

BMI The Lancaster Hospital

Quality Report

BMI The Lancaster
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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



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

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

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

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

Summary of findings

Overall summary

BMI The Lancaster is operated by BMI Healthcare Limited. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 25 and 26 October 2016 along with an unannounced visit to the hospital on 8 November 2016. This was part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical services and outpatients and diagnostic services as these incorporated the activity undertaken by the provider.

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

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

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

We rated this hospital as requires improvement because:

- The hospital had received a Regulation 28 report from the coroner. A Regulation 28 is a report that the coroner has a duty to make where they believe action should be taken to prevent future deaths. The report highlighted areas where failings occurred and improvements were required. We found an action plan had been implemented for this but there had been elements of the action plan that had not been followed through completely.
- We found that some areas of compliance with mandatory training were low.

- The environment had not been suitably adapted to respond to the needs of patients living with dementia. For example signage was not clear, and there were no quiet spaces for patients who may be feeling anxious or confused.
- The hospital had a newly appointed management team who were in the process of identifying gaps in governance and assurance. However, this process had not yet been completed and embedded fully across the hospital.
- There were examples of where the hospital had put controls in place to mitigate the level of certain risks. However, we found that they had not always been implemented in a timely manner. Some actions that had been implemented had not always been monitored to ensure compliance had improved.
- The governance processes did not ensure the correct or most current policies and procedures were being used. This included staff dependency tools to assess nurse staff numbers and assessments of staff competence.

In surgery we also found:

- We observed that the 'sign out' phase of the 5 steps of safer surgery including the WHO surgical safety checklist was not always completed fully following a patient undergoing surgery.
- Hand washing facilities in the inpatient ward did not meet current guidance.
- Records indicated that some members of key staff had not been assessed for appropriate competencies before undertaking certain roles within the hospital. This was brought to the attention of the manager following the inspection and assurance was given that action would be taken.
- Records indicated that anaesthetic equipment was not being checked on a daily basis in line with AAGBI guidelines.
- We found that the storage of endoscopes was not compliant with Department of Health guidelines.

Summary of findings

- Written patient information was available in English language only.

In diagnostics and outpatients we also found:

- There were patient records which did not have a clinical entry made on the day of consultation and the copy letter to the GP was not signed. This meant that records were not always accurate, complete and contemporaneous. This was brought to the attention of the manager following the inspection and assurance was given that action would be taken.
- There was no separate dirty utility room in the outpatient department which meant staff were disposing of waste, such as urine samples, in the clean treatment room. A formal risk assessment had not been completed to ensure this was being managed effectively.
- Carpeting and seating in the outpatient department did not assist in maintaining good standards of infection control. This was being addressed by the service.

We found areas of good practice including:

- We observed all areas to be visibly clean and uncluttered.
- The hospital had clear safeguarding policies and processes for staff to follow. Staff were able to describe what constituted a safeguarding incident and how this was reported.

- Care and treatment was provided in line with up to date Evidence Based practice.
- Care and treatment was delivered in a caring and compassionate way. Privacy and dignity was maintained for patients when they received care and treatment.
- Complaints and concerns were dealt with in a timely manner and there were examples of the services provided being improved as a result.
- The hospital had a vision and strategy which was underpinned by the overall BMI vision and strategy.
- There was a clear leadership structure in place. Staff informed us that the new management team were visible and approachable.
- Staff throughout the hospital described there being a friendly and open culture.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help it move to a higher rating. We also issued the provider with two requirement notices that affected both surgery and outpatients and diagnostic services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals North.

Summary of findings

Our judgements about each of the main services

Service

Rating Summary of each main service

Surgery

Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-reference the surgery section. We rated this service as requires improvement overall. The service was good in caring and responsive but requires improvement in being safe, effective and well-led.

Requires improvement



- Staff on the inpatient ward were using the incorrect dependency tool to calculate the number of staff required. The number of staff calculated had not been achieved on a regular basis. This meant that we were unsure whether there had been sufficient numbers of staff to care for patients.
- We observed that the 'sign out' phase of the WHO checklist was not always completed fully following a patient undergoing surgery.
- We found that the entrance to the theatre area was unsecured. This meant that there was the potential that members of the public could gain access unsupervised.
- Records indicated that anaesthetic equipment was not being checked on a daily basis in line with AAGBI guidelines.
- We found that the storage of endoscopes was not compliant with Department of Health guidelines.
- Records indicated that some key members of staff had not been assessed for appropriate competencies before undertaking certain roles within the hospital.

Outpatients and diagnostic imaging

Requires improvement



Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-reference to the surgery section.

Summary of findings

We rated this service as requires improvement overall. The service was requires improvement in being safe, and well-led and was good in caring and responsive. We do not rate effective in this service.

- There were patient records which did not have a clinical entry made on the day of consultation and the copy letter to the GP was not signed. This meant that records were not always accurate, complete and contemporaneous.
- There was no separate dirty utility room in the outpatient department which meant staff were disposing of waste, such as urine samples, in the clean treatment room. A formal risk assessment had not been completed to ensure this was being managed effectively.
- Cleaning checklists for the consulting rooms had not always been fully completed which made it unclear if all the areas had been clean on a regular basis.
- Carpeting and seating in the outpatient department did not assist in maintaining good standards of infection control. This was being addressed by the service.
- Staff at all levels in the service were unable to tell us how their service performance was monitored and what were the key performance indicators.
- The manager of the outpatient department also managed the surgical services. This lead to concerns that this shared post was not allowing a complete overview of both services.

Summary of findings

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Requires improvement 

BMI The Lancaster Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The Lancaster Hospital

BMI The Lancaster is operated by BMI Healthcare Limited. It is a private hospital in Lancaster, Lancashire. The hospital was opened in 1985 as part of the Nuffield Group and was acquired by BMI Healthcare in 2008 and now provides a wide range of services. The hospital primarily serves the communities of the Lancaster, Morecambe Bay and South Cumbria areas. It also accepts patient referrals from outside this area. The hospital is situated very close to a large NHS general hospital.

The hospital has had an interim registered manager in post since 30 September 2016. This manager is registered with CQC at another BMI Healthcare Hospital in Lancashire. At the time of this inspection they were managing both hospitals until a permanent manager was appointed. Since the inspection this person has become the executive director of the hospital and relinquished their responsibility for the other BMI Healthcare Hospital.

The hospital also offers cosmetic procedures such as dermal fillers. We did not inspect this service.

Our inspection team

We carried out an announced comprehensive inspection of BMI The Lancaster hospital on the 25 and 26 October 2016 and an unannounced visit on 8 November 2016. This was part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical services and outpatients and diagnostic services as these incorporated the activity undertaken by the provider, BMI Healthcare Limited, at this location. This hospital had not previously been inspected.

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and two specialist advisors with expertise in surgery and governance. The inspection team was overseen by Ann Ford, Head of Hospital inspection.

Information about BMI The Lancaster Hospital

BMI The Lancaster is operated by BMI Healthcare Limited. The hospital has 25 beds which includes a six chaired ambulatory care facility. There are seven consulting rooms, one treatment room and a diagnostic service of plain X-ray and ultrasound. CT and MRI scans are undertaken at one of the provider's sister hospitals. There is one operating theatre and a minor operations/ endoscopy room.

We inspected two core services at the hospital, which covered all the activity undertaken. These were surgery and outpatient and diagnostic services.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Family planning.

- Surgical procedures
- Treatment of disease, disorder or injury.

During the inspection, we visited the inpatient ward, outpatient department, physiotherapy department, operating theatres and diagnostic department. We spoke with 22 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 12 patients and six relatives. During our inspection, we reviewed 19 sets of patient healthcare records and six physiotherapy records. We held two focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Committee.

Summary of this inspection

In the reporting period July 2015 to June 2016 there were 2,803 inpatient and day case episodes of care recorded at the hospital; of these 73% were NHS funded and 27% were other funded. 15% of all NHS funded patients and 24% of all other funded patients stayed overnight at the hospital during the same reporting period. There were 5,583 outpatient total attendances in the reporting period; of these 30% were NHS funded and 70% were other funded.

Ninety two surgeons worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a week on week off rota. There were 12.7 full time equivalent registered nurses employed and nine other healthcare staff.

There were a total of 126 clinical incidents in the period July 2015 to June 2016. Out of these clinical incidents 87% (109 incidents) occurred in surgery or inpatients and 1% (one incident) occurred in other services. The

remaining 13% of all clinical incidents occurred in outpatient and diagnostic services (16 incidents). The hospital reported none of the incidents as severe or death. The rate of overall clinical incidents was mainly higher than the rate of other independent acute hospitals we hold this type of data for in the reporting period. However 69.8% of the incidents resulted in no harm. There was a positive approach to reporting incidents.

In the past 12 months there were no serious injuries and no incidences of hospital acquired serious infections such as Methicillin-resistant Staphylococcus (MRSA).

There have been no safeguarding concerns reported to CQC between July 2015 and June 2016. In the same period there were 31 complaints with one complaint being received by CQC.

The endoscopy service was not accredited by the Joint Advisory Group on GI endoscopy (JAG).

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as requires improvement because:

- There were patient records which did not have a clinical entry made on the day of consultation and the copy letter to the GP was not signed. This meant that records were not always accurate, complete and contemporaneous.
- We found that some areas of compliance with mandatory training were low in surgery services.
- We observed that the 'time out' phase of the WHO checklist was not always completed fully following a patient undergoing surgery.
- Records indicated that anaesthetic equipment was not being checked on a daily basis in line with AAGBI guidelines.
- The hospital had a major incident policy. However, staff were unable to tell us what their role in a major incident would be.
- Carpeting and seating in the outpatient department did not assist in maintaining good standards of infection control. This was being addressed by the service.

However

- There were sufficient numbers of medical staff to provide care and treatment. There was a Resident Medical Officer present at the hospital 24 hours a day, seven days a week. All care and treatment was led by a consultant who had overall responsibility for a patient during their stay at the hospital.
- We observed the ward and theatre areas to be visibly clean and uncluttered.
- The hospital had clear safeguarding policies and processes for staff to follow. Staff were able to describe what constituted a safeguarding incident and how this was reported.
- Patient safety was monitored and staff reported incidents using an incident reporting system. Staff were aware of lessons learnt and that improvements were made from investigations.
- Medicines were stored safely and given to patients in a timely manner. There were systems in place to manage the safe administration and prescribing of medication. Audits were undertaken and actions had been identified to help staff improve when standards had not been met.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

Requires improvement



Summary of this inspection

- Records indicated that some key members of staff had not been assessed for appropriate competencies before undertaking certain roles within the hospital. This was raised with the Registered Manager and appropriate actions were taken to ensure the safety of patients.

However

- Care and treatment appeared to be delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
- Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.
- The Hospital monitored patient outcomes through surveys to ensure that patients were satisfied with the service they received. Patient satisfaction was benchmarked against other BMI healthcare hospitals.

Are services caring?

We rated caring as good because:

- Care and treatment was delivered in a caring and compassionate way. Privacy and dignity was maintained for patients when they received care and treatment.
- Patients that we spoke to were positive about the care and treatment that they had received during their time at the hospital.
- Patients told us all staff explained what they were doing in a way that they understood. If they did have any questions, they felt comfortable to ask.
- We observed staff providing reassurance to patients before undergoing surgery. Every effort was made to reduce patient anxieties as much as possible.

Good



Are services responsive?

We rated responsive as good because:

- Consideration was given to the needs of patients throughout the surgery treatment pathway. This started at the pre-operation assessment stage.
- Targets for referral to treatment standards for admitted NHS funded patients were consistently met.
- Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Good



Summary of this inspection

However:

- The environment had not been suitably adapted to respond to the needs of patients living with dementia. For example signage was not clear, and there were no quiet spaces for patients who may be feeling anxious or confused.

Are services well-led?

We rated well-led as requires improvement because:

- The hospital had a newly appointed management team who were in the process of identifying gaps in governance and assurance. However, this process had not yet been completed and embedded fully across the hospital.
- Staff, other than managers, were not aware of the vision and strategy for the service.
- There were gaps in some of the governance processes. This included poor monitoring of compliance with action plans, a lack of systems for monitoring local adherence with BMI policies such as personnel documentation and a lack of timely follow up where audits and surveys identified issues.
- There was acknowledgment that staff had not been as involved as they should have been in improvements in the service.
- Results from the hospital staff satisfaction survey indicated that only 39% of staff recommended the hospital as a place to work. This was below the national average of 70%.
- There was a central hospital risk management plan which included identified risks. However, there had been no date set for actions to be completed by or to be reviewed assessing if the level of risk had changed.
- Managers had not ensured that key members of staff had the formal competencies for their role and had not taken steps to manage potential risks to patient safety associated with this. We therefore had limited assurance that the member of staff had the correct skills to undertake the role, although there was no evidence to suggest they were not capable of doing the job. We received assurance from the management team that appropriate actions would be taken.
- There were examples of where the hospital had put controls in place to mitigate the level of certain risks. However, we found that they had not always been implemented in a timely manner. Some actions that had been implemented had not always been monitored to ensure compliance had improved.
- The information required to ensure consultants who had practising privileges were fit to work at the hospital was not present on all personnel files.

However:

Requires improvement



Summary of this inspection

- The new management team was described as visible and approachable.
- Staff throughout the hospital described a friendly and open culture.






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	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement 

Incidents

- The hospital had an up to date incident reporting policy that was available on the intranet. Staff that we spoke with were able to identify types of things that were reported as incidents.
- Staff were familiar with and encouraged to use the hospital's policy and procedures for reporting incidents. Incidents were reported through a paper reporting system which was uploaded centrally onto an electronic system. We spoke with a range of staff across the service that were all aware of how to report incidents.
- A root cause analysis (RCA) tool was used to investigate serious incidents, and we saw that, where required, an action plan was put in place to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions for learning. Where necessary, action plans indicated where further training in processes for staff was required.
- BMI policy stated that if a patient developed a venous thrombo-embolism (VTE), this should be investigated using a root cause analysis (RCA) approach. An RCA is used to examine the full history of occurrences when an incident occurs so that the root cause can be identified and improvements made where required.
- There had been no 'never events' in surgical services. 'Never events' are serious incidents that are wholly

preventable as guidance or safety recommendations that provide strong systemic protective barriers, are available at a national level and should have been implemented by all healthcare providers.

- We reviewed one additional RCA that had been completed in the last 12 months. We found that this had been completed by an appropriate member of staff, a full timeline of events had been documented and action plan had been implemented to make improvements where needed.
- Between the period of June 2015 and July 2016 there were 109 clinical incidents reported by staff in theatre or the inpatient ward. The majority of these had resulted in no patient harm. However, 31 had resulted in a low level of patient harm and seven had resulted in a moderate level of patient harm. Additionally, there had been 22 non-clinical incidents reported during the same period.
- We reviewed a sample of incident reports between the period of February 2016 and July 2016. The majority of incidents reported had been as a result of surgery cancellations, unplanned transfers, surgical site infections and medication errors. There was evidence of incidents being investigated after being reported.
- Staff confirmed that they had received feedback after submitting an incident report. We were given examples of how learning from incidents had been disseminated. Examples of this included via email or as part of the daily handover.
- Senior staff told us general feedback on patient safety information was discussed at staff meetings or in informal handover between staff. Senior staff facilitated time with staff to look at lessons learnt from incidents.

Surgery

- All levels of staff were aware of their responsibilities relating to Duty of Candour legislation and were able to give us examples of when this had been implemented. The hospital had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

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

- The hospital submitted data to the NHS safety thermometer for NHS funded patients who had received care and treatment. The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care.
- Between June 2015 and July 2016, there had been one reported incident of venous thromboembolism (VTE). A VTE is a blood clot which can be potentially life threatening.
- Guidelines from the National Institute for Health and Care Excellence (NICE) recommend that all patients should be VTE risk assessed on admission and reassessed 24 hours after surgery. Records indicated that monthly audits had been completed to monitor compliance with this. Between June 2015 and July 2016, records indicated that VTE pathways had been followed in accordance with NICE guidance on 100% of occasions on all but three months. Records showed that there had been 98% compliance in April 2016, 95% in June 2016 and 98% in July 2016.
- Patients were also assessed for the risk of falls and pressure ulcers on admission to the hospital. Completed audits showed that falls assessments were completed on 96% of occasions during January 2016 and on 100% of occasions during July 2016.

Cleanliness, infection control and hygiene

- The hospital had an infection control policy which was available on the intranet. Staff were able to locate this when needed. The hospital also had an infection and prevention control lead.

- We observed both the theatre and ward areas to be visibly clean. Housekeepers were available during normal working hours, seven days a week and were responsible for cleaning the ward and theatre areas. The management team confirmed that if housekeepers were not available out of hours then a room or area would be closed until the following morning.
- The hospital had one theatre which used a laminar flow system. Laminar flow is a system that is used to circulate filtered air in order to reduce the risk of airborne contamination and exposure to chemical pollutants. If staff were to enter or leave theatre during an operation, they had to use the anaesthetic room so that the air flow in theatre was not affected. Staff informed us that this laminar flow system was old and had been identified on the risk register. However, there was an alarm system that alerted staff if it was not working properly and there had not been any reported issues with this.
- The number of surgical site infections that were acquired during operations was monitored by the management team. Between June 2015 and July 2016, there had been one incidence of surgical site infection reported. This had been reported to the infection and prevention control group as well as the medical advisory committee. This had been investigated using an RCA approach.
- The hospital had reported no incidences of hospital acquired infections between the period of June 2015 and July 2016. This included infections such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDIFF), methicillin-sensitive staphylococcus aureus (MSSA) and carbapenemase producing enterobacteriaceae (CPE).
- The hospital had a service level agreement (SLA) in place with a local hospital which provided decontamination services for all theatre equipment including endoscopes. Staff informed us that they did not usually have any problems with equipment being returned ready for use.
- The hospital complied with the general principles listed as part of the Health Technical Memorandum 01-06 Part A (decontamination of flexible endoscopes). This meant

Surgery

that they were washed immediately after use, secured and transported to a decontamination facility in a timely manner. Once decontaminated, they were packaged and it was clear that they were sterile and ready for use.

- However, the hospital did not comply with Part B of the same guidance. This was because decontaminated scopes were being transported in the same container as contaminated ones and they were not stored in the recommended area. This meant that there was an increased risk of infection being transmitted to patients undergoing these procedures.
- Records indicated that theatres were deep cleaned once every 12 months. This service was provided by an external company.
- Patients were screened for infection as part of the pre-operative clinic. If a patient was positive for having an infection such as MRSA, the infection control policy stated what precautions had to be implemented. This included using appropriate personal protective equipment (PPE) and managing the patient in a cubicle with a door.
- We found that staff were compliant with 'bare below the elbow' guidance and that PPE was used on a regular basis in line with trust policy. PPE was also provided for visiting relatives when needed.
- In theatre we found that surgical staff showed consideration to infection and prevention control procedures and best practice guidance (NICE CG74) in using sterile gowns and gloves as well as the use of incision drapes and antiseptic skin preparation.
- On the ward area, there was only one basin in the patient bedrooms we looked at. It is recommended that a minimum of one clinical hand wash basin is available in each single room, in addition to the general hand wash basin for personal hygiene in the en-suite facility (Health building note 00-09, Infection control in the built environment, Department of Health). There were no additional hand wash basins on the ward corridors for patients, the public or staff to use. There were plans in place to address this issue.
- There were hand gel dispensers at the entrance to the theatre area. We observed staff using these appropriately. However, dispensers were not always

available outside patient bedrooms on the inpatient ward. This meant that there was a risk of spreading infection as staff had to wash their hands in a communal area after treating a patient.

- The hospital took part in patient led assessments of the care environment (PLACE). Between February 2016 and June 2016, the hospital scored 90% for cleanliness which was lower than similar services nationally.

Environment and equipment

- Surgery services in the hospital were based on two floors. There were 25 individual en-suite rooms as part of the ward area which was located on the first floor.
- At the time of the inspection most bedrooms had carpets which did not meet with current Department of Health guidance. Health Building Note 00-09: Infection control in the built environment recommends that carpet is not used in clinical areas and rooms. Patient rooms are included in this as clinical care takes place in these rooms due to the increased risk of infection. There were plans to replace this flooring within the refurbishment of the rooms.
- The hospital had one theatre which was used for all surgical procedures. Additionally, there was also a minor procedures room. This was used for treatment such as endoscopy and injections into joints.
- Theatre was accessed by manual doors which were unsecured. This meant that there was the potential that members of the public could gain access unsupervised. The theatre had its own anaesthetic room. There was also a two bedded recovery area which was used to recover patients post-surgery.
- Both the ward area and theatre had access to resuscitation trolleys and a difficult airway trolley. Tamper tags were present on all of them which meant that staff were assured that nothing had been used since the last time that they were checked. Both in theatre and on the ward, records indicated that these had been checked appropriately and all equipment was in date.
- Records indicated that staff had not always checked equipment in the anaesthetic room. Between 1 September 2016 and the time of the inspection, checks had not been completed on 10 occasions. This was not in line with guidance from the Association of

Surgery

Anaesthetists (2009) for the safe management of anaesthetic related equipment and there was limited assurance that staff had made sure that this equipment was safe prior to use.

- The service had equipment that was used to transfer a patient to another hospital when needed. This equipment included things such as a portable ventilator. We found that this had been stored appropriately and was sealed with a tamper tag.
- We checked a sample of equipment in theatre and on the ward for compliance with servicing and portable appliance safety testing and found these to be in date. The management team had begun to compile an asset register which provided oversight of all equipment in theatre and on the ward. However, this had not been fully completed. This meant that there was a risk equipment would still be used despite it being overdue a check for safety. Additionally, managers were unaware of what service dates were on equipment within their department.
- Control of substances hazardous to health (COSHH) legislation was adhered to on all occasions. Flammable liquids were stored in appropriately designated areas.
- Waste was managed appropriately in dirty sluice rooms. Clinical waste was segregated from domestic waste and dirty linen bins were used when needed.
- Staff were positive about the availability of the correct amount of equipment. We found that staff rotated disposable equipment so that the risk of them going out of date was reduced.
- The service used a paper based recording system to identify serial numbers of implants that were used. This provided a system to identify patients if a safety alert about the implant that had been used was received.
- Patient led assessments of the care environment (PLACE) are undertaken by teams of health care providers, and include at least 50 per cent members of the public (known as patient assessors). Results from the most recent PLACE were published in June 2016 using data collected between February and June 2016. The report compared the scores from the hospital site with the scores for the BMI organisation. Areas assessed included communal and ward areas but not theatres.

- The hospital site scored 94% for condition, appearance and maintenance which was slightly better than the organisational average of 92%.
- The national audit of Patient-led assessments of the care environment (PLACE) between February 2016 and June 2016 were the same or higher than the England average for condition, appearance and maintenance, disability. However, the hospital scored lower than the England average in cleanliness.

Medicines

- We saw that the service had current medicines management policies and procedures available in order that staff could be guided in the correct processes to manage medicines safely. Staff we spoke to confirmed that they were informed via a computer system of any changes to policy.
- There was a pharmacy department that was open for a number of hours, five days a week. The hospital employed a pharmacist who was responsible for ensuring that medications were available when required and dispensed appropriately. The pharmacist worked in between two other hospitals providing pharmacy services.
- When the pharmacist was not available, the resident medical officer (RMO) was able to access the pharmacy when required. Hospital policy stated that they had to be accompanied by a nurse if any medication was withdrawn.
- Controlled drugs were managed in accordance with the Misuse of Drugs Act 1971. We checked cupboards on the ward and in theatre and found that the quantity of drugs reconciled with what was recorded in the register and they were in date. Additionally, all records had been countersigned and the amount administered and disposed of had been recorded.
- Fridge temperatures were all found to be within normal ranges at the time of the inspection, which meant that medicines were stored at the correct temperature. Records indicated that staff completed daily fridge temperature checks in line with the hospital policy. Records for October 2016 indicated that daily checks had been completed on all occasions. Medicines in the fridges were stored correctly and were in date.

Surgery

- Additionally, the hospital medicines management policy stated that all medicines should be kept in a locked cupboard at all times. We found that propofol (a drug used in the anaesthetic process) was kept in an unlocked cupboard in the anaesthetic room and staff had no record of the quantity available. This meant that staff would be potentially unaware if any was unaccounted for. This was brought to the attention of the theatre manager during the inspection.
- Other general medicines were stored and prepared appropriately in locked clinical areas. We checked a sample of these, finding them to be in date and stored correctly.
- Lockable cupboards were available in each room so that patient's medication was stored appropriately. This medication was added to the patient's prescription card and administered by a member of staff. If patients attended with medicines that were classed as a controlled drug, these were locked away securely.
- We checked a sample of five prescription cards and found that allergies were documented and that they had all been completed correctly. A pharmacist had also reviewed these on all occasions.
- The hospital's mandatory training programme did not include medicines management training for staff to complete.

Records

- The hospital used a paper based records system. We found that records were kept appropriately in a secured staff area. Additionally, records were also kept by the patient's bedside. These records consisted of charts listing physiological signs, risk assessments, medications prescribed and the treatment pathway that the patient was following.
- We looked at six sets of records and found that they had been completed correctly on all occasions. These included clinical notes, anaesthetic records, surgical records and post operation care plans. We found that all records were clear and legible as well as being signed and dated appropriately.
- The physiotherapy department held separate clinical notes to the patient record. This meant there was a risk that patient information may not be available when needed. However, senior staff told us that hospital

records were easily accessible to the clinical team when required. Theatre registers were completed for every procedure undertaken. We found that staff members involved in each procedure were easily identifiable.

Safeguarding

- Safeguarding policies and procedures were accessible to staff, which included both vulnerable adults and children guidance. Staff we spoke to knew how to locate this. Additionally, each department had a resource folder which had safeguarding pathways for staff to follow. Staff were able to describe what constituted a safeguarding concern and were able to describe how it would be escalated.
- Although the service did not provide care and treatment to children, staff were aware that children attended the service as visitors, and so a policy in relation to safeguarding children was in place.
- The policy included information and guidance for staff in relation to female genital mutilation (FGM). This was important as since October 2015, it has been mandatory for health and social care providers to provide information of any known cases of FGM to the police. All staff we spoke with in the outpatient service knew how to raise FGM as a safeguarding concern; however staff that we spoke to in the surgical services were unable to tell us about this and how it was recognised.
- The hospital had a safeguarding lead that provided advice and support if required. The hospital also undertook regular NHS and BMI audits which ensured that all safeguarding measures were up to date.
- Staff completed an on-line electronic training module as part of their mandatory training for safeguarding adults and children. 100% of staff in the hospital had completed safeguarding adult training level 1 training. Additionally, 70% of staff had completed safeguard adults level 2 training.
- PREVENT training was undertaken by staff which looked at protecting people at risk of radicalisation. The compliance rate across the hospital was 92%. PREVENT training is used to inform health care professionals about recognising extremism and radicalisation in the health care system.

Mandatory training

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- Staff received mandatory training on a rolling annual, bi annual or three year rolling programme in areas such as infection control, information governance, health and safety and fire. This included temporary staff and doctors who had BMI Healthcare as their designated body on the general medical council website.
- Mandatory training was available to all hospital staff and was mainly completed via e-learning. The e-learning modules had been developed by the BMI education team and were available to all staff employed directly by BMI.
- A process was in place to ensure staff not employed directly by the service had received the appropriate mandatory training. For clinicians that had practising privileges, mandatory training was undertaken through their primary employer. The service monitored this at the clinician's bi-annual review. The term 'practising privileges' refers to medical practitioners being granted the right to practice in an independent hospital after being approved by the medical advisory committee (MAC)
- The hospital had an overall target of 90%. Overall compliance was 90% for staff who worked in theatre; however for staff on the ward it was below the target at 70%.
- Role-specific training was provided which included things such as blood transfusion, managing violence and aggression, mental capacity and management of controlled drugs. Compliance with this was varied. For example, 72% of staff were up to date with blood transfusion training and 67% of staff were up to date with acute illness management (AIMS). Staff informed us that they sometimes struggled to find the time to complete these due to completing their daily roles.
- Mandatory training for agency and medical staff were completed by their agencies or the Trusts that employed them. The management team kept training records for the resident medical officers and monitored the training for consultants as part of the appraisal process.
- All patients received a pre-operative assessment in line with the National Institute for Health and Care Excellence (NICE) guideline CG3. The hospital had a clear policy indicating the level of assessment that patients required, which we found staff were following.
- As part of the first consultation, patients were required to complete a medical questionnaire which was reviewed by a member of staff. Changes had been made to the medication policy as a recent incident had found that not all medication was being stopped prior to undergoing surgery.
- A nurse led telephone consultation or a face to face appointment was arranged if indicated. If a patient had been scored as high risk, a referral was made to the anaesthetist for further review.
- Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify patients with any medical conditions or those deemed at risk of developing complications after surgery and a decision was made whether they could be operated on at the hospital.
- On admission, risk assessments were completed for all patients including assessments for VTE, falls and pressure ulcers. Pregnancy testing was also provided for patients of child bearing age. If a patient was at risk of bleeding, protocols were in place to request four units of cross matched blood to be ready in case of an emergency.
- A theatre team brief was held before each theatre list was started. This meeting highlighted all procedures that were being undertaken and allowed staff to confirm that the appropriate equipment was available to complete this. Additionally, any areas of risk were discussed and plans were made to manage this.
- Pre-operative marking is required to promote correct site surgery, including operating on the correct side of the patient and/or the correct anatomical location or level. The national patient safety agency (NPSA) and the Royal College of Surgeons (RCS) strongly recommend that the mark should subsequently be checked against reliable documentation to confirm it is (a) correctly located, and (b) still legible. This checking should occur at each transfer of the patient's care and end with a final verification prior to commencement of surgery. All team

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

Surgery

members should be involved in checking the mark. This was completed for the procedures we observed at the time of the inspection and site marking had been completed by the consultant prior to attending theatre.

- The 5 steps of safer surgery including the World Health Organization (WHO) surgical safety checklist identifies three phases of an operation: before the induction of anaesthesia (sign in), before the incision of the skin (time out) and before the patient leaves the operating room (sign out). In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation. We found that 'sign in' and 'time out' was completed on all occasions that we observed as part of the inspection. However, the 'sign out' phase was not completed fully in two out of three procedures that we observed.
- The BMI audit programme highlighted that documentation audits measuring compliance with the 5 steps of safer surgery including the WHO surgical safety checklist should be completed on a monthly basis. Records indicated that overall compliance was varied. There was 79% compliance in January 2016 and 80% compliance in February 2016. The main area that required improvement during this period was the 'time out' phase. However, between March 2016 and July 2016, compliance with all phases had been 100%.
- The hospital used modified versions of the WHO safety checklist for ophthalmic surgery and endoscopy procedures.
- Guidance from the National Patient Safety Agency (NPSA) states that 'stop before you block' procedures should be used when patients are undergoing an anaesthetic. 'Stop before you block' is used to prevent any avoidable patient harm caused by a wrong site anaesthetic block. The hospital used visual aids and reminders which promoted this to staff in the anaesthetic room. We observed it being completed in procedures that we were present for. The hospital did not currently have an observational audit programme measuring compliance with this.
- On the days of inspection, patients were recovered by a recovery nurse. This was done on a one to one patient to staff ratio. Recovery staff followed policy and procedures when transferring a patient to the ward.
- Paper charts were used to record baseline observations. The anaesthetist completed this during the operation and this was then continued in recovery and on the ward. This allowed staff to see any changes in a patient's condition.
- The hospital used the national early warning score (NEWS) to identify a deteriorating patient. Staff were aware of this and were able to describe when they would ask for a patient to be reviewed. This was in line with hospital policies and procedures. NEWS charts and guidance was included as part of each individual observation chart. We checked a sample of ten patient records and this had been completed correctly on all occasions.
- A sepsis screening tool (SIRS) was used to identify patients who were suffering from septic shock. This criterion was based on patient's baseline observations. If the criteria was met, the patient was reviewed immediately by the resident medical officer (RMO).
- Staff in theatre had access to a major haemorrhage pathway which was in line with Association of Anaesthetists in Great Britain and Ireland (AAGBI, 2010) guidelines. The hospital had a fridge for storing blood. This contained two units of 'o negative' blood for emergency use and cross matched blood for specific patients.
- The hospital was a member of the Lancashire Critical Care Network and had a formal written transfer agreement in place with the network to ensure patients could be transferred to a local acute trust if needed, as required by the Independent Healthcare Advisory Services (2015). Staff had access to contact details for the local trust if they were required to transfer a patient. An emergency ambulance was requested to complete the transfer.

Nursing and support staffing

- A planning meeting took place once a week which members of the management team attended. This was to determine how many staff were required to safely care for patients. This was based on the number and types of operations that had been scheduled as well as the needs of the individual patients.
- The ward used a dependency tool that calculated the number of staff required to provide a safe level of care

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and treatment to patients. This was based on assessing the level of individual patient risk which was determined by factors such as the type of surgery they were having or if they were likely to be immobile for a period of time post-surgery. However, on reviewing the number of staff needed which had been calculated using the tool, the required number had not been met on 13 separate occasions during October 2016.

- We spoke to the management team about this and we were informed that the incorrect dependency tool was being used and that they had been unaware of this. As part of the unannounced inspection, we reviewed staffing numbers for a three week period and found that the correct dependency tool was being used. For this period, the correct staffing levels had been met.
- There was a senior member of staff on duty during the day, seven days a week. Out of hours, the ward area was staffed by a number of registered nurses and there was an on call manager available if required. However, there were no clear escalation guidelines for nursing staff to follow which determined when a manager should be called apart from in the event of a serious incident.
- Nursing staff handed over patient information that they were responsible for at the end of every shift. We attended a nursing handover and found that a set handover structure was followed and that the handover process was robust.
- A high number of bank nurses were used on the ward. The average monthly use of registered bank nurses varied from 16% to 28% between June 2015 and July 2016. The hospital had also used a high number of bank health care assistants during the same period.
- In theatre, staffing levels had not met guidelines set by the Association for Perioperative Practice (AfPP). These guidelines state that if there is more than one procedure on the theatre list, the staffing requirements are a circulating nurse, an operating department practitioner (ODP), two scrub practitioners and a recovery nurse. The AfPP guidelines also state that if an operation requires a surgical first assistant (SFA), then they must be in addition to the numbers previously mentioned.
- We looked at rotas for August 2016 and September 2016. Records indicated that there had not always been sufficient numbers of staff in theatre. This was because when an SFA was needed, there was only one additional

scrub nurse present. The newly appointed theatre manager had identified this as a risk and had stopped this practice. On reviewing rotas for October 2016, staffing in theatre had been in line with AfPP guidelines.

- The use of agency staff in theatre had been high. Between June 2015 and July 2016, the monthly average varied between 7% and 22%.

Medical staffing

- Care and treatment was consultant led. The surgical team included a consultant and an anaesthetist who were employed through practising privileges. This meant that the hospital had agreed to them providing care and treatment based on their experience and qualifications.
- Once a patient had undergone surgery, the consultant who had undertaken the operation was responsible for the continued care of the patient. This included responding to a change in a patient's condition or if any advice was sought.
- There were informal arrangements if the consultant or anaesthetist who had carried out the surgery were unavailable. These included a named person, for both consultants, identified as the available contact in their absence. ,
- There was an emergency on call theatre team covering out of hours periods and were able to attend if a patient needed to return to theatre.
- The hospital had two resident medical officers (RMOs) who were employed through an agency. The RMO was available 24 hours a day, seven days a week and were resident on site. If the RMO was unable to fulfil their duties, another RMO from the same agency was provided. We saw that the RMO had an induction to the hospital and their training records were kept on site and included things such as advanced life support.
- We found that there was no formal patient handover from the consultant to the RMO. The RMO completed a daily review of all patients and was available in the hospital 24 hours, seven days a week. As a result of a recent serious incident, the RMO had been asked to make follow up calls to patients following surgery if the hospital was closed. The RMO was aware of this arrangement. However, staff informed us that on occasion a member of nursing staff completed this.

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Emergency awareness and training

- There was a corporate business continuity policy that was available on the intranet. Additionally, there were documented major incident plans for the hospital and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Fire exits were clearly indicated throughout the hospital and were free of hazards. However, we were unsure if it was possible to evacuate an anaesthetised patient through the main exit point. This was because the exit ramp was cramped and at the time of inspection a drill had not taken place to risk assess this.
- Only one member of the management team had been involved in a table top scenario which simulated a major incident. Training had not been included as part of the mandatory training that staff received. Staff that we spoke to, including other members of the management team were unsure of their role in the event of a major incident.
- The hospital had a back-up generator which was used in the event of a power failure. This had been tested regularly by the on-site maintenance team. An uninterrupted power supply was provided for the theatres when required.

Are surgery services effective?

Requires improvement 

Evidence-based care and treatment

- The service used national and best practice guidelines to care for and treat patients.
- The hospital used care pathways that had been designed by BMI and were followed when delivering care and treatment to patients. However, there were a limited number of these available. For example, there were individual pathways for hip and knee replacements as well as an endoscopy pathway. Additionally, there were general and minor surgery pathways available for all other treatments. Care pathways had been developed in accordance with National Institute for Health Care Excellence (NICE)

guidelines and The Royal College of Surgeons guidelines. These were readily available and placed in patient records for use. The care pathways incorporated the majority of documentation, including pre-admission, risk assessments and discharge records.

- Regular updates were also received from BMI, including updates on NICE guidance as well as safety and drug alerts. At bi-monthly Clinical Governance Committee meetings NICE guidance was discussed.
- The hospital had an annual audit time table that was followed by each department. Designated members of staff had the responsibility of completing these. We saw from the audit plan that performance against each monthly audit was tracked and we saw evidence that audit findings were discussed in the clinical governance meeting and the medical advisory committee (MAC) meetings but it was unclear from the minutes if areas for improvement had been identified
- Audits included compliance with completion of records and risk assessments as well as compliance with the 5 steps to safer surgery including the WHO surgical safety checklist. The audit timetable showed that most planned audits had been completed in a timely manner.
- Compliance with the National Early Warning Score (NEWS) was not part of the organisations audit programme.
- The hospital used a paper based system to record all implants used. However, they had registered with the health and social care information centre (HSCIC) to be involved in the national breast and implant register when the system is up and running. This was in line with the regulations stated in the Department of Health (2016) Review of the Regulation of Cosmetic Interventions (2016) which require that hospitals keep electronic details of implants used and should be easily accessible in the case of a product recall.

Pain relief

- Pain relief was discussed as part of the pre-operative assessment process. Each consultant had their own preference to the type of pain relief used which depended on the individual patient and the procedure that was being undertaken. This was indicated in the patient records so that it was easily identifiable for the resident medical officer and nurses.

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- Prophylactic pain relief was administered prior to surgery and pain relief was monitored by the recovery practitioner prior to discharge to the ward. The hospital used a numerical rating to assess the level of pain a patient was in. It was the responsibility of the anaesthetist to review the pain relief if required while the patient was in recovery.
- Nurses undertook hourly rounding (a system by which every patient is seen by a healthcare assistant or nurse every hour). During this patients were asked about their levels of pain. We checked a sample of ten records and found that pain scores had been recorded appropriately on all occasions. Additionally, if pain relief had been administered, we found that the efficacy of the medication administered had been recorded on five occasions.
- A pain relief audit had been undertaken as part of the BMI audit calendar in February 2016. Results from this indicated that analgesia had been given appropriately on 97% of occasions for day case patients and 82% of occasions for inpatients. Although there were areas for improvement, an action plan had not been implemented.
- Patients that we spoke to confirmed that staff had been responsive if they had been in any discomfort during their stay.
- On discharge, advice on pain management was discussed. Patients were advised to call the hospital if they felt that this required reviewing post-discharge.

Nutrition and hydration

- Patients were required to not eat for six hours or drink for two hours prior to surgery which was in line with BMI and best practice guidelines. The hospital had not completed a full audit for this (compliance with patients' not eating for six hours was not measured). This meant that they were unable to tell us about the compliance with this part of the guideline. More importantly, staff were unable to tell us if improvements needed to be made.
- Nutrition and hydration was assessed using the malnutrition universal screening tool (MUST). There was access to a dietician who was employed by another hospital. Arrangements for this were made at the pre-assessment stage if it was needed.

- Food and fluid intake was monitored using food charts and fluid balance charts. We saw that ten out of ten records that we checked all had fluid balances documented in line with BMI guidelines.
- Additional dietary advice or special requirements were discussed with the patient on arrival to the ward and daily throughout their admission. The majority of patients we spoke with said they were happy with the standard and choice of food available.
- We saw there was a selection of meals available from a menu which was available for patients.

Patient outcomes

- The hospital had collected patient reported outcome measures (PROMS) and had participated in audits undertaken by the National Joint Registry (NJR). Records indicated that outcomes for primary knee replacements and primary hip replacements had been similar to outcomes reported by similar services nationally.
- PROMS data had also been collected for groin hernia surgery but had not been able to compare outcomes for this nationally as there had only been 30 cases between April 2014 and March 2015. However, records indicated that out of 9 available records, 33% of patients had reported in an improvement following their procedure.
- The Royal College of Surgeons (RCS) recommends that providers routinely collect and report on Q-PROMs for all patients receiving procedures such as breast augmentation (enlargement) and blepharoplasty (cosmetic surgery to the eyelids). Q-PROMs are patient report outcome measures, which describe the level of patient satisfaction with certain operations. The hospital did not use the Q-PROMs recognised tool to collect patient satisfaction with the operation. There were no plans to implement this at the time of inspection.
- The Private Healthcare Market Investigation Order (2014) requires every private healthcare facility to collect a defined set of performance measures and to supply that data to the Private Healthcare Information Network (PHIN). PHIN was not available at the time of the inspection but the hospital was fully engaged with this process and was in a position to provide data when PHIN was officially launched.

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- Between June 2015 and July 2016, there had been one unplanned return to theatre. Additionally, during the same period, there had been four unplanned readmissions. This was not high when compared to a group of independent acute hospital which submitted performance data to the CQC. Records indicated that all of these incidents had been investigated so that improvements were made when needed.
- The Hospital monitored patient outcomes through surveys to ensure that patients were satisfied with the service they received. For example, Impression of consultants, nursing care and overall quality of care. Patient satisfaction was benchmarked against other BMI healthcare hospitals. Information provided by the hospital showed that in September 2016 the hospital ranked 6th out of 55 BMI healthcare hospitals. The hospital had been in the top ten BMI hospitals for the past 12 months.
- There were no formal processes in place to support staff in recognising patients who had become delirious during their stay. Staff that we spoke to had a limited understanding of this. Delirium is a state of confusion that sometimes occurs following an anaesthetic being administered, with the risk being higher for patients who are anaesthetised for a longer period of time.

Competent staff

- Staff received an annual appraisal so that achievements, development opportunities and areas for improvement were discussed. Records indicated that 100% of staff in theatre and 75% of staff on the ward had completed this between October 2015 and September 2016.
- Competencies were assessed for all roles including but not limited to health care assistants, registered nurses, operating department practitioners and scrub nurses. We sampled a number of staff records to check that they had completed and were up to date with competencies for the role that they were undertaking.
- We found that the recovery practitioner had not completed competency checks. The management team had not implemented a risk assessment to manage potential risks to patient safety associated with this. This meant that we had limited assurance as to whether the recovery nurse had the correct skills to undertake the

role. We sought further assurance from the management team following the inspection. We were informed that a competency check had been implemented and was to be completed by December 2016. We were also given assurance of how this role would be carried out safely in the meantime.

- The competence of staff to complete pre-operative assessments had not been assessed or they were not up to date for all those who completed this role.
- Other staff in theatre and on the ward did have completed competency checks. This included operating department practitioners, nursing staff and health care assistants.
- The perioperative care collaborative (PCC) had set out clear guidance for competencies of surgical first assistants (SFA). The SFA role involved assisting consultants with key skills such as retraction and the movement of internal organs during procedures. These skills were in addition to those of a scrub practitioner.
- The PCC position statement regarding the SFA (2012) stated that this must be undertaken by someone who has successfully achieved a programme of study that has been benchmarked against nationally recognised competencies underpinning the knowledge and skills required for the role.
- Staff informed us that the hospital had not complied with these guidelines under the old management team. The new management team had recognised this gap and there was one member of staff who was enrolled to start an external course in December 2016 to achieve the correct competencies. A risk assessment had been completed to manage this in the interim. This included the member of staff having a named consultant mentor as well as all skills performed being under the supervision of the operating surgeon.
- The hospital had a policy for staff commencing employment at the hospital. New staff received a hospital induction as well as a supernumerary period. This meant that staff had the opportunity to work alongside a more experienced member of staff without having the responsibility of looking after patients. Records indicated that staff had received these.

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- The hospital had an induction checklist that a member of agency staff undertaking their first shift had to complete and sign. This included things such as receiving an orientation.
- Doctors working at the hospital did so under practicing privileges. Practicing privileges refer to medical practitioners not directly employed by the hospital who have permission to practice there. The hospital had a policy for granting and reviewing practising privileges. All doctors who worked under practicing privileges provided evidence of their disclosure and barring service (DBS) checks and indemnity insurance. This was verified by the hospital's medical advisory committee (MAC). All applications had been reviewed by the medical advisory committee who ensured that they had undertaken the treatment they had applied to provide on a regular basis.
- We reviewed the personal files of 15 doctors working at the hospital and saw that practicing privileges arrangements had been recorded. However there were no up to date appraisals on three files.
- The hospital had a system in place to ensure qualified nursing staff continued to maintain their registration. Information supplied by the hospital showed 100% completion rate of validation of registration for nurses and for doctors working under practicing privileges.
- We observed a theatre team huddle, which was well organised. Any issues for the day were discussed using a communication book as were the individual needs of the patients.
- We attended a daily morning communication cell meeting. We saw that it was well attended by all departments throughout the hospital and included both junior and senior members of staff. This meant there was effective communication and staff were aware of concerns across the hospital.

Seven-day services

- Surgery was scheduled between Monday and Saturday on a weekly basis. The inpatient ward area was open and staffed 24 hours a day, seven days a week when required. The hospital closed on some days throughout the year, including when there were no inpatients. The hospital had a 24 hour theatre on call team available if patients needed to return for further treatment.
- At times when the hospital was closed, arrangements had been made with a nearby hospital for patients to attend if they had concerns that required further review.
- The consultant and anaesthetist responsible for delivering treatment were on-call 24 hours a day if further advice was needed. In the event of them not being available, they arranged cover that was provided by another consultant who worked in the hospital. The resident medical officer confirmed that there were not normally any problems contacting someone if required.
- Pharmacy services were available five days a week during normal working hours. Procedures were in place for the resident medical officer to access medication if it was unavailable.
- Other diagnostics such as pathology (blood testing) were also based on site and were available five days a week. Arrangements were in place to access pathology services at a different hospital if needed.

Multidisciplinary working

- The theatre and ward managers held a weekly planning meeting that was used to discuss the individual needs of patients who attended for treatment. Staffing numbers and equipment required were discussed during this meeting.
- Members of the pre-operation assessment clinic worked closely with the physiotherapy department. This meant that patient's rehabilitation needs were considered before treatment so appropriate arrangements were made if necessary.
- Staff liaised with a number of different services when co-ordinating a patients discharge. This included hospitals and community services, depending on where the patient was from.

Access to information

- Staff had access to information using computers that were available. This included access to the internet and intranet which included hospital policies and procedures as well the email system.
- When a patient was discharged, a paper discharge form was sent to the patients GP. However, information about

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implants (including prosthesis) was not sent as part of this. This was not in line with the Review of the Regulation of Cosmetic Interventions (2014) which stated that details of the surgery and any implant used must be sent the patient's GP.

- Hospital policies were accessible to staff that had access to the electronic system. Care pathways were pre-printed documents that all staff had access to as part of the patient records. Continuity of patient care was maintained as all individual patient records and medication charts were paper based, so all staff were able to use them.
- On discharge, a form was completed. This was sent to the GP and a copy was given to the patient. This included information about treatment that had been provided and any changes to medication. It also included information about the treatment they had received during the time at the hospital.
- All patient records are kept on site for 18 months and then archived following a patient discharge. If a patient re-attended for further treatment, the hospital was able to request the old records if required.
- Patient Information was protected, records were kept in secure storage, and all computers were password protected. The hospital had a Caldecott guardian who was a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had in place a mental capacity act policy which incorporated deprivation of liberty safeguards (DoLS). DoLS is part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. The policy included capacity assessment and best interest forms for staff to complete.
- The policy stated that all staff should undertake an e-learning course which covered MCA and DoLS.

Additionally, they should undertake a three yearly update. However, from the training records provided by the hospital there was no record of any staff compliant with this training.

- If staff had concerns at the weekend or out of hours, advice was sought from the resident medical officer or the on-call manager. Staff that we spoke to had a basic understanding of MCA and DoLS and what their responsibilities were if they found that a patient lacked the capacity to make a decision.
- Consultants completed consent forms at different times. Some completed them at the pre-admission stage and they were then confirmed on the day of treatment. Others completed them on admission, which included patients undergoing cosmetic surgery.
- We reviewed a sample of ten patient records, and found that consent had been obtained on all occasions. Patients that we spoke to confirmed that their treatment had been discussed with them. This included any possible risks that were associated with the treatment that they were having.
- The management team had undertaken audits for compliance with consent guidelines in March 2016 and June 2016. Results for both periods were 83%. When asked, staff were unaware of improvements that were required to increase compliance with this.
- There was no formal guidance for consultants to adhere to regarding the 'two week cool off period' which is recommended by the Royal College of Surgeons professional standards for cosmetic surgery (2016). On reviewing a sample of ten patient records, we found that this had been adhered to on all occasions. Staff confirmed that information was given to patients about their right to cancel during the initial consultation.
- We reviewed the patient exclusion policy and saw that under the equality impact assessment the policy did not affect one group of people less or more favourably than another including those patients with learning, physical, sensory disabilities or impairment and mental health disorders.

Are surgery services caring?

Surgery

Good 

Compassionate care

- Care and treatment at the hospital was delivered in a compassionate and caring way. We observed how staff interacted with patients in a positive way. Staff introduced themselves and behaved in a courteous manner.
- The privacy and dignity of patients was maintained at all times. This included drawing curtains or closing doors when examination was taking place. We observed staff knocking on patient's doors before entering.
- We observed staff in theatre ensuring that patients were treated in a caring way once anaesthetised. We saw staff taking care when moving and handling patients and they ensured that the patient was covered appropriately at all times.
- Physiotherapy staff took time to support patients with mobility following surgery in a caring way. This helped patients build confidence and promoted recovery. Patients also informed us that the nursing staff had done a 'great job' in supporting them to do things independently such as washing and dressing.
- Patients that we spoke to were positive about the care and treatment that they had received at the hospital. Patients told us that they knew who was looking after them and that they had been treated in a caring way.
- Patient led assessments of the care environment (PLACE) showed that 91% of patients thought that their privacy and dignity had been maintained during their time at the hospital.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The hospital collected test data for all NHS-funded patients that were seen at the hospital.
- The test data between January 2016 and June 2016 showed the hospital had consistently achieved scores of between 98% and 100% with response rates between 56% and 71%. This showed that patients were very

positive about recommending the hospital to their friends and family. The patient scores and response rates were similar to the England average for independent sector NHS patients during this period.

Understanding and involvement of patients and those close to them

- Consideration was given to the ongoing needs of the patient and their relatives during the pre-admission assessments. Records indicated that arrangements for discharge had often been made during the initial assessment.
- We checked a sample of ten records. These indicated that staff had had conversations with relatives to discuss the patient's treatment on seven occasions.
- All patients we spoke with told us that their treatment had been discussed with them and that they were fully aware of the plan for their care. On one occasion we observed staff discussing the process of what would happen both before and after surgery with a patient.
- Relatives were encouraged to visit when possible. When a patient was discharged, staff involved relatives when providing information of what to do over the next few days or if there were any concerns.
- In the hospital patient satisfaction survey for August 2016, 100% of patients said that they were involved in discussion about their care.

Emotional support

- Staff provided regular support to patients by completing comfort rounds on an hourly basis. This included checking if a patient needed anything, including food and drink and pain relief.
- Staff spent time with patients, discussing any fears or anxieties that they had before, during or after treatment. We saw members of staff comforting patients on their way to theatre and in the anaesthetic room. Additionally, we saw staff providing emotional support to patients when they were recovering from an anaesthetic.
- Contact details were given to patients when they were discharged. They were able to contact staff at the hospital 24 hours a day, seven days a week if they had any concerns or anxieties.

Surgery

Are surgery services responsive?

Good 

Service planning and delivery to meet the needs of local people

- The exclusion contract criteria for NHS patients were no patients under the age of 18, no patients with a body mass index (BMI) exceeding 40, no patients with an incapacitating disease that posed a constant threat to life, e.g. cancer, patients who had previously experienced an adverse reaction to anaesthetics and patients who were undergoing treatment for a mental health condition. For private patients all these criteria did not automatically apply and decisions were made on a case by case basis.
- In the year July 2015 to June 2016, 70% of the patients were funded by the NHS. We were told that admission process and care provided was the same for self-funded patients and NHS patients.
- Referrals to the service were mainly from GP's, and this was done electronically. Once a referral had been made, an appointment was made to see the consultant who was able to provide the treatment required. Patients had the option to choose the date of their pre-operation assessment as well as the date of their admission.
- At the initial assessment stage, the service was able to assess whether they had the correct staff and resources to provide the care and treatment that was needed. If they did not, then the patient was referred back to the GP and treatment was provided by a different service. That meant that the hospital were able to control the level of care that was given.
- The hospital used BMI care pathways when planning and delivering treatment. This meant that things such as discharge planning and pain control were discussed at the initial assessment stage. For example, if a patient was having a joint replacement, consideration was given to the type of accommodation they lived in and how much support they had from carers, family members or friends. This allowed appropriate arrangements to be made for discharge before the patient received treatment.

- The hospital provided individual en-suite rooms for inpatients which allowed privacy to be maintained. The hospital provided shower facilities in all rooms. However, modernisation of the ward area had not yet started and the hospital were unable to provide a definitive date for when this would start.
- Additionally, the hospital used two rooms that had been adapted to accommodate ambulatory patients who were undertaking procedures such as endoscopy or were having pain management injections administered. Two separate rooms were used so that the service ensured that guidance on mixed sex accommodation was adhered to.

Access and flow

- The hospital reported that over 90% of admitted NHS patients began treatment within 18 weeks of referral for each month between July 2015 and June 2016. The only exception to this was in September 2015, when this national indicator was met on only 84% of occasions. Elective waiting times were reviewed by staff to identify patients approaching the 18 week wait period and these patients were prioritised so they could be begin treatment prior to breaching the 18 week wait time national indicator.
- Between July 2015 and June 2016, there had been a total of 2,774 attendances to theatre. 2,306 of these were day case attendances and 497 had been inpatient admissions.
- The BMI admissions policy provided clear guidelines relating to pre-operation assessments. As part of a patient's initial consultation, they completed a medical questionnaire which was reviewed by a member of the pre-operation assessment team. Depending on the level of risk to the patient a decision was made if a patient required a pre-operative telephone assessment or a face to face assessment. Following this, patients were referred for anaesthetic review if required.
- Admission times were staggered throughout the day so that patients did not have to wait for a long period of time once admitted. However, on a small number of occasions delays occurred. Reasons for this included consultants being late for surgery and operations that had overrun.

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- The duration of a patient stay was estimated during the admission assessment and was based on the individual need of the patient as well as the type of treatment that was being provided.
- The service had attempted to keep the number of cancellations for treatment to a minimum. The hospital recorded all incidents of cancellations for both clinical and non-clinical reasons so that future improvements were made. Between July 2015 and June 2016, the hospital had reported surgery had been cancelled on 16 occasions for non-clinical reasons. The main reasons for this were problems with booking or Consultants not attending on the day. All patients that had procedures cancelled were offered another appointment within 28 working days.
- Between July 2015 and June 2016, there had been 11 patient transfers to another hospital (which was higher than the national average for similar services). The reasons for these were mainly as a result of a patient deteriorating and requiring a higher level of care than the hospital was able to provide. The management team had reviewed these incidents so that improvements could be made if this was indicated.
- However, dementia training was available for staff via an e-learning module. Records indicated that 90% of identified staff in the hospital had completed this.
- There was easy access for patients of relatives who used a wheelchair. The hospital had a ramp which led to the entrance of the hospital and had elevators to transport patients to the first floor if needed.
- There was access to psychological services that were provided by another hospital if required. If a patient was having cosmetic surgery, the consultants providing the treatment made referrals to their own preferred services if needed. Additionally, there was a cosmetic lead nurse who was part of all cosmetic surgery pre-admission assessments and was sensitive to the needs of patients undergoing this type of treatment.

Learning from complaints and concerns

Meeting people's individual needs

- The hospital provided a range of information leaflets about different conditions and treatments. For example, there was a leaflet for having a hip replacement which described what to expect before, during and after treatment. These leaflets were only available in English. Additionally, staff informed us that leaflets were not currently available in another language.
- The hospital had access to translation services and interpreters if required. The needs of the patient and family were assessed during the initial assessment and a translator or an interpreter was booked in advance if needed.
- The hospital had not made any reasonable adjustments to the facilities that met the needs of patients living with dementia. Staff were able to give some examples of how a patient living with dementia would be managed and we were told that it was very rare that a patient was accepted for treatment at the hospital. This was because patients were assessed for mental capacity during the initial assessment stage.
- The hospital had a policy for managing complaints and concerns. Staff that we spoke with were able to tell us about the complaints process and that if a complaint or concern was raised, it was escalated to the department manager. There were leaflets in the main reception area that staff were able to give the patients if they wanted to make a formal complaint.
- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 20 working days for routine complaints. Where the complaint investigation had not been completed within 20 working days, staff were required to send a holding letter explaining why a response had not been sent, followed by further holding letters every 20 days until the complaint was resolved.
- This was monitored in management team meetings, ensuring that the hospital met this target. Staff informed us that the hospital manager had oversight of this process and responsibility for making sure that BMI policy was adhered to. The management team told us that if it was taking longer than this, communication was made with the complainant and a new timescale was agreed.
- The number of complaints that the hospital had received had been similar since 2013. Records indicated that there had been 37 complaints between April 2015 and March 2016.

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- Minutes of meetings indicated that complaints and concerns were discussed at management team meetings and as part of the medical advisory committee (MAC) meetings.
- Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns with the Independent Sector Complaints Adjudication Service (ISCAS) for privately funded patients.
- Records indicated that between July 2015 and June 2016, there had been one referral made to ISCAS for further investigation.

Are surgery services well-led?

Requires improvement 

Vision and strategy for this this core service

- BMI had a corporate vision and strategy for the company as a whole leading up to 2020. This was for patients to have the best experience, the best outcomes in the most cost effective way. Additionally, there were eight strategic priorities. These were having an effective governance framework, superior patient care, performance and culture, financial growth, maximising efficiency and cost management, facilities and sustainability, internal and external communication as well as information management.
- The hospital had identified their own priorities locally to develop services that they provided in line with the corporate vision and strategy. The management team informed us that the overall aim was to provide exceptional care and the best patient experience.
- The hospital's vision and strategy had been developed by taking the hospital's strengths and weaknesses into consideration. The management team had also identified opportunities for further growth and some of the key risks that the hospital currently faced.
- The management team informed us that they used staff appraisal to engage them fully with this. However, staff that we spoke to were not sure about what the vision and strategy was, although they told us that their priority was to provide the best possible patient care.

Governance, risk management and quality measurement

- The hospital had a newly appointed management team who were in the process of identifying any gaps in governance and assurance. However, this process had not yet been completed and therefore resulting changes were not embedded fully across the hospital.
- The risk management policy and procedures were new documents issued in August 2016. Due to this any changes to the management of risks had not been fully implemented or embedded.
- The risk register was a generic document provided by the corporate team (external to the hospital) and risk rated by the hospital staff. Additional information, such as actions to be taken were added to the document to localise some of the risks. This included the categories and controls in place mapped into these categories. Further actions required had also been identified and ownership for risks was documented.
- However, there had been no date set for review of risks to ensure ongoing assessment of the level of risk. There were no completion dates included.
- There were examples of where the hospital had put controls in place to mitigate the level of certain risks. However, we found that they had not always been implemented in a timely manner. This meant that we were not assured that some risks were managed fully.
- Managers had not ensured that a key member of staff had the formal competencies for their role and had not taken steps to manage potential risks to patient safety associated with this. We therefore had limited assurance that the member of staff had the correct skills to undertake the role, although there was no evidence to suggest they were not capable of doing the job. We sought further assurance from the management team following the inspection and were told that competency checks would be completed by December 2016. In the meantime, the member of staff would be shadowed by someone with the relevant competencies.
- Between the period of June 2015 and July 2016, the hospital had received a Regulation 28 report from the coroner. A Regulation 28 is a report that the coroner has

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a duty to make where they believe action should be taken to prevent future deaths. The report highlights areas where failings occurred and improvements are required.

- The management team had implemented an action plan regarding this. Some actions had been completed in a timely manner. For example, further education about Venous Thrombo-Embolism had been delivered. Staff confirmed that they had completed this. Also, improvements in the way risk assessments were communicated to the operating surgeon required improvement. A process was now in place that involved the surgeon signing to say that they had read all of the relevant information prior to surgery. We observed this being completed on a number of occasions.
- However, there was an area of the action plan that had not been completed in a timely manner. The pre-operation assessment nurses should have received training about changes to the medication policy. This had not been delivered.
- The risk management plan did not include risks identified from the Regulation 28 report by the coroner. This meant that the level of these risks had not been formally calculated.
- Some actions that had been implemented had not been monitored to ensure compliance and improvement. An example of this was that monitoring of compliance with the new medication policy had not taken place. The person who had responsibility for this was unaware that this was their role. Subsequently, the senior management team were unaware of this gap in their actions for improvement.
- The theatre manager had begun to compile a list of risks for the theatre area. However, this was still in its infancy stage and had not yet been adapted into a formal tool. This was because although certain actions had been taken to stop poor practice, all controls and actions to manage these risks had not yet been identified and implemented. However, the senior management team confirmed that they had held meetings with the theatre manager and were supporting them to achieve this.
- The hospital had introduced a daily communications meeting which all staff were invited to attend. We found that this allowed staff to raise any issues or for the management team to disseminate any learning or anything that staff needed to be aware of. Additionally, the management team held a number of meetings at different levels. At departmental level, the ward and theatre teams met monthly. Any issues from these were fed to the senior management team meeting and the medical advisory committee (MAC) who had overall oversight.
- The hospital had a Clinical Governance Committee as part of its governance structure. We reviewed minutes from December 2015 to June 2016. The minutes varied in quality and did not always give sufficient detail to demonstrate challenge, discussion or urgency of any agreed actions. For example, for the Incident and RCA section in June 2016 the minute stated 'PM went through the above incidents, elaborating as appropriate'. This does not provide sufficient detail to review progress between meetings.
- The BMI corporate team received regular patient safety alerts as well as updates from the National Safety Standards for Invasive procedures (NatSSIP). These were then cascaded to the hospital for implementation. However, the management team had not developed an action plan against current gaps in practice. This was important as it had been introduced to support providers in reducing the number of avoidable patient safety incidents.
- The chair of the medical advisory committee (MAC) was able to identify what had been discussed in recent meetings and informed us that there was positive engagement from the other members of the committee.
- The MAC had clear terms of reference which included consultants from different specialities asked to attend. We saw minutes of these meetings and found that topics such as National Institute for Health Care Excellence (NICE) guidance, incidents and complaints and mortality were discussed. The chair of the medical advisory committee was able to identify the key risks and challenges that the hospital currently faced. The MAC also had oversight for reviewing applications for consultants to work at the hospital under practicing privileges.
- We reviewed 15 consultant's personnel files. Not all information required was present in these files which included the most up to date appraisal and signed copies of the practising privileges terms and conditions.

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We were told until September 2016 these files had been held at another local BMI hospital and since they had been returned to this hospital it had been recognised not all necessary documentation was present. There was a plan in place to improve this and ensure the requirements were met.

- The hospital ensured that all consultants working under practicing privileges had the appropriate indemnity cover. Evidence of this was documented in their individual files.
- The MAC had a system where individual performance could be fed back to the consultant's employer when needed. However, we found one file that had not been updated with important information for a number of years. The documentation stated that practicing privileges had been removed and there was no documentation to say that they had been reinstated despite the Consultant still practising. We received evidence following the inspection that the Consultant had been deemed fit to practice, but the management team acknowledged that there was a gap in documentation.
- Incidents and complaints were investigated by the appropriate members of staff and oversight of this process was provided by the hospital director. Outcomes and learning from incidents and complaints was disseminated to staff through team meetings or by email.
- A BMI audit plan was used to monitor levels of compliance with care and treatment provided. Results of these were discussed as part of senior management meetings and at the medical advisory committee meetings. Compliance with treatment provided to NHS funded patients was monitored through key performance indicators.
- There were no arrangements to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT. SNOMED-CT uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems. Additionally, the hospital did not currently submit patient outcome measures for cosmetic surgery which was used to measure patient satisfaction and provide a comparison to similar services nationally.
- Staff told us that they felt the new management team were both visible and approachable. They felt supported and if they had any issues they were able to raise them. The managers were present during the day in the various departments and the size and layout of the hospital meant they were easily accessible.
- The hospital manager conducted staff forums quarterly at which feedback on any corporate developments, hospital performance, people development/ opportunities and governance framework was communicated.
- Staff told us they enjoyed working at the hospital and felt that they delivered a high standard of patient care. They were proud that they were able to deliver such a good service.
- We were concerned that the joint arrangements for managing the inpatient ward and outpatient services did not allow a complete overview of issues in each area.
- The theatre manager had only been in post for four weeks. This meant that there had not been sufficient time to identify all areas that required improvement and make changes where needed. However, staff informed us that there had been a change in culture since the new management team had been in place and that they felt supported.
- Staff throughout the hospital described a friendly and open culture.
- The management team were open and honest throughout the inspection and acknowledged the areas for improvement which were discussed.
- Sickness rates for nursing staff had been low between June 2015 and July 2016, with the highest monthly average being 20% in September 2015. The monthly average for sickness had been 0% on seven occasions during this period. Additionally, staff turnover was low. Between the same period 10% of staff had sought employment outside of the organisation.

Public and staff engagement

- BMI undertake a staff survey on a bi-annual basis. We were provided with the Lancaster results from the 2016 survey, comparing results to the 2014 survey. Only 39% of staff were 'likely' or 'extremely likely' to recommend

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BMI Healthcare as an employer with 54% proud to work for BMI. Only 31% felt valued as an employee, which was a drop of 6.6% since 2014. However, 78% saw themselves working for the company in twelve months' time.






- Staff reported positively in the survey about their team members with 92% saying they could rely on the other people in their team and many positive responses about their autonomy and support from line managers.
- There was no action plan in place to improve the staff survey results. However, a number of staff forums had been held under the interim management arrangements and there was an intention to develop an action plan.
- Staff were rewarded for exemplary performance through an 'above and beyond' staff reward programme. Anyone could nominate another member of staff for any reason. We saw evidence that staff had participated in the programme.
- Feedback was sought from inpatients via postcard questionnaires and a more in-depth questionnaire. The

resulting feedback, both positive and negative was shared at the daily communication cell, monthly head of department meetings and recorded within the clinical governance reports. This information was used to improve practices where necessary.

Innovation, improvement and sustainability

- There was acknowledgement from the management team that improvements were required in several areas of the service, especially the governance and risk management. Plans to make these improvements were underway and had been shared with leaders of parts of the service where appropriate.
- They were open about the fact staff had not been as involved as they should have been in the development and improvement of the service. There were plans to improve this.
- Staff of all grades were focused on providing a good service to patients. There had not been an emphasis on innovation but there was anticipation that this would change with the new management team.

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement 

Incidents

- See the Surgery section for main findings.
- In the last 12 months outpatient services at the hospital reported no never events. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between August 2015 and June 2016 outpatient and radiology services at the hospital reported 16 incidents. Of these, none were reported as severe harm with the majority being reported as low or no harm to patients. The biggest risk was the cancellation or rescheduling of clinics due to consultants running late or not being able to attend. These incidents were currently being investigated to see if there was any learning or actions that needed to be put in place to mitigate the risk of cancelled clinics.
- Between August 2015 and June 2016 there had been no serious incidents reported in outpatient or radiology services at the hospital.
- The service had not reported any Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or magnet related events incidents in the last 12 months.

- The manager of outpatients said that information from incidents was shared in emails and in newsletters. We saw copies of the clinical governance and quality and risk bulletin in the department which outlined key learning points from incidents.
- Staff were able to describe an example of a change following an incident where additional checks have been put in place following an incident where a patient had received an additional x-ray when they came out of theatre. The second x-ray was not required. The incident caused no harm to the patient.
- Information about incidents was discussed for outpatient services as part of clinical governance meetings each month as well as the medical advisory meeting (MAC). The report included learning and actions taken following incidents.
- The hospital reported there had been no patient deaths following discharge from outpatient clinic between July 2015 and June 2016. There was a process in place so that if a patient death occurred at the hospital, it would be reviewed and investigated through the hospital's

Cleanliness, infection control and hygiene

- See the Surgery section for main findings.
- Staff followed good practice guidance in relation to the control and prevention of infection in line with hospital policies and procedures. There was a sufficient hand gel in consulting rooms and at the entrance to departments. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment where appropriate.

Outpatients and diagnostic imaging

- The departments used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Monthly hand hygiene audits were undertaken by staff being observed. Results were 100% across outpatient services.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use.
- We looked at the cleaning checklists for the consulting rooms and found that the majority had been completed. However, there were some areas that had not been fully checked. Weeks commencing 29 September 2016, 3 October 2016, 10 October 2016, 17 October 2016 and 24 October 2016.
- The outpatients, diagnostic imaging and therapy department were visibly clean, tidy and free from clutter. An infection control lead was available and had introduced a checklist for each area of the service. These were collected and reviewed on a monthly basis in order to make sure that a consistent approach to cleanliness and the prevention of infection was available.
- There was an appointed link in the outpatient department for infection prevention and control who was responsible for coordinating audits. Staff we spoke to all confirmed that they were aware of infection control audits and who to contact should they need guidance and support.
- We saw the risk assessment and policy for nasal endoscopy. The policy stated the equipment was to be cleaned in a separate space to where the procedure had occurred in order to reduce any risks of the spread of infection. We observed there was an appropriate area that was used to clean the nasal endoscopes in-between patients.
- Seating within the waiting areas of the outpatient department and radiography department did not assist in the prevention of the spread of infection. The seating and some flooring was not washable or wipe clean, so if it became soiled could present a risk of infection.
- There was carpet on the floor in some of the consulting rooms, physiotherapy department and in the corridor on the outpatient department. This increased the risk of infection. This had been risk assessed and there was a programme in place to replace the carpets with appropriate flooring. However, no timeframe had been identified to replace the carpet

Environment and equipment

- See the Surgery section for main findings.
- There was no separate dirty utility room in the outpatient department which meant staff were disposing of waste, such as urine samples, in the treatment room. Processes had been put in place to ensure that the risk of decontamination was reduced but there had been no formal risk assessment completed.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place in the outpatient department.
- There were systems to maintain and service equipment as required. Records indicated that defibrillator equipment had been checked.
- Electrical testing had been carried out on electrical equipment regularly and electrical safety certificates were in date.
- Staff told us they always had access to equipment and instruments they needed to meet patients' needs, and confirmed any faulty equipment was either repaired or replaced promptly.
- Staff confirmed that they checked single-use sterile instruments in order to make sure they were in date. We saw that all the majority of single use instruments were all within their expiry dates. There were cervix brushes that had an expiry date of April 2014. This was brought to the attention of staff who said others were on order.
- The diagnostics imaging department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were available for staff to refer to. This ensured that patients were not exposed to excess levels of radiation

Outpatients and diagnostic imaging

- All diagnostics and imaging equipment had routine quality assurance and calibration checks in place to ensure the equipment was working effectively and protective gowns were clean and free from damage.
- Staff working in radiation areas wore personal radiation monitoring devices or dosimeters (PMDs). The PMD's detect various forms of radiation a worker may be exposed to. The dosimeter or badge detects the exposure of a person to x-rays, gamma radiation, neutron and beta particles. We saw that staff were required to wear the PMD's. Accumulated doses from the various types of radiation was measured by the dosimetry service provider and reported back to the hospital and were clearly displayed on the wall in the radiology department.

Medicines

- See the Surgery section for main findings.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were consistently completed in the departments we visited. Staff were able to tell us the system identified to follow up if there were gaps in these records.
- Controlled drugs (medicines which are required to be stored and recorded separately) were stored and recorded appropriately. Access was limited to qualified staff employed by the hospital.
- Suitable cupboard and cabinets were in place to store medicines. We sample checked medicines on the outpatient department and found them to be in date, indicating there was good stock management systems in place.
- Emergency medicines were available for use and records indicated that these were regularly checked and were in containers with tamper-seals in place.
- Pharmacy staff were available for the outpatient department Monday to Friday 8.30am to 3pm with out of hours support covered by an on-call pharmacist and support from the RMO.
- There were monthly medicines management audits which looked at compliance with storage and stock levels of medicines. Where there were gaps in standards actions had been put in place, for example, external and

internal preparations are stored separately in the main drug cupboard. We observed that prescription pads were kept securely. Records reflected that each prescription was logged with its number requested by a consultant. We observed them being signed out by staff and recorded when a consultant requested one.

- If a patient required an injection in the outpatient clinic, there was a clear recording form which was completed by the healthcare assistant or nurse to ensure that the correct drug was administered by the consultant. The completed form was then kept in the patient record.
- Treatment and medicines administered in the radiology department were recorded in a treatment records book. We saw that patient details, date and procedure undertaken were accurately recorded.

Records

- We reviewed 12 patient records of patients that had been seen in the outpatient clinic the previous two weeks to the inspection. We found that in 10 of these there had been no clinical entry made on the day of consultation. On eight occasions, copies of letters that had been sent to the patient's GP did not appear to have been signed by a consultant. This was not in line with the Royal College of Surgeons Good Practice Guidance 2014.
- Additionally, there were four records in which the letter from the consultation had not yet been completed. We were told that this takes approximately five working days. This meant that accurate, complete and contemporaneous records had not been kept in respect of each patient. The records were not immediately available if needed and had not been authorised by the appropriate person.
- The hospital used paper-based records. Patient records were stored securely, and access was limited to those who needed to use them.
- The physiotherapy department held separate clinical notes to the patient record. This meant there was a risk that patient information may not be available when needed. However, senior staff told us that hospital records were easily accessible to the clinical team when required. We reviewed six physiotherapy records and entries were all legible, dated, timed and signed. The

Outpatients and diagnostic imaging

hospital did not undertake any medical records audits associated with outpatient and diagnostic imaging records to ensure compliance with identified standards for record keeping.

- Radiology information was available to clinicians who needed it. The service currently kept radiological images as a hard copy and not electronically. We were told that they intended to implement an electronic Picture Archiving and Communication System (PACS) in September 2016. However, this was still not in place at the time of the inspection but the assessment had been completed. This would allow for shared access throughout the hospital and the other two hospitals that work together within the local cluster.
- Patient records were requested by the administration and clerical staff in advance of a clinic to allow sufficient time to identify any gaps or issues. Patient files were checked and set up by the healthcare assistants in advance of the appointment. This was done in order to make sure that patient records were readily available and checked for accuracy and completeness. Records were taken back to the medical records storage area after the clinics. We were informed that consultants were not able to remove patient records from the hospital to ensure patient notes were always available.
- Staff told us that they had no issues with accessing patient's notes for their clinics, and they could not remember a time when patient records were not available. Information provided by the hospital showed that from June 2015 to July 2016, all patients were seen with their medical notes being present.

Safeguarding

- See the Surgery section for main findings
- Staff completed an on-line electronic learning training module as part of their mandatory training for safeguarding adults and children. At the time of our inspection, 100% of outpatient staff including reception staff had completed safeguarding adult training level 1 training.
- Basic Safeguarding training was included in induction training for all temporary staff before commencing work in the departments

- Staff and managers in the outpatient department we spoke to were able to explain the process if a safeguarding concern was identified and how they would make sure that this was appropriately actioned.
- We observed staff in the outpatient department appropriately referring safeguarding issues following an individual coming into the hospital off the streets that required help and care. This was dealt with in a caring and appropriate manner.

Mandatory training

- See the Surgery section for main findings
- At the time of our inspection, 78% of staff in the outpatient department, 100% in physiotherapy and 94% in radiology and diagnostic imaging had completed their mandatory training. The target was 90%.
- Staff reported that they were aware of what training was available and when they needed to complete it by. They told us that they were encouraged and supported to complete the on line training and to remain up to date with their training needs.

Assessing and responding to patient risk

- The Five Steps to Safer Surgery includes the world health organisation (WHO) safe surgery checklist. The WHO checklist identifies three phases of an operation or procedure: before the induction of anaesthesia (sign in), before the incision of the skin (time out) and before the patient leaves the operating or procedure room (sign out). In each phase, a checklist coordinator must confirm that the team has completed the listed tasks before it proceeds with the operation.
- This was used in the radiology department when undertaking procedures using local anaesthetic, for example pain injections. In September 2016 an audit showed compliance with the world health organisation (WHO) surgical safety checklist was 100%.
- Staff involved in diagnostic imaging demonstrated an understanding of their role with regards to Ionising Radiation (Medical Exposure) regulations 2000 (IR(ME)R) and protecting patients from the risks of unnecessary exposure to radiation. We saw that staff on the department had an IRMER file containing the regulations and guidance.

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- The hospital had an appointed radiation protection supervisor and a radiation protection adviser (RPA) in accordance with IR(ME)R regulations.
- An IR(ME)R review of radiology equipment was undertaken every 12 months. The radiation protection supervisor conducted audits and produced risk assessments in accordance with IR(ME)R requirements.
- The hospital had an examination of females of child bearing age policy, which included a pathway flowchart for staff to follow. However, staff in the radiology department told us that they do not carry out X-rays or scans on pregnant women. Warnings signs asking patients to tell staff if they may be pregnant were clearly displayed on doors into radiation controlled areas. This was to help protect an unborn child from radiation exposure which may cause it harm. We reviewed six records and found that information regarding the date of the last menstrual period and pregnancy status had been completed appropriately.
- There was electronic signage in the radiology waiting area to inform patients that radiation exposure was taking place. We observed that the electronic signage was in working order.
- In line with IR(ME)R regulations, there was an up to date list of staff approved to request x-rays. There was guidance available on appropriate requesting of radiation diagnostic tests and staff were confident to challenge inappropriate requests.
- There was a procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated whilst on the hospital premises. required by the Independent Healthcare Advisory Services (2015). Staff told us they had a number to contact the local trust if they required to transfer a patient, however if the patient was deteriorating fast they would call for an emergency ambulance to transfer.
- There was a nurse call bell system and there was an additional light system to indicate which room the emergency had occurred in.
- When patients were being referred for surgery from the outpatient clinic, they completed a health questionnaire prior to the pre-assessment clinic appointment. This identified any key risk areas, for example allergies and adverse reactions, past cardiovascular (heart) problems

and any known blood disorders. We saw completed health questionnaires in one of the notes we reviewed and observed a patient completing one following their consultation.

- The physiotherapy department conducted risk assessments before they authorised the use of equipment in order to maintain patient safety, and meet their individual needs.
- Staff in the service undertook basic life support and immediate life support training. At the time of the inspection the compliance rate was 100% for both basic life support training and immediate life support training.

Nursing staffing

- The out patient department had a sufficient number of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Registered nurses worked three days a week and healthcare assistants worked five days a week. Consultants and patients we spoke to confirmed there had been no impact on care provided for patients using this model of working. There were a limited number of procedures that the nursing and support staff undertook and competencies were in place to support this.
- There was no use of bank and agency between July 2015 and June 2016. At the time of the inspection there were no staff vacancies in the outpatient department.
- There was no use of bank and agency healthcare assistant staff between July 2015 and June 2016.
- Between July 2015 and June 2016 the turnover rate for nursing and healthcare assistants was zero.
- There was zero rate of sickness for nurses and healthcare staff working in outpatient departments between July 2015 and June 2016.

Medical staffing

- Consultants had planned clinics. We saw in the incidents records that there was three occasions in the last 12 months when some clinics had to be cancelled due to the absence of the consultant. All the patients were contacted and received a rescheduled appointment within two weeks.

Outpatients and diagnostic imaging

- There were a total of 92 consultants who had been granted practising privileges to work at the hospital who had worked there for over six months. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital.
- Under the conditions of practising privileges, consultants working at the hospital had to be accessible as necessary. Staff confirmed they were able to contact consultants when required and had not experienced any problems.
- Staff had access to an up to date lists of consultants that worked at the hospital with telephone numbers and their medical speciality.
- There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant if required

Allied healthcare professionals staffing

- The radiology department employed three radiography staff, who all worked part time and covered a range of hours. There was a bank of radiographer who was available to cover unfilled shifts. They were experienced within the department and had received up-to-date training, risk assessments and were within their documented scope of practice.
- The department had a radiologist who also worked at a local acute NHS hospital. They came into the department once a week. This meant that reporting of x-rays was not always done within 48 hours. Patient Archiving Communication System (PACS) was being put in place within the next few months that would enable the radiologist to report on x-rays remotely from other sites.
- The physiotherapy department had four staff in total. Staff worked flexibly to meet the needs of the department, which included a weekend rota.

Emergency awareness and training

- See the Surgery section for main findings.
- There were documented major incident plans for the hospital and these listed key risks that could affect the provision of care and treatment. There were clear

instructions for staff to follow in the event of a fire or other major incident. However, there was not a copy available in the outpatient department at the time of the inspection.

- Not all staff were aware of what they would need to do in a major incident and only the lead had been involved in major incident exercises.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

Evidence-based care and treatment

- See the Surgery section for main findings.
- Clinical governance and quality bulletins provided all staff on the department with safety alerts, lessons learnt across BMI healthcare hospitals and information as to NICE guidance updates. We saw that the information cascaded from senior managers to staff at all levels. The bulletins included actions required by managers with target and completion dates to implement changes.
- The Radiology department had implemented the Five Steps to Safer Surgery World Health Organisation (WHO) safety checklist for non-surgical interventional radiology. The safety checklist was audited every three months to ensure the checklist was being completed and was evident in patient notes. In the September 2016 audit the department scored 100%.
- Diagnostic reference levels (DRL's) were displayed in the radiography department. DRL's means dose levels in medical radio- diagnostic practices. These levels are expected not to be exceeded for standard procedures when good and normal practice regarding diagnostic and technical performance is applied. An annual review was carried out by an external radiation protection advisor and its findings discussed in the annual radiation committee meeting. Results from the review found that that all DRL's in place were lower (good) than the national average.

Pain relief

Outpatients and diagnostic imaging

- Pain relief was managed on an individual basis and was regularly monitored. Patients told us that they were consistently asked about their pain during appointments and supported to manage it.
- All recommendations regarding medications for pain relief were included on the letter sent to the patient's GP.
- If a patient experienced pain during a physiotherapy appointment they would be assessed and if necessary the resident medical officer would be contacted to examine the patient and prescribe pain relief if required.
- Staff we spoke to in the therapy department reported that they received good support and guidance and we saw completed competency assessments. These included assessing function and movement and correct walking aids and equipment.
- There were staff competencies kept on the outpatient department which included competencies in suture removal and wound care.
- There were competency checks for health care assistant staff administering eye drops. However this was for only one healthcare assistant. The other healthcare assistant was relatively new, but we saw evidence that this was being put in place.

Nutrition and hydration

- Patient's nutrition and hydration needs were met. There was provision of free hot and cold drinks in two waiting areas. Where delays in clinics happened patients were able to get food from the canteen.

Patient outcomes

- The physiotherapists worked with the pre-assessment nurses for patients requiring orthopaedic surgery to assess their rehabilitation needs and any equipment needed on discharge. This ensured that the appropriate package of care was in place on discharge to help improve activities of daily living.

Competent staff

- Staff were supported in their development using the appraisal process, which was undertaken annually with a mid-year appraisal every six months. Information supplied by the hospital showed that 100% of nursing and healthcare staff across the outpatients and diagnostics department had received their annual appraisal. Staff confirmed that they received their appraisal with their line manager.
- All qualified staff within the radiography department were registered with the Health professions Council (HPC) and maintained their registration with regular continuing professional development. A record of all professional development activities for each radiographer was kept on their personnel file on the department. We saw evidence of training and annual assessment records for staff competency for radiographers.

- Due to the staffing model on the outpatient department, the nurse was only available three days a week. If patients required treatment which was out of the scope of the health care assistants competencies on the other two days, they would get help from the nurses on the ward. Consultants confirmed that there had been no issues with the competencies available in the clinics.
- Staff had completed competencies in blood transfusion and taking blood samples from patients.
- The cosmetic surgery nurse specialist was up to date with their clinical appraisal which included competencies in suture removal and wound advice.
- Newly appointed staff underwent an induction process. Staff we spoke with confirmed they had an adequate induction and we saw completed induction checklists.
- The hospital ensured that healthcare support workers undertook the care certificate. A healthcare support worker from the outpatient had completed the qualification. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants.
- Staff were given opportunities to develop their role and enhance their knowledge and skills. For example staff working in the diagnostic imaging department were supported to observe appropriate procedures in theatre.

Multidisciplinary working

Outpatients and diagnostic imaging

- Staff had access to the full range of allied health professionals and team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring care was regularly reviewed by all team members and kept up to date.
- We observed a daily morning communication cell meeting. We saw that it was well attended by all departments throughout the hospital and included both junior and senior members of staff. This meant there was effective communication and staff were aware of concerns across the hospital
- Staff told us it was easy to contact a consultant if they needed advice. There was information in the department office with details of how to contact a consultant.

Seven-day services

- The outpatient service was offered five days a week, Monday to Friday, and did not offer a seven-day service
- Outpatient physiotherapy was provided on weekdays only
- The consultant radiologist and radiographers provided on call cover out of hours and at weekends and could report on scans remotely. This meant that emergency scans could be carried out on site and helped inform treatment plans even though there was not a seven-day service in the imaging department.
- We saw evidence that radiology maintained an on call rota 24 hours per day, seven days per week.

Access to information

- Staff in the imaging department scanned all referrals for imaging and attached these to the imaging scan. This meant that the radiologist had all the information they needed when reporting on images or scans.
- A new electronic Patient Archiving Communication System (PACS) was planned for late 2016. This would allow for improved storage, retrieval and accessibility to scans. This would improve the reporting rate on x-rays as they could be accessed by the radiologist remotely.
- Hospital staff received medical information regarding NHS patients from their GP as part of their referral

process via the 'choose and book' system. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

- From April 2016 to June 2016 all patients were seen with the relevant records being available.
- Patient records were paper based and stored centrally on site. Records from other BMI healthcare hospitals and NHS hospitals were requested 3-4 days in advance to ensure they were available for patient consultation. Records were transported to and from the hospital by a hospital courier to ensure there was no delay in receiving or providing records.
- Information from team meetings was e-mailed to staff and displayed in staff areas to read and sign. This ensured that all staff had access to the latest information.
- Discharge letters and summaries were typed and sent to patients and their GP's. We were told that this was not audited so data was not available to provide assurances that letters were provided to GP's within seven days.
- Information on the hospital website provided patients with the relative costs for treatment. There were also leaflets available about services provided. However staff said that the BMI leaflets were not available in other languages.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- See the surgery section for main findings.
- If patients were highlighted that they may lack capacity on referral a capacity assessment question was undertaken to identify any additional support required.
- We reviewed five patient records that required a surgical procedure, and found that consent to the procedure had only been documented in three records prior to surgery. Consent was also confirmed on the day of the surgery.
- In the September 2016 consent audit the hospital scored 100% which was above the hospital compliance target of 90%. We reviewed that there was a current consent policy in place and it had been reviewed. Staff informed us that the consent policy was accessible through their hospital intranet.

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- Staff had the appropriate skills and knowledge to obtain consent from patients. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment

Are outpatients and diagnostic imaging services caring?

Good 

Compassionate care

- Outpatient and diagnostic imaging services were delivered by, caring and compassionate staff. We observed staff treating patients with dignity and respect.
- In the hospital patient survey for August 2016, 100% of patients reported that they were treated with privacy and dignity.
- All members of staff introduced themselves to the patients and we saw that staff respected a patient's privacy by always knocking on doors before entering whilst in the treatment room.
- We spoke to 12 patients and relatives throughout our inspection. All the patients we spoke with were positive about their care and treatment. Comments included 'prompt nursing care', 'staff are very friendly' and 'treated as an individual and a person'.
- Patients said staff always introduced themselves.
- Patients we spoke with said they had received good information about their condition and treatment.
- The service offered patients the support of a chaperone. This person acted as a safeguard and a witness for patients during medical examinations or procedures. For clinics that involved examinations that were more intimate, a nurse was always assigned to support patients throughout. There was a chaperone policy and we saw posters to inform patient about this service.
- At reception, we observed that patients were not asked to provide confidential information to protect their confidentiality other than their name and address.
- In the imaging department, there were changing areas for patients where they could get undressed behind a

locked door and with a lockable locker to store their belongings. However, the patients then had to walk through the imaging waiting area wearing a hospital gown. Staff told us their aim was to reduce the time the patient had to wait in the waiting area after they had put on the gown

Understanding and involvement of patients and those close to them

- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients told us all staff explained what they were doing in a way that they understood. If they did have any questions, they felt comfortable to ask.
- Discussions around the cost of procedures were always approached with sensitivity.
- During our observations we saw staff reassuring patients and giving them time to understand the treatment they were due to have.
- We spoke with one patient's partner who said that she had been involved in all aspects of the patients care. Staff gave her information and support.
- Patients who were paying for their treatment were informed of the costs prior to consultation. The hospital website also displayed the costs of treatment in order for patients to be prior informed of costs.

Emotional support

- We observed a surgeon giving reassurance to a patient during an outpatient consultation and explaining that she was welcome to contact him again prior to her operation if she required further explanation.
- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive.
- Consultations rooms were private. This assisted in maintaining patient's privacy should they be upset during consultations.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good 

Service planning and delivery to meet the needs of local people

- See the Surgery section for main findings.
- All hospital referrals were screened by experienced senior nurses to ensure the needs of the local people could be met. Senior nurses were conversant with the hospital exclusion policy and explained that high risk patients with multiple co-morbidities may be referred on to other care and treatment centres based upon the complexity of their needs.
- We observed there was signposting through the hospital to the outpatients and diagnostic imaging departments to support patients in locating the right clinic area.
- There was free car parking at the hospital for patients and visitors and public transport available.
- The main hospital reception area was welcoming and bright. It was clean and tidy and had seating areas with magazines, free refreshments and toilet facilities. Reception staff were professional and greeted patients warmly. They offered help immediately and directed patients to the appropriate area or on occasions escorted the patient.
- We spoke with patients who told us they were happy with their care and treatment because the hospital had changed appointment to suit their needs and preferences, patients had 'a lot of faith' in the hospital and the staff and they received follow up telephone calls from the consultant, which they 'very much appreciated'

Access and flow

- There was only a radiologist available once a week to report on x-rays. This meant that the BMI target of reports being available 48 hours later was not always being met. There was no data available to identify if there had been any issues due to the target not always being met.
- The hospital had scheduled clinics with set specialities on a weekly basis. There were 5,583 attendances to outpatients between July 2015 and June 2016. All clinics were held at the hospital and no services were offered at a patient's home.
- Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs. Clinic times were available up to 6pm during the week. We observed staff booking in patients and found that they offered appointment times to suit the needs of the patients.
- Physiotherapy appointments were also booked directly with the patient by telephone to ensure the appointment best suited them.
- Patient waiting times were not displayed, however nursing staff kept patients informed of any delays in being seen. During the inspection we did not find any appointments that were late.
- Did not attend rates (DNA) for the department were below the indicator of 5% for new appointments but above the target rate for follow up appointments from April 2016 to September 2016. In September 2016 the rate had increased to 8.2%. We were told that patients who did not attend their appointment were contacted and sent another appointment. However, NHS patients were sent a second appointment and if they failed to attend they would be discharged and referred back to the GP. There were no investigations undertaken as to why DNA rates were above the target rate.
- The department met the referral to treatment standard of 92% for non-admitted pathways from July 2015 to June 2016. Non-admitted pathways mean those patients whose treatment started during the month and did not involve admission to hospital.
- The department met the hospital standard of 92% for referral to treatment rates each month for incomplete pathways between July 2015 and June 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- Referrals to other departments within the hospital, for example, to the therapy team were paper-based

Outpatients and diagnostic imaging

referrals. These were completed by the referring consultant and then passed to the therapy team for triage. Appointments could be made whilst the patient was at the hospital at a time to suit their needs.

- Managers informed us that appointment length was determined upon triage. Patients with complex needs and new patients often required longer appointments than those patients who required a follow up appointment. We saw that clinics did not over run and patients we spoke to told us that they had enough time to ask questions.
- Patients were able to call the physiotherapy department in between appointments if they required help and advice. We observed that these calls were dealt with promptly and efficiently.

Meeting people's individual needs

- The waiting area did not have pictorial signage, different coloured toilet seat or adaptations to the area that would have provided an aid for patients living with dementia.
- Vulnerable adults, such as patients with a learning disability and those living with dementia were identified at the referral stage; steps were taken to ensure they were appropriately cared for. This included seeing the patient at the start of clinics and extra staffing to support the patient if required.
- We asked one of the nursing staff how they would manage a patient with dementia. They were able to give good, appropriate examples of how these patients were managed including completion of a risk assessment for dementia, ensuring that they were given a quiet space and letting their carer stay with them.
- The layout of the services meant all areas were accessible for people in a wheelchair. Patient waiting areas had access to toilets and there was a toilet adapted for patients who were disabled.
- A hearing loop was available for those patients with a hearing impairment.
- There was a cosmetic surgery nurse specialist who supported self-funding patients during their outpatient appointment. They offered them advice regarding surgical and non-surgical procedures and were available in an advisory capacity to staff about pain relief.

Learning from complaints and concerns

- Initial complaints were dealt with by clinic managers in the outpatients department in an attempt to resolve issues locally. However, if this could not be resolved then the complaint would be escalated to the senior management team.
- Information about how to raise a complaint was displayed in the main reception area but not in the outpatient department. All staff reported they tried to resolve complaints at a local level first but knew how to escalate complaints to managers if needed.
- From January 2016 to July 2016 there had been six complaints made about the outpatient department. We saw that complaints tracker was collated to support reviewing of any trends or themes and provided outcomes and learning..
- We saw from clinical governance meeting minutes that complaints were an agenda and were discussed. Information was cascaded back to staff in outpatient and diagnostic imaging departments.

Are outpatients and diagnostic imaging services well-led?

Requires improvement 

Vision and strategy for this core service

- There was a corporate vision and strategy.
- Not all staff on the departments were aware of the hospital strategy and vision but they told us that they wanted to deliver the best possible patient outcomes and experience.
- We saw that the vision for the hospital was posted on the walls on the department.

Governance, risk management and quality measurement for this core service

- See the Surgery section for main findings.
- There was a corporate risk register but the only risk on the risk register for outpatient and diagnostic imaging was the installation of the Picture Archiving

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Communication System (PACS) in radiology. PACS is a healthcare technology for the short and long term storage, retrieval, management, distribution and presentation of medical images. The carpets in the department was not on the risk register neither was the lack of a dirty utility room. This meant that not all risks were being identified with timeframes to mitigate the risk in a timely way

- Annual environmental risk assessments had been completed for the service. We saw that these risks had recently been reviewed in 2016. These included the manual handling of equipment, the manual decontamination of the nasoendoscopes and transferring patients from a bed to the x-ray table. They included any additional controls that needed to be put in place to mitigate the risks. However, a formal risk assessment had not been completed for using the treatment room to dispose of clinical waste.
- Staff at all levels in the service were unable to tell us how their service performance was monitored and what were the key performance indicators.
- There was a programme of internal audits in the outpatients and diagnostic imaging services. The data from these audits was used to monitor the quality and compliance. For example, in the imaging department they audited compliance with theatre images having patient details on prints. However, it was not clear how compliance with these audits was monitored by staff in the departments to improve practice.
- Following a serious incident, in June 2016, there had been a directive that it was mandatory for there to be a copy of outpatient consultant notes in the patient medical records. However, this was not audited to check for compliance and we found that this was not always being done at the time of inspection. This was brought to the attention of the hospital manager following the inspection and assurance was given that action would be taken.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results. There was also copy of the minutes in files for staff to read.
- We saw documented evidence in the radiography department that radiation risk assessments had been

completed. For example, radiation risk assessment for radiographic examinations in the x-ray room. These were completed by an external organisation and had been updated annually.

- We saw that there was an Ionising Radiation Safety Policy in place that had been reviewed recently. The policy set out the governance arrangements and the roles and responsibilities of those staff involved in radiological interventions.
- Managers of the department attended clinical governance meetings on a monthly basis, where complaint and the risk register were discussed. We saw that these meetings were discussed at the team meetings.
- The department had service level agreements (SLA's) with several different organisations. These organisations provided services to the hospital to ensure the hospital was able to function. These services included pathology and medical equipment maintenance. We saw that contracts were in place and review dates documented.

Leadership and culture of service

- See the Surgery section for main findings.
- Staff we spoke with said they were well supported by their managers who were visible. They also told us that the management team were approachable and that they would feel comfortable raising any concerns they may have.
- All staff spoke positively about the leadership within the hospital and said they felt valued and respected. They enjoyed working in the team and enjoyed working at the hospital.
- The overall lead for the diagnostic imaging department was the director of clinical services.
- All the staff we spoke with were highly motivated and positive about their work. Staff told us there was a friendly and open culture.
- The overall staff sickness rates between July 2015 and June 2016 for nursing and health care assistants was 0%.

Public and staff engagement

Outpatients and diagnostic imaging

- Staff were rewarded for exemplary performance through a 'above and beyond' staff reward programme. Anyone could nominate another member of staff for any reason. We saw evidence that outpatient staff had participated in the programme.
- There were leaflets in waiting areas encouraging patients and their carers to provide feedback about the care they received. Staff also encouraged patients to fill in feedback forms.
- In the hospital patient satisfaction survey August 2016, 100% of patients said they would recommend diagnostic imaging services and 92% would recommend the physiotherapy service. Overall 99% of patients said treatment met their expectations.

Innovation, improvement and sustainability

- We saw no evidence of innovation, improvement and sustainability in the department.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The hospital must ensure that the staff have been competency assessed before undertaking roles within the hospital so that patient safety is ensured.
- The hospital must ensure that all risks are identified and mitigated in a timely way.
- The hospital must ensure that areas of poor compliance that have been identified are dealt with in an appropriate and timely way.

Action the provider **SHOULD** take to improve

- The hospital should consider ways in which they can comply with National Standards in the way that they store endoscopes following decontamination.
- The hospital should consider how to comply with Department of Health standards by having a sink for clinical use available in all clinical areas.
- The hospital should consider placing hand gel dispensers outside all patient rooms for staff to use after providing care and treatment.
- The hospital should consider securing the theatre area so that members of the public are unable to gain access unsupervised.
- The hospital should make sure that the asset register is completed fully for all equipment in the hospital.
- The hospital should make sure that propofol is kept in a locked cupboard in the theatre area so that they are adhering to their own medicines management policy.
- The hospital should consider ways to ensure that all staff are fully aware of Female Genital Mutilation and how this should be reported.
- The hospital should make sure that all staff are up to date with mandatory training.
- The hospital should consider including medicines management training for staff to complete.

- The hospital should ensure that the 'sign out' phase of the WHO checklist is completed following all surgical procedures.
- The hospital should ensure that they continue to adhere to AFPP guidelines for the correct number of staff in theatre.
- The hospital should consider introducing a 'red flag' system so that it is clear when staff need to escalate any issues to the on-call management team.
- The hospital should make sure that all staff are aware of their role if a major incident was to occur.
- The hospital should consider the use of Q-PROMS so that they can compare patient satisfaction following cosmetic surgery with other similar services nationally.
- The hospital should make sure that all personnel files are kept up to date with the most recent information.
- The hospital should consider how to identify current gaps in practice against patient safety and NatSSIP alerts.
- The hospital should take action to replace carpeting and seating to assist in maintaining good standards of infection control. The seating and some flooring was not washable or wipe clean if it became soiled and could present an infection risk.
- The hospital should ensure that cleaning checklists are fully completed to ensure that cleaning had taken place.
- The hospital should ensure that a risk assessment be completed for the lack of a dirty utility room
- The hospital should consider identifying and allocating a separate area as a dirty utility room in the outpatient department.
- The hospital should consider physiotherapy patient notes being available in the patient health record so that all patient information is in one place

Outstanding practice and areas for improvement

- The hospital should consider BMI leaflets available in reception are also available in other languages.
- The hospital should take action to improve the environment to take into account the needs of patients who require additional support. The environment had not been suitably adapted to respond to the needs of patients living with dementia. For example signage was not clear.
- The hospital should consider having a loop system to help patients who have a hearing impairment
- The hospital should consider investigating did not attend rates for outpatient clinics and alternative ways of reminding patients of their appointment.
- The hospital should ensure that appropriate staff are aware of the strategy and vision and key performance indicators for the services provided.
- The hospital should ensure that key performance standards, such as consultant notes in the outpatient records is monitored.
- The hospital should ensure that learning from audits is recorded and monitored.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.</p> <p>This was because not all risks had been identified in a timely manner. Additionally, there had been areas when actions had not always been monitored and improvements had not always been made.</p>
Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>How the regulation was not being met:</p> <p>The service did not provide sufficient numbers of suitably qualified, skilled and experienced persons.</p> <p>There was limited evidence of staff undertaking the role of a surgical first assistant, recovery nurse and or pre-op assessment nurse having been competency assessed by an appropriate person before undertaking their role.</p>

This section is primarily information for the provider

Enforcement actions

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.