varied therefore the hospital used a staffing tool which was based on an analysis of the dependency of the patients and the subsequent nursing activity required to meet the patients' needs.
- The numbers of nursing staff required was then adjusted accordingly. This was completed five working days in advance and was reviewed daily by the ward manager to ensure that the ward had appropriate numbers of nursing staff to provide safe care to patients.
- The vacancy rates for operating department practitioners and healthcare assistants was at 15%.
- During our inspection we saw that planned numbers of nursing staff had been met. In January, February and March 2018 there were no unfilled shifts at the hospital.
- The inpatient department had 20 full time equivalent (FTE) nurses and 7.6 health care assistants (HCAs).

- The service had made a significant improvement to contracted staffing levels within the theatre department, further reducing reliance on agency workers. The theatres had 15.3 full time equivalent (FTE) operating department practitioners (ODPs) and 5.8 FTE registered nurses.
- The rate of bank and agency nursing staff usage in the inpatient department (ward area) ranged between 5-15% from June 2017 to January 2018.
- We observed a structured nursing handover within the ward. The handover gave clear concise information on each patient. Nurses used a printed handover sheet, which contained the patients' personal details, diagnosis, and treatment plan.
- There was 17% turnover for nurses, 21% for healthcare assistants, and 16% turnover for other staff within the inpatient department from February 2017 to January 2018. This was lower than average when compared to other independent acute hospitals.
- The endoscopy unit employed one substantive qualified nurse and one healthcare assistant. Staff used agency and bank staff to provide extra cover. In mitigation, the hospital had advertised for two qualified posts.

Medical staffing

- There was an up-to-date corporate The executive director and medical advisory committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.
- The service had a resident medical officer (RMOs) who provided a 24 hours a day, seven days a week service, on a rotational basis. RMOs were employed through an agency the company had a formal contract with. They worked a two week on two week off rota. This ensured that their duty weeks were balanced with consolidated periods of rest.The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support.
- The hospital employed RMOs of a senior grade with anaesthetic experience, as the role required a doctor with a degree of confidence in managing an acutely unwell patient. The RMO told us that they were never asked to complete a procedure that they did not have the skills to undertake.
- Patient care was consultant led. There were 209 doctors and dentists employed or with practising privileges working at the hospital. The hospital practising privileges agreement required all consultants to be available within 30 minutes. In addition, it was required that patients be reviewed daily on the ward, more frequently if necessary. Staff we spoke with confirmed that consultants were available and did review patients when requested to do so. We saw evidence of this in patients notes. We saw consultant contact numbers were available on the wards.
- All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS.
- We saw evidence that practising privileges were reviewed every other year in accordance with the hospitals practising privileges policy.
- Consultant anaesthetists had practising privileges within the hospital and provided on call cover when needed. The hospital switchboard staff were aware of this and had contact numbers.
- The endoscopy service was a consultant led service. Nursing staff said consultants were available when needed.

Emergency awareness and training

- There was an up to date major incident policy and a business continuity plan in place due for review in August 2018. Staff told us they were aware of the policies and their responsibilities under it. Theatre, endoscopy and ward staff knew what to do should an emergency arise. Action cards were held on reception desks to provide immediate guidance to staff should a major incident arise.
- Nursing staff were able to demonstrate that they were able to access the major incident policy for the organisation.
- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services such as electricity and water supply or in the event of staff shortages due to severe weather disruption.

Good

Surgery

- Mandatory fire safety hospital training compliance was 94% and fire warden/marshal training was 83%. There were further training sessions for fire warden training to be undertaken by non-compliant staff in June 2018, we saw evidence of this.
- During our inspection we observed testing of the fire alarm system. All qualified nurses were trained in mandatory immediate adult life support and had completed major haemorrhage training.
- We saw the hospital carried out scenarios with staff for emergency situations such as fire and cardiac arrest. Staff were provided with feedback and any lessons learnt were shared with the department.

Are surgery services effective?

Good

In this section, we also cover hospital-wide arrangements such as the use of current-evidence based guidance and how they ensure staff are competent to carry out their duties, in the relevant sub-headings within the effective section. The information applies to all services unless we mention an exception.

We rated effective as **good.**

Evidence-based care and treatment

- The hospital used current evidence-based guidance and quality standards to inform the delivery of care and treatment.Staff could access national and local guidelines through the hospital's intranet.
- Not all corporate policies were up to date. We found 38 national (corporate) policies had expired review dates, some of which dated back to 2015. The expired policies included consent and duty of candour. We raised this with the senior management team, who were aware of the policies needing review and assured us that they were in communication with the corporate team regarding these. When we returned to the hospital for our unannounced visit, we saw action had been taken corporately. We were told a newly appointed corporate quality and risk lead was planning to roll-out two updated guidelines a week. This was confirmed during our unannounced visit when we saw recently updated versions of the consent and duty of candour policies were available.
- Staff were informed of updated policies via email, the weekly corporate newsletter and staff noticeboards. Each department also had a policy co-ordinator, who was responsible for ensuring staff read updated guidance. We observed policy checklists in various departments, which had been signed by staff when they had read a new or updated policy.
- Hospital policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.
- The hospital had an audit programme, and collated evidence to monitor and improve care and treatment. We were provided with the local audit programme for the hospital, which was set corporately by the BMI Healthcare group. The hospital was able to benchmark the results from the audits with other hospitals within the BMI healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the WHO safer surgery checklist, and medicines management.
- The audits were based on national guidance, standards and legislation, including the National Institute for Health and Clinical Excellence (NICE), the Royal College of Surgeons (RCS), and the Health and Safety Executive (HSE).
- We saw the service had systems in place to provide care in line with best practice guidelines (NICE CG50: Acutely ill patients: Recognition of and response to acute illness in adults in hospital). For example, an early warning score was used to alert staff should a patient's condition deteriorate, guidance was available on when to escalate if a patient condition deteriorated.
- We observed that audits and policies were a regular agenda item on the medical advisory committee meetings. For example, in May 2017 a new antimicrobial stewardship policy was discussed to ensure the hospital improved the use ofantimicrobialmedications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics, and decreasing unnecessary costs.

- In 2017-18 a two year CQUIN was agreed with the CCG, to commit to creating a safety culture, through joining the sign up to safety campaign. Through this work a safety improvement plan had been developed and described how BMI Meriden would save lives and reduce harm to patients over a three year period. The plan included actions to reduce inpatient falls, sepsis awareness and continuous learning from patient feedback and safety incidents.
- Staff participated in the Patient Reported Outcome Measures (PROMs) audit as part of the preadmission assessment process. The PROMs captured details of patient's health and quality of life pre and post operatively through a questionnaire. The information was shared through a database to assist in the improvement of quality of procedures within the NHS.
- Some policies were developed centrally such as infection prevention and control. These meant hospitals within the company could be benchmarked for compliance against one set of standards when audited.
- Patients who were assessed as being at risk of venous thromboembolism (VTE), which are blood clots, were prescribed VTE prophylaxis, in accordance with NICE guidelines.

Pain relief

- The surgical care pathway used prompted staff to assess record and manage pain effectively. Patient's records showed that pain had been assessed using the pain scale within the NEWS charts, appropriate medicines given as prescribed and effect of analgesia individually evaluated.
- Effectiveness of analgesia would also be measured through pain scores on the (NEWS) tool which was used to identify patient's vital signs.
- We spoke with a patient who said their wound had been checked regularly and pain assessments were made frequently.
- Patients were given pain relief following surgery. Pain scores were routinely monitored post operatively. If patients in recovery were in pain following their surgery, they were kept in recovery until the pain relief had taken effect, so that they were not transferred to the ward whilst they were uncomfortable.
- Patient controlled analgesia (PCA) pumps were available and staff felt they had sufficient quantities to meet the needs of the patients at any one time.
- Patient pain was discussed at handovers when appropriate.
- We observed two drug rounds and found patients were offered pain relief medicines. Patients we spoke with said they had been offered pain relief and felt their pain was being managed appropriately.
- On discharge, patients were given contact numbers to call if their pain relief medicines were not sufficient or they needed more.

Nutrition and hydration

- Patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).
- Pre-admission information for patients gave them clear instructions on fasting times for food and drink prior to endoscopy procedures. Records showed checks were made to ensure patients had adhered to fasting times before procedures went ahead.
- Staff followed best practice guidance on fasting prior to endoscopy. For healthy patients who required a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before. Pre-operative fasting guidelines were aligned to the recommendations of the Royal College of Anaesthetists (RCOA).
- Intravenous fluids were prescribed, administered and recorded appropriately in all patient notes we reviewed.
- Nausea and vomiting was formally assessed and prescribed treatment was given appropriately.

Patient outcomes

- BMI the Meriden participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- The hospital did not have a quality assurance system, such as Joint Advisory Group (JAG) accreditation. JAG measures quality and safety indicators, including outcomes.In endoscopy consultants recorded individual

patient outcomes including; caecal intubation, comfort/ pain scores and sedation scores. However, at the time of inspection the system was not interrogated to monitor colonoscopy outcomes including individual consultant outcomes to drive improvement. Therefore, we could not be assured of the effectiveness of the endoscopy service. The hospital was in the preliminary data collection stages of working towards JAG accreditation. Following our inspection, senior staff had issued an endoscopy department action plan. We reviewed this action plan and saw there were plans for the endoscopy lead and endoscopy user group to undertake a six monthly review of comfort scores and to escalated to the if concerns were identified.

- The hospital participated in the national audit programmes particularly Patient Reported Outcome Measures (PROMs), National Joint Registry (NJR),theatre quality assessment document (QuAD) audit, Commissioning for Quality and Innovation (CQUIN), the National Blood Comparative audit and Patient Led Assessment of the Care Environment (PLACE). In late 2017 they benchmarked their clinical outcomes against other hospitals and identified that whilst 88% of patients reported improvement following knee surgery this was slightly lower than the national average. The senior management team, had been reviewing each surgeon with practising privileges since. This was still under review at the time of our inspection.
- Results were monitored and discussed at the hospital's clinical governance and medical advisory committees on a monthly basis as well as at a regional and corporate level. The hospital was working towards EQ-5D, which is a patient-reported outcome measure (PROM) that captures five dimensions of health-related quality of life: mobility, self-care, usual activities, pain/ discomfort, and anxiety/depression.
- We reviewed the service's CQUIN audit from July to October 2017 on the average length of stay and saw that overall average length of stay was 2.8 days which was below and better than the target of 3.5 days. Staff had carried out an analysis of patient records for patients who had delayed discharges and found 83% had had a knee replacement, 58% had undergone a previous orthopaedic surgery and 50% were patients above 70 years. An action plan was in place to reduce the number of delayed discharges in this group of patients, which included prioritising patients attending a joint school. was a service specifically for people who are about to undergo a hip or knee replacement.
- From February 2017 to January 2018, there had been seven readmissions to theatre and 10 unplanned transfers of patients to NHS hospitals. The hospital reported six unplanned readmissions within 28 days of discharge in the reporting period. No trends had been identified with regards to, for example, types of surgery or surgeon.
- BMI the Meriden was one of the first hospitals to adopt the Private Healthcare Information Network (PHIN) system. This was a new requirement, where private providers had to commence submitting data by 1 September 2016 to the Competition and Markets Authority.
- In late 2017, the hospital benchmarked their clinical outcomes against other hospitals and identified that whilst 88% of patients reported improvement following knee surgery this was lower than the national average.

Competent staff

- Patients had their needs assessed, preferences and choices met, by staff with the right skills and knowledge.
- Information provided by the hospital confirmed that for the appraisal year run from November 2016 to October 2017, all theatre staff had undergone an annual appraisal. Appraisals were completed by 93% of ward staff and 88% of other staff. This was an improvement from the last inspection which identified only 38% of theatre staff had received an appraisal. Staff we spoke with said the appraisal process was a positive experience.
- The hospital had made significant improvements in supporting staff with appraisals, which was evidenced through the 'BMI Say' annual staff survey and action plan.
- Theatre and ward staff received regular one to one meetings with their managers to review learning needs and discuss any issues.
- We saw evidence of the competency document for all new staff to complete. The ward manager told us that specialised competencies were being added to reflect

the versatility of skills needed by ward staff in caring for various speciality surgery patients. We also saw evidence of completed competencies for two bank staff employed in the endoscopy unit.

- The theatre manager was able to confirm that staff had completed specific competencies that were recorded in a competency booklet and we saw a sample of these. For example, theatre nurses had completed competencies in all areas including recovery, anaesthetic, and scrub techniques.
- The BMI Learn system also allowed staff members to enrol on additional training courses to enhance their job role, should they wish; for example, pre-assessment courses.
- There was a brief induction for agency staff, which covered the layout of the department, emergency procedures and where to find essential information. We saw evidence of completed induction checklists for agency staff in theatres, endoscopy, cardiac catheter laboratory and the ward.
- The role of the medical advisory chair (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document. Consultants appraisals were carried out by their NHS employer. It was the responsibility of the registered manager, with advice from MAC to ensure consultants were skilled, competent and experienced to perform the procedures they undertook.
- There were arrangements, which required the consultant to apply to undertake a new technique or procedure not undertaken previously by the practitioner at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which may have taken specialist advice such as that of the National Institute for Health and Care Excellence or the relevant Royal College. The practitioner was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure.
- New consultants completed an application pack which included a demonstration of all relevant clinical experience relating to the practice which they wished to bring into the hospital. They were expected to provide many supporting documents including; curriculum vitae, certificates of qualification, annual appraisal, GMC specialist register registration and medical indemnity certificate. The application would progress through to the MAC for it to be fully ratified. This decision would be based on the applicant's credentials, qualifications, experience, competence, judgement, professional capabilities, knowledge, and current fitness to practice, character and good standing, locality.
- Practising privileges for consultants were reviewed annually. The review included all aspects of a consultant's performance. The review included an assessment of their annual appraisal, volume and scope of activity plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges. The hospital used an electronic system to check when privileges were due to expire.
- Consultants were required to provide updated documentation annually. Failure to provide or renew documentation prior to expiry would lead to temporary suspension or withdrawal of practising privileges.
- From February 2017 to January 2018, 16 of the consultants had relinquished their practicing privileges for various reasons. For example, seven had retired, three had relocated and six consultants were inactive. In the same period, 24 consultants had been suspended for documentation non-compliance. There were no consultants on supervised practice during this time.
- The hospital provided an induction programme for most new staff. Agency staff in theatre, endoscopy and the ward completed an induction checklist orientating them to the hospital and department during their first shift at the hospital.
- Staff attended role specific training to enhance competencies. For example, staff within the cardiac catheter laboratory had attended a conscious sedation course and a simulation training which consisted of cardiac arrest scenarios.
- We reviewed seven staff files and found they all contained relevant information such as up to date disclosing and barring service (DBS) checks, references and evidence of registration with the Nursing and

Midwifery Council (NMC) or Health and Care Professions Council (HCPC) as required. We saw the hospital had a process to check when staff information was due for renewal for example DBS.

- Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice.

Multidisciplinary working

- We saw evidence of multidisciplinary (MDT) team communication across all departments. The hospital had introduced a daily 'communication cell' meeting, which took place every morning and was attended by the senior management team and a representative from each department, including theatre, endoscopy, pharmacy, outpatients, imaging, patient services, and catering. We observed a brief overview of hospital activity, utilisation, staffing, incidents and complaints reported over the last 24 hours, medical alerts, mandatory training compliance, and potential risks to the service were discussed. This information was then taken back to each department and cascaded to the remaining staff.
- Medical and nursing staff reported good working arrangements and relationships with the local NHS hospital.
- The hospital had various service level agreements (SLAs) with the local trusts and had access to some of their services, for example, stoma care and breast care nursing services.
- There was a strong MDT approach across all of the areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. We observed good collaborative working and communication amongst all members of the MDT. Staff reported that they worked well as a team.
- We observed effective team working among managers, administrative, clinical, nursing and ancillary staff during our inspection.
- Staff described the multidisciplinary team as being very supportive of each other. Staff told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.
- We observed in patient records that GPs were kept informed of treatments provided; follow up appointments and medications to take on discharge.

Seven-day services

- The management team operated a 24-hour, seven day a week on-call rota system. Staff could access them for advice and support as needed.
- Resident medical officers (RMOs) provided a 24 hour a day, seven days a week service on a rotational basis. All RMOs working at the hospital were selected specifically to enable them to manage varied patient caseload.
- Consultants were on call seven days a week for patients in their care. Staff we spoke with confirmed that consultants reviewed patients at the weekend.
- There was a senior manager on call 24 hour a day for staff to access for support and advice.
- Patients requiring endoscopy out of hours would be transferred to the local NHS trust.
- There were on- call arrangements in place to provide staffing if a patient needed to return to theatre.
- The imaging department was open Monday to Saturday with appointments completed according to clinical need. Emergency provision of MRI and CT scanning was completed by the local NHS trust under a service level agreement.
- The hospital ran theatre sessions from 8am to 8pm Monday to Friday and ran half day sessions on Saturdays. There were no theatre lists on Sundays. The endoscopy unit had endoscopy sessions from Monday to Wednesday.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- There were pathways for different types of procedures. These pathways ensured that the progress was made and any deviation from the prescribed pathway could be identified and an appropriate intervention made swiftly.

Good

Surgery

- Consultants were responsible for ensuring appropriate records were available to other staff caring for the patient. These included details of the procedure completed for therapy staff, and planned treatments for nursing staff.
- Discharge letters were sent to the patient's GP, immediately after discharge, with details of the treatment provided, follow up care and medications provided.
- Computers were available on the wards and theatre areas. All staff had secure, personal login details and had access to email and all hospital IT systems.
- Results of blood tests and x-rays were readily available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were completed correctly within patient records we looked at and appropriately detailed the risks and benefits of the procedure.
- The service ensured there was a two week cooling off period between patients being seen in outpatients and the procedure taking place. This gave the patient time to decide whether to go ahead with a cosmetic procedure and allowed time to cancel if needed. This was in line with national guidance from the General Medical Council and British Association of Aesthetic and Plastic Surgeons. We saw evidence from patient records, that consent had been discussed and documented.
- Patients we spoke to told us they had been given clear information about the benefits and risks of their surgery in a way they could understand prior to signing the consent form.
- Patients said they were given enough time to ask questions if they were not clear about any aspect of their treatment.
- We looked at 23 sets of notes and saw consent forms were fully completed, signed and dated by the consultant and patient. The forms identified the procedure planned and the associated risks and benefits. The hospital consent forms complied with Department of Health guidance.
- Data provided by the hospital showed 96% of staff were up-to-date on the consent training which was above the hospital's target of 90%. All patients undergoing surgery were consented by the consultant providing care. All patients undergoing surgery had their consent documented. We saw that this process commenced within the outpatient's department during consultations.
- During our last inspection in May 2016, some staff we spoke with were unclear of what actions they would take if they were concerned about a patient's capacity and who would complete the formal assessment. During this inspection, nine out of the 11 staff we spoke with understood deprivation of liberty safeguards and when they may be required. However, all staff could tell us how they would access the policy and guidance.
- The hospital had an up to date corporate policy regarding the Mental Capacity Act 2005 and deprivation of liberty safeguards. This included responsibilities and duties, training, key principles assessing capacity, best interest and refusal to be assessed. Staff could access this through the hospitals intranet.
- Data provided by the hospital showed 95% of required staff had undertaken dementia awareness training, which meant staff were aware of their roles and responsibilities for dealing with patients who were living with dementia.
- Training on mental capacity and deprivation of liberty safeguards was included in the mandatory safeguarding adults training.

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

- Staff understood and respected people's personal, cultural, social and religious needs, and took these into account.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. Patient satisfaction scores results from January to December 2017 showed 98% of all patients said the quality of the

care was very good and were likely or extremely likely to recommend the service to friends and family if needed, with 11% of all patients rating it as very good. The response rate in February 2017 was 69% which was better than the average England response rates for NHS patients which was 59%.

- The Patient Led Assessment of the Care Environment (PLACE) assessment for the period of March to June 2017 showed the hospital scored 87% for privacy, dignity, and well-being, which was higher than the England average of 84%. The PLACE assessment for privacy, dignity and well-being, focused on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also included the practicality of male and female services such as bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.
- We spoke with five patients and a relative during our inspection. Patients reported staff were polite, friendly and approachable, always caring and respectful. One patient told us 'the care on the ward from all members of staff was first class'.
- We reviewed patient comments on comment cards and found a patient had written, "Staff made me feel at ease. Very caring."
- Patients told us staff were kind and attentive. They felt they were kept well informed about their care and were involved in making decisions about their treatment at each stage. The costs were explained to them before admission.
- Relatives said staff treated them with care and compassion.
- In theatres we observed staff delivering care with empathy and compassion. We saw theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious. We saw theatre staff ensure that patients were not left exposed unnecessarily and that patients' dignity was preserved when opening theatre doors.
- The hospital had a committed team of hardworking staff who worked flexibly to deliver a caring service for patients.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in the planning of their care. They told us they had received full information about their treatment and the care and support would be offered following the procedure.
- One relative we spoke with told us, following the surgical procedure of their relative, staff made a phone call to offer reassurance and support to them.
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. In addition, the cost for treatment was fully explained and there was written information, both general and individual to support what had been discussed verbally.
- Staff communicated with patients so that they understand their care, treatment and condition.
- Patients we spoke to confirmed that staff explained their care and treatment in easy to understand terminology and that all relevant risks and benefits of the operation had been discussed prior to the patient consenting.
- Consultants visited patients following their operation and answered any questions that patients had.
- We observed nurses, doctors and allied professionals introducing themselves to patients at all times.
- The patients care records had individualised care plans, which involved the patient in their planning.
- Consultants visited their patients throughout the day and were available to answer any questions they had. In addition, they were able to inform patients what to expect and their treatment plans.
- Patients told us that they felt comfortable asking questions and that staff took time to explain and answer their queries.
- The service had an open visiting policy; this meant that patients could be supported by friends and family when needed.
- Staff supported patients to be mobile and independent postoperatively. Physiotherapists encouraged and worked with patients to mobilise soon after surgery and promoted independence.

Emotional support

- Surgical services had arrangements in place to provide emotional support to patients and their families when needed.
- Patients told us that staff had enough time to provide them with adequate emotional support.

Good

Surgery

- Patients received specialised emotional support with coming to terms with changes in their body image and clinical nurse specialists provided support to both the family and patients going through a poor prognosis or diagnosis.
- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.
- Patients told us staff regularly checked on their wellbeing and to ensure their comfort.
- Staff told us they had time to sit with patients and discuss the patient's fears and reassure them.

Are surgery services responsive?

Good

In this section, we also cover hospital-wide arrangements such as service planning and learning from complaints, in the relevant sub-headings within the responsive section. The information applies to all services unless we mention an exception.

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The services provided reflected the needs of the population they served and ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including orthopaedic surgery, general surgery and endoscopy.
- The hospital had a commitment to private patients as well as agreements with thelocal commissioners to provide services for NHS patients, and it ensured that services commissioned from them were safe and of a good quality.
- The hospital worked collaboratively with NHS commissioners to ensure future planning of services were developed to meet the needs of the local population. The hospital's main activity was orthopaedics and they planned to develop ambulatory care pathways that would enable them to increase their capacity, and improve patient experience and outcomes.
- We saw the hospital had a service level agreement with a local acute hospital to provide pathology services, blood products and critical care services. This was in date and reviewed every two years.
- The hospital had good working relationships with the local clinical commissioning group to manage services for NHS patients. The hospital also assisted with additional work from the local NHS hospitals to assist with increased demand. In addition, local agreements were in place with the local NHS Trust to support areas of capacity concern.
- Staff planned and developed services to meet the needs of the local population for both private and NHS patients.
- The hospital is located adjacent to an acute hospital, and offered the opportunity to engage highly skilled consultants across a wide range of specialties to deliver high standards of care and outcomes to patients.
- The hospital had an admissions policy which detailed the criteria for NHS patients that could be safely treated at the hospital. These criteria had been agreed with the clinical commissioning groups that commissioned NHS care at the hospital
- Consultants had planned and dedicated theatre lists which enabled patients to be booked onto these lists in advance.
- Theatre lists for elective surgery were planned with the theatre manager and bookings team. This ensured all aspects of the patient's requirements were checked and considered before booking a patient on to the list and ensured that operating lists were utilised effectively.
- Patients attending the hospital had access to a small free car park in front of the hospital. Patients who were unable to park in this area could use the local NHS trust car park free of charge, which was a very short distance from the hospital. This was manned by a security guard who allowed access and exit.

Access and flow

- Patients had timely access to initial assessment and treatment.

Good

Surgery

- National waiting time targets for NHS referral to treatment (RTT) times in surgery were within 18 weeks (admitted pathway). The RTT waiting time was 92% and met the target of 92% of NHS admitted patients beginning treatment within 18 weeks of referral.
- Waits for appointments and treatment were minimal for private patients. Patients we spoke with told us that from their initial referral or appointment, they were seen quickly and without delay. All the patients we spoke with were happy with the length of time between initial consultation and the operation occurring.
- Patients accessed care and treatment at a time to suit them. Patients we spoke with told us they were given a choice of dates for their procedure.
- Staff began planning the patient's discharge during the pre-admission process where they gained an understanding of the patient's home circumstances and daily care needs.
- We observed patient access and flow was discussed at a daily huddle during our inspection. The number of new and follow-up clinic appointments, including the number of patients undergoing treatment was discussed. The huddle enabled key safety information to be shared with each department and cascaded to staff as necessary.
- Staff within the endoscopy unit understood the process for managing patients who 'did not attend' their appointment. A staff member telephoned a patient to find out the reason for the missed appointment and to provide a second appointment. A second date was confirmed in a further appointment letter.
- Care and treatment was only cancelled or delayed when necessary. The service cancelled 15 procedures for non-clinical reasons from February 2017 to January 2018. Cancellations were explained to patients, and they were supported to access care and treatment again as soon as possible. All 15 of the cancelled patients were offered another appointment within 28 days of the cancelled appointment.
- Care and treatment for patients with the most urgent needs were prioritised. Patients who had co-morbidities to be considered, for example those with diabetes, were placed at the beginning of the theatre lists so that they got operated on as quickly as possible, regardless of whether they were private or NHS patients. Once any urgent patients had been treated, privately funded patients were prioritised over any non-urgent NHS patients.
- The hospital had three laminar flow theatres (where air is moved at the same speed and in the same direction, to avoid contamination). The laminar flow theatres operated Monday to Saturday 8am to 9pm. All the laminar flow theatres had provision for emergency procedures for general surgery and orthopaedics if a patient had an unplanned emergency return to theatre.
- There was a service level agreement (SLA) in place for the provision of several services with the local acute NHS trust. This included pharmacy, blood testing, sterile services, dietetics, stoma care and radiation protection.
- There was a SLA in place with a local NHS trust for theatre specimens which were collected twice a day.

Meeting people's individual needs

- Services were mostly planned and delivered to take account of the needs of different people.
- Staff admitted and discharged patients in dedicated four bedded recovery area within the endoscopy unit. The cubicles had walls and curtains to maintain patient privacy and dignity. During the inspection, we observed staff booking a patient in for a colonoscopy procedure and we could overhear patient confidential information (for example, past medical history) being discussed. This could be overheard by another patient being booked in on the adjacent cubicle. We could not be assured that patient confidentiality was being maintained. We raised this with senior staff at the time of our inspection. During our unannounced inspection, we saw senior staff had taken actions to mitigate risk and patients were being admitted on the ward with ensuite bedrooms and taken to the endoscopy unit for their procedure. However, the ward was on the first floor while the endoscopy unit was on the second floor which meant a lot of time was lost transferring patients from one department to the other. Senior staff told us they were considering undertaking the patient pre-assessment over the telephone prior to their endoscopy procedure to ensure no confidential information is discussed when patients arrived at the department. We requested for an endoscopy standard operating procedure following our inspection. The hospital sent an action plan for the endoscopy department which included an action to convert the endoscopy office into an admission/ discharge patient room by the end of May 2018 to provide patients with a comfortable area where privacy could be maintained.

Good

Surgery

- During our inspection, we observed there was one toilet within the endoscopy unit which was used by all patients attending the department including patients who had been administered bowel preparation. We observed a patient had been given phosphate enema in one of the four bedded cubicles. Patients require immediate access to a toilet following administration of an enema. A phosphate enema is a medicine used for bowel cleansing before a procedure. Staff within the endoscopy unit recognised this as a risk; however, they had not escalated this issue to the senior management team. We raised this with senior staff at the time of our inspection. During our unannounced inspection, we saw patients were being admitted on the inpatient ward with ensuite bedrooms, bowel preparation was administered on the ward and patients were taken to the endoscopy unit when they were ready for their procedure. However, the ward was on the first floor while the endoscopy unit was on the second floor which meant that toilets facilities were not easily accessible in the event of urgent need.
- Staff used oxygen during colonoscopy procedures to insufflate bowels. Use of oxygen insufflation during a colonoscopy can significantly increase abdominal discomfort during and after the procedure. The National Institute for Clinical Excellence (NICE) guidelines recommend the use of carbon dioxide insufflation for patients undergoing a colonoscopy procedure. There was a risk that patients could experience a lot of discomfort including trapped wind following a colonoscopy procedure. We raised this with senior staff at the time of our unannounced inspection who acknowledged this as an issue. During our unannounced inspection, we saw evidence that senior staff had contacted a local NHS trust for advice and were in the process of ordering an additional device to mitigate this risk.
- The hospital had a service in place to identify patients who require specialist communication services, for example, interpreters where English is not a first language. In addition, a loop recorder was available on reception to support patients who were hard of hearing and text messages were used to remind patients of appointments.
- The hospital took part in the annual Patient Led Assessment of the Care Environment (PLACE) audit, which had helped identify how to improve the way to care for patients living with dementia.
- The PLACE audit from March to June 2017 showed the hospital scored 84% for dementia, which was better than the England average of 77%. The PLACE assessment for dementia was included for the first time in 2015, and focussed on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- The PLACE assessment from March to June 2017 showed the hospital scored 89% for disability, which was better than the England average of 83%. The PLACE assessment for disability was included for the first time in 2016, and focussed on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.
- The Meriden Hospital published all NHS services on the national NHS referral portal, to ensure patients can easily access treatment and to give patients a greater choice of appointment times. Private patients could book appointments through the hospital's centralised team or website, which included a 'live chat' support function.
- All clinical areas were accessible to patients and relatives who had reduced mobility.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by a doctor, the RMO and if necessary reassessed by the admitting consultant or anaesthetist where required.
- Patients' special needs such as specific dietary requirements were identified at pre- admission.
- The hospital took part in the Patient Led Assessment of the Care Environment (PLACE) audit from March to June 2017, which showed the hospital scored 98% for organisational food, which was significantly better than the England national average of 88%. For ward food the hospital scored 100%, which was significantly better than the England national average of 90%. The assessment for food and hydration covers organisation questions looking at the catering services provided such as choice of food, 24 hour availability, mealtime, and access to menus. It also included an assessment of food services at ward level, looking at areas such as the taste and temperature of food.
- Patient feedback on comment cards we reviewed described physiotherapy as adaptive with exercises tailored to meet patients' needs and abilities.

- The hospital had a standard operating procedure (SoP) for dementia. Nursing staff we spoke with knew about the SoP and provided examples of extra steps that they would take if a patient living with dementia was admitted to the ward. They explained that as these patients often find hospitalisation distressing, they would allow family members to remain with the patient for longer than usual, to help orientate them and calm their fears.

Learning from complaints and concerns

- The service had a clear process in place for dealing with complaints. There was a complaints policy in place, which was under review at the time of our inspection. Staff we spoke to were aware of the complaints procedure. We saw complaints leaflets, 'Please tell us', were available throughout the hospital and saw the hospital website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email. All staff had attended a 'Think Customer' training session to promote the delivery of high standards of customer care.
- Senior managers, including the executive director, were all involved in the management and investigation of patient 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. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining why. At the time of our inspection the hospital were meeting their 20 day response time target.
- The hospital received 11 complaints from February 2017 to February 2018. One complaint was referred to the independent healthcare sector complaints adjudication service.
- Themes from complaints included patient waiting times due to consultants arriving late for appointments and complaints about charges and invoicing. A change in the complaint process was made in February 2018 to include the consultant's response, alongside the complaint response letter when a patient had complained of a late consultant arrival. A patient liaison officer position was introduced following a review of complaints to provide patients and consultants with improved access to a staff member to assist with pricing queries.
- Staff told us new complaints and learning from complaints were discussed at relevant committee meetings. We reviewed three sets of minutes from monthly clinical governance team meetings, medical advisory committee meetings and heads of department meetings that demonstrated complaints were a regular agenda item. We observed the number of ongoing complaints was discussed at the daily 'communication cell' meeting during our inspection. Learning from complaints was cascaded to staff in regular huddles and within team departmental meetings.
- The executive director had overall responsibility for the management of complaints.Complaints were logged on the electronic incident reporting system, which alerted staff when there was a new complaint, and investigations were carried out by the head of the department as appropriate. Complainants were offered a face to face meeting or a telephone call with the executive director and appropriate staff such as the clinical services manager.

Are surgery services well-led?

Good

In this section, we also cover hospital-wide arrangements such as, leadership, the management of risks and governance processes, in the relevant sub-headings within the well-led section. The information applies to all services unless we mention an exception.

We rated well-led as **good.**

Leadership / culture

- The hospital was led by an executive director, who had overall responsibility for the hospital, a director of clinical services and the operations manager. All the heads of department reported to one of these three leaders. The medical advisory chair and heads of department supported the senior management team.
- Since the 2016 inspection, significant changes had been made within the senior leadership team including a

change in executive director and director of clinical services. Clinical leadership at the hospital had been significantly strengthened through the appointment of a highly experienced director of clinical services, supported by proactive departmental heads.

- Our inspection in May 2016 prompted the hospital's leaders to carry out a thorough review of their processes in addition to changes in senior management and clinical heads of departments. An improvement plan was developed and significant progress has been made. Meeting legislative requirements has been the priority of leaders and was acknowledged as the hospital's highest risk on the hospital's risk register.
- The hospital had
- The executive director attended regular meetings with other executive directors within the region, and told us they were well supported by the corporate senior management team.
- The BMI Healthcare organisation supported staff to develop leadership and management skills, with courses available for all levels of staff.
- Staff told us members of the senior management team were very visible and approachable, and we observed this during our inspection. The management team walked the hospital floor throughout the day, and were well known by the staff. Each member of the senior management team had their office on each of the floors, so they were always visible and accessible from each department.
- The senior management team spoke with pride about the work and care their staff delivered on a daily basis.
- Staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care for their patients.
- The hospital culture encouraged openness and honesty. Staff told us they were able to raise concerns and felt the hospital had a "learning culture, not blame culture".Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.
- The hospital celebrated staff success. The BMI Healthcare group ran an annual recognition awards scheme entitled "above and beyond". The categories included "true inspiration", "outstanding care", "brilliant leadership", and "amazing support". Staff were invited to nominate a colleague who they felt had gone "above and beyond" and deserved recognition.We saw that compliments were shared with staff via the staff newsletter, noticeboards and meetings. The hospital also held annual long service awards, which recognised every staff member who had worked at the hospital for five, 10, 15, 20 and 25 years.

Vision and strategy

- The hospital was committed to the BMI Healthcare corporate vision, which was to offer "the best patient experience and best outcomes in the most cost effective way". The vision had been translated into eight strategic priorities, which were entitled:
  - Governance framework
  - Superior patient care
  - People, performance and culture
  - Business growth
  - Maximising efficiency and cost management
  - Facilities and sustainability
  - Internal and external communications
  - Information management
- We saw the hospital's operational business plan was aligned to the corporate vision and strategic priorities. It included a quality improvement action plan, which detailed specific objectives the hospital had set in order to deliver the strategic priorities. Progress against achieving the objectives was reviewed and monitored at various committee meetings, including hospital governance and heads of department meetings.
- Staff were aware of the vision and strategy and understood their role in achieving it. We observed the BMI Healthcare vision was prominently displayed throughout the hospital.

- Providing the best patient experience was one of the three priorities within the corporate vision. All staff spoken with said they were committed to providing a positive patient experience.
- BMI the Meriden Hospital had clear vision and strategic goals, driven by quality and safety, aligned to the BMI Healthcare corporate vision and underpinned by BMI behaviours. The hospital strategy had been developed by the senior management team (SMT) with defined objectives, underpinned by a clinical and non-clinical strategy cascaded to the team.
- The hospital's clinical and non-clinical vision and strategic objectives that underpin the BMI Healthcare Group 5-Year strategy, provided staff with a foundation to drive positive change and further improve the quality of service provision.
- The aim of the strategy was to ensure an integrated approach where risk management, clinical governance and quality improvement were part of the culture and everyday management practice. The objectives of the strategy were to promote an honest, open and blame-free culture where risks are identified and addressed at every level and escalated appropriately, to ensure standards.
- The hospital's vision and strategy was cascaded to teams through departmental meetings, staff forums and notice boards. A presentation was produced to facilitate communication at meetings and a one page visual strategy was posted on departmental notice boards.

Governance, risk management and quality measurement

- The director of clinical services supported the quality and risk manager and ensured systems were monitored to keep patients safe from abuse and avoidable harm. The reporting of incidents had increased since the 2016 inspection as the culture of openness had improved.
- There was a governance structure within the hospital, which consisted of various appropriate committees, which ultimately reported to the BMI board. All these committees had terms of reference, which reflected their role in the hospital, their structure, and purpose.
- Since our last inspection in May 2016, an experienced executive director (ED) and a director of clinical services (DCS) had been employed to provide leadership and enhance the leadership team. The quality & risk manager had been replaced and this role was directly supported by the DCS. The senior management team (SMT) comprising of the ED, DCS and operations manager (OM) had worked extensively with the hospital team to provide sound and open leadership to support safe clinical practice for staff and patients.
- The hospital had a corporate risk register which was regularly reviewed and updated to ensure risks were monitored and appropriately managed. The hospital's risk register was also managed through the electronic reporting system. We reviewed this during our inspection and found each risk was adequately detailed, with a description of mitigation and controls in place. An assessment of the likelihood of the risk materialising and its possible impact was included. We saw that risks were reviewed regularly and updated when changes to mitigation had been taken.
- Heads of departments managed departmental risk registers which fed into the hospital's risk register. Governance and risk performance was discussed through the committee meeting structure. Our last inspection in May 2016 highlighted medicines fridge being left unlocked in endoscopy and issues with storage of medicines within theatres. These were recorded as departmental risks within the corporate risk register and had been actioned.
- The hospital's governance framework facilitated monitoring of their performance. They reviewed outcomes at local committee meetings including medical advisory, health & safety, clinical governance and head of department committee. However, there was no effective governance system in place to monitor, interrogate, and collate colonoscopy outcomes. For example, consultants used a gastrointestinal reporting tool to measure colonoscopy outcomes. There was no effective governance system in place to interrogate the reporting system to monitor patient outcomes.
- Following our inspection, senior staff had introduced an endoscopy department action plan. The action plan included concerns raised during our inspection with regards to colonoscopy outcomes and maintaining patient privacy and dignity during admission and

discharge. Senior staff had put actions in place to mitigate future risk and had introduced a quarterly endoscopy user group meeting in accordance with the BMI policy.

- We were not assured of effective communication of concerns between the endoscopy staff and the senior management team. Staff highlighted the need for extra toilet facilities for patients who were receiving bowel preparation. The issue was highlighted to the inspection team by the endoscopy staff. Once we highlighted the issue to the senior management team, mitigating actions were swiftly put into place.
- Staff participated in integrated audits, peer review, self-assessment and developed action plans to evidence their progress against objectives and areas of concern. Heads of departments took ownership of departmental action plans which fed into clinical and non-clinical strategies.
- There was a clear governance framework in place with policies and committees such as clinical governance, head of department, health & safety and medical advisory committee (MAC). Governance information was easily accessible for staff on information boards in departments and on a Health & Safety Board.
- The role of the MAC chair included ensuring that all consultants were skilled, competent, and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document, these were reviewed annually. Registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, DBS check and indemnity insurance were all checked by the hospital and ratified by the MAC. An email was automatically generated to remind a consultant if for example their appraisal or indemnity was overdue or expired.
- The MAC would also discuss new procedures to be undertaken to ensure they were safe, equipment was available and staff had relevant training. The MAC chair met with the hospital executive director regularly to discuss the MAC agenda and review complaints and incidents.
- Consultants represented a wide range of specialities at the bi-monthly medical advisory committee. All consultants received the minutes of each MAC to promote learning and understanding. The MAC minutes showed discussions including key governance issues, such as incidents, complaints and practising priviledges.
- Staff members were clear on their objectives and understood how they contributed to the hospital success. Heads of departments identified training needs of staff through appraisal and supported training at BMI training academy. Training and development was a focus for 2018 as reflected in the 'BMI Say' action plan.
- There was a monthly bulletin, which supported risk management by identifying changes in legislation and NICE guidance.

Public and staff engagement

- Staff
- There was an organisation newsletter, which was distributed throughout the hospital to update staff on current issues and plans.
- The hospital encouraged patients to participate in the BMI patient survey. We saw patients being offered a form to complete and there were boxes throughout the hospital to place completed forms.
- The theatre and ward team meetings encouraged staff to raise any concern or share an experience. The theatre manager was new in post and had recently introduced one to one meetings with staff in which they could raise concerns or make suggestions for improvement.
- The service used the friends and family survey and Patient Led Assessment of the Care Environment (PLACE) audits to gain feedback on patients' experiences.
- All staff enjoyed working within and were proud of their department and service.
- We saw the FFT results were publicly displayed throughout the hospital, and were also detailed on the hospital's website. In 2017, feedback showed 99% of patients would recommend the hospital to their family or friends.
- At the time of our inspection (April 2018), the hospital was trying to recruit service users to join their patient

participation group. Once established, the group would then meet with the senior management team to discuss how the hospital could improve. The SMT had already approached a previous patient to be part of this group.

- Patients and the public could access a wide range of information from the hospital's website, including information on treatments, self-funding options and performance outcomes.
- Members of the public were invited to attend open events held at the hospital throughout the year, where a consultant would speak about a particular health topic including the various treatment options available.
- Staff told us they had regular team meetings, and we saw evidence of this in meeting minutes we reviewed. Information was shared with staff in a variety of ways, such as face-to-face, email, newsletters and noticeboards.

Innovation, improvement and sustainability

- A daily 'Communication Cell' team brief was held to discuss the day's operational issues. The huddle meeting lasted 10-15 minutes. Daily huddle update sheets were produced and displayed daily in all departments to update all staff. The senior management team operated an "open door" policy for staff and consultants and regular walk arounds meant that they were visible and approachable. The chair of the MAC met regularly with the executive director and director of clinical services and was involved with hospital decisions.
- The hospital was working towards JAG accreditation, which would enable the development of endoscopy services to facilitate the introduction of NHS patients. Currently, NHS providers require endoscopy units to have JAG accreditation for patient referrals as this denotes the standard of service required. In addition, processes within the JAG accreditation will enable benchmarking of practice against other providers and organisations.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The hospital followed their corporate 'Incident Management' policy, including Serious Incidents' (dated November 2017). Heads of departments and clinical leads had completed route cause analysis (RCA) and human factors training. RCA and human factors training was on-going for staff to improve incident reporting, the quality of data provided, and to increase understanding of how incidents happen and how staff can prevent and/or correct errors.
- Since the May 2016 inspection, the hospital had introduced a new electronic incident reporting system, had updated policies to closely mirror the serious incident framework, and had completed a full review of incidents to gain assurance that incidents had been graded and reported correctly.
- All staff had received training and told us they were encouraged to report incidents on the electronic reporting system. However, not all staff had been required to report an incident.We observed refresher training to update staff on the use of the electronic reporting system was planned at the time of our inspection.
- Data received from the hospital showed between February 2017 and January 2018 there had been 212 clinical incidents reported across the hospital and 76 (36%) occurred within outpatients and radiology. Thirty-five were clinical incidents and 41 were non-clinical incidents.
- The hospital did not report any 'never events' between February 2017 and January 2018. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- All staff we spoke with in the radiology department, told us they were encouraged to report incidents using the electronic reporting system, this included both radiation and non-radiation related incidents. A service level agreement (SLA) with a local NHS trust oversees any radiation related exposure incidents as well as providing expert radiation protection support and advice.
- The hospital reported no Ionising Radiation (medical exposure) Regulations (IRMER), 2000 incidents to the Care Quality Commission (CQC) in the last 12 months. A radiation protection adviser (RPA) based at Nottingham was available for advice if required. The RPA delivered a recent presentation to all radiology staff at BMI The Meriden hospital and provided an update on Ionising Radiation (Medical Exposure) Regulations 2000.
- A Radiation Protection Supervisor (RPS) was employed by the hospital to ensure compliance with the Ionising

Radiation Regulations 1999(IRR '99) and Ionising Radiation (Medical Exposure) Regulations 2000.The RPS was the first point of reference in the investigation of all radiation related incidents.

- There was a yearly radiation protection committee, where radiation incidents and actions were discussed. The most recent radiation protection committee was held in April 2018.
- All incidents and adverse events were discussed at the monthly Medical Advisory Committee (MAC), and the monthly Clinical Governance Committee (CGC), and Heads of Department (HoD) meetings. We saw the minutes of the MAC, CGC, and HoD meetings that confirmed this.
- A weekly staff bulletin was displayed on notice boards throughout the department and we observed this included information on new incidents, ongoing investigations and lessons learned. Staff we interviewed confirmed they read the bulletins and were informed about learning following a review of incidents. For example, one staff member told us about an incident when a 17-year old patient was provided with an appointment for treatment. A chaperone reported the error to the consultant and, as the hospital was not registered to provide services to children and young people under the age 18 years, an apology was made and the treatment did not proceed. A review of the incident took place and learning shared to remind consultants of the requirement to check a patient's age. We saw the incident and learning was discussed in the November 2017 medical advisory committee meeting.
- Two physiotherapists provided an example of learning being shared across departments following a review of incidents. A reminder to all staff was made to request a falls risk assessment was completed when necessary, following an increase in patient fall incidents.
- Staff described the principle and application 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 person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened.

We spoke to one healthcare assistant (HCA) who gave us an example of duty of candour following an incident they were involved in. They explained how they contacted the patient, explained what had happened and apologised.

- One patient told us that following a delay in treatment, staff apologised, kept them informed of the investigation and of the outcome, and of the opportunity for staff to 'sharpen practice'. The patient reported they were 'really impressed' with the openness and way the concern was brought to their attention.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- At the time of our May 2016 inspection, a refurbishment programme was in progress to update flooring throughout the outpatient's department. Some consultation rooms were carpeted that was not deemed best practice due to an elevated risk of infection. During this inspection, the second phase of the refurbishment programme was underway and consultation rooms had been refurbished and flooring was replaced with vinyl to improve the hospital's compliance with infection, prevention control. This was in line with the Health Building Note (HBN) 00-10 regulations that consider floors should be washable, and have curved edges to prevent bacterial growth. The provider told us the carpet in the hospital outpatient corridor would be replaced during the third phase of the refurbishment programme.
- Rooms used for clinical procedures were adequately equipped to maintain safety and complied with infection control standards. Appropriate air filtering systems and air changes were in place for the minor operations procedure room.
- There were reliable systems in place to protect and prevent people from healthcare-associated infections. Data confirmed there had been no cases of hospital acquired MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile), E.Coli or surgical site infections in the reporting period February 2017 to January 2018.

Good

Outpatients and diagnostic imaging

- The hospital had an infection prevention and control (IPC) lead nurse and link nurses in clinical areas. Link nurses completed monthly audits on IPC and cleaning schedules and monitored action plans to improve compliance when required. From November 2017 to February 2018, overall compliance for hand hygiene was 97%. The hospital had an infection prevention and control annual programme action plan for 2017/2018. The hospital had systems in place to manage and monitor the prevention and control of infection and data was reviewed by the infection prevention and control committee.
- As at January 2018, 100% of eligible staff had completed level 1 and level 2 IPC training.
- Staff followed their corporate 'Hand Hygiene Policy (including training) (dated May 2016), which included training, types of hand hygiene, soap and water and wearing of jewellery. Staff in all the departments we visited were observed adhering to 'arms bare below the elbow' guidelines. An arms bare below the elbow audit completed in physiotherapy department in March 2018 demonstrated 100% compliance.
- There were sufficient handwashing sinks and alcohol hand sanitising gel within the departments we visited. Overall staff cleaned their hands in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'. We saw that a WHO hand hygiene audit completed in OPD in March 2018 demonstrated 100% compliance. This meant, the hospital could be confident that all staff are cleaning their hands as per corporate policy.
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety and reduce risks of cross infection when performing procedures.
- The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.
- We saw 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), health, and safety at work regulations.
- Diagnostic imaging rooms were cleaned daily and only radiology staff cleaned the equipment. This was to ensure the safe maintenance of the equipment.
- Patient Led Assessments of the Care Environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance.
- The PLACE assessment for cleanliness for the period March to June 2017 was 100%, which was better than the England national average of 98%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.

Environment and equipment

- The service had suitable premises and equipment and looked after them well. The outpatient service had 16 individual consulting rooms, one minor procedure rooms, used for minor operations such as lumps and bumps and treatment, one treatment room, dirty utility area, a nurses' work station and an outpatient waiting area.
- All rooms were locked when not in use with either keypad or key access. The consulting rooms were tidy and equipped with a desk and chairs for discussions with patients, and a couch area for procedures.
- There were 'sharps' bins available in all the consultation rooms and we noted the bins were correctly assembled, labelled, and dated. None of these bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.
- The service had rooms allocated to specialties which were prepared with appropriate equipment for investigations or treatment. This enabled equipment to be easily accessible to reduce waiting time.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures.

Good

Outpatients and diagnostic imaging

- The radiology department consisted of one radiography room, one ultrasound room and one fluoroscopy room. The imaging rooms and equipment were visibly clean and 'I am clean' labels were on equipment which were dated and signed.
- In the radiology department, staff were able to show us six recent risk assessments. These were comprehensive risk assessments that covered occupational, environmental and radiation safety; this included risks to people using the service, staff, and the public. The senior radiographer had completed the assessments.
- In the radiology examination rooms, we observed the correct storage of specialist PPE including lead aprons, thyroid shield, and gloves. We observed each item was labelled with the thickness of lead and we observed a robust audit programme was in place to ascertain if any cracks or folds had appeared. This complied with Regulation 9 (3) of the Ionising Radiation Regulations 1999 (IRR'99). No further actions were required following the March 2018 audit.
- Staff were seen wearing personal radiation dose monitors and these were monitored in accordance with the relevant legislation.
- We observed systems and processes were in place to ensure the maintenance and servicing of imaging equipment. Across the department, we saw that a quality assurance (QA) programme was in place for all radiographic equipment requiring all checks to be performed at regular intervals on all equipment, as required by current legislation.
- We found some equipment in the imaging and cardiac catheter laboratory was nearing the end of its life span. In mitigation, this was included in the department's risk register and under regular review to monitor faulty equipment and timeliness of repair to minimise impact to service continuity. Staff told us this was escalated to senior managers as required to review funding for replacement equipment.
- Audits were completed of daily and monthly cleaning schedule compliance in diagnostic imaging services. We observed an audit completed in March 2018 found that daily warning light checks had not been completed as required. An action plan was in place to add warning light checks to the daily agenda and record however, we reviewed the daily check sheet and found this had not been actioned. A monthly check of warning lights was completed.
- We observed equipment competency assessments were completed in diagnostic imaging. This ensured staff remained competent at using equipment.
- The Patient Led Assessment of the Care Environment (PLACE) for the period of March to June 2017, showed the hospital scored 96% for condition, appearance, and maintenance, which was better than the England average of 94%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.
- The physiotherapy department consisted of a gymnasium, two private treatment rooms, four curtained cubicles and a hand therapy station. The department was tidy and well equipped; the cubicle area had disposable curtains which had been changed within the last six months.
- Staff in the physiotherapy department had competency documents to show they were trained in the use of specialist medical equipment, this meant the hospital ensured staff were safe and competent to use medical equipment with patients.
- We observed three resuscitation trolleys in radiology, physiotherapy and outpatient areas. All trolleys were locked and records indicated that the trolleys were checked daily on days when clinics operated. All drawers had correct consumables and medicines in accordance with the checklist. We saw consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator worked and suction equipment was in order.
- There was a service level agreement with the local acute NHS trust for the decontamination and maintenance of equipment. Staff reported that equipment was usually returned to the department within 24 hours, and stated they had sufficient equipment to meet the demands of the service.

- Clinical waste was segregated appropriately and removed from the department at regular intervals.
- The Patient Led Assessment of the Care Environment (PLACE) for the period of February to June 2017, showed the hospital scored 94%, for condition, appearance, and maintenance, which was better than the England average 93%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.

Medicines

- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- The hospital had a policy for the safe management of medicines dated August 2017. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs. Staff told us, and we observed in the May 2017 Medical Advisory Committee minutes, that the medication policy had been reissued to staff.
- The hospital had a service level agreement with the local acute NHS trust for the provision of medications and pharmacy services. This included weekly attendance to outpatients to review medications, provision of stock items and prescription pads.
- Consultants attending the department for a clinic would be issued with a prescription pad upon request. During the May 2016 inspection, we found there was a robust system which required consultants to sign out the prescription pads, and the nurse confirmed return at the end of a clinic. However, there was no process in place to check the usage of prescriptions, or the number returned. There was no record of daily serial numbers or an audit trail that showed the serial number of prescriptions from issue to prescription. We were not assured there was safe management of prescription pads.
- During this inspection, we saw a reconciliation process was in place with an audit schedule to monitor compliance. We saw the register for recording of prescription pads; this indicated when a prescription had been issued, to whom and what for. This was in line with guidance from NHS Protect, security of prescription forms, 2013. We were assured there was a robust system for the management of prescription pads.
- During this inspection, we found safety measures had improved to monitor the movement of keys used to access a shared medication refrigerator in the endoscopy unit. During the May 2016 inspection, all qualified staff had access to a key safe with a key code to obtain the key to obtain medications for use in the cardiac catheter laboratory. However, there had been no system to monitor the location of the keys throughout the day. We observed a key register had been put in place to record staff access to the keys at all times, and we were assured there was a safe management of medicines system in place.
- Medicines that needed to be kept below a certain temperature were stored in locked fridges, which we observed were checked daily for temperature compliance. Records for the previous month did not show any issues or periods where temperatures were outside recommended levels. The temperatures within the treatment rooms were also recorded to confirm safe storage.
- In the radiology department, staff told us contrast media was used for some imaging investigations and reported that prescribing of contrast media was completed by the consultants prior to the investigation.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Records

- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to staff providing care. There was a corporate retention of records policy, which stated that information had most value when it was accurate, up-to-date, and accessible when required.
- We saw that the outpatient and diagnostic imaging departments stored records safely and securely in line with the Data Protection Act, 1998.
- The hospital had implemented a single patient record in February 2018 each NHS and private patient had a set of notes that did not leave the hospital. These ensured

patient records were always available for clinics. Patient records were recalled from a medical records store in time for the patient's outpatient appointment, or a patient record was set up for new patients.

- Medical staff, who kept their own private patient records, obtained a photocopied set of notes for their own records and took responsibility for the safe management of patient records off site.
- The service used a paper based record system for recording patients care and treatment. We reviewed 20 patient records and found that 18 out of 20 (90%) were clear and legible. This meant 10% of records were not legible and could not be easily read or understood which may raise a safety concern in the event of an emergency.
- We observed that timely communication was made with GPs to detail treatment plans, actions taken, medication and details of next appointments in all (100%) of files we reviewed.
- Referrals to request radiology services were paper based and we saw audits were completed in December 2017, January and February 2018 to ensure correct information was made available. This included patient's name and date of birth, the date of request, reviewed that the correct procedure was requested, and that forms were signed by the referrer. No actions to improve practice had been required following the audits.
- During the May 2016 inspection, we found that the five steps to safe surgery checklist, designed to prevent avoidable harm was completed for all patients undergoing invasive procedures. We observed however, audits of its completion considered the paper check list only and did not audit whether the process, prior to surgery or procedure taking place had been observed and was part of the audit. Data submitted for this inspection confirmed audits completed in January and February 2018 demonstrated 100% compliance, and that these included a review of the process prior to surgery or invasive procedure.
- We observed and staff told us that health care assistants (HCAs) wrote contemporaneous notes in patient records. The notes were countersigned by a qualified nurse to confirm the quality and accuracy of information. HCAs completed information governance and patient record note taking training during a six week HCA development course.
- Data received from the hospital indicated that 96% of the required staff had completed their mandatory training in documentation and legal aspects and 90% of required staff completed information governance training. This was the same as, or better than the hospital target of 90%. This meant the hospital could be confident staff were aware of their roles and responsibilities to keep patients information safe.

Assessing and responding to patient risk

- Systems and procedures were in place to assess, monitor and manage risks to patients.
- We observed good practice for reducing exposure to radiation in the Radiology department. Local rules were available in the areas we visited. The radiographic examinations room had all the necessary warning notices on the doors and illuminated boxes outside the rooms that light up when a radiographic exposure is made. The warning signs are checked every month to ensure they are working correctly, we saw evidence of these checks. This was in accordance with current legislation.
- We found the patient alarm bell in the imaging process room was faulty. This was reported as an incident in June 2017, and a quote for a new alarm to be fitted was being processed. To mitigate the risk, a sign was placed on the reception desk to notify radiographers that a patient was undergoing a process.
- In the radiology department, we saw they used a modified version of the World Health Organisation Safety checklist. This included checks such as patient identity, allergies and ensuring the consent form had been signed. The radiologist and radiographer completed these checklists, in the room with the patient present.
- To comply with Ionising Radiation Medical Exposure Regulations (IRMER), departments had to establish the pregnancy status of a patient prior to any relevant medical exposure. 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. Departmental policy states that all patients between the ages of 18-55 years must be asked about their pregnancy status. We observed one patient being asked about their status before the procedure took place.

- During inspection we noted that the imaging department had a variety of policies and standards of practice in place relating to the safe management of patients undergoing investigative procedures. This included the safe use of contrast medium and guidelines for patients with underlying clinical conditions.
- Staff could access advice from the Radiation Protection Advisor (RPA) by telephone and email. Radiographers told us the RPA had assisted the department during the last six months with ensuring new IRMER regulations were complied with, and also supported radiation protection within the service. We observed the April 2018 radiation protection committee minutes confirmed this.
- Imaging staff were aware of how to report a significant, unexpected finding. For example, if a radiologist was concerned following interpretation of an image, they would escalate the findings immediately to the patient's consultant.
- There were emergency procedures in place in the OPD including call bells to alert other staff in the case of a deteriorating patient or in an emergency.
- Patients identified as being unwell upon arrival to the department were reviewed and their condition was discussed with a consultant. Patients were referred to the inpatient area for admission when appropriate.
- The service always had access to a resident medical officer (RMO), provided by external provider, on duty, who was trained in advanced life support and advanced paediatric advanced life support (APLs). The RMO provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would be transferred to the local acute NHS Trust in line with the emergency transfer policy. Staff reported this rarely happened.
- Care and communication of the deteriorating patient training had recently been introduced as new mandatory training. Data confirmed 25% of staff had completed this as at January 2018.
- On arriving in the radiology department, we observed patient checks were completed to ensure the right person received the correct radiological scan at the right time.A safety questionnaire was completed by the radiographer prior to the scan being performed. This ensured the patient had been adequately checked and was medically safe to enter the MRI scanning room.

Safeguarding

- Staff understood how to protect patients from abuse and were aware of the requirement to work well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- During the May 2016 inspection, nursing staff did not have access to a registered children's nurse or had not received level 3 safeguarding children's training. This was not in line with national guidelines. Since this inspection, the hospital had reviewed service provision and no longer provided a children's and young person's service.During this inspection we found the hospital had also strengthened safeguarding training and processes. Training was delivered in line with the BMI safeguarding children and safeguarding adult's policy and intercollegiate safeguarding adults' document.
- There was an up to date corporate 'Safeguarding Adults Policy Incorporating Mental Capacity and Deprivation of Liberties and PREVENT for England and Wales' (dated May 2015) and 'Safeguarding Children Policy' (dated May 2017) with defined responsibilities at national, regional and hospital level.The Prevent duty is the duty in Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways to prevent people from being drawn into terrorism. The Prevent mandatory training was completed by 96% of staff across the hospital.
- The Director of Clinical Services (DCS) was the hospital safeguarding lead for both vulnerable adults and children, and trained to level three. The DCS had access

to the BMI regional safeguarding lead trained to level 4. This was in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.

- A senior nurse was the nominated clinical safeguarding lead for outpatients and diagnostic imaging services. They explained they cascaded information to staff, assisted with mental capacity act (MCA) assessments, and escalated or sought advice from the local trust's safeguarding team as required.
- Staff received mandatory training in the safeguarding of adults and children.All staff we spoke with knew who the lead was for safeguarding. We saw that there were posters displayed in each department for example, 'Procedure for managing a disclosure of suspected/ actual child or vulnerable adult safeguarding incident'. These posters contained flow charts and actions to be taken and who to contact in the event of adult or child safeguarding issues arising. Staff told us the actions they would take if they suspected a safeguarding incident; this was in line with policy.
- Safeguarding of vulnerable adults training was completed by 96% of required staff had completed level one, and 91% of required staff had completed level two, which was better than the BMI Healthcare target of 90%. Level three safeguarding of vulnerable adults indicated 100% of required staff had completed this training.
- The Safeguarding Children Policy was in-date and was accessible to staff via the hospital's intranet, and had clear pathways and guidance on female genital mutilation (FGM).
- Safeguarding of children training was undertaken every three years for levels one, two and three. Data indicated, 98% of required staff had completed level one, and 93% of required staff had completed level two, which was better than the BMI Healthcare target of 90%. Also, 100% of required staff had completed level three training for safeguarding of children.

Mandatory training

- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. Staff received training through the BMI online learning package (BMI Learn), face to face and practical sessions.
- Staff completed a number of mandatory training modules. These included infection prevention and control, basic life support, Control of Substances Hazardous to Health (COSHH), fire, equality and diversity, documentation, display screen equipment and safeguarding children and vulnerable adults.Dementia awareness training was also included as an e-learning module as part of mandatory training for clinical staff.
- Documentation provided by the hospital showed 91% of staff had completed their mandatory training which exceeded the hospital target of 90%.
- New mandatory training had been introduced during 2017 and included care and communication of the deteriorating patient, female genital mutilation, and safeguarding chaperoning. Staff were compliant with the 90% hospital target.
- There was a mandatory competency programme in place for staff in the diagnostic imaging department, this included plain film x-ray and ultrasound.
- Resident medical officers (RMOs) were trained in advanced life support (ALS). Some senior nursing staff and operating department practitioners were also trained in ALS.
- Staff told us they received an email from the OPD manager to remind them to complete mandatory training and refresher training, and were also reminded in daily huddles and at staff meetings.
- Mandatory training was predominantly completed through electronic teaching packages, and staff reported they were allocated time during quieter periods during their working day to complete training.
- Resident medical officers (RMOs) completed mandatory and yearly update training with the external provider. BMI The Meriden received training certificates that verified RMOs training status.
- Nursing staff completed medicines management training, 100% of staff in OPD were compliant.
- Data provided by the hospital showed 95% of required staff had undertaken dementia awareness training, which meant staff were aware of their roles and responsibilities for dealing with patients who were living with dementia.

Nursing staffing

Good

Outpatients and diagnostic imaging

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- At the time of the May 2016 inspection, there was no baseline staffing tool used in the outpatient's department to monitor staff levels. During this inspection, we saw the hospital had introduced a nursing dependency and skill mix planning tool to support the management of a safe staffing level and mix.
- Unqualified staff members including health care assistants (HCAs) and reception staff supported clinical staff.
- There was no use of bank and agency nurses in the outpatient department from February 2016 to March 2017.
- As of 1 January 2018, there was 2.7 full time equivalent (FTE) outpatient nursing staff employed and three FTE HCAs for outpatients. There were no nursing or HCA vacancies in the outpatient department as of 1 January 2018.

Allied Health Professional Staffing

- There was a team of seven full time physiotherapists, one physiotherapy assistant and one administrative member of staff who provided inpatient and outpatient care. The service also used three bank physiotherapists to provide cover on the ward and in clinics at the weekend.

Radiology staffing

The radiology department consisted of 5.4 full time equivalent radiographers, plus a radiology department manager that was sufficient to manage the service provided.

Medical staffing

- There were 209 consultants who had been granted practicing privileges at the hospital from June to December 2017. Practicing privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these also worked at other NHS trust in the area.
- There was a corporate The Executive Director and Medical Advisory Committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.
- The hospital had a resident medical officer (RMOs) who provided a 24 hours a day, seven days a week service, on a rotational basis. The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support.
- Staff in the outpatient department told us they had experienced issues with consultants 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 onto the next available appointment. This would be documented as an incident and we saw evidence that once a consultant had been late for their clinic three times, the Director of Clinical Services wrote them a letter. This would ask why they were arriving late and if they needed any support, or the clinic times changing.
- There was sufficient consultant staff to cover outpatient clinics. All staff we spoke with told us they had very good relationships with the consultants.
- No medical staff members were subject to fitness to practice hearings at the time of inspection.

Emergency awareness and training

- The service planned for emergencies and staff understood their roles if one should happen. There was an up to date major incident policy for staff to access.
- There was a business continuity plan in place due for review in August 2018. Staff told us they were aware of the policies and their responsibilities under it. The outpatient and diagnostic imaging staff knew what to do should an emergency arise. Action cards were held on reception desks to provide immediate guidance to staff should a major incident arise.
- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services such as electricity and water supply or in the event of staff shortages due to severe weather disruption.

Good

Outpatients and diagnostic imaging

- Mandatory fire safety hospital training compliance was 94% and fire warden/marshal training was 83%. During our inspection, we observed testing of the fire alarm system. All qualified nurses were trained in mandatory immediate adult life support and had completed major haemorrhage training.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Specialities within outpatient services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate. Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. Staff in outpatients, radiology, 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.
- We observed that audit and policies was a regular agenda item on the medical advisory committee meetings. For example, in May 2017 a new antimicrobial stewardship policy was discussed to ensure the hospital improved the use ofantimicrobialmedications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics, and decreasing unnecessary costs.
- The Ionising Radiation (Medical Exposure) Regulation 2000 (IRMER), stipulate the basic measures that need to be in place to provide radiation protection of persons undergoing a medical exposure. Within the imaging service, we observed the regulations were being actively implemented.
- We saw evidence of standard operating procedures, clinical protocols; local referral guidelines based on the Royal College of Radiologists guidelines, justification policy to ensure all medical exposures were justified prior to the exposure being made.
- The Ionising Radiation Regulations1999 (IRR '99) aims to protect the public and the health of the staff who work with ionising radiation, by specifying the duties of the hospital to ensure compliance to the regulations. We were able to observe compliance to the regulations within the department through the carrying out of risk assessments, quality assurance programmes, the provision of personal protective equipment (PPE), the development of local rules for each modality and the employment of Radiation Protective Services (RPS). Radiation protection policies, including local rules, were available within clinical areas.
- The OPD undertook a variety of local audits. There had been a change in the way audits were undertaken as of February 2018. Previously they were completed by the director of clinical services and there was a lack of ownership by heads of departments, or other members of staff. Since this time, audits were completed by individual departments who performed their own audits and actions were recorded against departmental action plans.
- They were to check equipment, medicines management, electronic records, hand hygiene, environmental and monthly spot check audits. We saw examples of these audits, along with action plans arising from them.
- The hospital was in the process of developing a dementia strategy based on the National Institute of Health and Care Excellence (NICE) guidance, such as NICE CG42 Dementia: supporting people with dementia and their carer's in health and social care.

Pain relief

- Patients we spoke with had not required pain relief during their attendance at the outpatient departments.
- Pain relief was not routinely administered within the service as patients attended for short period and usually took analgesia prior to attendance. Nursing staff we spoke with told us consultants would normally prescribe relevant pain medication for patients under their care.

- Nurses assessed patients using a pain scoring tool of 1-3 and if they assessed a patient required urgent pain relief, if the consultant was unavailable the registered medical officer could be used to assess the patient and prescribe the relevant pain relief.
- Pain advice booklets were provided to patients undergoing minor procedures and GPs were advised of a patient's treatment and prescription plan to support continuity of care on discharge from the OPD service.

Nutrition and hydration

- Reception staff told us they offered patients who appeared anxious or distressed a drink and provided assistance to patients who required additional support to purchase refreshments.
- We observed that patient appointment letter detailed whether patients were able to eat and drink prior to their appointment or scheduled procedures.
- Malnutrition and nutrition screening would be undertaken as part of the patient's assessment in the outpatient's department.

Patient outcomes

- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The OPD and diagnostic imaging departments contributed to the BMI hospital's corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- The OPD participated in national 'Patient Reported Outcome Measures' (PROMS) and in the National Joint Registry (NJR). Results were monitored and discussed at the hospital's clinical governance and medical advisory committees on a monthly basis, as well as at a regional and corporate level. Outcomes were benchmarked against other comparable services and, where poor outcomes were identified, we saw actions in place to improve performance.
- For example, an action plan was in place to support improved outcomes following knee and hip operations. A senior physiotherapist told us NHS patient knee exercise classes had been reviewed to include a beginners, and a more advanced group class, to meet patient needs. This enabled more 'control' work to be completed within advanced patient classes which aimed to improve patient outcomes. Follow-up appointments were also extended post-operatively with some patients to monitor outcomes more effectively.
- 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. See the main surgery report for a breakdown of the PROMs data.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff we spoke with confirmed they had completed all mandatory training and competency assessments and told us they were given time to complete electronic learning.
- Throughout our inspection, we found staff received training to support the delivery of care and individual's developmental needs. For example, a qualified nurse had undertaken an additional five-day, clinical minor procedure course to support safe care. The OPD manager had been supported to complete an institute of management and leadership course (ILM), and a qualified nurse was undertaking an ILM course at the time of our inspection. All qualified nurses in the department completed a six-week wound care programme at a local NHS hospital and health care assistants (HCAs) completed wound care training at an alternative NHS hospital.
- All hospital staff were supported to complete additional training available at the BMI corporate academy. One HCA was completing an assistant practitioner course that would provide a foundation degree qualification, and two HCAs were completing a 10-day HCA care certificate at the time of our inspection. One HCA was supported to attend a three-day urodynamics course during 2017, to support their role with setting up equipment safely, in preparation for a consultant to assess a patient's bladder and urethra functions.

Good

Outpatients and diagnostic imaging

- A recently appointed radiographer attended a radiation protection supervisor (RPS) training course. This provided information on the role and duties of a RPS. A physiotherapist had completed acupuncture and trigger point therapy training. (Trigger point therapy training was designed to speed up recovery from injury, correct muscular imbalances and relieve pain).
- Evidence showed that 100% of OPD staff had received an appraisal, which were recorded on the corporate electronic recording system The BMI staff survey completed in June 2017 found that 89% of respondents across the hospital stated they were satisfied with the quality of their appraisal discussion. Staff told us development opportunities were identified during their appraisals and that they felt supported to request additional training at other times as required. A radiologist told us they were being supported to attend a two-day cardiac course in June 2018.
- We observed that all new employees underwent an induction and competencies were assessed and reviewed as required. For example, we observed competencies for radiologists and radiographers in the use of equipment were signed and in date.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) approach across all the areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. 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 they were proud of their multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another. Medical and nursing staff reported good working relationships. One patient who had received treatment from the OPD, diagnostic imaging and surgery reported, “I feel as if throughout the whole experience, everyone knows what is going on. I don’t have to repeat things”.
- Collaborative working between the radiology and surgical department meant each area knew the number and type of patient that would be receiving treatments and may need interventions.
- Physiotherapists worked collaboratively with OPD staff to ensure patients received a timely and streamlined service.
- There were a number of service level agreements in place with nearby organisations, which involved teamwork to ensure continuity of care for patients. For example, the imaging department had a service level agreement with the local acute NHS trust to provide medical physics support. Staff reported that the interdepartmental working relationship was effective, and staff were readily available and willing to assist where necessary.
- We observed in patient records that GPs were kept informed of treatments provided; follow up appointments and medications to take on discharge.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The implementation of one patient record meant all information about the patient’s investigations, procedures, treatment and consultation was available in one location.
- There were pathways for different types of procedures. These pathways ensured that the progress was made and any deviation from the prescribed pathway could be identified and an appropriate intervention made swiftly.
- Consultants were responsible for ensuring appropriate records were available to other staff caring for the patient. These included details of the procedure completed for therapy staff, and planned treatments for nursing staff.
- Patients medical records were always available for their clinic appointments.
- Discharge letters were sent to the patient’s GP, immediately after discharge, with details of the treatment provided, follow up care and medications provided.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). In addition to this, staff could access the neighbouring hospitals PACS. Pathology test results could also be accessed electronically.

Good

Outpatients and diagnostic imaging

- Computers were available on the outpatients and diagnostic imaging departments. All staff had secure, personal login details and had access to email and all hospital IT systems.

Seven day services

- The outpatient department ran clinics from 8am to 8pm, Monday to Friday and 8am to 4pm on Saturdays as required. Staff cover was provided between these times.
- Since the previous inspection in May 2016, the physiotherapy had extended its hours and was open from 8am to 7pm Monday to Thursday and 8am to 3.30pm on Fridays. The department was also open each weekend when appointments had been booked.
- The diagnostic imaging department was open from 8am to 8pm Monday to Friday and 8am to 6pm on Saturdays as required. The imaging department provided an on call service for plain images and ultrasound, with out of hours provision of MRI and CT scans being completed by the local NHS trust.
- Resident Medical Officers (RMOs) provided a 24 hour a day, seven days a week service on a rotational basis. All RMOs working at the hospital were selected specifically to enable them to manage varied patient caseload.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service followed their corporate 'Mental Capacity Policy' (due for review June 2020), which included responsibilities and duties, training, key principles assessing capacity, best interest and refusal to be assessed.
- Staff completed mental capacity act and deprivation of liberty safeguards training within the safeguarding adult's mandatory training.
- Staff in outpatients and physiotherapy told us they rarely encountered patients with dementia or who lacked capacity. However, they were able to describe the process they would follow if they suspected a patient lacked capacity, and knew who to contact for further support or advice on this. One member of staff told us of the process they followed when a patient was disorientated and displayed challenging behaviour in the OPD waiting area.
- We saw there were contact details for the hospital safeguarding lead and the local safeguarding team on display in the nurse's office, so staff would know who to contact if they had any concerns.
- Data provided by the hospital showed 96% of staff were up-to-date on the consent training which was above the hospital's target of 90%. Initial consent for surgery was completed by the consultant providing care in the outpatient's department. All patients undergoing surgery were consented by the consultant providing care during consultation.
- Patients told us they had been given clear information about the benefits and risks of their surgery in a way they could understand prior to signing the consent form.
- Patients said they were given enough time to ask questions if they were not clear about any aspect of their treatment.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- Staff cared for patients with compassion. All patients we spoke with were highly complementary of the care they had received in outpatient services and many had used the services for a length of time. Patients and their relatives told us staff were extremely friendly and helpful. The main concerns patients had were the delays in appointments, access to the hospital grounds, and car parking.
- Patients were treated with respect and compassion throughout their care within outpatient services. Staff responded sympathetically to queries in a timely and appropriate way. We observed caring interactions with patients whilst they were booking in at the main reception or being assisted in the departments. One patient told us "It makes a difference having receptionists who are excellent. I would like to send them a thank you card".

Good

Outpatients and diagnostic imaging

- Throughout our inspection, we saw patients were treated with compassion, kindness, dignity, and respect. We received comments such as, "I have always found the staff to be very caring. I have always felt at ease with the staff and they treat me with dignity and respect at all times", "Staff are very friendly and patient", and "I feel the hospital service is fantastic and would recommend it to family and friends".
- Staff respected patients' social, cultural, and religious needs. We observed positive interactions between staff, patients, and relatives. Staff introduced themselves and took time to interact in a considerate and sensitive manner.
- We heard an example of when staff had gone the extra mile to provide compassionate patient care. For example, we saw a receptionist had repaired a pair of glasses for a patient who was waiting for treatment, and could not see clearly without them.
- The PLACE assessment for the period of March to June 2017 showed the hospital scored 87% for privacy, dignity, and well-being, which was higher than the England average of 84%. The place assessment for privacy, dignity and well-being, focuses on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also includes the practicality of male and female services such as bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction they have received. The test data for all patients in February 2018 showed 98% of respondents would recommend the hospital against an average of 94% respondents. The response rate in February 2017 was 69% which was better than the average England response rates for NHS patients which was 59%.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives said they felt involved in their care. They had been given the opportunity to speak with the staff looking after them. Relatives we spoke with said they had been given time with the nurses and doctors to ask questions.
- A patient's relative told us they had had been kept 'well-informed' of the process they were undergoing in diagnostic imaging and that they felt able to query any concerns with the consultant. A telephone number was provided and the patient was advised to request any further information once they left the hospital if they had a query.
- All outpatient services offered patients a chaperone and departments clearly displayed signs in waiting areas and consulting rooms. Patients were given the opportunity to be accompanied by a friend or relative and there were chaperones available when personal care was provided. For example, female nurses or healthcare assistants were available to act as chaperones when required.
- Staff encouraged patients to give feedback through satisfaction questionnaires and the Friends and Family Test. Staff told us and we observed the director of clinical services was visible to patients attending the outpatient's department and actively sought feedback from them.

Emotional support

- Staff throughout the department understood the need for emotional support. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. Staff had a good awareness of patients with complex needs and those patients who may require additional support should they display difficult behaviours during their visit to outpatients. Patients we spoke with told us they knew who to contact if they had any worries about their care and said staff had supported them emotionally as well as physically where there had been bad news following diagnostic results.
- The provider had a service level agreement with a local trust. Breast care specialist nurses from the local NHS trust attended patient appointments with a consultant when required to deliver difficult news. This ensured patients had access to information about services in the community who could provide specific emotional support.

Good

Outpatients and diagnostic imaging

- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The outpatient's and diagnostic imaging services planned and developed services to meet the needs of the local population for both private and NHS patients.
- The service had good working relationships with the local clinical commissioning group to manage services for NHS patients. The service also assisted with additional work from the local NHS hospitals to help meet increased demand. In addition, local agreements were in place with the local NHS trust to support areas of capacity concern.
- The hospital was located adjacent to an acute hospital, and offered the opportunity to engage highly skilled consultants across a wide range of specialties to deliver high standards of care and outcomes to patients.
- Scheduling of appointments was completed in line with requirements for the procedure, for example availability of equipment and specialists.
- Patients attending for outpatient and diagnostic imaging appointments had access to a small free car park in front of the hospital. Patients who were unable to park in this area could use the local NHS trust car park free of charge, which was a very short distance from the hospital. This was manned by a security guard who allowed access and exit. However, patients told us parking was difficult and we observed OPD complaints were often related to car parking. Patient also complained that it was difficult to access the hospital grounds as there was often congestion from the volume of traffic entering the site. BMI The Meriden reported they were submitting a proposal to introduce outpatient clinics at an outreach location, to reduce traffic congestion for patients on the shared site.
- Both, the outpatients and diagnostic imaging departments had appropriate facilities to meet the needs of adult patients awaiting appointments. This included comfortable seating, access to bathrooms, drinks machines and reading material.
- General information leaflets relating to most services provided, including complaints, were also available in the waiting areas.
- Written information on medical conditions, procedures and finance was available and accessible throughout the department.
- The main waiting area was within the reception area of the hospital. All patients waited in one waiting area, where they were collected by staff and taken to the appropriate area. There was clear signage throughout the hospital to guide patients to the relevant outpatient, radiology, and physiotherapy departments.
- There was a service level agreement in place with the local NHS trust for the provision of several services. This included pharmacy, microbiology, blood testing, sterile services, dietetics, and stoma care.

Access and flow

- People could mostly access the service when they needed it. Waiting times from referral to treatment were in line with good practice.
- There were 4,431 NHS funded patients who attended the outpatient and radiology department for their first appointment from February 2016 to January 2018. There were 10,706 NHS funded patients who attended the outpatient and radiology department for follow up in the same period.
- There were 7,261 patients who were funded either from insurance or self-pay schemes who attended the outpatient and diagnostic department for their first appointment from February 2016 to January 2018. There were 11,575 of this group of patients who attended the outpatient and radiology department for follow up in the same period.
- The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All hospitals that treat NHS patients are required to submit performance data to NHS England, which then publicly report how hospitals perform against this

standard. The maximum waiting time for non-urgent consultant-led treatments was 18 weeks from the day a patient's appointment is booked through the NHS e-Referral Service,or when the hospital or service receives the referral letter.

- In May 2017, the hospital transferred to a new patient administration system that caused patient's 'stop clocks' to be wrongly removed. This meant the service could not report accurate 18-week RTT performance data. The hospital engaged with the local clinical commissioning group (CCG) who continued to monitor the situation at the time of our inspection. The CCG reported significant progress was made with data integrity during 2018 and further work continued to move towards the accurate reporting of RTT data.
- At the time of the May 2016 inspection, hospital data showed that 95% of patients started non-admitted treatment within 18 weeks of their referral from January to December 2015. This was above the England average of 92%.
- During this inspection, the hospital told us patients continued to access the service within 18 weeks of referral. Staff told us the hospital had capacity and resource to meet RTT targets.
- We reviewed performance data submitted to NHS England before the hospital changed to a new patient administration system. This confirmed that in March 2017, 100% of patients started non-admitted treatment within 18 weeks of referral.
- During this inspection, we reviewed 20 patient records which confirmed all (100%) of non-admitted patients were seen within 18 weeks of referral.
- We observed patient access and flow was discussed at a daily 'huddle' during our inspection. This included all senior staff members. The number of new and follow-up clinic appointments and the number of patients undergoing minor treatment were discussed. The huddle enabled key safety information to be shared with each department, identified any risks to the service, for example staff sickness, and enabled information to be cascaded to staff across the department each morning.
- BMI The Meriden under-performed against the constitutional standard of completing diagnostic testing within six weeks of referral, and achieved the standard on one occasion from June 2017 to February 2018. The department completed a low number of tests each week and staffing issues had impacted on performance. The CCG continued to monitor the hospital's remedial action plan to ensure quality of care was maintained.
- Patients could book appointments on the NHS referral portal that provided patients with a choice of appointment time. Private patients could book appointments through the centralised team or the website, which also provided a 'live chat' support function.
- Access to outpatient appointments was fast and patients told us they were more than satisfied with the amount of time it had taken to obtain an appointment. Patients also told us they were able to book appointments at times that suited them.
- Appointments were available at weekends in the imaging department, according to clinical need.
- The physiotherapy service had extended the department's opening times to enable patients to access the service during evenings and at weekends.
- On arrival, patients reported to the receptionists who logged them in via an electronic booking system and directed them towards the appropriate clinics and waiting areas.
- Staff managed patients who did not attend clinics (DNAs) by text reminders. The hospital had very low 'did not attend' (DNA) rates. All patients who missed their appointment were followed up and offered a second appointment within 28 days. 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.
- Care and treatment was only cancelled or delayed when necessary. Clinic cancellations and DNAs were monitored and reported to the local CCG.
- Staff monitored clinic delays. Many staff told us, and patients confirmed, clinics did not always run on time. In mitigation, the department had introduced a system to monitor clinic start times to identify any themes that occurred. Consultants were reminded of the need to arrive on time and a formal oversight meeting was held with the governing trust following three late arrivals.

Good

Outpatients and diagnostic imaging

Meeting people's individual needs

- The service took account of patient's individual needs.
- Hearing loops were available in the waiting area, along with portable hearing loops, which helped those who used hearing aids to access services on an equal basis to others.
- A range of refreshments were available for patients from vending machines situated in the main reception area.
- High-back chairs were available in most waiting areas to accommodate older patients or those with mobility issues. We also observed that bariatric chairs were also available in the main outpatients waiting area, and bariatric wheelchairs and trolleys were accessible throughout the department.
- We reviewed seven completed CQC patient comment cards regarding the physiotherapy service. The service was described as adaptive with exercises tailored to meet patients' needs and abilities.
- Staff in the physiotherapy service that private patients generally received a shorter follow-up period than NHS patients. They explained that this was related to private insurance company commissioning policies.
- An interpreting service for NHS patients who did not speak English was available and staff knew how to access it. Staff told us private patients were required to arrange their own interpreter, which we were told was often a family member, and not in line with best practice.
- We saw appointment letters, which contained clear information about appointments and what to expect. Booking administrators sent information about how to get to the hospital and specialist information depending on which clinic they were attending. All patients told us they were provided with a good, clear explanation and most were provided with written information about their condition.
- Patients had access to a variety of information leaflets in the hospital. All information leaflets were in English, however staff told us they could access written patient information in other languages through an electronic system and obtained when required. There were no radiology patient information leaflets however, a senior radiographer told us corporate information leaflets were being adapted and would be available once approved.
- 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 ensured that patients understood the costs involved. Leaflets were available that explained the payment options, and procedures and gave advice of who to contact if there were any queries. The hospital website also clearly described the different payment options available.
- The outpatient, radiology, and physiotherapy departments were accessible to patients with a physical disability, as patient lifts were available. There was ramped access to the hospital and we saw there were wheel chairs in the front entrance for patients to use, along with wheelchair accessible toilets.
- One staff member told us they would offer patients with a back or spinal injury an opportunity to lie on a bed in a consultant room whilst they waited for their appointment.
- Staff told us on one occasion they arranged, and the service funded a taxi for an NHS patient when the transport was significantly delayed. This was to meet the individual need of the patient.
- The hospital took part in the Patient Led Assessment of the Care Environment (PLACE) audit March to June 2017, which showed the hospital scored 98% for organisational food which was significantly better than the England national average of 88%. For ward food the hospital scored 100%, which was significantly better than the England national average of 90%, and 99% for food, which was better than the national average of 90%. The assessment for food and hydration covers organisation questions looking at the catering services provided such as choice of food, 24-hour availability, mealtimes, and access to menus. It also included an assessment of food services at ward level, looking at areas such as the taste and temperature of food.
- Patient Led Assessment of the Care Environment (PLACE) for March to June 2017 showed the hospital scored 84% for dementia, which was better than the England average of 77%. The place assessment for

dementia was included for the first time in 2015, and focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.

- The PLACE assessment for the period of March to June 2017 showed the hospital scored 89% for disability, which was better than the England average of 83%. The PLACE assessment for disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which could prove helpful to people living with disability.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.
- The OPD, including diagnostic imaging, received 34 complaints from 1 August 2017 to 31 January 2018. No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISACS). The Care Quality Commission (CQC) had assessed the level of complaints was similar to the rate of other independent hospitals we hold this type of data for.
- The hospital had a clear process in place for dealing with complaints, a 'Complaints Policy' dated October 2015 that we observed was under review at the time of our inspection. Staff we spoke to were aware of the complaints procedure. We saw complaints leaflets, 'Please tell us', were available throughout the hospital and saw the hospital website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email. All staff had attended a 'Think Customer' training session to promote the delivery of high standards of customer care.
- Senior managers, including the executive director, were all involved in the management and investigation of patient 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. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining why.
- Staff told us that new complaints and learning from complaints were discussed at relevant committee meetings. We reviewed three sets of minutes from monthly clinical governance team meetings, medical advisory committee meetings and heads of department meetings that demonstrated complaints were a regular agenda item. We observed the number of open complaints was discussed at a daily huddle during our inspection. Learning from complaints was cascaded to staff in the department in regular huddles and within team meetings.
- Themes from complaints included patient wait times due to consultants arriving late for appointments and complaints about charges and invoicing. A change in the complaint process was made in February 2018 to include the consultant's response, alongside the complaint response letter when a patient had complained of a late consultant arrival. A patient liaison officer position was introduced following a review of complaints to provide patients and consultants with improved access to a staff member, to assist with pricing queries.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as **good.**

Leadership and culture of service

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. BMI The Meriden was led by an executive director, a clinical director of services and manager of operations. All the heads of department reported to one of these three leaders.
- At a department level, OPD staff reported to the outpatients' manager, who reported to the director of

clinical services (DCS). Radiology staff reported to the radiology manager, who reported directly to the DCS. Physiotherapy staff reported the physiotherapy manager, who reported to the DCS.

- Most staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to. Staff said any inappropriate behaviour would be dealt with immediately.
- Departmental action plans gave ownership to heads of departments to ensure that objectives were cascaded to staff at all levels. Progress was regularly reviewed through the heads of department committee meeting and departmental meetings.
- Feedback from staff forums and the weekly open door clinic was discussed with the appropriate manager and fed back to the leadership team via the monthly heads of department committee meeting.
- The majority of staff said the senior leadership team were approachable, visible and supportive and leaders were positive, proud of the hospital and motivated staff.
- Many staff had worked at the hospital for a long time and reported that their direct line managers were supportive and kept them informed of day to day running of the departments. One staff member told us they had been 'empowered' to speak up through the support provided by the OPD manager. A second member of staff told us the manager was supportive and they couldn't talk highly enough about them.
- The nursing team, diagnostic team, physiotherapy team and administration team communicated well together and supported each other.
- Managers encouraged learning and a culture of openness and transparency. They operated an 'open door policy' and encouraged staff to raise concerns directly with them. We saw senior managers visiting the outpatient's department during our inspection. Staff told us this was a normal daily occurrence.
- We saw that the culture of all the areas we visited during our inspection centred on the needs and experiences of the patients. For example, if a mistake happened this was handled in a sensitive and open way.

Vision and strategy for this core service

- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The hospital's vision was to provide the best patient experience and outcome in the most effective way where clinical excellence, safety, care provision and quality were at the heart of everything completed whilst they grew the business. The provider had a five-year vision from 2015 to 2020, with eight strategic objectives to drive positive change and further improve the quality of service provision.
- Providing the best patient experience was one of the three priorities within the corporate vision. All staff spoken with said they were committed to providing a positive patient experience.
- BMI the Meriden Hospital had clear vision and strategic goals, driven by quality and safety, aligned to the BMI Healthcare corporate vision and underpinned by BMI behaviours. The hospital strategy had been developed by the senior management team (SMT) with defined objectives, underpinned by a clinical and non-clinical strategy cascaded to the team.
- The hospital's clinical and non-clinical vision and strategic objectives that underpin the BMI Healthcare Group 5-Year strategy, provided staff with a foundation to drive positive change and further improve the quality of service provision.
- The aim of the strategy was to ensure an integrated approach where risk management, clinical governance and quality improvement were part of the culture and everyday management practice. The objectives of the strategy were to promote an honest, open and blame-free culture where risks are identified and addressed at every level and escalated appropriately, to ensure standards.
- The hospital's vision and strategy was cascaded to teams through departmental meetings, staff forums and notice boards. A presentation was produced to facilitate communication at meetings and a one page visual strategy was posted on departmental notice boards.

- The 'BMI vision' was 'best patient experience', 'best outcomes' and 'most cost effective'. This was supported by eight strategic priorities, these included, 'governance framework', 'people, performance and culture', 'facilities and sustainability' and 'superior patient care'.
- Across the outpatients' service the majority of staff were clear on the wider vision and strategy for the hospital. Staff were proud of the job they did and aimed to provide safe and high quality care and could articulate the hospital's values.

Governance, risk management and quality measurement

- The service had clear governance systems in place. The hospital held meetings through which governance issues were addressed. The meetings included medical advisory committee, heads of department (HoD) meeting, infection control and medicines advisory committee.
- The hospital followed their corporate 'clinical governance policy' (dated March 2017), which included clinical governance leadership and monitoring and compliance.
- The clinical governance committee (CGC) was responsible for ensuring that the appropriate structure, systems, and processes were in place in the hospital to ensure the safe delivery of high quality clinical services.
- The clinical governance committee (CGC), met every month and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, risk register review. There was also a standing agenda item to review external and national guidance and new legislation, such as National Institute of Health and Care Excellence (NICE) guidance. For example, NICE NG77, management of cataracts in adults we observed was reported in the December 2017 CGC minutes. This ensured the hospital implemented and maintained best practice, and any issues affecting safety and quality of patient care were known, disseminated managed and monitored. During our inspection we saw the minutes of the CGC held in October 2017 to January 2018.
- The MAC met quarterly and the minutes of the meetings held in May, July, November and December 2017 and February 2018 were reviewed. The minutes showed key governance areas such as never events and incidents, practising privileges, and feedback from the CGC were discussed.
- The Heads of Department met monthly and the minutes showed items discussed included complaints, clinical governance, audit results, and key departmental feedback. These meetings also shared staff experiences and information was shared back with staff in the departments.
- The service had a radiation protection committee (RPC), which met every year and was an important part of the radiation clinical governance process. Staff told us that radiation protection had been as added as a standing agenda to the Health and Safety committee to strengthen governance processes.
- Staff members were clear on their objectives and understood how they contributed to the hospital success. Heads of departments identified training needs of staff through appraisal and supported training at BMI training academy. Training and development was a focus for 2018 as reflected in the 'BMI Say' action plan.
- The hospital had a corporate risk register which was regularly reviewed and updated to ensure risks were monitored and appropriately managed. Heads of departments managed departmental risk registers which fed into the hospital's risk register. Risks documented on the outpatients, diagnostic imaging and physiotherapy risk registers reflected what staff had told us. Governance and risk performance was discussed through the committee meeting structure. Our last inspection in May 2016 highlighted medicines fridge being left unlocked in endoscopy and issues with the safe management of prescription pads. These were recorded as departmental risks within the corporate risk register and had been actioned.
- There was a monthly bulletin, which supported risk management by identifying changes in legislation and NICE guidance.

Public and staff engagement

- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. We saw there were boxes throughout the hospital to place completed forms. The hospital also gathered patient

opinion from the friends and family test (FFT), and patient led assessment of the care environment (PLACE). Departments used the results of the survey to improve the service.

- 'Best practice' was discussed at the daily communications cell meeting where colleague's contribution to achieving 'best practice' was shared. We observed that the corporate BMI 'Reward and Recognition' scheme had been introduced, and that each month an employee would be nominated to receive a reward in recognition for going above and beyond their normal duties.
- Other staff recognition schemes, included service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years.
- The Executive Director provided protected time slots for staff to meet with them either individually or in groups to discuss issues and ideas.

Innovation, improvement and sustainability

- There was a culture of continuous staff development across the departments. We were told that one health care assistant staff had started their assistant practitioner training and that the OPD manager had completed an institute of management and leadership (ILM) course. A qualified nurse was undertaking the course at the time of our inspection. This demonstrated the hospital's commitment to continuous staff learning and improvement.
- All qualified nurses in the department completed a six-week wound care programme at a local NHS hospital and health care assistants (HCAs) completed wound care training at an alternative NHS hospital.
- The hospital was currently undergoing a programme of refurbishment, and there was a plan in place to upgrade all the corridor flooring in the OPD.

Outstanding practice and areas for improvement

Outstanding practice

The provider provided a holistic approach to safety, quality and engagement. Since the previous inspection in May 2016, the provider had introduced a daily communications cell meeting. This was set to improve safety, staff engagement, communication and multidisciplinary working. Representatives from each clinical and non-clinical area were invited, such as, engineering, catering, housekeeping and administrative staff. A brief overview of the day's activity, utilisation, staffing, incidents, medical alerts and potential risk to the service were discussed. The staff were also informed of any visitors, such as, outside contractors, that would be onsite. The staff then took this back to their department and shared with the rest of the staff.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure bowel preparation is administered in an environment where appropriate toilet facilities are available to patients.
- The provider should ensure patients are admitted and discharged in an environment where privacy and dignity can be maintained.
- The provider should ensure all medicines are safely administered to patients as per nursing and midwifery standards.
- The provider should ensure patient outcomes for colonoscopy are routinely monitored.
- The provider should provide patient information leaflets for patients in diagnostic imaging.