BMI The Winterbourne Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Winterbourne Hospital was opened 1982 and is one of 62 hospitals and treatment centres provided by BMI Healthcare Ltd.

The hospital provides a range of surgical and diagnostic services. There are a limited number of medical procedures; the oncology service was recently discontinued.

The facilities include two operating theatres with laminar airflow, two treatment rooms, and eight consulting rooms supported by an imaging department offering X-ray and ultrasound. There is a ward of 31 beds, in single rooms, with an extended recovery unit in the centre for up to two patients requiring a higher level of observation post surgery. The hospital offers physiotherapy treatment as an inpatient and outpatient service in its own dedicated and fully equipped physiotherapy suite and hydro therapy pool. A mobile MRI scanner, provided by an external company, visits the hospital twice a week.

Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral and maxillofacial surgery, general medicine, dermatology, physiotherapy, endoscopy and diagnostic imaging. Most patients are self-pay or use private medical insurance. Orthopaedic, ophthalmology and general surgery services are available to NHS patients through NHS e-Referral service.

The announced inspection took place between 5 and 6 January 2016, followed by a routine unannounced visit on 7 January 2016.

This was a comprehensive planned inspection of all core services provided at the hospital: surgery, and outpatient and diagnostic imaging. Medical services were not inspected as a core service as a limited number of patients mostly treated in outpatients or theatre. Oncology services had discontinued. One patient attended for completion of a course of chemotherapy during the unannounced visit and appropriate staff were on duty to oversee their care and treatment.

There is no critical care facility or emergency department at the hospital and no maternity services. There are no services for patients under 16 years, a few outpatients are aged 16 -18 years, and the majority of patients are adults.

The Winterbourne Hospital was selected for a comprehensive inspection as part of our routine inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology.

The overall rating for this service was 'Requires improvement'.

The services at this hospital were rated as good for caring and responsive but there where were areas for improvement in surgical services, in particular the operating department, where more robust safety processes, staff training and competency assessment was required. Patients were consistently positive about the care and treatment received. They were appropriately assessed and received treatment from caring and compassionate staff, following best practice and national guidance. The registered manager provided positive leadership, but quality monitoring and identification and management of risk needed to improve across the hospital.

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean that people are protected from abuse and avoidable harm.

- The hospital protected patients from the risk of abuse and avoidable harm. Most staff reported incidents and openness about safety was encouraged, however there were some inconsistencies in reporting of incidents in the operating department.

Summary of findings

- Incidents were monitored and reviewed but staff in some departments did not consistently receive feedback and learning from incidents.
- Staff understood the principles of Duty of Candour regulations, and senior managers were confident in applying the legislation.
- All clinical areas were appropriately equipped to provide safe care, but in surgery several items of medical equipment were not serviced or appropriately tested.
- The departments were visibly clean and there were good infection prevention and control policies to reduce the risk However, some staff did not consistently adhere to the organisations policies. There were lapses in adherence to 'bare below the elbows' and use of personal protective equipment
- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The surgical ward participated in the NHS Safety Thermometer for NHS patients. Senior staff conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. Information about the audits was not displayed. This is not mandatory, but is considered good practice.
- Medicines were stored securely and managed correctly in most areas, but some medicines in the operating department were not stored appropriately and some had passed their expiry date. Whilst three monthly audits were undertaken of controlled drugs held by wards or departments, similar processes were not undertaken within the pharmacy department.
- There was regular monitoring of patient records for accuracy and completeness. They were securely stored and available when needed.
- Staff undertook appropriate mandatory training for their role and electronic records showed more than 90% compliance across the hospital. However, ward and theatre staff had not all undertaken and completed patient moving and handling update training with in the last year.
- Safeguarding policies and procedures and staff were appropriately trained and knew how to respond to safeguarding concerns. The director of nursing was the safeguarding lead for the hospital.
- Nurse staffing levels and skill mix were planned appropriately, implemented and reviewed. Staff shortages were responded to quickly and adequately.
- There was sufficient medical cover provided by resident medical officers (RMOs) who covered the hospital 24 hours a day for all specialities. Consultants were available daily and provided on call cover and advice out of hours if necessary.
- There were suitable arrangements for handover between shifts, and all staff attended the daily 'huddle' for a brief update on patients and relevant information for the day.
- Clinical staff identified and responded to patients' risks. They received simulation training to ensure they could respond appropriately if a patient became unwell. A sufficient number of staff were trained to provide advanced resuscitation skills.
- In diagnostic imaging, local rules and safe systems of work were in place. There was a nominated Radiation Protection Supervisor (RPS) and Laser Protection Supervisor (LPS), who had received appropriate training. There were good communication and support from Radiation Protection Adviser and NHS medical physics team.
- Emergency business contingency plans were in place and regular fire drills practised.

Are services effective at this hospital?

Summary of findings

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

- Most staff were competent, skilled and knowledgeable. However, there was not documented evidence of training or assessed competency for some roles in the operating department. There was no evidence of competency assessments for theatre staff or nursing staff assisting with endoscopy.
- Theatre nurses worked as surgical first assistant (SFA) under supervision as partway through the training and assessment.
- Most staff were supported in their role through appraisals. However, appraisal rates varied across the services, the majority of operating department staff had not completed an annual appraisal. Some staff reported a lack of support in accessing training they believed would enhance the care they provided to patients in their department.
- Care and treatment followed best practice and evidence-based guidance across services. The medical advisory committee reviewed policies and guidance and advised on effective care
- The medical advisory committee was actively involved in reviewing outcomes and renewal of practising privileges of individual consultants. However not all departments were aware of the competencies for individual consultants and there was no record kept within outpatients.
- Outcomes of patient care and treatment was monitored in surgery and outpatients. Patient outcome data was reported for comparative analysis for surgical services. Surgical services performed well in national audits. Unplanned readmission and return to theatre was not higher than expected.
- Patients had access to different methods for effective pain relief. Patients' pain was monitored and the effectiveness of pain management evaluated.
- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- There was evidence of good multidisciplinary working and information sharing across the hospital and with the local NHS trust. Out-of-hours services were provided when needed
- The consent process for patients was well structured, with written information provided prior to consent being given. Consent was regularly audited.
- Staff were trained in the Mental Capacity Act 2005 and there was appropriate guidance and tools to assess patient mental capacity.

Are services caring at this hospital?

By caring, we mean that staff involve and treat patients with compassion, dignity and respect.

- Feedback from patients about their care and treatment was always positive and we observed staff being supportive and compassionate to patients.
- Patients told us they felt they had sufficient information to allow them to be involved with their care and had their wishes respected and understood.
- Staff treated patients courteously and respectfully, and maintained their privacy and confidentiality.
- Patients were contacted by the hospital after they had been discharged offering help and advice if required.
- Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

Summary of findings

Are services responsive at this hospital?

By responsive we mean that services are organised so they meet people's needs.

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service and there were ongoing plans for development. The hospital worked with Dorset Clinical Commissioning Group (CCG) in developing services for NHS patients.
- Some aspects of the environment did not fully support privacy; the hospital was taking steps to address these issues.
- Patients were able to access services when needed, waiting times, delays and cancellations were minimal. Services were responsive to meeting individual patient needs, including patients living with dementia, or with a learning disability. NHS and private patients' experienced the same levels of care.
- There was information on specific procedures, conditions and hospital charges, but not in other languages or formats, such as braille. The hospital had minimal numbers of patients who could not understand English. There was a translation service available if needed.
- The hospital had a system for responding to and managing patients' verbal or written complaints. However, guidance on how to make a formal complaint was not on display at the time of inspection . There was evidence of learning from complaints

Are services well-led at this hospital?

By well-led, we mean that the leadership, management and governance of the organisation, assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- There was a clear vision and strategy for development at the hospital, which aligned with the corporate strategic vision for high quality and convenient patient care.
- There was a governance structure in place, with a range of committees. The clinical governance committee met bimonthly to discuss a range of governance issues across the hospital.
- The medical advisory committee (MAC) met regularly; membership included consultant leads across specialities. The MAC was involved in quality assurance of medical staff and monitoring of clinical issues. There was a supportive working relationship between the MAC chair and the registered manager and director of nursing.
- The registered manager regularly reviewed a BMI quality dashboard which compared a range of performance and quality metrics across hospitals.However there were not robust systems to monitor quality across all areas of the hospital.
- A BMI provider visit pre inspection had identified some quality issues particularly in the operating department. However these and the issues identified at inspection had not all been identified through the hospital governance and quality monitoring processes. The director of nursing sought reassurance of quality through knowing and working with staff and walkabouts.
- The registered manager had a good understanding of risk management but there was not understanding by all managers at other levels, or across all departments. Some managers were not aware of all the risks specific to their areas of work, not all had training in risk management and there were no departmental risk registers. The hospital risk register followed the corporate policy and was designed to capture health and safety risks and not all types of risk.

Summary of findings

- In most departments staff valued and had confidence in their local leaders and there was a strong ethos of team working. However there was low morale amongst staff in the operating department, without local leadership they were looking forward to the arrival of a new theatre manager.
- The registered manager was accessible to staff and encouraged a positive, open culture within the hospital.
- There was evidence of innovation and development of services, particularly in the physiotherapy and diagnostic imaging departments.
- Results of the latest patient survey showed a high level of meeting patient's expectation, with the hospital scoring 98.1%.

There were areas of poor practice where the provider needs to make improvements.

Importantly, the provider must ensure:

- learning from investigations, incidents and complaints is appropriately shared across the hospital.
- clinical equipment checks and servicing are carried out in accordance with the hospitals policy.
- all staff consistently adhere to best practice in infection prevention and control
- staff complete all mandatory training, including training in patient moving and handling.
- systems and processes are in place to ensure out of date medicines are identified and replaced
- medicines being stored in freezers are kept at the correct temperature, as recommended by manufacturers
- working practices in the operating theatre reflect the hospital policy and procedures and are in line with current national guidance. Theatre and endoscopy staff must have appropriate competencies and supervision in relation to their role.
- Staff have the opportunity to contribute to yearly appraisals
- risks are identified, assessed and managed effectively across all areas of the hospital
- there are processes in place to effectively monitor the service provision and identify areas for improvement
- there are effective systems in place to assess, monitor and mitigate all risks relating to the health, safety and welfare of service users.

In addition the provider should ensure:

- all equipment used by the service is clean and properly maintained. There should be a clear process in place to demonstrate the hoist slings have been cleaned, with appropriate dates and times recorded.
- all staff adhere to the 'bare below the elbow' guidance to allow thorough hand washing and reduce risk of cross infection.
- the risks associated with the use of heat pads in the microwave are identified, assessed and managed effectively.
- that medicines are appropriately labelled.
- appropriate arrangements for monitoring and auditing the management and use of controlled drugs by the Controlled Drugs Accountable Officer, in all areas including the pharmacy, are in place
- the local identification, planning, action, review and records relating to Central Alert System (CAS) notifications for medicines
- all departments are made aware of the practising privileges and any restrictions on practice of medical consultants

Summary of findings

- all staff have the opportunity for appraisals and regular supervision

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	We rated surgery as 'requires improvement' because: The surgical services required improvement in some aspects of patient safety such as appropriate actions and learning from incidents and complaints and medicines not being managed safely in the operating theatre. In general equipment was maintained though there were a number of pieces of medical equipment that needed portable electrical testing. There was a low staff appraisal rate and there was no documented evidence that staff in operating theatres, or nurses assisting with endoscopy, had undertaken appropriate competency assessments. Service leaders had not identified key risks about the service or classified them on a risk register, for mitigation and escalation. This meant there was a possibility that risks would not be communicated and managed effectively. There were governance processes, including evidence of investigation of incidents and audits but there was a lack of detail and recording to demonstrate how some issues had been comprehensively investigated or how action plans would be used to drive improvements Staff completed comprehensive patient risk assessments from the initial pre-assessment clinic through to discharge. Care was provided in-line with national best practice guidelines and outcomes for patients were better than average. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Patients had assessments of their needs and access to different methods for pain relief. Staff monitored and responded to patients' pain levels appropriately. Feedback from patients about their care and treatment was always positive. We observed

Summary of findings

patients were treated with kindness, compassion and dignity throughout our visit. However the ward environment did not ensure patient privacy and dignity was always maintained.

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic screening as 'Good' because:
Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole.
There were appropriate systems in place to keep patients safe. Staff reported incidents however it was not always apparent that learning was shared locally and across the hospital. We saw that outpatient areas were clean and that equipment was well maintained. Staffing levels were appropriate without any use of agency staff. Patient records were available for appointments and the department had timely access to test results.
There was good multidisciplinary team working. Staff told us there was good support in their role, with appropriate opportunities to develop their skills further.
We observed that staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care. Staff were able to access interpreters for patients whose first language was not English.
Hospital staff, together with consultant private secretaries, managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities.
Staff worked effectively in teams and were generally positive about the leadership of the service at both a local and senior level. There was an open culture and staff were encouraged to make suggestions to improve services for patients.
The hospital used different methods to gather feedback from patients about their experience.

Summary of findings

Contents

Requires improvement

BMI The Winterbourne Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to BMI The Winterbourne Hospital

BMI The Winterbourne Hospital was opened 1982 and is one of 62 hospitals and treatment centres provided by BMI Healthcare Ltd.

The on-site facilities include two operating theatres with laminar airflow, two treatment rooms, and eight consulting rooms supported by an imaging department offering X-ray and ultrasound. There is a ward of 31 beds, in single rooms, with an extended recovery unit in the centre for up to two patients requiring a higher level of observation post surgery. There is no critical care facility or emergency department at the hospital.

The hospital provides a range of surgical and diagnostic services to patients aged 16 years and over. Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral and maxillofacial surgery, general medicine, dermatology, physiotherapy, endoscopy and diagnostic imaging. Most patients are self-pay or use private medical insurance. Orthopaedic, ophthalmology and general surgery services are available to NHS patients through NHS e-Referral service. There are a limited number of medical procedures, mostly endoscopy, and the oncology service was recently discontinued.

The hospital offers physiotherapy treatment as an inpatient and outpatient service in its own dedicated and fully equipped physiotherapy suite and hydro therapy pool. A mobile MRI scanner, provided by an external company, visits the hospital twice a week.

The registered manager, Theresa Starling, registered in 2012.

The nominated individual for BMI Healthcare Ltd is Liz Sharp.

Our inspection team

Our inspection team was led by:

Inspection lead: Anne Davis, Inspection Manager, Care Quality Commission (CQC)

The team of 11 included three CQC inspectors and assistant inspector, a pharmacist inspector and a variety of specialists: a general surgeon, theatre nurse specialist, cosmetic surgery nurse, senior governance manager, outpatient nurse manager and radiography manager.

Why we carried out this inspection

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at the two core services provided by the hospital: surgery; outpatients and diagnostic imaging. Medical services were limited and most medical patients were treated in outpatients or in theatre for endoscopy procedures . Findings are reported under the two main core services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of this inspection

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. We carried out an announced inspection visit between 5 and 6 January 2016, and a routine unannounced inspection 7 and 15 January 2016.

We visited all areas of the hospital. We held focus groups for staff in the hospital and also spoke with staff and managers individually. We talked with patients and staff from the ward, physiotherapy department, operating department, X-Ray, and outpatient services. We observed care, reviewed patient records and staff training records. We reviewed information provided on CQC feedback cards from patients using the service. Before, during and after our inspection we reviewed the provider's performance and quality information.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at BMI The Winterbourne Hospital.

Information about BMI The Winterbourne Hospital

Key facts and figures

The hospital is registered for 38 beds, 31 were in use at the time of inspection. The hospital provides a range of services to patients aged 16 years and over, who are self-pay or use private medical insurance. Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral & maxillofacial surgery, general medicine, oncology, dermatology, physiotherapy, endoscopy and diagnostic imaging. Orthopaedic, ophthalmology and general surgery services are available to NHS patients through NHS e-Referral service. 26% of all patients October 2014 to October 2015 were NHS funded.

Hospital activity between October 2014 to October 2015:

- 2946 day-case inpatients;
- 974 overnight inpatients;
- 3,695 visits to theatre;
- 7385 outpatients (first attendees)
- 13585 outpatients (follow up)

The most common surgical procedures were :

- 900 cataract procedures
- 273 multiple arthroscopic operations on knee
- 196 primary total hip replacement procedures.
- 195 primary repair of inguinal hernia
- 176 total knee replacement

The most common other procedures were :

- 70 diagnostic gastroscopy or endoscopy
- 77 facet joint injection (under x-ray control) - 5 to 6 joints
- 61 facet joint injection (under x-ray control) - 3 to 4 joints

The accountable officer for controlled drugs is Theresa Starling, registered manager

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Information about the service

BMI The Winterbourne Hospital provides elective surgery to patients who pay for themselves or who are insured. The hospital also offers services to NHS patients, including orthopaedic, general surgery and cataract surgery. The hospital did not provide surgical services for children

There were 3695 admissions for surgery between October 2014 and September 2015. The five most commonly performed procedures were phacoemulsification of lens with implant (900), arthroscopic knee procedure (273), hip replacements (196), hernia procedures (195) and knee replacement (176). Surgical specialities offered include, orthopaedics, ophthalmology, general surgery, endoscopy, gynaecology and cosmetic surgery.

NHS care was approximately 40% of activity and self-funded care 60%. From October 2014 to September 2015, there had been 343 NHS-funded overnight inpatients for operations and 1238 inpatient day cases. There were 631 self-funded overnight inpatient stays and 1708 self-funded day case procedures.

There are two operating theatres and one main ward with 38 patient rooms suitable for inpatient and day case care. All rooms are single with ensuite facilities. Thirty one rooms were in use at the time of inspection.

During our inspection we visited theatres, the ward and the pre-assessment clinic. We spoke with 10 patients, one relative and 32 staff. The staff included managers, health care assistants, registered nurses, medical staff, theatre personnel, operating department assistants and administrative staff. We looked at the patient environment and observed patient care in all areas. We reviewed eleven patient records and seven medication charts. Before, during and after our inspection we reviewed the provider's performance and quality information

Requires improvement

Surgery

Summary of findings

We rated surgery as 'requires improvement' because:

The surgical services required improvement in some aspects of patient safety such as appropriate actions and learning from incidents and complaints and medicines not being managed safely in the operating theatre. In general equipment was maintained though there were a number of pieces of medical equipment that needed portable electrical testing.

There was a low staff appraisal rate and there was no documented evidence that staff in operating theatres, or nurses assisting with endoscopy, had undertaken appropriate competency assessments. Service leaders had not identified key risks about the service or classified them on a risk register, for mitigation and escalation. This meant there was a possibility that risks would not be communicated and managed effectively.

There were governance processes, including evidence of investigation of incidents and audits but there was a lack of detail and recording to demonstrate how some issues had been comprehensively investigated or how action plans would be used to drive improvements

Staff completed comprehensive patient risk assessments from the initial pre-assessment clinic through to discharge. Care was provided in-line with national best practice guidelines and outcomes for patients were better than average. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

Patients had assessments of their needs and access to different methods for pain relief. Staff monitored and responded to patients' pain levels appropriately.

Feedback from patients about their care and treatment was always positive. We observed patients were treated with kindness, compassion and dignity throughout our visit. However the ward environment did not ensure patient privacy and dignity was always maintained.

Are surgery services safe?

Requires improvement

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as 'requires improvement.'

- Incidents were not always reported and staff did not consistently receive feedback or the learning from patient safety incidents.
- Medicines in the operating department were not stored appropriately and some medications that had passed expiry date.
- Several items of medical equipment were not serviced or appropriately tested
- Staff had not completed and undertaken patient moving and handling update training within the last year
- Infection prevention and control policies and procedures were not consistently followed.

However,

- All clinical areas were appropriately equipped to provide safe care
- Ward and theatre area were visibly clean
- Medicines were appropriately managed on the wards.
- Patient records were accurate, stored safely and provided detailed records of care and treatment.
- Most staff had completed mandatory training, including safeguarding training.
- Nurse staffing levels and skill mix were planned appropriately, implemented and reviewed. Staff shortages were responded to quickly and adequately.
- There were effective staff handovers at shift changes, and appropriate assessment and response to individual patient risks.

Incidents

- The hospital classified incidents in terms of clinical and non-clinical and there were two reporting books which reflected this. Staff told us they knew how to report incidents but had not received formal training on incident reporting.
- Staff could identify what they should report, however, some staff did not report the incidents themselves, they reported it to their line manager and relied on them to complete the form. They did not receive feedback from incident reporting and were not aware of outcomes.
- There had been 93 clinical incidents across the hospital reported between October 2014 and September 2015.
- The theatre department and the ward did not keep copies or records of every incident reported in their department. The incident report was torn from a book and sent to the quality and safety support officer. Most staff in the theatre department told us they were not aware of any incidents or any lessons learned.
- The quality and safety support officer investigated and reviewed all incidents and complaints. They completed a form which detailed a summary of the investigation, actions taken and lessons learned. These were passed to the Executive Director (Registered Manager)for additional action if needed.
- Senior ward staff told us they were given a copy of the summary of the investigation form and the learning points were discussed with them. These forms were stored in a folder on the ward and there were three incidents in the folder at the time of the inspection. When we spoke with ward staff about what incidents had been reported for their department they were unable to remember or to talk about feedback or lessons learned.
- We saw an example of a clinical incident form and a summary of the investigation relating to confusion with insertion of sutures. There was evidence of lessons learnt and procedures changed.
- Theatre staff told us they completed regular de-briefing forms and used these to escalate their concerns. The form was placed in a box, but they were unsure who collected and read them. A staff member told us they had completed a form, found the box was full and was concerned that issues were not being considered promptly.
- 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 had a variable understanding of the Duty of Candour and it was not well known to all staff; however some staff could describe the principles of the regulation and knew of the policy.
- The hospital clinical governance committee reviewed selected incidents at their bimonthly meetings in order to identify and share lessons learnt. Incidents discussed at senior nurse meetings were not always fed back to ward staff.

Safety thermometer or equivalent

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harm that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. The surgical ward participated in the NHS Safety Thermometer. Senior staff conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. The audits showed that patients received predominantly 'harm free' care. However, information about the audits was not displayed. It is considered to be best practice to display the results of the Safety Thermometer audits which allows staff, patients and their relatives to assess how the ward has performed.
- Data provided by the hospital showed that 100% of patients had been risked assessed for venous thromboembolism (VTE) from October 2014 to September 2015. There had been one incident of hospital acquired VTE during this period.

Cleanliness, infection control and hygiene

- The ward area was visibly clean and well maintained. Domestic staff were seen on the ward with cleaning trolleys and they used a colour-coded system to minimise the risk of cross infection.
- The hospital had an infection control lead nurse, who worked across two hospitals and maintained links with the local NHS infection control team. The lead nurse monitored the implementation and results of audits,

provided guidance at senior nurse meetings and managed the infection prevention programme. This included training and supporting link nurses in each department of the hospital.

- There was clear process for the management and prevention of infection. We observed most staff adhered to the 'bare below the elbow' policy, bare below the elbow means clinical staff were not wearing long sleeves, jewellery on wrists or fingers and no false nails. Staff, washed their hands between patients and used personal protective equipment, such as disposable aprons and gloves. On the ward we observed medical staff did not always adhere to bare below the elbow policy.
- Policies and procedures for the isolation of patients to minimise the spread of infections, were implemented when required.However we observed four members of staff that did not follow procedures when a patient was isolated due to infection. One member of staff was observed talking to a patient in their room, without wearing the correct personal protection equipment, the patient was isolated due to infection. This was highlighted to the nurse in charge.
- Hand sanitizer gel was available at the entrance to the ward and theatres, along corridors, and in each of the patient's rooms.
- The theatre suite was visibly clean, and there was a safe 'flow' from clean to dirty areas to minimise the risk of cross contamination of equipment. The cleaning records showed there was a programme of daily and weekly cleaning these were completed and up to date. The hospital used single use equipment where possible.
- Surgical patients were routinely screened for Methicillin resistant Staphylococcus aureus (MRSA) if they were to undergo an invasive operation. There had not been any reported incidents of MRSA or Clostridium difficile infections between October 2014 and September 2015.
- The infection control nurse monitored incidents of surgical site infections (SSIs) and took part in monthly audits. The results were displayed on the providers' quality dashboard and discussed at clinical governance meetings. There had been 13 SSIs October 2014 to September 2015.
- Patient Led Assessments of the Care Environment (PLACE) for February 2015 to June 2015 showed the hospital scored 99% for cleanliness which was higher than the England average of 98%.
- In operating theatres we saw staff adhered to the infection control policy. Information was clearly displayed above sinks to remind staff about correct hand washing procedures. We observed staff were bare below the elbows and were seen washing their hands and using hand sanitiser appropriately.
- On the ward we observed that equipment had 'I am clean stickers,' indicating it was clean and ready for use. However we found hoist slings that staff could not assure us were clean and staff could not confirm the procedure for cleaning slings between patients, this posed a risk of cross infection.
- Recent audits of 10 staff on the ward in November 2015 showed 67% compliance in hand hygiene and 80% compliance for 'bare below the elbow' policy. The audit included nurses, doctors and healthcare assistants. The hand hygiene audit undertaken in theatres showed 80% compliance in hand hygiene and 100% compliance for 'bare below the elbow' policy. The target was 100%. The infection control lead nurse was aware of these results and was working with link nurses in theatres and the ward to improve compliance.
- There were carpets in some of the inpatient rooms. The hospital recognised this was an infection control risk and there was a rolling programme for removal of carpets. The carpets were clean and did not have visible stains. We saw schedules for cleaning the carpets these were signed and dated as completed.

Environment and equipment

- The ward and theatres each had a portable resuscitation trolley. The trolleys contained medication which was to be used in the event of a cardiac arrest. We saw a daily check sheet which recorded all trolleys had been checked to ensure equipment was available and in date. The resuscitation trolley on the ward had a tamper evident tag to alert staff to any potential removal of equipment. The resuscitation trolley in theatres however did not have a tamper evident tag to prevent access by unauthorised personnel.

- In theatres and the ward we found nine pieces of equipment that were not within their servicing date or tested for electrical safety, which meant that equipment may not have been fit for purpose. This was highlighted to the nurse in charge and the equipment was removed.
- In the clinical room there was a microwave, which staff stated was used for warming heat pads. We were unable to see risk assessments or instructions for length of heating times so as to avoid the risk of burning patients.
- The ward was a horseshoe shape and at each end the theatre was accessible. There was one main entrance, the other entrance was not used for patient access, and we found that these doors were not secure which meant there was no restricted access to the theatre. This was highlighted on an action plan following the provider visit in November 2015 with plans to make a single point of access.
- The hospital had two laminar flow operating theatres in the theatre suite. All theatres had an adjoining anaesthetic room where patients were prepared for their operation. There was an adjoining lay-up room between the two theatres available which allowed equipment to be prepared in advance for the next procedure.
- There was a four bedded recovery ward, equipped with appropriate facilities to care for patients in the immediate post-operative period before they returned to the ward.
- The Association of Anaesthetists of Great Britain and Ireland safety guidelines Safe Management of Anaesthetic Related Equipment (2009) were being adhered to. There was a logbook with each anaesthetic machine to record the daily pre-session check and these had been completed.
- There was a difficult intubation tray which contained equipment to be used when a patient's airway was difficult to manage. There was a completed checklist to indicate that daily checks were made.
- Single use equipment such as syringes, needles, oxygen masks were readily available on the ward and in the operating theatre department.
- Staff were positive about being able to access the equipment they needed and said they had sufficient equipment to care for patients.
- Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of Legionella bacteria colonisation.

Medicines

- The hospital had an on-site pharmacy. This was staffed by two pharmacists and two pharmacy technicians who worked across two hospitals. The pharmacist usually visited the ward daily.
- Pharmacy services were available Monday to Friday 8.15am to 4.15pm with a service level agreement for out of hours support from the local trust which included medicines enquiries and in-patient supply. The senior nurse on the ward and Resident Medical Officer together had access to pharmacy out of hours.
- The pharmacists covered two hospital sites and during inspection was on sick leave and so left limited cover when both hospitals needed pharmacist input at the same time. The hospital had been unable to recruit a bank pharmacist.
- Medicines, including controlled drugs, were not consistently stored securely. During our inspection we identified a medicines trolley had been left unattended and unlocked and the clinical room door lock on the ward was faulty. Staff rectified these issues when we informed them.
- There were three monthly audits of controlled drugs held by wards or department, similar processes were not undertaken within the pharmacy department.
- Medicines should be kept at the correct temperature to ensure their efficacy. The refrigerator and room temperatures on the ward were monitored and we saw that appropriate actions had been taken when staff had made recording errors.
- Emergency medicines including oxygen were available for use and expiry dates checked on a weekly basis.
- To Take Out (TTO) packs were available for patients, if discharged home when the pharmacy was closed.
- The labelling of some medicines was non-compliant with Medicines (Labelling) Regulations 1976, by failing to display the address of the supplying hospital pharmacy. During out of hours and when pharmacy was shut, the hospital permitted the Resident Medical Officer in exceptional circumstances to dispense discharge

medication from ward stock. However, dispensing labels were not available to undertake this process and therefore patients were given medication without the correct information on labels

- Medicines were not always managed safely in the operating department. During our inspection we found three rescue medications out of date. A freezer that contained medication which should be stored below -18c had been checked and records indicated that it had been -13c or -14c consistently. Intravenous fluids were kept in an unlocked equipment room although in a controlled area. We found a controlled drug that had expired the previous month.
- Whilst Central Alert System (CAS) were received and actioned for medicine recalls, pharmacy staff were not aware of Patient Safety Alerts circulated via the CAS.

Records

- We reviewed 10 patient records and saw that they contained pre-operative assessments, records from the surgical procedure, recovery observations, nursing notes and discharge. The entries were legible and had been signed and dated by the members of staff.
- The hospital used printed booklets for recording patient care for different care pathways. These standard care pathways included prompts to record key information about patients, including their past medical history and medication, as well as details of their pre-operative risk assessments.
- All of the care records included risk assessments appropriate to the type of operation and length of stay in hospital. For example all care records contained risk assessments for venous thromboembolism (VTE) assessments. Patients who needed to stay overnight or for longer periods also had manual handling, pressure ulcer risk and nutritional assessments.
- The booklets for surgery included the World Health Organisation (WHO) five steps to safer surgery checklist. There were pages to complete with details of the patient's care during anaesthesia, surgery and recovery as well as their discharge arrangements. Records were comprehensive, fully completed, accurate and up to date.
- Patient records included multi-professional clinical notes, which included those from physiotherapists, to support safe care and treatment.
- Patients' records were stored securely behind the nurses' station, which ensured they were kept confidential.
- An operating theatre register was maintained, which was found to contain all the information needed to ensure that an accurate record was kept.

Safeguarding

- There was a safeguarding children's and vulnerable adult's policy. The hospital did not provide services for children. The director of nursing was the safeguarding lead for the hospital and she was level 3 trained, so safeguarding issues could be investigated in a management capacity.
- There were no safeguarding concerns reported in the last year. Staff could explain how they would respond if they witnessed or suspected abuse.
- Data provided by the hospital showed that all ward nurses had completed level two safeguarding training for adults and children; they had also completed training on Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). There were printed policies for the MCA and the DoLS.
- All of the staff we spoke with had a clear understanding about the processes and practices that were in place to keep patients safe and safeguarded from abuse.
- The hospital had never made a DoLS application for any patient.
- Relevant checks against professional registers, and the Disclosure and Barring Service (DBS) were completed for medical and nursing staff.

Mandatory training

- Mandatory training at the hospital included consent, fire safety, Mental Capacity Act 2005, safer blood transfusions and health record keeping. Staff could access training online and face to face training was available for basic life support, intermediate life support, manual handling and aseptic technique.

- Each staff member was linked to a role-profile in the BMiLearn system so they were automatically assigned to a relevant mandatory training plan.
- Most staff had completed their mandatory training; however, training records showed no members of staff in theatres or on the ward had completed an update on patient moving and handling training.
- Staff and heads of departments received an electronic reminder when training was due.
- There was an induction programme for all new staff. This covered all the key statutory and mandatory training.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but the medical advisory committee checked assurance of mandatory training. The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems. The RMO stated they had to complete the hospital induction training before they commenced at the hospital.

Assessing and responding to patient risk

- Patients' risks were assessed and monitored at surgical pre-assessment, and checked again before treatment. These included risks about mobility, cognitive understanding, medical history, skin damage and venous thromboembolism (VTE). Patients had to meet certain criteria before they were accepted for surgery, these minimised risks to their health and wellbeing.
- Patients were required to complete a comprehensive preadmission questionnaire to assess if there were any health risks which may be a contraindication to their surgery or require further investigations. Health questionnaires were discussed with patients in the pre-admission clinics. If a patient was identified as being at risk, referral was made by telephone or emailed to the anaesthetist responsible for the patient.
- The cosmetic surgeon or the pre-assessment nurse carried out psychological screening for cosmetic surgery patients. The surgeon and nurses identified if the patient needed additional psychological assessment in advance of agreeing to surgery.
- Ward nurses met for a handover at the start of their shift, where all patients on the ward were discussed. We observed thorough and patient-centred handovers and staff handed over changes in patient's conditions which ensured that actions were taken to minimise any potential risk to patients.
- On the wards patients with a known risk of falls were accommodated in rooms closest to the nurses' station. Nurses were aware of those needing close observation and additional supervision to minimise risks of falls.
- In theatre staff used the "Five Steps to Safer Surgery" check list. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning of each theatre list and the World Health Organisation (WHO) surgical safety checklist. (A tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications). We observed a team briefing and WHO checklists being completed.
- The completion of the WHO checklist was audited monthly and the hospital had recently taken steps to improve compliance with this procedure. For example, ward staff were asked to ensure that they completed their section of the checklist. This showed 86% in September 2015 and 100%. in April, May, June and November 2015.
- Staff on the ward and in recovery completed national early warning score (NEWS) to assess patient observations. This was a system that allowed staff to record observations and gave protocols to follow if the patient's condition deteriorated.
- A ward nurse told us if a patient bled following surgery, they would remain in theatre recovery until stable then transferred to the ward. If the patient's health deteriorated and they needed acute clinical intervention or monitoring, they would be transferred to the local acute trust.

Requires improvement

Surgery

- Between October 2014 and September 2015 there were nine patients who had an unplanned transfer to another hospital. There were no facilities onsite to support patients who needed critical care. In these cases, the hospital followed procedures to transfer the patient to the local NHS hospital that was in close proximity. In an emergency, the procedure was to call emergency services for a rapid transfer. The resident medical officers outlined how they had managed such events and commented that the procedures had been managed safely.
- The resident medical officer (RMO) was on site at all times. The RMO was the doctor responsible for the care of the patients in the absence of the consultant. The RMO was trained in advanced life support and held a bleep for any queries which included cardiac arrest in the hospital.
- Staff took part in scenario-based training provided by the local acute NHS trust, including resuscitation simulation. Teams were not aware when the training would take place. The trainer running the session, provided verbal and written feedback on how the team responded to the situation, with learning points and actions to take, shared with all staff in that area.

Nursing staffing

- The ward staffing levels were based on a BMI nursing dependency and skill mix tool. This was used to plan the skill mix requirements for each shift one week in advance. There was scope for the ward manager to adjust the tool's predicted staffing requirement based on experience and professional judgment. Fewest clinical hours were required at weekends, when there was reduced activity, and staffing hours were highest midweek.
- The ward was fully staffed apart from one staff nurse vacancy; agency staff had been employed at times to increase staffing numbers if there had been a clinical need.
- Staff worked flexibly, and said there were enough staff to provide safe care. The night shift was always staffed with at least two registered nurses, this included when patient occupancy levels were low. This enabled staff to respond to emergency situations.
- The resident medical officers stated they had high level of confidence in the skills and experience of the nursing staff.
- Senior nursing cover was provided by the ward sister who worked Monday to Friday early shift and a senior nurse was present on the late shift.
- In the operating theatre there was one peri-operative assistant who had just completed their training. A perioperative or operating room assistant supports nursing and medical staff with operating room preparation and maintenance, patient treatment and care before, during and after surgery.
- In theatre, they operated with a ratio of a nurse manager to three nurses and 5.8 operating department practitioners (ODPs). There was no theatre manager in post; we had been informed that one had recently been appointed. In October 2015, the hospital reported 25% significant vacancies for theatre care assistants and 15% for theatre nurses. We saw evidence of recruitment activity across the department to reduce period of reliance on bank and agency staff.
- We reviewed rotas and found appropriate numbers and skill mix of staff, in line with Royal College of Surgeons guidelines and the Association for Perioperative Practice (AfPP).
- Nursing staff conducted handovers of care when new staff arrived on duty. We observed a taped handover from the night staff to day staff and a verbal handover for a change of staff during the day. Handover sheets were used and updated with any change to a patient's care and plans for discharge.

Surgical staffing

- There were 84 consultants with practising privileges at the hospital. All had this status reviewed every two years by the hospital Medical Advisory Committee to check they continued to be suitable to work at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is given permission to work within the independent sector. We reviewed four practising privileges that were current and had been updated.
- Consultants were required, as part of the practising privileges hospital policy, to remain available (both by phone and in person) or arrange appropriate alternative

named cover if unavailable when they had inpatients in the hospital. They were also required to attend the hospital within a time period agreed with the Executive Director and the Medical Advisory Committee. The time period agreed would depend on the speciality and the response time required in relation to specific procedures that had been performed.

- The nursing staff told us that medical cover was good and consultants were always obtainable. They said they would return to see their patients if necessary and always provided cover arrangements when not accessible. There was an on call anaesthetist and the resident medical officer to provide support. Staff knew how to access the support and here were no incidents where consultant support was not accessible.
- The resident medical officer (RMO) was at the hospital 24 hours, seven days a week on a two week rotational basis. The role of the RMO was to review patients on a daily basis, prescribe additional medication and liaise with the consultants responsible for individual patients care.
- All staff we spoke with reported good communication links with consultants and the RMOs.
- Handovers between RMOs were effective and the RMOs also attended the handover to night shift. This ensured that the RMOs had an understanding of the patients' needs on the ward.

Major incident awareness and training

- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Fire evacuation drills were held three times a year. All staff understood their responsibilities if there was a fire within the building.
- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as internet or electricity failure. The business continuity plans were available in folders on site and on their intranet.

Are surgery services effective?

Requires improvement

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

We rated effective as 'requires improvement.'

- There was no documented evidence of training or assessed competency for some roles in the operating department, including theatre staff and the nursing staff assisting with endoscopy.
- Most staff in theatres and 50% of staff on the wards had not completed an annual appraisal.

However,

- The hospital had policies and procedures that took account of evidence-based guidance and standards.
- Outcomes of surgical procedures were monitored and national benchmarking showed good outcomes.
- There was evidence of good multidisciplinary working within the hospital and out-of-hours services were provided when needed.
- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Patients had access to different methods for effective pain relief. Patients' pain was monitored and the effectiveness of pain management evaluated.

Evidence-based care and treatment

- Policies and guidelines were developed in-line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example the national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50.

Requires improvement

Surgery

- Venous thromboembolism (VTE) assessments were completed in accordance with NICE clinical guideline 92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital.
- Consultants confirmed that BMI surgical procedures were in-line with best practice and were always followed. The clinical governance and quality and risk bulletins highlighted latest NICE guidance, however it was not clear how this information was used or being communicated.
- The hospital had set up off-site endoscopy decontamination, as their endoscopy suite had not met the requirements and guidance on decontamination, issued by the Joint Advisory Group on gastrointestinal endoscopy (JAG) of the Royal College of Physicians. The service had not achieved JAG accreditation but was working towards this.
- There was an on going audit programme to evaluate care and review clinical practice. For example blood transfusion, medical records and controlled drugs compliance were undertaken; however they did not show a high level of compliance or targets being met.
- The hospital followed NICE guidance CG74 for preventing and treating surgical site infections. Orthopaedic patients were asked to complete a surgical wound healing questionnaire post discharge to assess infection rates.
- There was a formal nursing audit programme for theatres and the surgical wards, outlining which audits needed to be completed in which clinical areas and when. We saw evidence this programme was adhered to and audit findings were presented at governance meetings. Recommendations for improvement were identified and actions to do this were put in place.

Pain relief

- The patients we spoke with on the ward reported that their pain was well managed and pain relief came quickly.
- Patient's pain and the effectiveness of pain management were assessed regularly using a nationally recognised scoring system.
- Patients had access to pain relief appropriate to their operation. This included epidural and patient controlled analgesia (PCA). Records demonstrated patients were regularly assessed to ensure pain levels were controlled and they were monitored for unwanted side effects.
- The patient satisfaction inpatient survey done in November 2015 identified of 128 patients surveyed 93.8% stated that everything was done to help control the pain.
- Patient records showed that pre-operative assessments included details of post-operative pain relief. Patients were given an information leaflet on "pain relief after surgery" at their preoperative assessment. This ensured patients knew of the type of medication available to them.

Nutrition and hydration

- Patients were advised of fasting times before surgery, at pre-assessment. Their pre-assessment guidance leaflet included what and when to eat and drink before and after surgery.
- Patient records showed that fluid intake and output was monitored and recorded on fluid balance charts. This was to ensure patients were sufficiently hydrated after their operation
- Inpatients had a choice of meals for breakfast, lunch and dinner, and were offered additional snacks in the mornings and afternoons. They could ask for meals at other times, from a more limited range of options, and change their orders if they preferred.
- The inpatients survey had shown reduced levels of satisfaction with the food following a recent change to the catering contract. The hospital was addressing these concerns. However most of the patients we spoke with told us they found the choice and quantity of food offered was good.
- In the Patient-Led Assessments of the Care Environment (PLACE) for February to June 2015 the hospital scored 96% for ward food which was above the England average of 94%.

Patient outcomes

- The hospital monitored outcomes such as transfers out, returns to theatres and infection rates, day case conversion rates and readmission rates.

Requires improvement

Surgery

- There were no recorded unplanned readmissions within 29 days of discharge, October 2014 to September 2015.
- Two patients had unplanned return to theatre from October 2014 to September 2015. CQC assessed the proportion of unplanned returns to be 'similar to expected' compared to the other independent acute hospitals we hold this type of data for.
- Patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement, inguinal hernia repair and varicose veins. PROMS measures the quality of care and health gain received from the patients perspective. Between April 2014 and March 2015 data from PROMS showed the hospital was within the expected range for knee replacement surgery with regards to the oxford knee score.(A patient-reported outcome measurement which contains 12 questions on activities of daily living that assess function and pain in patients undergoing total knee replacement).
- Patients who had undergone orthopaedic surgery were followed up by a telephone call 14 to 28 days post-operatively as part of the surgical site infection surveillance, Public Health England. This service allowed hospitals to record incidents of infection after surgery, track patient results and review or change practice to avoid further infections. Data provided by the hospital showed there had been six orthopaedic patients who had surgical site infections from January 2015 to January 2016.

Competent staff

- Nurses in the operating department were acting in the role of surgical first assistant (SFA). The Perioperative Care Collaboration PCC (2012) recommends that a practitioner who has successfully completed a nationally recognised competency training programme undertake the role of the SFA. The role of the SFA must be included in the person's job description and the employer should address the issue of indemnity cover.
- The hospital 'Policy for the Provision of Surgical First Assistants November 2013' states the SFA role must be undertaken by a competent practitioner who has received and completed recognised training.
- There were three scrub practitioners who were undertaking the Association for Perioperative Practice (AfPP) Surgical First Assistant course. At the time of inspection they had undertaken the first module and assisted under the supervision of a consultant surgeon.
- There was evidence of competency training and assessments for recovery staff. However, there was no documentation for operating theatre staff.
- There was a group of nurses assisting with endoscopies in theatre. We were told they had undertaken necessary training, including full decontamination training before relocation of decontamination of scopes off site. The Joint Advisory Group on gastrointestinal endoscopy (JAG) of the Royal College of Physicians states that nursing staff working in endoscopy should demonstrate adherence to an established competency framework. The hospital told us, "all staff within the theatre and outpatients departments involved in the endoscopy process are assessed appropriately and management team are confident that all staff are working within these competencies." However no documentary evidence of competency training and assessments was available when requested.
- The Registered Manager, following consultation with the medical advisory committee (MAC), was responsible for granting and reviewing practising privileges for medical staff. New consultants were required to provide evidence of qualifications, training, and registration. The chair of the MAC gave examples of when they had refused admitting rights to consultants, or had withdrawn practising privileges, when concerns about their skills and competencies. There was liaison with the medical director at the local NHS trust in relation to the competency and any restriction of practice for NHS consultants.
- Staff with practising privileges had to reapply and undergo reviews biennually, which included reviews of clinical outcomes, complications, training and appraisal records. The hospital maintained a list of consultants showing their indemnity insurance and review dates, and all had submitted appraisals as required.
- Supernumerary nursing students worked on the ward during clinical placements and were supervised by nursing mentors. Newly qualified nurses were mentored through a BMI preceptorship programme.

- A staff nurse told us that there were link roles for nurses that included infection control; dementia, resuscitation and sepsis. Staff received protected time to attend training for these specific roles.
- Data provided from the hospital showed that none of the theatre staff had received an appraisal within the last year and 50% of staff on the ward had received one to date. An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner.

Multidisciplinary working

- Throughout our inspection we saw evidence of good multidisciplinary working in all areas. We observed positive interaction and respectful communication between professionals.
- Our review of patient records, talking with staff and patients confirmed there was effective multidisciplinary (MDT) working practices which involved nurses, doctors, pharmacists and physiotherapists.
- Clinicians reported effective working relationships with the local NHS hospital, in a wide range of contexts. This included sharing information about consultants, obtaining specialist advice, training or equipment.
- Nursing staff maintained good links with the local NHS trust, particularly about infection control.
- Physiotherapy services were planned to support effective recovery and rehabilitation, including follow up appointments at outpatient clinics.

Seven-day services

- Most surgical operations were scheduled to take place Monday to Friday with the occasional Saturday list.
- The hospital ward was staffed to provide nursing care seven days a week.
- A resident medical officer (RMO) was based on site 24 hours a day, seven days a week.
- Consultants provided 24-hour on-call cover for their patients and out of hours they were contactable by phone. Those with patients on the wards conducted daily ward rounds.
- A senior nurse was always available at the hospital as a contact point for staff and patients, this included helping resolve patient queries and to accept out of hours admissions, they were available via bleep or telephone.
- There was an on-call rota operated by the pharmacy and radiology teams should support be needed out of hours, as well as an on call emergency theatre team.
- The physiotherapy service provided care to inpatients seven days a week.

Access to information

- Discharge summaries were provided to GPs which informed them of their patient's medical condition and the treatment they had received. A copy was given to the patient on discharge, one kept in the patients' records and one posted to the GP. This ensured that GPs knew of their patient's discharge.
- Staff told us that they could easily access patient related information and records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms, we reviewed, showed that patients consent for surgical procedures was gained on the day of the operation or the day before the operation. We saw that the consent forms had been completed correctly and detailed the risks and benefits of the procedure.
- All patients who were booked for joint replacement were asked for consent to be registered on the National Joint Registry (NJR) which monitors infection and revision rates. We saw in medical records that 100% of patients had consented to participate in the register which ensured their care and joint replacements were monitored nationally.
- The three monthly consent compliance audits of patient records showed most staff explained procedures and gained their consent before starting treatment. However the results were difficult to interpret and were the below the 60% target.

Requires improvement

Surgery

- Staff had received training in the Mental Capacity Act 2005 (MCA). Guidance and policy documents were available for reference. They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.
- Patients undergoing cosmetic surgery were given a two-week 'cooling off period' so they could change their mind before giving consent to the procedure. However, staff we spoke with were unsure how this was managed.

Are surgery services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as 'good.'

- Feedback from patients about their care and treatment was always positive and we observed staff being supportive and compassionate to patients.
- Patients told us they felt they had sufficient information to allow them to be involved with their care and had their wishes respected and understood.
- Patients were contacted by the hospital after they had been discharged offering help and advice if required.

Compassionate care

- All patients and relatives spoke positively about the care and support they had received. For example, one patient commented that they were "very pleased with the care, staff are brilliant and I have had some good banter with them".
- Another patient told us that "the food is good and I am kept comfortable. The care here is the best of what is possible", another patient stated "very friendly staff that are well-informed at changeovers".
- The hospital took part in the Friends and Family test. There was no breakdown of the figures therefore it was not possible to identify the significance of these figures with regards to the surgical services. For the reporting period April to September 2015 the hospital reported consistently high at 100% of patients would recommend the hospital to their friends and families. The response rate ranged between 26% to 55%.
- Throughout our visit we observed that patients were treated with respect. Staff knocked on doors and waited for permission to enter and then would introduce themselves.
- The inpatient satisfaction survey the hospital conducted in November 2015 indicated 100% of patients stated they were treated with respect and dignity.
- Staff knew about of the chaperone policy and notices for patients were displayed in clinical rooms.

Understanding and involvement of patients and those close to them

- Patients told us they were kept informed and doctors and nurses discussed their care with them and their family as appropriate. Self-funded patients received information on finance arrangements.
- All patients and relatives we spoke with were very complimentary about the way they were treated.
- Information was given to patients about their procedures at their pre-admission appointments. All of the patients we spoke with told us they felt they had been given sufficient information pre-operatively to prepare them for the procedure and their post-operative requirements.
- The hospital's inpatient survey for November 2015 showed a high rating for 'meeting patient expectations' 98.1% and 100% felt involved in the decision regarding their care and treatment.

Emotional support

- We observed that when patients were about to undergo surgery staff were supportive and compassionate. For example, one patient we spoke with told us that the doctor had visited within two hours of admission and discussed the operation in full, including possibilities of "things going wrong" and was given a leaflet about the operation.

- Patients could not access specific psychological counselling services at the hospital. If staff considered patients needed additional psychological support before agreeing to treatment, such as cosmetic surgery, they refused or postponed treatment.
- Patients were asked if they would like to be contacted by the ward 48 hours after they had been discharged for further help and advice.
- The infection control lead gave information to patients to contact her or the ward once they had been discharged if they suspected they had an infection.

Are surgery services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as 'good.'

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service and there were on going plans for development.
- The service met national waiting times for patients beginning treatment within 18 weeks of referral.
- Patients were admitted on a planned basis for elective surgery, this included private patients and NHS patients.
- Pre-assessment nurses reviewed patients' needs before treatment.
- Staff provided care in a timely way and NHS and private patients' experienced the same levels of care.
- The hospital had a system for responding to and investigating patients' verbal or written complaints. However staff did not always get feedback on complaints and learning from complaints

However,

- Information and guidance on how to make a complaint was not on display at the time of the inspection.
- Patients' privacy and dignity was not always maintained, as room door windows were not fully occluded during care and treatment.

Service planning and delivery to meet the needs of local people

- The hospital worked with the local Clinical Commissioning Group (CCG) in planning services for NHS patients. Operating sessions were made up of a mix of patients who had selected the hospital through Choose and Book and private patients.
- All admissions were pre-planned so staff could assess patients' needs before treatment. This allowed staff to plan patients' care to meet their specific requirements, including cultural, linguistic, mental or physical needs.
- The hospital used admission criteria for patients and only accepted patients for treatments with low risks of complication and whose post-surgical needs could be met through ward-based nursing care.
- The hospital was developing an ambulatory care unit for patients who did not require full admission to the ward.

Access and flow

- The operating department was open from 8am to 6pm Monday to Friday. Occasionally it remained open until 8pm on Wednesday and Thursday and ran extra operating lists on a Saturday to meet demand. This meant there was a planned programme of activity.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the National Health Service (NHS) in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- Dates for surgery were discussed with patients at their initial outpatient's appointment. NHS patients were given a choice of two dates and were booked in the same way as self-funded patients.
- For October 2015 to September 2015 the hospital met the target of 92% of incomplete admitted patients beginning treatment within 18 weeks of referral. The hospital met national targets of 90% of admitted patients' beginning treatment within 18 weeks of referral in the reporting period October 2014 to September 2015.
- Pre-assessment was used effectively this ensured the hospital only treated patients if they could meet their

needs. The pre-assessment nurse confirmed that all patients were pre-assessed for surgery in advance. If the nurse identified any concerns, they had good communication links with the surgeons for advice and discussion.

- Consultant surgeons and nursing staff planned and checked surgical admissions. To improve patient experience and overall efficiency, the hospital had recently implemented a 'five day rule,' requiring all surgical lists to be planned and communicated five days in advance. This was to ensure the right staff and equipment were in place to meet patients' specific needs on the day of surgery. However, theatre staff told us new cases were being slotted in and they were being asked to work beyond their shift times sometimes until 8pm, when their shift finished at 4pm. After the inspection the hospital informed us 5% of all admissions were booked with less than 7 days in advance.
- Staff communicated planned changes to the surgical lists effectively. For example, they had implemented a different coloured sheet for changes to the order of theatre list on the day.
- The staff in the operating theatres provided an on-call service to ensure that the department could be opened if there was a need for a patient to return to theatre urgently.
- Discharges were authorised by the patient's consultant. On occasions the resident medical officer (RMO) would discharge the patient with the consultant's instructions. Patients could be discharged in a timely manner.

Meeting people's individual needs

- All doors to patient rooms had a window pane which was not fully occluded and had no privacy curtain. We could see directly into the rooms from the corridor, which is a public thoroughfare. Patients privacy and dignity was not being maintained and patients were unaware they could be seen. During the unannounced visit we saw that this was being addressed and the gaps in the windows were being covered as rooms were vacated
- Staff described the support they provided to meet patients' specific needs, including those with a disability, particular physical or emotional support or patients with specific language requirements.
- Nursing staff informed us that if a patient had a special dietary requirement the chef would attend the ward to speak to them. Menu options were available for patients who needed special diets for religious or cultural reasons.
- Pre-admission nurses identified and discussed patients' care needs and planned their treatment in consultation with medical staff where necessary.
- Patients received information to help them to recover post-operatively, gain independence and mobility. One patient however, commented that they felt they had received too much information.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 95% for dementia friendly environment which was higher than the England average of 87%.
- For patients whose first language was not English a telephone translation services was available from the local NHS trust. However, staff told us this was rarely used as patients did not require interpreters.
- Family and friends could visit patients on the ward at any reasonable time.
- Call bells were accessible for patients on the ward to allow them to call for assistance if needed.
- Patients had access to physiotherapy equipment and a hydrotherapy pool if needed.

Learning from complaints and concerns

- The hospital had an up to date complaints policy with a clear process to investigate, report and learn from a complaint. There had been 11 complaints for the ward and the operating theatre for the period January 2015 to December 2015.There were five complaints concerning different aspects of admission, discharge and transfer arrangements.
- All complaints were monitored by the hospital director and responded to in-line with the hospitals policy. An acknowledgement of the complaint was sent within two working days and a full response within 20 working

days. Complaints were investigated by the relevant head of department with involvement from consultants and nurses if needed. However, procedures for sharing and learning from complaints across the hospital were not robust.

- All of the patients we spoke with told us they had no complaints about the care and treatment they had received at the hospital.
- All staff received information about the complaints procedure as part of their induction. The staff we spoke with were clear on the process and procedure
- During our inspection we did not see any guidance, posters or leaflets instructing patients on how to make a complaint. The hospital told us they had "Please tell us Leaflets" which explained how to raise a concern or complaint.
- The hospital informed us that all patients were actively encouraged to complete a patient satisfaction survey that encouraged feedback. Patient feedback forms were part of the standard room set up for all admitted patients.

Are surgery services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as 'requires improvement.'

- The governance processes were not effective to ensure that risks to patients were adequately assessed or managed.
- Managers were not aware of specific risks to their areas of work, not all had training in risk management and there were no departmental risk registers
- The quality of the service was not effectively monitored through audit and some practices were did not reflect the hospital policies or current national guidelines.
- Minutes of meetings demonstrated that discussions on findings from audits, incidents or complaints was variable and did not clearly identify any action points or plans from any decisions reached.
- Staff in theatres had not met regularly to discuss the quality or safety of the service.
- Staff in theatres identified low morale in this service

However,

- Staff were aware of the vision and strategy for surgical services, the direction of the business and the aims of the provider were well known.
- Staff worked well within their clinical teams
- Staff were invited to have tea with the executive director monthly.

Vision and strategy for this this core service

- The hospital's registered manager outlined the BMI corporate vision, to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. BMI had focused on the principles of the '6 C's', initiated within the NHS, to put their vision into practice. These were to demonstrate commitment, courage, communication, care, compassion and competence. It was not clear how the vision was translated into the hospital and departmental strategies but most staff were familiar with the 6 C's and were passionate about delivering a high quality service.
- All staff we spoke with knew about the hospital-wide vision for the future and could describe them to us. For example, staff reported the hospital was improving rehabilitation outcomes for patients by implementation of new pathways and opening a new ambulatory care unit.
- All staff we spoke with were positive about the service they provided and believed they always put the patient first.

Governance, risk management and quality measurement for this core service

Requires improvement

Surgery

- There was a governance structure in place with committees such as infection control, medicines management and health and safety, feeding into the medical advisory committee (MAC) and hospital management team.
- The clinical governance committee met bimonthly to discuss a range of governance issues across the hospital, the minutes showed evidence that discussion on findings from audits, incidents and complaints took place. However they did not clearly identify any action points or plans from any decisions reached.
- Consultants from a variety of surgical specialities attended the MAC meetings on a quarterly basis.The MAC was in place to assist the Registered Manager and ensure patients received the best possible treatment; maintaining high standards and improving quality. Records demonstrated a variety of topics were discussed for example incidents, complaints and practising privileges.
- Senior staff told us the main risk register for the ward and theatre was held and maintained by the risk and quality manager at the hospital.Not all risks were identified and managed effectively and some key risks were not on the hospital risk register. The data provided to us before the inspection, showed there were six items on the hospital risk register, one dating from 2012. The risk of the failure of scope washer had been added to the register in March 2015. The hospital had since moved the endoscopy decontamination scope processing off site. Managers were not aware of specific risks to their areas of work, not all had training in risk management and there were no departmental risk registers. The registered manager explained it was corporate policy to keep hospital risk registers to high level issues. Action logs from operational lead meetings evidenced monitoring of local issues and risks. However this did not include all concerns identified through inspection such as, warming heat pads, lack of staff competencies, the vacancy of a manager in the theatre department and the faulty lock on the clinical room door.
- Practices were taking place in the operating theatre that were not following the hospital's policies and procedures. For example, staff assisted with endoscopies without the relevant completed competencies or assessments in place. These risks had not been identified through the hospital governance processes.
- The MAC had a role in reviewing consultant contracts and maintaining safe practising standards amongst consultants and clinicians. Each consultant was required to complete biannual reviews with the MAC chair, during which data on their clinical performance was discussed. The hospital also ensured that surgeons had appropriate professional insurance in place and received regular appraisals.
- The operating department team had not had a team meeting since June 2015 other than a meeting with theatre staff to discuss 'never events' across the organisation. There had been one ward meeting and two senior nurse meetings held within the last six months.
- Arrangements for implementing and embedding learning from incidents across the hospital were not robust. Feedback from hospital-wide meetings was not disseminated to theatre and ward staff.
- The governance team monitored the number of cancelled operations and extended in-patient lengths of stay.

Leadership / culture of service related to this core service

- The director of nursing provided direct line management for the ward and theatres managers, and was more taking a more operational role in managing theatres whilst awaiting a new manager.
- Theatre staff expressed their concerns regarding the lack of theatre manager in place. For example, one member of the theatre clinical staff spoke how the team had low morale due to the lack of managerial presence and low staffing levels.
- Staff in all areas told us they felt they worked well as a team, and ward staff were well supported by their immediate line manager.
- Theatre and ward staff said the senior leadership team were seen during daily walk arounds, however some of the staff we spoke with told us that some were not approachable.

Requires improvement

Surgery

- The resident medical officers (RMOs) were positive about the culture and commented that all staff worked well together.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.

Public and staff engagement

- The infection control lead was involved in improving patient outcomes. The specialist nurse was involved in patient and staff education. They maintained effective links with other health professionals outside the organisation.
- A BMI employee survey was completed in April 2014; the results incorporated the whole of the organisation. An action plan for the hospital was produced this recommended that senior management had interaction with staff through daily walks around the hospital.
- Patients were encouraged to provide feedback through the Family and Friends Test and the BMI patient survey. Results of the latest patient survey showed a high level of meeting patient's expectation, with the hospital scoring 98.1%. Areas of concern, such as catering were being addressed. The hospital was tenth place across the BMI group for patient satisfaction scores.
- All heads of department were contacted on a monthly basis to invite staff to have tea with the executive director (registered manager).

Innovation, improvement and sustainability

- Staff said they could suggest areas for improvement.For example, the ward had put forward a proposal to change a storeroom into a multidisciplinary and teaching area.
- The hospital found they were unable to secure the services of a plumber as a result one of the maintenance staff received help and support to train as a plumber.
- We saw evidence of successful recruitment of new staff for theatre and wards. There had been recruitment activity across the hospital to reduce reliance on bank and agency staff.
- The hospital had a rolling programme of flooring replacement and approximately 50% of patient room floors had already been replaced.

Good

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at BMI The Winterbourne Hospital cover a wide range of specialities. These include ENT (Ear Nose and Throat), urology, general surgery, orthopaedics, gynaecology, ophthalmology, pain management, cardiology, dermatology, gastroenterology, neurology, respiratory medicine and rheumatology. Diagnostic imaging facilities provided by BMI The Winterbourne Hospital include X-Rays and ultrasound. Magnetic resonance imaging (MRI) scans are available on site, but run by another provider and therefore not included in this inspection process. Outpatient physiotherapy services are provided and were inspected.

The outpatient clinic has eight consulting rooms, two general treatment rooms and a room for urodynamic procedures and cystoscope procedures. Any specialty could use the consultation rooms. Clinics were all consultant led.

The physiotherapy department comprised of one gym, two examination bays and a hydrotherapy pool.

In the period October 2014 to September 2015 there were 20,970 outpatient appointments, 7,385 of which were new appointments and 13,585 were follow-up appointments. The hospital provided a service for NHS patients though block NHS contracts. A total of 4,961 NHS patients were seen in outpatient clinics, 2,074 of these being first appointments and 2,887 being follow-up appointments.

During our inspection, we visited the outpatients, physiotherapy and diagnostic imaging services. We spoke with four patients and 13 staff, including nurses, medical staff, healthcare assistants, physiotherapists, administrators, receptionists and managers. We reviewed information provided on CQC feedback cards from patients using the service. We reviewed patient records and staff training records. We observed care being provided. Before, during and after our inspection we reviewed the provider's performance and quality information.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall this core service was rated as 'good'. Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole.

There were appropriate systems in place to keep patients safe. Staff reported incidents however it was not always apparent that learning was shared locally and across the hospital. We saw that outpatient areas were clean and that equipment was well maintained. Staffing levels were appropriate without any use of agency staff. Patient records were available for appointments and the department had timely access to test results.

There was good multidisciplinary team working. Staff told us there was good support in their role, with appropriate opportunities to develop their skills further.

We observed that staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care. Staff were able to access interpreters for patients whose first language was not English.

Hospital staff, together with consultant private secretaries, managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities.

Staff worked effectively in teams and were generally positive about the leadership of the service at both a local and senior level. There was an open culture and staff were encouraged to make suggestions to improve services for patients. The hospital used different methods to gather feedback from patients about their experience.

Are outpatients and diagnostic imaging services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as 'good'.

- Patients in outpatients were protected from the risk of abuse and avoidable harm. Staff had a good understanding of how to report incidents.
- Staff attended appropriate mandatory training for their role. Staff told us they had support to keep this up-to-date.
- Clinical areas and waiting rooms were all visibly clean and tidy. Infection prevention and control practices were followed, and regularly monitored, to prevent the unnecessary spread of infections.
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested in-line with manufacturer's guidance. Medicines were managed safely and securely.
- Staffing levels and the skill mix of staff was appropriate for the outpatient clinics. Staff told us that agency staff were not used, with staff working flexibly as a team.
- Records were stored securely. Staff told us that patient records were available before appointments.
- In diagnostic imaging, local rules and safe systems of work were in place .There was appropriate signage on X-Ray doors to show when in use and prevent people entering.
- Staff could demonstrate the procedures in the event of a medical emergency. There was a call bell system in clinical areas and an on-call team within the hospital who were Advanced Life Support (ALS) trained. Staff received simulation training, to ensure they could appropriately respond if a patient became unwell or a major incident happened
- There was a nominated Radiation Protection Supervisor (RPS) and Laser Protection Supervisor (LPS), who had received appropriate training. There were good communication and support from Radiation Protection Adviser and NHS medical physics team.

Good

Outpatients and diagnostic imaging

However,

- Although there were limited incidents in outpatients, it was not always apparent that learning from incidents was shared locally and at organisational level.
- Cleaning records were not always in place or, where they were, it was not easy to determine when cleaning had taken place and which items had been cleaned.

Incidents

- All staff knew their responsibility to report incidents but had not received formal training on incident reporting. Staff reported incidents on a paper incident report form, which the quality and safety support officer entered onto the electronic reporting system.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- In the reporting period October 2014 to September 2015, there were 93 clinical incidents reported across the hospital. There was no breakdown of incidents by each department on the report so it was not clear what the track record for incidents was in the outpatient services.
- We reviewed clinical incident report documentation held in the OPD. Three incidents had been investigated, only one remained open since 26 November 2015. The OPD lead was unaware of the reason for this incident still remaining open.
- The hospital reported there were no serious incidents requiring investigation in outpatients during period October 2014 to September 2015.
- Following BMI Healthcare processes, patient falls and sharps injuries were not classified as clinical incidents. This did not fully support the identification of risks to the quality of clinical care.
- The hospital clinical governance committee, a group of heads of department, reviewed selected incidents at their bimonthly meetings to identify and share lessons learnt.
- The medical advisory committee (MAC), a leadership group of 14 consultants, held meetings every three months. The director of nursing provided an overview of incidents, we could not see from the minutes submitted by the hospital that there was evidence of detailed discussion around incidents that had happened.
- Diagnostic imaging recorded an incident regarding an ultrasound machine being taken to be used in theatre. It was retained in theatre after use despite being needed in X-ray. Staff reported that they had not received any feedback from this incident.
- Safety alerts, for example about medical devices, medicines or infections, were received by the hospital and communicated to heads of department.

Duty of Candour

- 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.
- Senior staff told us they had received information and training on the duty of candour. However not all staff we spoke with knew about the principle of duty of candour.

Cleanliness, infection control and hygiene

- Outpatient, physiotherapy and diagnostic imaging departments were visibly clean and tidy.
- The hospital had an infection control lead nurse, who worked across two hospitals and maintained links with the local NHS infection control team. The lead nurse monitored audits, provided guidance at senior nurse meetings and managed the infection prevention programme. This included training and supporting link nurses in each department of the hospital.
- We reviewed cleaning records for outpatient clinic rooms which showed cleaning had taken place regularly. However records were not easy to understand. This meant it was unclear at what time a room had been cleaned, for example before or after a clinic, and which items in the room had been cleaned.
- There was no cleaning record in the outpatient treatment rooms. We were therefore unable to determine if this room had been cleaned and how often. This could result in a potential infection control issue.
- The diagnostic imaging department had been subject to an infection control audit in November 2015. The audit highlighted issues requiring intervention such as a dusty floor in the X-ray room, dust on X-ray machines and other equipment. The floor was described as being of poor repair and a handwashing sink was identified as

not clinical. Cleaning issues were resolved with the hotel services manager before the inspection. The flooring and sink concerns were on the hospital risk register to be changed.

- Hand sanitisers were widely available throughout the outpatient, physiotherapy and imaging departments to encourage hand hygiene.
- Nursing staff and other healthcare workers adhered to the 'bare below the elbow' guidance to allow thorough hand washing and reduce risk of cross infection.
- Medical staff in OPD did not always adhere to the 'bare below the elbow' guidance to allow thorough hand washing and reduce risk of cross infection.
- Personal protective equipment, 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.
- There were carpets in some of the outpatient areas. It was recognised that there was a rolling programme for removal of carpets. The carpets were clean and did not have visible stains.
- We reviewed cleaning records for the physiotherapy department. Cleaning had taken place in accordance with the schedule. Green stickers were available and in use to show when a piece of equipment had been cleaned.
- Water in the hydrotherapy pool was checked twice daily by the physiotherapy team. We saw manual records in the physiotherapy department confirming this practice. A sample of water was taken and checked for temperature, PH and chlorine levels. Samples were also sent to the microbiology for testing for further analysis.

Environment and equipment

- All of the items of equipment checked were labelled with the last service and review date. All had an asset number to allow easy tracking if it needed servicing or maintenance.
- Lasers were in use within the OPD for ophthalmology procedures. The OPD lead was the Laser Protection Supervisor. All protocols and standard operating procedures were appropriately signed and in date.
- The appointed Radiation Protection Adviser was provided through a service level agreement with St George's University Hospitals NHS Foundation Trust. There was an appointed and trained Radiation Protection Supervisor. Their role was to oversee equipment safety and quality checks, and ionising radiation procedures, in accordance with national guidance and local procedures.
- Outpatient treatment rooms and storerooms were locked and accessible via keypad entry.
- In the diagnostic imaging department, specialised personal protective equipment was available and used in radiation areas. Staff wore personal radiation dose monitors.
- The X-ray table did not lower sufficiently to allow easy access for patients with restricted mobility difficulties. Risk assessments were in place, which included action to be taken to lessen the identified risk.
- Signs in the diagnostic imaging department identified when X-rays were being taken and not to enter the room.
- Resuscitation equipment was located in OPD on a trolley. The trolley was sealed with tamper-proof tags. We saw a daily check sheet which recorded the trolley had been checked to ensure equipment was available and in date.
- Waste disposal was well-managed by the housekeeping team who checked the dirty store daily. There was clear labelling of all clinical waste bins in clinical rooms.
- External contractors serviced the pool and visited six monthly to service and carry out tests.
- Drinking water was available for patients within the pool area to help prevent dehydration while using the hydrotherapy pool.

Medicines

- Medicines were stored safely. All medicines cupboards were locked and the keys held by the lead nurse on duty. Staff we spoke with knew who held the keys. Fridges were locked and temperatures checked daily and logged, to ensure medicines were stored at the correct temperature. We checked a random sample of medicines in OPD and radiology, all of which were in date.
- Contrast media in diagnostic imaging were stored safely. All medicine cupboards were locked and the keys held securely in the department. Staff we spoke with knew how to access the keys. Only consultants administered the contrast media.
- No controlled medicines were kept within OPD and radiology. No medicines were kept in the physiotherapy department.

- Staff reported that if a consultant wrote a prescription and the pharmacy was closed then drugs were occasionally dispensed from the drug stocks in the OPD treatment room. A copy of the prescribed drugs prescribed was provided to the pharmacy to allow stock to be replenished.

Records

- The individual consultant's secretary created patient record files for private patients seen for the first time in OPD. Staff in OPD reported these were available in a timely manner and contained accurate and legible information to enable the consultant to assess the patient appropriately.
- Records held by the hospital were held securely on site by the records medical department. When records were in the outpatient department they were either held in the consulting/treatment room with the relevant practitioner, or stored in secure areas the department.
- Staff said records were always available for scheduled appointments.
- The hospital's radiological images were stored on a nationally recognised PACS (Picture Archiving and Communication System) and had the same Computerised Radiology Information System as the local acute NHS trust hospital for patient demographic records and radiological reporting. Access to these records meant patients who had previously had radiological examinations in the NHS did not need them repeated, and so were not exposed to unnecessary radiation procedures.
- The imaging department had access to an image exchange portal for images held on other systems. Meaning that patients were not exposed to unnecessary X-rays.
- Should an image be needed urgently a 'blue light' procedure had been developed with the local NHS trust. This procedure meant that images could be obtained urgently if required.

Safeguarding

- There was a safeguarding children's and vulnerable adult's policy. The hospital did not provide services for children. The director of nursing was the safeguarding lead for the hospital and she was level three trained, which allowed safeguarding issues to be investigated in a management capacity.
- Staff confirmed in conversations that safeguarding vulnerable adults was included in their mandatory training. Hospital training records confirmed this.
- Staff that we spoke with demonstrated a good understanding about safeguarding processes. They knew what actions they needed to take if they suspected a patient or a visitor to the hospital had been subject to abuse.
- Processes were in place and followed to ensure the right patient received the correct radiological scan at the right time. A senior radiographer reviewed all X-ray requests before X-ray. Consultant radiologists reviewed all GP referrals before X-ray.

Mandatory training

- Mandatory training included data protection, blood transfusion, equality and diversity and moving and handling. Training was delivered through the BMI online learning package (BMiLearn) followed by face-to-face teaching and practical sessions. Staff reported they completed online learning and booked dates for the practical/ face-to-face teaching sessions.
- Each staff member was linked to a role-profile in the BMiLearn system so they were automatically assigned to a relevant mandatory training plan.
- BMI set a target of 90% compliance with mandatory training. Records provided by the hospital showed that the compliance rate for OPD staff was 94%, for diagnostic imaging staff 100% and for physiotherapy staff 86%.
- Consultants completed their mandatory training at the NHS establishment they routinely worked at. They were required to provide evidence of completion of mandatory training to the hospital and medical advisory committee (MAC).The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced.

Assessing and responding to patient risk

- Staff in all outpatient departments knew how to respond to patients who became unwell and how to obtain additional help from colleagues. Should a patient become unwell support would be provided from either that department or the hospital emergency team, depending on the severity of the patient's illness.

Good

Outpatients and diagnostic imaging

- Call bells were provided in all clinical rooms. Once a week in outpatients, the call bell system was checked in a clinical room to ensure it was working and the outcome logged and reported if necessary.
- Staff in all outpatient departments had training in basic life support, with some staff trained in intermediate and advanced life support.
- Staff completed scenario-based training provided by the local acute NHS trust, including resuscitation simulation, at least every six months. Teams were not aware when the training would take place. The trainer running the session, provided verbal and written feedback on how the team responded to the situation, with learning points and actions to take, shared with all staff in that area.
- Pull cords and call bells were located within the hydrotherapy pool room.
- There was always a registered medical officer (RMO) on duty, who was trained in advanced life support. They provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would be transferred to the inpatient ward or to the local acute NHS Trust in line with the emergency transfer policy. Staff reported that this rarely happened.
- The phlebotomy clinic was always held in a treatment room with a bed, to ensure appropriate management and support for patients who felt faint and became unwell.
- Procedures for evacuation of the hydrotherapy pool were in place should a patient become unwell. The physiotherapy manager was recently appointed and confirmed the resuscitation nurse had been contacted to in order review the current procedures. In the imaging department, staff completed imaging request cards which included pregnancy checks for patients. This was to ensure women who might be pregnant informed staff before exposure to radiation. Multi-lingual posters were on display advising patients who might be pregnant to inform staff accordingly.
- A senior radiographer reviewed all x-ray requests before X-ray. Consultant radiologists reviewed all GP referrals before x-ray.

Nursing staffing

- There were no set guidelines on safe staffing levels for OPD. Outpatient, diagnostic imaging and physiotherapy departments reported they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner.
- Consultants could contact the department at any time requesting an ad hoc clinic. This was agreed if there was an available consulting room and sufficient staff.
- No outpatient areas used any agency staff during the period October 2014 to September 2015.

Medical staffing

- The hospital at the time of inspection had 84 medical staff with practising privileges The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and MAC chair liaised appropriately with the GMC and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital OPD and administration team.
- Staff told us that medical staff were supportive and advice could be sought when needed.
- There was a registered medical officer RMO on duty 24 hours a day to provide medical support to the outpatient, physiotherapy and imaging departments.
- In the diagnostic imaging department, there was a service level agreement (SLA) for consultant radiologist support from the local NHS acute trust hospital. This allowed for timely reporting of scans and images to support diagnosis and safe treatment.

Major incident awareness and training

- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Fire evacuation drills were held three times a year. All staff understood their responsibilities if there was a fire within the building.
- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as internet or electricity failure. The business continuity plans were available in folders at reception and on their intranet.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

We inspected but did not rate effective as we do not currently collate sufficient evidence to rate this.

- National guidelines were used, there was evidence that clinical audits were being undertaken in all outpatient areas, including recording of patient reported outcomes.
- Staff were supported in their role through appraisals. All staff were appraised or had appraisals booked with their managers. Staff were encouraged to participate in training and development to allow them to deliver good quality care.
- There was evidence of multidisciplinary team working across the hospital and with the local NHS acute trust. There was good sharing of information for example sharing of radiology images electronically between the hospital and local NHS trusts.
- Consent forms were completed for all minor surgical procedures.
- Patients pain needs were met appropriately during a procedure or investigation that was carried out in clinic.
- The hospital had a process for checking competency and granting and reviewing practising privileges for consultants. Radiology staff were aware of competencies of consultants for procedures and use of equipment.

However,

- Senior staff in OPD were not formally aware of the competencies of individual consultants and there was no record kept within the OPD of these competencies.

Evidence-based care and treatment

- Staff in OPD reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure. Changes were made to practices in response to audit findings.
- New practices were reviewed and signed off by consultant radiologists.
- Consultant radiologists reviewed all GP referrals for imaging to ensure patients are not receiving unnecessary exposure to radiation.
- The imaging manager participated in a BMI imaging user group. The user group met quarterly to share best practice across the organisation.
- Staff in the physiotherapy department reported they followed national guidelines regarding the use of the hydrotherapy pool to ensure patients received effective and safe care. We saw guidelines produced by the Chartered Society of Physiotherapy regarding hydrotherapy.

Pain relief

- In OPD, staff discussed options for pain relief with the patient, during their consultation before any procedure being performed. Many procedures could be performed with the use of local anaesthetic, enabling the patient to go home the same day. Patients were given written advice on any pain relief medications they may need to use at home, during their recovery from their outpatient procedure.
- Patient records evidenced pain relief was discussed and local anaesthesia was used for minor procedures.

Patient outcomes

- The Medical Advisory Committee (MAC) monitored outcome data for individual consultants as part of the biannual review of consultant's practising privileges. This included readmission rates, development of venous thromboembolism (VTE) and hospital acquired infection.
- Patients were offered opportunities to participate in data collection to measure outcomes of treatment. All patients who were booked for joint replacement were asked for consent to be registered on the National Joint Registry (NJR) which monitors infection and revision rates. We saw in medical records that we reviewed patients had consented to participate in the register which ensured their care and joint replacements were monitored nationally.

- Patients were offered the opportunity to take part in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement, inguinal hernia repair and varicose veins. PROMS measures the quality of care and health gain received from the patients perspective. Between April 2014 and March 2015 data from PROMS showed the hospital was within the expected range for knee replacement surgery with regards to the Oxford knee score. (A patient-reported outcome measurement which contains 12 questions on activities of daily living that assess function and pain in patients undergoing total knee replacement.)

Competent staff

- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed. Staff confirmed they were well supported to maintain and further develop their professional skills and experience.
- Appraisal rates for the year October 2014 to September 2015 were 80% for nursing staff in OPD, 75% for healthcare assistants in OPD and 50% for allied health care professionals, which included physiotherapists and radiography staff.
- Staff told us the induction process was comprehensive including department tours and introductions to heads of department and colleagues. Staff were supernumerary for a period during their induction. We saw new staff being shown around the hospital during our inspection.
- Staff reported that time was not set aside for mandatory training however they could fit it in around their usual duties.
- There was an image intensifier in theatre. To ensure safety this was only used by a trained radiographer. Records were kept in theatre detailing who used the image intensifier and when.
- Consultant radiologists signed competency forms detailing which procedures they could carry out and which equipment they could use. Sample signatures were kept within the imaging department so that X-ray referrals could be checked.
- Diagnostic imaging bank staff routinely worked at another BMI hospital to ensure competency and learn different imaging techniques.
- A process was followed by the registered manager and Medical Advisory Committee to ensure all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake the treatment they were performing at the hospital. The competencies and skills were reviewed biannually, this included review of outcomes, appraisal and revalidation.
- Details of the competencies were not held in OPD. OPD staff were not directly aware of individual consultant competencies. There was a potential risk that consultants could be practising outside of their agreed competencies without the OPD being aware.

Multidisciplinary working (related to this core service)

- There was a service level agreement between the hospital and a mobile magnetic resonance imaging (MRI) provider (which was part of another organisation and not subject to this inspection process). The mobile MRI visited the hospital twice a week.
- There were service level agreements with the local acute NHS Trust, for support services to the hospital. This included processing and reporting on radiology, radiology monitoring, and support with life support training including the provision of emergency scenarios.
- From the care we observed, there was effective team working, with strong working relationships between all staff groups. We were told of an elderly patient who had attended an outpatient appointment who required admission to hospital. The various OPD teams completed the required tests and pre-operative assessments during the initial visit. This meant the patient did not have to make another visit to the hospital before admission.

Seven-day services

- OPD ran clinics Monday to Friday from 8am until 8pm, there were occasional Saturday clinics.
- The diagnostic imaging department ran from 8am until 8pm, with an on-call service available at the weekend.

Access to information

- Staff we spoke with reported timely access to test results such as from bloods and diagnostic imaging. Results were available for the next appointment or for certain clinics, during that visit, enabling prompt discussion with the patient on the findings and treatment plan.

Good

Outpatients and diagnostic imaging

- Medical staff mainly used their own private patient records during the outpatient consultation and took responsibility for ensuring the records were available.
- Most results were reported electronically, accessible by the clinician at the hospital, with a written copy also being sent.
- X-rays were available electronically for consultants to view in the clinic.
- Physiotherapy staff kept their own patient records but ensured that a copy was always available in the hospital records for each patient.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment. Medical staff we spoke with confirmed the transfer methods used and understood the required security aspects of data transfer.
- Doctors dictated clinic letters and they were typed by their private secretaries. GP's were sent the clinic letter and a copy was retained on the patient records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2008 and associated Deprivation of Liberty Safeguards was covered in the mandatory safeguarding training. Staff demonstrated in conversations a good understanding about their role with regard to the Mental Capacity Act.
- The consent process for patients was well-structured, with written information provided before consent being given.
- Verbal consent was given for most general X-ray procedures, OPD procedures and physiotherapy treatments carried out.

Are outpatients and diagnostic imaging services caring?

Good

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as 'good'.

- Staff in all outpatient areas were caring and compassionate. Patients commented positively about the care provided from all of the outpatient staff. Staff treated patients courteously and respectfully.
- Staff maintained patient privacy and dignity.
- Patients could make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively.
- Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

Compassionate care

- We observed that staff took all possible steps to promote patients' dignity and they were afforded privacy at all times. We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.
- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.
- Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. Patients told us staff were helpful and supportive.
- The hospital took part in the Friends and Family Test (FFT). There was no breakdown of the figures therefore it was not possible to identify the significance of these figures with regards to outpatients. For the reporting period April 2015 to September 2015 the hospital reported consistently high at 100% of patients would recommend the hospital to their friends and families. Between 26% to 55% of patients responded to the FFT.

Understanding and involvement of patients and those close to them

- Patients told us they had been provided with the relevant information, both verbal and written, to make informed decisions about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- Comments from patients who received physiotherapy indicated they were fully involved in their plan of treatment.

Emotional support

- When having conversations with staff it was clear they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

Good

Outpatients and diagnostic imaging

- Staff told us that they always offered to chaperone patients undergoing examinations and we saw records that showed patients were supported in this way. We saw medical staff requesting chaperones for their patients.

Are outpatients and diagnostic imaging services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as 'good'.

- Services were planned and delivered in way which met the needs of patients. The hospital environment was designed and maintained to support the individual needs of patients and to support privacy.
- Patients told us that there was good access to appointments and at times that suited their needs.
- Waiting times, delays and cancellations were minimal, physiotherapy and X- ray appointments were on time and patients were generally kept informed of any delays in outpatient clinics.
- The turn-around times for x-ray reports were all within 48 hours however generally this happened in 24 hours in this service.
- There was information on specific procedures, conditions and hospital charges in the waiting area. This was in English and not in other languages or formats, such as braille. The hospital reported that they had minimal numbers of patients who could not understand English.
- Staff were knowledgeable about the process and confident that complaints were investigated.

However,

- Staff did not receive feedback on complaints or learning from complaints.
- Some aspects of the setting in outpatient department did not fully support effective service provision. Staff had to access a storeroom through the general treatment room. This had a possible impact that equipment would not be accessible for clinics if a patient was receiving treatment in the room. An alternative storeroom had been identified within outpatients before the inspection to help alleviate this problem.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs and demands of patients. OPD clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.
- The hospital outlined their plan for a static magnetic resonance imaging (MRI) scanner to be located on site. This would provide a more responsive service to patients requiring imaging.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the National Health Service (NHS) in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- Clinics were held Monday to Friday, 8am to 8pm, with occasional outpatient clinics held at weekends to meet patient's needs.
- There was a combined waiting area for OPD, diagnostic imaging and the physiotherapy departments, a range of different style chairs meant patients could chose a chair that was comfortable for them while waiting.
- In the diagnostic imaging department there were two cubicles for patients to use to change before their X-ray appointment. Patients therefore had an appropriate area in which to change prior to their scan.
- Reception desks were sufficiently away from waiting areas so patients could speak to receptionists and staff, without their conversation being overheard.
- OPD had two treatment rooms. They were general treatment rooms used for minor procedures such as removal of sutures, wound dressings and removal of skin lesions.
- OPD also had a third treatment room used for urodynamic studies and cystoscope procedures.
- The treatment rooms in OPD had a storeroom that could only be accessed through the treatment room. This meant if a patient was having a procedure in the treatment room, there was a risk that staff would not be able to access equipment needed for use in other

consulting rooms. To lessen the risk of this occurring staff collected equipment needed for the other clinics and the beginning of morning and afternoon sessions. An alternative storeroom had also been identified within the outpatient department to help alleviate the issue.

Access and flow

- Patient's appointments were arranged through the consultant's individual secretaries and with the outpatient reception team.
- NHS patients who used Choose & Book, and were subject to NHS waiting time criteria, were managed by the hospital's own administration team.
- For the reporting period October 2014 to September 2015, the hospital consistently met the target of 95% of non-admitted patients beginning their treatment within 18 weeks of referral.
- For NHS patients the six-week diagnosis targets were consistently met.
- All patients we spoke with felt the availability of appointments was good and appointments were provided at times that fitted in with their needs. Most patients left with their next appointment date or, if appropriate, an admission date for surgery. Patients were very complimentary about the efficiency of the service as a whole. We saw patients arranging appointments with reception at a time that suited their requirements.
- Staff told us that physiotherapy and X-ray clinics usually ran to time. Staff told us if there were delays, they would speak to patients and keep them informed, either directly or via the reception team. If patients needed procedures such as X-ray or ultrasound or scans these could usually be carried out at the same time as their OPD appointment, reducing the number of visits they made to the hospital.
- Patients could get their X-rays carried out by the hospital on the same day as their appointment.
- Staff in the imaging department reviewed clinic lists daily to determine if any patients would require an X-ray. They liaised with OPD staff accordingly to schedule patients for imaging.
- The turn-around times for x-ray reports were all within 48 hours however generally this happened in 24 hours in this service. The only causes for delays were requests for previous images from other organisations for comparison.
- There was no formal system in place to inform patients if a clinic was running behind schedule. OPD staff would advise the reception team who would, in turn, advise patients as they arrived for their appointment. Information regarding how long patients waited was not captured and could therefore not be analysed to identify any concerns.
- Staff in OPD reported that it was not unusual for clinics to run over their time allocation. Nursing staff stayed on duty, working over their rostered hours to ensure patients had their consultation. There was no data to demonstrate how frequently clinics ran late or how long patients had to wait in the waiting area for their consultation.

Meeting people's individual needs

- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. However, staff noted there were rarely patients who had complex or additional needs.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 95% for dementia which was higher than the England average of 87%.
- There was ample seating in the waiting area. There was access to tea and coffee in the waiting area. Outpatients, diagnostic imaging and physiotherapy were located immediately adjacent to the main reception desk.
- All written information, including pre-appointment information and signs were in English. These were not available in other formats such as other languages, pictorial or braille. Staff described there were rarely patients whose first language was not English. There were BMI policies for accessing translation services, however staff had rarely had to access these and were unsure of the process.
- A loop system was installed in the reception area for patients who were hard of hearing.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by BMI Healthcare.
- In diagnostic imaging, a range of leaflets were available and provided to patients about diagnostic imaging procedures.

Learning from complaints and concerns

- All complaints were monitored by the hospital director and responded to in-line with the hospitals policy. An

Good

Outpatients and diagnostic imaging

acknowledgement of the complaint was sent within two working days and a full response within 20 working days. Complaints were investigated by the relevant head of department with involvement from consultants and nurses if needed. However, procedures for sharing and learning from complaints across the hospital were not robust.

- All staff received information about the complaints procedure as part of their induction. The staff we spoke with were clear on the process and procedure
- During our inspection we did not see any guidance, posters or leaflets instructing patients on how to make a complaint. The hospital told us they had "Please tell us Leaflets" which explained how to raise a concern or complaint.
- The hospital informed us that all patients were actively encouraged to complete a patient satisfaction survey that encouraged feedback. Patient feedback forms were part of the standard room set up for all admitted patients.
- Staff were confident complaints were investigated, but said they did not always receive feedback about the outcome of complaints.

Are outpatients and diagnostic imaging services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as 'good'.

- There was a corporate clinical strategy. Although staff did not always know the details of the strategy, they exhibited the ethos of the strategy in their commitment to provide quality and compassionate care for patients in an effective and efficient manner.
- Staff had confidence in their immediate managers. Staff reported that senior management within the hospital were visible and although they were not always approachable.
- There was evidence of innovation and development of services in the physiotherapy and diagnostic imaging departments. This included developing individual skills of physiotherapists and working towards obtaining a static MRI scanner onsite.
- In OPD, the team leader was working with the hospital administration team to streamline the booking process to release administration time within the OPD.
- Staff were invited to have tea with the executive director monthly.

However,

- Individual departments did not maintain their own risk registers.

Vision and strategy for this this core service

- The BMI corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The registered manager used this as the basis of the hospital wide strategy and vision.
- Although staff in the individual departments could not detail the corporate strategy, all demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner. Some staff also talked about growing developing their service to better serve their patients and to increase business revenue.
- The director of nursing told us about the ambition to embed the values of the "6C's" across the nursing teams at the hospital. The "6C's" are care, commitment, courage, compassion, communication and competence. Not all nursing staff we spoke with knew about the "6C's".
- The physiotherapy manager had a clear vision of how they wanted the service to be developed to enhance services for the local population. As the manager had only been recently appointed this had not yet been realised, however from discussion it was clear that this vision was supported by the executive team.
- Managers in outpatients, physiotherapy and diagnostic imaging knew about the executive team plans for developing their respective services. The plans included expanding clinic room capacity within OPD and a static MRI scanner.

Governance, risk management and quality measurement for this core service

Good

Outpatients and diagnostic imaging

- There was defined governance and reporting structure in the hospital, which fed into the organisations governance processes. Departments held their own team meetings, in which information was fed back from hospital clinical governance meetings, operational leads and senior nurse meetings.
- The imaging manager attended the clinical governance meetings at the hospital, with informal feedback provided to the imaging team.
- We reviewed minutes from OPD team meetings from October 2014 to December 2015. Items on the agenda were operational team, and departmental feedback, complaints, moving forward, charges, and emergency call-bell check.
- Individual departments did not maintain their own risk registers. The registered manager explained it was corporate policy to keep hospital risk registers to high level issues. Action logs from operational lead meetings evidenced monitoring of some local issues as well as high level risks. The registered manager told us of actions to address risks, for example a new roof over the hydrotherapy pool and a new pharmacy. They were aware of the staffing risks for such a small department as X Ray and were considering adding this to the hospital wide risk register
- There was a positive attitude among staff with regard to wanting to share learning from incidents across the hospital and organisation. However in outpatients there had been limited opportunities to learn given the limited number of incidents.
- Risks identified by OPD were not included on the hospital risk register. There was no assessment of risks identified by OPD to determine the level of risk posed to patients and staff. Though staff in OPD stated they had identified risks to the hospital management, however there was no formal audit trail to demonstrate when concerns had been escalated and what actions had been taken.

Leadership / culture of service

- Managers in the outpatient, radiology and physiotherapy departments had clinical roles and were easily accessible. Staff reported good support and guidance from their managers. Managers in all three departments were passionate about their teams and caring for their patients.
- All three managers had a vast range of experience within their fields of expertise to allow them to manage their departments effectively. Although not having budgetary responsibility managers reported they could to make decisions for their service within a supportive framework.
- The executive team were highly visible within the hospital, at least, twice a day they would around the departments. Staff confirmed this practice and we observed these rounds taking place.
- Medical staff we spoke with confirmed a positive relationship with the executive director. One reported that “if she says she will do something then she will do it”.
- The registered manager was the line manager for radiology and physiotherapy departments and the director of nursing was the line manager for OPD. Staff reported that communication via line management for OPD was not as positive or as clear as it could be. This meant that issues or concerns felt by department managers were not always raised.

Culture within the service

- Most staff said they felt listened to and respected. They felt they could raise concerns and they would be investigated. However they were not always aware of actions taken as a result.
- Staff told us there was also limited opportunity for sharing experiences at a peer level across the organisation.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test.
- Staff told us that they are able to have tea with the executive director at pre-arranged sessions. This allowed staff to discuss in an open forum their thoughts and ideas for the hospital.
- Results of the latest patient survey showed a high level of meeting patient’s expectation, with the hospital scoring 98.1%. Areas of concern, such as catering were being addressed. The hospital was tenth place across the BMI group for patient satisfaction scores.

Innovation, improvement and sustainability

- Most staff reported the hospital supported innovation with the executive team responsive to requests and suggestions for improvement.

Good

Outpatients and diagnostic imaging

- In diagnostic imaging an idea developed by an imaging assistant was agreed and implemented. It involved producing chaperone stickers confirming whether a patient wanted a chaperone or not. The stickers provided a quick and easy visual reference for staff regarding the patient's decision.
- Staff within OPD told us that they were working with the administration teams to streamline booking processes. This did not affect patients directly however it would make the internal process more efficient, therefore saving time for staff releasing them to spend more time with patients.
- The physiotherapy manager told us how the plan for physiotherapists is to use and develop their own areas of expertise, for example with sports rehabilitation, for the benefit of specific patient groups.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure all incidents are recorded and learning from investigations, incidents and complaints is appropriately shared across the hospital.
- The hospital must ensure that clinical equipment checks and servicing carried out in accordance with the hospital policy.
- The hospital must ensure all staff consistently adhere to best practice in infection prevention and control
- The hospital must ensure staff complete all mandatory training, including training in patient moving and handling.
- The hospital must ensure that system and processes are in place to ensure out of date medicines are identified and replaced
- The hospital must ensure that medicines being stored in freezers are kept at the correct temperature, as recommended by manufacturers
- All staff must have the opportunity to contribute to yearly appraisals.
- The hospital must ensure working practices in the operating theatre reflect the hospital policy and procedures and are in line with current national guidance. The hospital must ensure that theatre and endoscopy staff have appropriate competencies and supervision in relation to their role.
- The hospital must ensure risks are identified, assessed and managed effectively across all areas of the hospital
- The hospital must ensure there are processes in place to effectively monitor the quality of service provision and identify areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure that all equipment used by the service is clean and properly maintained. There should be a clear process in place to demonstrate the hoist slings have been cleaned, with appropriate dates and times recorded.
- The hospital should ensure all staff adhere to the 'bare below the elbow' guidance to allow thorough hand washing and reduce risk of cross infection.
- The risks associated with the use of heat pads in the microwave should be identified, assessed and managed effectively.
- The hospital should ensure that medicines are appropriately labelled.
- The hospital should ensure appropriate arrangements for monitoring and auditing the management and use of controlled drugs by the Controlled Drugs Accountable Officer, in all areas including the pharmacy, are in place
- The hospital should review the local identification, planning, action, review and records relating to Central Alert System (CAS) notifications
- The hospital should ensure that all departments are made aware of the practising privileges and any restrictions on practice of medical consultants
- The hospital should ensure

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (e) (g) (h) How the regulation was not being met: • Despite procedures being in place to check equipment some clinical equipment in surgical services had passed service dates. • There were lapses in medicines management systems, including some out of date medicines, and some lapses in security and storage. Medicines stored in freezers were not always kept at the correct temperature as recommended by manufacturer's instructions • Not all staff were following infection prevention and control precautions such as using personal protective equipment.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (b) How the regulation was not being met: Not all risks were identified at service level. The risk register was not reflective of all risks. The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2) (a)** How the regulation was not being met: • There was no evidence of training and assessment of competencies for operating theatre and endoscopy staff. • Most staff in surgical services had not received appropriate appraisal and supervision.