BMI The Somerfield Hospital

Quality Report

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

Ratings

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

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 Somerfield Hospital in Maidstone Kent, is operated by BMI Healthcare Ltd. Facilities include three operating theatres and the Hospital provides surgery, outpatients and diagnostic imaging. We inspected surgery and outpatients and diagnostic imaging services.

The hospital has 38 beds split across two inpatient wards. The hospital has three main theatres, 8 consulting rooms, as well a physiotherapy department and health screening. The hospital has ultrasound, X-ray and digital mammography within its imaging department. The hospital offers a wide range of surgical and medical procedures, including ENT, orthopaedics, gynaecology, general surgery, general medicine and ophthalmology,

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 12 and 13 December, on along with an unannounced visit to the hospital on 21 December 2016.

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

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

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

We rated this hospital as Good overall.

- The senior management team, supported by the heads of departments, had a good knowledge of how services were being provided and provided string leadership to teams.
- The care delivered was planned and delivered in a way that promoted safety and ensured that peoples individual care needs were met. We saw patients had their individual risks identified, monitored and managed and that the quality of service provided was regularly monitored.
- The executive director was in overall charge of the hospital and all employed staff were line managed through her direct reports.
- The Medical Advisory Committee (MAC) met quarterly and included representation from all specialities offered at the hospital. It was attended by the Executive Director and the director of clinical services. A wide range of topics were discussed and action taken in response to any concerns raised. The minutes of the MAC meetings were distributed to all consultants.
- The hospital used an agency that provided a Resident Medical Officer (RMO) onsite 24 hours a day, seven days a week, on a rotational basis. The RMO undertook regular ward rounds to make sure the patients were safe.
- The hospital used the corporate BMI Healthcare Nursing Dependency and Skill Mix Planning Tool, to determine staffing levels. The nursing rota was entered into the system monthly. This meant that the hospital ensured that staffing levels and mix were sufficient to provide safe care for patients.
- We saw a strong safety culture with policies and systems in place, and we saw that staff reported incidents appropriately.
- There were robust governance systems that were known and understood by staff and which were used to monitor the provision and to drive service improvements. The Clinical Governance Committee (CGC), met every two months and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, risk register review.

We found areas of practice that required improvement in both surgery and in outpatients and diagnostic imaging services.

Summary of findings

- The outpatient undertook their own decontamination of nasendoscopes using a three-wipe system. This system had a barcode tracking system. This enabled the hospital to track the cleaning of nasendoscopes used by individual patients for quality control. Staff we spoke to were able to describe the decontamination process however, it was unclear if personal protective equipment (PPE) was worn during the decontamination process. This meant the endoscopy policy and Health Technical Memorandum 01-01 Decontamination of medical devices within acute services was not being adhered to as both documents recommend staff should wear PPE during the decontamination process.
- There was no designated area for cleaning of the nasendoscopes, a desk in one of the main corridors was used. This was not in compliance with Code of Practice on the prevention and control of infections and related guidance and HTM 01-01.
- Not all outpatient records were not retained by the hospital, which meant that there were no comprehensive patient records that were accessible by all staff.
- Outpatient staff did not have up to date with competencies in relation to decontamination of reusable medical devices, to ensure compliance with the "Choice Framework for local Policy and Procedures (CFPP) 01-06–Decontamination of Flexible Endoscopes: Policy and management."
- There were no dedicated hand wash basins in patient bedrooms, staff and visitors used the basin in the bedrooms en-suite bathroom or the hand washing facilities in the sluice.

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 the service improve. Details are at the end of the report.

Professor Edward Baker

Deputy Chief Inspector of Hospitals (South East)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated this service as good because it was, effective, caring, responsive and well-led, although it requires improvement for being safety. Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. All the staff we spoke with on the ward and in theatre told us they were encouraged to report incidents using the paper reporting system which is then entered into an electronic system. All incidents were placed on an electronic tracker to monitor the progress and completion of the investigation. The hospital was in the process of moving to an electronic reporting system but this was not complete at the time of the inspection. This system will also include the risk register and complaints/claims. Patients received care and treatment according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. Surgery services participated in national audits. Patients spoke positively about their care and we saw that patients were treated with privacy and dignity. The hospital was meeting national targets for referral to treatment times and processes were in place to support vulnerable patients. Complaints were dealt with efficiently. Governance structures were good and there was effective teamwork with visible leadership within the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers. However: We found patient bedrooms did not have dedicated hand hygiene sinks. We found that some clinical areas still had carpet in situ.

Summary of findings

Outpatients and diagnostic imaging

Good

We rated this service as good because it was, safe, effective, caring, responsive and well-led.
People who used the services were protected from abuse and avoidable harm and staff were aware of the processes and reporting systems for recording incidents and safeguarding concerns.
Staffing levels were sufficient to provide care in a safe way.
Hygiene and infection control practices were followed.
Patient records were held securely.
Safeguarding of vulnerable adults training was undertaken every two years for levels one and two. Data indicated, 98% of required staff had completed level one, and 93% of required staff had completed level two, which was better than the BMI Healthcare target of 90%.
The care and treatment provided to people was evidence based and in line with relevant standards and legislation, including National Institute for Health and Care Excellence (NICE) and professional organisational guidelines.
We observed staff providing care and treatment to people who used the services in a caring and compassionate way and people were involved in decisions about their care.
The hospital planned the services to meet the needs of the local population.
A range of outpatient clinics were available to meet the needs of the client group. According to data provided by the hospital, this included cardiology, dermatology, ear, nose and throat, general medicine, endocrinology, general surgery, haematology, gynaecology, pain control, podiatry, rheumatology, urology, neurology, orthopaedic, ophthalmology and dietitian. Orthopaedics, general surgery, general medicine, and ophthalmology had the highest attendance rates.
There were no waiting times for physiotherapy treatment and staff saw NHS as well as private patients.
The hospital met the target of 92% of patients on incomplete pathways waiting 18 weeks or less from time of referral in the reporting period (July 2015 to June 2016).

Summary of findings

Access to outpatient appointments was fast and patients told us they were more than satisfied with the amount of time it had taken, to get the appointment. Patients also told us they were able to get appointments at times that suited them.
There was a robust governance framework and strong management and leadership within the hospital.
However:
The outpatient undertook their own decontamination of nasendoscopes using a three-wipe system. This system had a barcode tracking system. This enabled the hospital to track the cleaning of nasendoscopes used by individual patients for quality control. Staff we spoke to were able to describe the decontamination process however, it was unclear if personal protective equipment (PPE) was worn during the decontamination process. This meant the endoscopy policy and Health Technical Memorandum 01-01 Decontamination of medical devices within acute services was not being adhered to as both documents recommend staff should wear PPE during the decontamination process.
Not all the staff who decontaminated reusable medical equipment had up to date competencies.
There was no designated area for cleaning of the nasendoscopes, a desk in one of the main corridors was used.
Not all outpatient records were not retained by the hospital, which meant that there were no comprehensive patient records that were accessible by all staff.

Summary of findings

Contents

Good

BMI The Somerfield Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to BMI The Somerfield Hospital

BMI The Somerfield Hospital is operated by BMI Healthcare Ltd. The hospital opened in 1983. It is a private hospital in Maidstone, Kent. The hospital primarily serves the communities of the Maidstone. It also accepts patient referrals from outside this area. The Hospital is led by a senior management team that consists of the Executive Director, Director of Clinical Services and Operations Manager and a team of clinical and functional heads of each department.

The hospital has had a registered manager in post since May 2012.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Sheona Keeler, other CQC inspectors and specialist advisors with expertise in surgery, outpatients and diagnostic imaging.

Why we carried out this inspection

The hospital has two wards and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.
- Surgical procedures.
- Diagnostic and screening procedures.
- Family planning.

The service provides outpatient and diagnostic imaging services as well as inpatient surgery in two wards.

Activity (June 2015 to July 2016)

- There were 3,205 inpatient and day case episodes of care recorded at the hospital in the reporting period July 2015 to June 2016 of these 60% were NHS funded and 40% were other funded.
- 18% of all NHS funded patients and 22% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 17,019 outpatient total attendances in the reporting period July 2015 to June 2016 of these 32% were NHS funded and 68% were other funded.

One hundred and forty consultants worked at the hospital under practising privileges. Two regular resident medical officers (RMO's) worked on a two weeks on, one week off rota.

The hospital employed 26.2 full time equivalent (FTE) registered nurses, 10.3 health care assistants and operating department practitioners, as well as having its own bank staff.

The accountable officer for controlled drugs (CDs) had been in place since September 2012.

During the inspection, we visited both wards, although there were no patients on one of the wards, and we spoke with staff including; registered nurses, healthcare assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with seven patients and one relative. We also received four 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been

Summary of this inspection

inspected before, and the most recent inspection took place in February 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Track record on safety:

- There were no never events in the reporting period from June 2015 to July 2016.
- There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) from June 2015 to July 2016.
- There were no incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA) from June 2015 to July 2016.
- There were no incidences of hospital acquired Clostridium difficile (C.diff) from June 2015 to July 2016.
- There were no incidences of hospital acquired E-Coli from June 2015 to July 2016.
- There were a total of 398 clinical incidents in the reporting period (July 2015 to June 2016).
- Out of 398 clinical incidents 55% (219 incidents) occurred in surgery or inpatients and 23% (92 incidents) occurred in other services. The remaining 22% of all clinical incidents occurred in outpatient and DI services (87 incidents).
- The hospital reported 0.5% of all incidents as severe or death.
- There were a total of 163 non-clinical incidents in the reporting period (July 2015 to June 2016).
- Out of 163 of these 7% (12 incidents) occurred in surgery or inpatients and 92% (150 incidents) occurred in other services. The remaining 1% of all non-clinical incidents occurred in outpatient and DI services (one incident).
- The hospital reported one serious injury in the reporting period from June 2015 to July 2016.
- The hospital received 19 complaints in the reporting period from June 2015 to July 2016.

Services provided at the hospital under service level agreement:

- Agency clinical staff
- Catering
- CT scanning
- Histopathology services
- Histopathology services
- Pathology services
- Radiation and laser protection support and advice
- Resident medical officer

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as Requires Improvement because:

- The outpatient undertook their own decontamination of nasendoscopes using a three-wipe system. This system had a barcode tracking system. This enabled the hospital to track the cleaning of nasendoscopes used by individual patients for quality control. Staff we spoke to were able to describe the decontamination process however, it was unclear if personal protective equipment (PPE) was worn during the decontamination process. This meant the endoscopy policy and Health Technical Memorandum 01-01 Decontamination of medical devices within acute services was not being adhered to as both documents recommend staff should wear PPE during the decontamination process.
- Not all staff who decontaminated reusable medical equipment had up to date competencies.
- There was no designated area for cleaning of the nasendoscopes, a desk in one of the main corridors was used.
- Not all outpatient records were not retained by the hospital, which meant that there were no comprehensive patient records that were accessible by all staff.
- There were no dedicated hand wash basins in patients' bedrooms, staff and visitors used the basins in the bedrooms en-suite bathroom or the hand washing facilities in the sluice.

However, we also found:

- Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated, and learned from to prevent recurrence.
- Lessons learnt from incidents were regularly communicated through handovers and staff meetings. We reviewed the theatre department 'incidents debrief meeting' minutes for September and October 2016 and saw that incidents were discussed with actions to be taken to prevent similar incidents happening in the future.

Summary of this inspection

- The hospital reported no Ionising Radiation (medical exposure) Regulations (IRMER), 2000 incidents to the Care Quality Commission (CQC) in the last 12 months. A radiation protection adviser (RPA) based at a local NHS trust was available for advice if required.

Are services effective?

Good

We rated effective as Good because:

- Policies and procedures used within the surgical department and the hospital, followed evidence based practice.
- There were formal systems in place for collecting comparative data regarding patient outcomes.
- The hospital took part in the Patient Led Assessment of the Care Environment (PLACE) audit February to June 2016, which showed the hospital scored 92% for food which was better than the England national average of 91%.

Are services caring?

Good

We rated caring as Good because:

- We observed the staff being very kind, caring, and compassionate towards their patients. All patients and relatives we spoke with told us staff always introduced themselves, were polite, and treated them nicely.
- Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment.
- Staff told us the consultants would inform them if they were about to break bad news to a patient so they would be available to support them.

Are services responsive?

Good

We rated responsive as Good because:

- The services were delivered in a way that met the needs of the local population and allowed patients to access care and treatment when they needed it. Waiting times, delays and cancellations were minimal and well managed.
- Sixty percent of the patients attending BMI The Somerfield Hospital were NHS patients who were referred to the hospital from two local NHS Trusts via 'choose and book'. Work performed included knee and hip surgery. BMI The Somerfield would deliver the pre and post-operative care. The patient would be referred back to local trust for follow up care.

Summary of this inspection

- Complaints management was transparent and open with learning communicated across the hospital.

Are services well-led?

Good

We rated well-led as Good because:

- BMI The Somerfield Hospital was part of the BMI corporate strategy as well as a local vision for the hospital. The BMI corporate strategy included a governance frame work to support the delivery of excellent services and minimise risks across all areas of the business, superior patient care by providing the highest quality clinical care and striving to be an employer of choice attracting the best consultants and staff. The BMI vision was to provide the best patient experience and outcomes, the most cost effective way.
- There were clear organisational structures and roles and responsibilities. The senior management team were highly visible and accessible across the hospital.
- Governance committee meetings were held monthly and the minutes we saw showed these meetings were structured and well attended. Discussions at these meetings were focused on quality and risks and we saw areas such as incidents, complaints, risk register and the audit calendar were discussed.
- All patients were actively encouraged to provide feedback. We saw examples of positive feedback and how changes suggested by patients had resulted in a change to the service delivered.

Good

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as Requires Improvement.

Incidents

- Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated, and learned from to prevent recurrence.
- BMI The Somerfield Hospital had not reported any never events in the surgical services in the period July 2015 to June 2016 (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 provider).
- All the staff we spoke with on the ward and in theatre told us they were encouraged to report incidents using the paper reporting system which is then entered into an electronic system. All incidents were placed on an electronic tracker to monitor the progress and completion of the investigation. The hospital was in the process of moving to an electronic reporting system but this was not complete at the time of the inspection. This system will also include the risk register and complaints/claims.
- A healthcare assistant (HCA) on the ward told us of an incident that occurred with a patient who had epilepsy. Since the incident anti-epileptic medication was now available on the ward. We were told if an incident occurred in the theatre, the ward would be informed prior to the patient coming back to the ward.
- Lessons learnt from incidents were regularly communicated through handovers and staff meetings. We reviewed the theatre department 'incidents de brief meeting' minutes for September and October 2016 and saw that incidents were discussed with actions to be taken to prevent similar incidents happening in the future. The theatre manager told us that following a recent serious incident a 'site marking policy' was developed. This required the consultant to mark the site, to be operated on the patient on the ward prior to surgery. This was then checked in theatre during the pre-surgical safer surgery procedure.
- In theatres, we saw the number of clinical incidents for the month was displayed on the staff room notice board for all staff to see. On reviewing the clinical governance and risk meeting minutes of October 2016, we saw all incidents for theatres, which took place all the BMI organisations and the actions that needed to be taken. These were highlighted in pink for staff to read. All staff signed to say they had read the minutes.
- BMI The Somerfield Hospital incident reports for July 2015 to June 2016 consisted of 308 clinical incidents with 219 incidents occurring in surgery or inpatients.163 non clinical incidents were reported with only 12 incidents occurring in surgery. Incidents reported were mainly around patients waiting in recovery for more than 40 minutes due to no porters, ward staff not available to escort the patient and lists cancelled due to

staff sickness. All incidents were classed as low to moderate harm. We saw robust systems were in place to investigate incidents with the learning from each incident discussed at departmental meetings.

- We reviewed the minutes from a variety of meetings including the Medical Advisory Committee (MAC), resuscitation meeting, clinical focus group and the quarterly Clinical Governance reports and saw incident reporting was a regular agenda item where incidents were discussed with learning outcomes. The RMO told us all relevant clinical incidents were reported and by attending the clinical governance meeting was aware of all clinical incidents. The RMO had no concerns about raising issues.
- There was no evidence that separate morbidity and mortality meetings took place. These meetings are peer reviews of complex patients or where there may have been concerns over the clinical care and lead to improved services. However, we saw all deaths, unexpected transfers, joint infections, and adverse events were discussed at the Clinical Governance and MAC Meetings. No deaths have been reported in the period July 2015 to June 2016.

Duty of Candour

- Staff we spoke with had a good understanding of the Duty of Candour requirement and were able to explain how it applied to their specific roles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Clinical Quality Dashboard

- There were systems and processes to measure the quality of care delivered at BMI The Somerfield Hospital. Quality indicators data was being collected and was placed on the notice boards outside the two wards. This information was collated from patient feedback and included 'the quality of the food served, temperature of the food, bathroom facilities, and response to call bells'. In October 2016, the wards achieved above 82% compliance for all areas.
- Data for the NHS safety thermometer was collected monthly. This included data on patient falls, urinary tract infections and catheters, pressure ulcers and venous thromboembolism (VTE). All Key Performance Indicators (KPIs) were monitored and discussed at the quality meetings with the Clinical Commissioning Groups and BMI The Somerfield Hospital clinical governance meetings. However, the data was not being displayed in public areas demonstrating a harm free care environment.
- We reviewed the safety thermometer data for July and October 2016. We saw harm free care was delivered during the reporting periods. There were no reported falls, pressure ulcers or urinary tract infections during the two months data we reviewed.
- All patients had their level of risk assessed for venous thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. We saw evidence of completed risk assessments in the patient records we reviewed. Across the reporting period (July 2015 to June 2016) no incidents of hospital acquired VTE or pulmonary embolism (PE) were identified.

Cleanliness, infection control and hygiene

- BMI The Somerfield Hospital had a service level agreement (SLA) with a local microbiologist to provide services. The microbiologist would link with the infection prevention control (IPC) nurse and attend the Infection prevention control meeting. The infection prevention control meeting met quarterly and discussed incidents, surgical site infections, water safety, and outbreaks of infection, infection control training, and feedback from audits or reports. We saw the minutes of the infection prevention control meeting held in June 2016 and saw the above areas were discussed.
- The microbiologist worked with the nursing staff, consultants, and resident medical officer (RMO) to review relevant results and discuss these with the most appropriate person. Other duties included calls from staff to give advice, overview of water sample results and environmental samples.
- During the reporting period (July 2015 to June 2016), no incidents of meticillin-resistant Staphylococcus aureus (MRSA) Clostridium difficile (C.diff) and Escherichia coli (E.coli) were reported.
- The endoscopy department undertook their own decontamination of endoscopies using an endoscopic

washer-disinfector. The washer-disinfector had a barcode tracking system. This enabled the hospital to track the cleaning of endoscopes used by individual patients for quality control. Staff we spoke to were able to describe the decontamination process however, it was unclear if personal protective equipment (PPE) was worn during the decontamination process. This meant the endoscopy policy and Health Technical Memorandum 01-01 Decontamination of medical devices within acute services was not being adhered to as both documents recommend staff should wear PPE during the decontamination process.

- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance
- The PLACE assessment for cleanliness for the period February to June 2016 was 100%, which was better than the England national average of 98%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings. However, during our inspection we found the minor procedure room, was not clean. We raised this with the Executive Director, Director of Clinical Services and Operations Manager during our inspection.
- All areas of the hospital we visited appeared visibly clean. The hospital corridors had carpet which could not be as easily cleaned as the laminated flooring when spills occurred. Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment states 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. However, we saw carpets were visibly clean and free from stains, we also saw regular deep cleans of carpets had taken place. We reviewed the carpet planning schedule. This gave assurance the carpets were being cleaned following the timetable.
- There were no dedicated hand wash basins in patient bedrooms, staff and visitors used the basin in the bedrooms en-suite bathroom or the hand washing facilities in the sluice. This is not in accordance with the Department of Health's (DoH) Health Building Note (HBN) 00-09: infection control in the built environment, which states 'Clinical wash-hand basins should be provided in addition to the general wash-hand basin provided for patients'. The corporate 'Infection Prevention and Control, Hand Hygiene Policy (including training)' (dated May 2016), states 'Basins in patients' bathrooms/en-suites must never be used for hand washing by clinical staff', and goes on to say single bed/ en-suite room should have one sink per room in addition and separate to patient's washbasin.
- The hospital told us a risk assessment of clinical hand wash basin had been undertaken by the infection prevention lead. We saw the risk assessment, which detailed clinical hand wash basins to be installed in accordance with HBN 00-09 in various areas across the hospital. However, this risk assessment did not included dedicated hand wash basins to be installed in patients bedrooms.
- The 'Director of Infection Prevention & Control Annual Report 2014 to 2015', which detailed activities undertaken to ensure the hospital met the requirements of the Department of Health:Code of Practice on the prevention and control of infections and related guidance. This programme of work was mapped to the compliance criteria within the code of practice and included systems to manage and monitor the prevention and control of infection, maintain a clean and appropriate environment, ensure appropriate use of anti-microbials and ensure all staff were fully involved in the process of preventing and controlling infection.
- In August 2016, the hospital introduced cleaning audits based on the NHS cleaning audits. Cleaning audits were undertaken on a weekly or monthly basis depending on the level of risk of the clinical area. The hospital have set targets to achieve which included 98% compliance in theatres, 95% in the wards and 90% in the out patients department. We reviewed the audit for November 2016 and saw theatres achieved 100% compliance.
- We saw records confirming deep cleans took place twice a year in theatres. The most recent deep clean took place in November 2016.
- On Gordon ward, 15 bedrooms were reviewed, nine achieved 96% compliance, and three achieved between 92-94%, and three achieved between 89-91% .This highlighted there was a need to embed practices and

improve the standard of cleaning on the ward. Action plans have been put in place with the Hotel services manager and Ward managers 'signing off ' when objectives have been met. All audits and action plans were discussed at hotel services committee, executive meetings and the lead nurses meeting.

- Any audits which were non compliant were reviewed monthly however we were told by the director of clinical services they will address areas of poor compliance as soon as possible for example in the pathology and theatre departments.
- Housekeeping staff had received appropriate training and were supplied with nationally recognised colour-coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination.
- The housekeeping staff were able to demonstrate their daily cleaning log with the duties they perform. This included cleaning the en-suite rooms and replacing towels. A full clean was performed after a patient was discharged.
- Personal protective equipment (PPE) such as disposable aprons and gloves were easily accessible for staff. We observed staff wearing them when delivering personal care and we saw the housekeeping staff were wearing the appropriate PPE when undertaking full cleans in the bedrooms.
- We observed alcohol hand gels were available in the patient rooms. However, we saw no posters around the gel to highlight to staff, patients, and the public to use the gel when entering and exiting an area. We also did not observe hand hygiene posters in the shower rooms to act as an aid memorandum for staff around the '5 moments for hand hygiene'.
- Once a year (because of low through put) a Mattress audit was undertaken to check the quality of the mattresses. On Gordon ward we spoke to a Registered Nurse (RN) who was able to describe the mattress tests undertaken. The RN told us the IPC nurse taught them how to conduct the mattress tests. If a mattress failed the test it was removed from the ward and a new mattress was bought.
- The hospital used a green tie to identify equipment was clean and ready to use. We saw ties on the ward on blood pressure devices, syringe drivers and the resuscitation trolley.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container.
- We observed staff were bare below the elbow as per hospital policy.
- Hand washing audits were carried out by the infection control and prevention (IPC) nurse on a regular basis in both the ward and theatre areas. We observed the ward and theatres were 100% compliant in August and November 2016.
- In each bedroom we visited, open waste bins were found in the bedrooms with foot controlled bins supporting clinical waste found in the showers rooms. Generally all waste bins should be foot operated. We did not see general waste bins in the shower rooms which could result in mixed waste streams.
- All patients were swabbed for MRSA during their preoperative assessment. The pre assessment nurse described the processes in place if a patient was found to colonised with MRSA. Staff told us patients colonised with an infection such as MRSA would be taken for surgery at the end of the theatre list to allow a thorough deep clean of the theatre prior to the next patient accessing the operating room the next day.
- The hospital had policies and procedures in place to manage IPC. Staff had access to the policies on the hospital's intranet and in policy folders on the ward and theatre.
- Clinical waste was separated and stored in line with national guidance.

Equipment and the environment

- The operating suite comprises of three operating theatres including endoscopy, one of which was a laminar flow theatre. (a system that circulates filtered air

to reduce the risk of airborne contamination). There were two washers to disinfect the endoscopes. The endoscopy manager told us they were sterilising the endoscopes at present but will be moving to an outside contractor in April 2017.

- We saw a building replacement programme was in place for theatres. Theatre one was having new lights installed and a new roof was planned for theatres. Staff we spoke to were aware of the replacement programme and were kept updated on progress.
- There was one recovery area with four beds. At the time of the inspection only two beds were in use as the department was waiting for new patient monitors to be delivered. In the theatre risk register we saw only one monitor was available in recovery and it does not have capnography monitoring (continuous recording of the carbon dioxide content of expired air). A process had been put in place to support patients in an emergency.
- We saw a centralised area was in place for the storage of sutures and prosthesis. This was tidy and organised. On the ward we saw there was adequate storage for medical and non-medical equipment. No equipment was left in corridors causing a trip hazard or infection control issue.
- In theatre water testing was undertaken weekly . This included the washer disinfector for endoscopes. If bacterial growths were found the water was treated immediately using the recommended disinfectants as per hospital policy. During a recent routine testing an abnormal result was found, we saw hospital policy was followed. The finding was reported as a clinical incident and the consultant was informed.
- On the wards, the housekeeping staff ran the water in the bedrooms/shower rooms that were not used regularly. This included flushing the toilet and running the shower and taps for two minutes twice week.
- In Gordon ward sluice we saw no bed pans were available .We also observed paper signage was in place which could led to contamination from spills or splashes .We saw commodes were cleaned and labelled following cleaning and a spillage kit was available.
- The endoscopy manager was able to describe the planned preventative maintenance which complies with the code of practice for endoscopes. We saw records which confirmed endoscopes were serviced every four months or when they were sent for repair.
- We spoke to the maintenance engineer who was able to show us equipment checks were undertaken to the theatre ventilation system including air flow checks. We saw records which showed the checks were undertaken daily. Plant room checks were undertaken every three months which included filter cleans and changes. An annual check by an outside contractor included airflow tests with samples taken along with air conditioning unit checks with air samples taken.
- In the anaesthetic room we saw the anaesthetic machine had daily checks completed. This was in line with the guidance for daily pre use checks from the Association of the Anaesthetists of Great Britain and Ireland (AAGBI) which provides assurance that anaesthetic machines work safely. We also saw the diathermy machine was checked.
- Equipment in the anaesthetic room was seen to be visibly clean and all had a record of being serviced and electrically tested. The theatre manager explained suppliers looked after all new equipment.
- On the wards and in theatre equipment faults were logged with the in house engineers. Non-medical equipment was supported by in house engineers, medical equipment was supported by the suppliers who would come in yearly to calibrate and service the equipment. The ward manager told us the blood sampling machine was recently faulty. The next day service allowed a new machine to be delivered the next day.
- Procedures were in place and equipment was available to prevent and treat hypothermia in patients undergoing surgery. This complies with NICE guidance CG65 for hypothermia: prevention and management in adults having surgery
- All the bathrooms and bedrooms had call bells. We saw these were regularly checked.
- The temperatures of the fridges in the theatres were checked daily and the staff members knew what to do if the temperature fell outside of the expected range.

- Resuscitation trolleys were available at the end of the wards and the theatre recovery area. We saw the oxygen was in date and the defibrillator was checked. Trolley checks were undertaken daily. On opening the recovery trolley, all equipment was seen to be correctly listed on the checklist. Resuscitation council guidelines were seen to be 2015 which are the most recent guidelines.
- A dedicated difficult airways trolley was in the process of being stocked up during the inspection. The theatre manager told us the necessary equipment was available in one of the theatres should the specialist equipment be required for a patient. We reviewed records that confirmed staff had attended the training in October 2016.The AAGBI guidelines "checking anaesthetic equipment" (2012) states "equipment for the management of the anticipated and or unexpected difficult airway must be available and checked regularly." .
- There was a system to review any alerts sent out by the Medicines and Healthcare products Regulatory Agency (MHRA) and ensure that the heads of departments were informed of any national safety alert. We reviewed the theatre meeting minutes and saw that MHRA alerts were raised and staff are asked to read the alerts and put any safety checks in place.
- The corridor running along the front of the hospital was narrow. These meant beds could not be moved from one ward to another. Patients would be placed on a trolley for any transfers.

Medicines

- The pharmacist attended the ward daily and reviewed prescription charts. The pharmacist proactively identifying patients due for discharge and ensured all take home medications were available. There were specified arrangements for staff to gain emergency access to the pharmacy out of hours.
- On admission the nursing staff would count in the patient's own medication with the RMO writing up the patients medication administration chart to support the stay in hospital. Patients would keep their own medication in secure cupboards in their room and sign to indicate they were responsible for their home prescribed medication. One patient told us they had brought their home medication in and were self-administering.
- We reviewed four medication administration charts and saw they were fully completed, including details of any missed doses and the reason for this. Allergies were also clearly documented on each chart.
- The medicine room on the ward was entered through a controlled key pad. We saw controlled drugs (CD's) were stored in accordance with guidance. A CD register was in place, we saw CD's were tracked and signed out by two members of staff at all times. The records seen showed us staff were checking the stock levels in line with the hospital policy.
- In the ward medicine room, IV fluids and patient controlled analgesia (PCA) machines were all safely stored.
- Blue sharps boxes were available in the medicine room for the disposal of medicines along with the register the staff completed when disposing of medications. Two members of staff told us they were unsure what the blue sharps boxes were for.
- Fridge temperatures were recorded daily, on the ward and theatre in line with best practice. The temperature of the fridge in the recovery area was seen to be checked daily and the staff members knew what to do if the temperature fell outside of the expected range.
- Antibiotic usage was being monitored across the hospital. An antibiotic policy was in place.

Records

- Staff followed their corporate 'Policy for the Retention of Records (including guidance for all business documentation and healthcare records)', which included record keeping, maintenance and closure and confidentiality.
- The hospital used a paper based record system to record all aspects of patients care. On the front of the medical records a variety of symbols identified to staff if the patients were cancer patient, had dementia, had an infection, or suffered from a mental health issue. These symbols did not constitute a breach in confidentiality as only staff were aware of the symbol meanings. Patient records contained information of the patient's journey through the service including pre assessment, investigations, test results and treatment and care provided. All ward medical records were managed safely and securely, in line with the Data Protection Act.

- On admission the Registered Nurse would complete the relevant sections of the care pathway booklet. Patients had a range of risk assessments carried out. This included use of the Malnutrition Universal Scoring Tool (MUST), venous thromboembolism (VTE), falls, pain and skin risk assessments. In the nine records we reviewed we saw the risk assessments were completed for each patient on admission.
- In the nine sets of medical records, we found prescription charts were signed and dated, with allergies documented. All patients had consent forms in place which were signed by the consultant and patient. Nursing notes were good. However entries by the HCAs were not countersigned by a registered nurse (RN).
- We saw the theatre register was checked and contains a clear record of patient details, procedure, consultant, and key theatre staff. We saw in the medical records we reviewed the WHO surgical check list were completed, anaesthetic charts were completed, theatre clinical notes were written up and stickers were in the medical records allowing the traceability of implants.
- The theatre manager was able to describe the process to safely check prosthesis. Staff were responsible for writing the size on the booking form and diary before ordering. The prosthesis were checked on arrival and checked prior to the procedure and as part of safe surgery checklist.
- The theatre manager told us all details regarding breast prosthesis were entered onto the breast registry by the consultants. This is in line with national guidance. All files were available in theatre regarding implant traceability. The theatre manager told us a staff member had completed the national joint registry training.
- We saw evidence the World Health Organisational (WHO) surgical checklist was completed correctly in the nine records we reviewed. The WHO Surgical Safety Audit was completed on a regular basis and actions were put in place to amend any non-compliance.

Safeguarding

- BMI The Somerfield Hospital had systems to safeguard adult patients who may be identified as at risk of abuse.
- No safeguarding concerns reported to CQC in the period July 2015 to June 2016.
- Staff we spoke with was aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the hospitals safeguarding policy. Data indicated, 98% of required staff had completed level one, and 93% of required staff had completed level two, which was better than the BMI Healthcare target of 90%.
- The senior management team had identified that the hospital was not able to meet the care need of children and young people according to current guidance. Therefore, the hospital director had given notice as from December 2016, the hospital no longer provides services to children. No children were booked in to have surgery in the coming months.
- The Director of Clinical Services (DCS) was the hospital safeguarding lead for both vulnerable adults and children and was trained to level three. The DCS had access to the BMI regional safeguarding lead trained to level four. Concerns would be escalated to the DCS and the appropriate safe guarding organisation.

Mandatory training

- The hospital had a mandatory training policy which specified the type of training each staff group was expected to undertake on an annual basis. All staff had access to the BMI Learn system which gives up to date records of staff training records.
- Staff completed their mandatory training though the online system and attended face-to-face training. Staff told us time was made available during the working week to complete the mandatory training.
- Mandatory training included fire, life support, moving and handling, infection control, and safeguarding training. We reviewed the ward staff training records and saw 16 staff were 100% compliant. Six staff were below 100% compliant. Overall the ward was 96.8% compliant.
- Nursing staff completed life support training. Registered nurses completed advanced life support training (ALS) with clinical support staff completing basic life support training.
- The RMO completed mandatory training prior to attending sites through training courses. Upon completion they are provided with a certificate which was included within the documentation sent to BMI The Somerfield Hospital. All RMOs undertook yearly updates

and completed modules which included: health & safety level two, child protection level three, first aid essentials level two, safeguarding adults level two and mental capacity level two.

Assessing and responding to patient risk

- The majority of patients attended a nurse-led pre-operative assessment prior to their surgery. However, the pre-assessment nurse told us some patients will have telephone consultations. This included patients less than 60 years of age, patients with no long term medical conditions and colonoscopy patients less than 60 years of age. If any issues were raised during the telephone consultation would lead to a full assessment. Any patients who were identified as not medically fit would be referred back to their General Practitioner(GP).
- We observed a pre-operative clinic and found the assessment to be thorough. The nurse recorded the patient's observations, reviewed their medical and drug history, completed an infection control screening and discussed the procedure they were being admitted for and the discharge arrangements. They also completed various risk assessment including VTE and pressure ulcers. Any medical tests undertaken elsewhere will be requested to ensure all the appropriate information was available on admission.
- Any concerns identified during pre-assessment were highlighted to the anaesthetist and consultant to ensure BMI The Somerfield Hospital provided a safe place of care. Theatre, the wards, and catering staff were informed of any special needs patients may have following the pre-assessment visit. This included personalised information including allergies, chronic medical conditions and infection control status. This ensures all staff were adequately informed prior to the patients admission.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients in the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of medical or surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.
- The hospital did not have the facilities to manage patients who required level two and three critical care support. We were told if a patient's condition deteriorates, they would be transferred as an emergency to the local NHS hospital. This meant the hospital carefully screened patients during the pre-admission consultation to exclude operating on patients assessed as a surgical risk.
- In theatres we observed pre-surgical safety huddle meeting where each patient on the list was discussed along with the instruments and drugs required and any allergies. During the huddle, it was decided the order of the list needed changing. We saw the hospital policy for the management of changes to the operating list were followed. The decision to change the list order was discussed and agreed as a team. The theatre list was reprinted.
- In theatre we saw guidelines for critical treatment management in anaesthetics. These guidelines were accessible and displayed in the anaesthetic room. Staff told us what would happen if an emergency were to happen. There was an internal alarm bell system to summon help in the case of patient collapse and cardiac arrest. This included dialling 2222 for the resuscitation team. Any patients requiring further interventions would be transferred to the neighbouring NHS Trust.
- The ward was using the National Early Warning Score (NEWS) scoring system to identify and escalate care of any deteriorating patients. When a patient was identified as deteriorating by nursing staff their concerns were immediately escalated to the RMO. The RMO was available on site 24 hours a day and reviewed any deteriorating patients immediately. If the RMO was concerned about a patient's condition, they contacted the consultant to make them aware of the situation.
- The theatre department had implemented the World Health Organisation (WHO) five steps to safer surgery. There was an established audit process. In the last audit '5 steps to safer surgery' achieved 91% compliance. We observed the nurse verbally confirming with the team the instrument, sponge and needle count were correct.
- Data provided by the hospital showed 100% VTE screening rates in the reporting period (July 2015 to June 2016).

- The duty manager had a folder giving access to emergency support. This included on call rotas, escalation process for the transfer of the patient and other clinical emergency processes.
- The anaesthetists in charge of the list were responsible for patient's airway management in the post- surgery period and were available if there were any requirements to return to surgery. Staff told us anaesthetists were easily contactable.
- Patients discharged are given the contact number of the ward and are told they can contact the ward at any time with any queries they may have. The nursing staff undertakes a telephone review 48 hrs post discharge. A template documenting the telephone conversation was completed. Nursing staff could then arrange for the patient to be reviewed by the RMO or the consultant if any serious concerns were raised.
- The theatre manager told us any risks were discussed at the heads of department meeting monthly and the clinical governance meeting. Any new procedures the consultants want to introduce into theatre must be agreed with the Medical Advisory committee (MAC).
- We saw appropriate evidence that pregnancy testing took place for all patients of childbearing years undergoing a procedure which needed sedation or general anaesthetic.

Nursing staffing

- The BMI Healthcare Nursing Dependency and Skill Mix Planning Tool 2015 was in use to guide staff to ensure the right members of staff are on duty at the right time and with the right skills, to ensure safe patient care. Staff populated this five days in advance so that staff levels were reviewed and planned in a timely manner. The Five Day Booking Rule meant no patients can be booked in, less than five days unless strict criteria are met and it is agreed and signed off by the Director of Clinical Services or the Executive Director. However, staff told us the Five Day Booking Rule policy was not always adhered to and extra patients could be added to the ward or theatre lists up until the last moment which meant staff felt pressured but care was not compromised.
- The ward manager completed duty rotas in advance. Staff worked flexible hours to cover the rota and all shifts. Bank staff generally covered gaps in the rota.
- The ward had an establishment of 14.2 whole time equivalent (WTE) registered nurses (RN's) and 3.5 WTE healthcare assistants (HCAs). Since the large majority of patients were elective admissions, staffing levels were planned in advance. However, staff felt the ward was understaffed when staff went off sick or were on annual leave.
- The use of bank and agency RN and HCAs in inpatient departments was 0% or lower than the average of other independent acute hospitals we hold this type of data for in the reporting period (July 2015 to June 2016).
- We observed the nursing handover and found it to be a structured and effective communication tool, which promoted continuity of good care. The handover took place in the ward office to protect patient confidentiality and privacy. Relevant information including NEWS, which indicates any risk of deterioration was discussed.
- The theatre manager described the theatre utilisation tool (TUT). This tool was used to analyse the number of key theatre department processes. The TUT increases the efficiency of the department by reducing staffing costs, creating capacity for additional caseload, improving patient safety and therefore ultimately increasing satisfaction for patients, consultants and staff.
- Theatres also use the BMI Resource Model for theatres, which incorporates Association for Perioperative Practice (AfPP) guidelines for safer staffing. In line with the recent new BMI Rostering Policy, four-week rostering was now in place across departments with variable shift patterns.
- In theatre establishment was 4.6 WTE operating department practitioners (ODP) and HCAs with 8.8 WTE registered nurses (RNs).The ratio of nurse to OPD and HCA of 1.9 to one. The theatre manager told us bank or agency staff would fill any gaps in the rota.
- We reviewed the data and saw that over the reporting period (July 2015 to June 2016) the use of bank and agency for theatre nurses, ODPs and HCAs was 0% or lower than the average of other independent acute provider we hold this type of data for in the reporting period (July 2015 to June 2016).
- On the theatre risk register the use of agency staff has an amber risk rating. If agency staff were used all had to

complete an induction programme and if possible the same agency staff were re-employed. The risk register stated theatres may not be able to provide a surgical first assistant on every occasion as not all staff had completed the training. A process had been developed to allow consultants to bring their own first assistant to support the theatre list.

- A physiotherapist was employed to work on the ward. The physiotherapist reviewed patients twice a day and organised outpatient physiotherapy appointments on discharge.
- Administrative assistants were employed in the operating theatre and on the ward to support nursing staff and enable them to concentrate on patient care.

Medical staffing

- Patient care was consultant led and the hospital practising privilege agreement required the consultant review inpatients admitted under their care at least daily or more frequently according to clinical needs. The ward manager told us this may be in the form of a telephone review. If on occasions the consultant was unable to review the patient they were required to nominate another named consultant (with practicing privileges) to provide cover. Up to date contact numbers for consultants were available to nursing staff in wards and operating theatres**.**
- BMI The Somerfield Hospital had two Registered Medical Officers (RMOs). There was a RMO on site 24 hours a day. One RMO worked two weeks on, one week off, and the second RMO worked for one week on a fixed rotation. Due to the nature of the workload, it was unusual to need to call upon the RMO out of hours. The ward team ensured all routine jobs had been identified and actioned prior to the RMOs last round of the day. In this way the RMO is only called due to an emergency or unexpected situation that cannot be postponed.
- The RMOs were contracted through an outside agency. The agency provided training and undertakes assessments on the RMOs. A RMO 'call out' proforma was in place to monitor the number, type and duration of any RMO contact during silent hours and weekends to ensure the RMO were not over worked which could compromise patient safety.
- The RMO took clinical responsibility for the patients 24 hours a day. The RMO's were supported by individual consultants who were contactable 24 hours a day by telephone. The RMOs told us consultants were approachable and provided appropriate support.

Emergency awareness and training

- All staff received fire training as part of their mandatory training programme; staff told us they had the opportunity to rehearse scenarios and we saw evacuation equipment was available on the ward. Fire alarms were tested weekly.
- BMI The Somerfield Hospital had a business continuity policy and plan in place with various scenarios that may affect the day-to-day running of the ward and theatres such as severe weather conditions, utilities failure, IT infrastructure failure and responses to a major incident. We saw procedures in and out of hours were in place along with the contact details of all relevant persons and emergency response numbers.
- In theatre we saw a folder containing major incident information. The folder contained up to date rotas, consultant contact numbers, and key policies.

Are surgery services effective?

Good

We rated effective as Good.

Evidence-based care and treatment

- Policies and procedures used within the surgical department and the hospital, followed evidence based practice. We saw the majority guidelines were up to date and referenced to current best practice from a combination of national and professional guidance. Reviewing the clinical governance meetings minutes we saw new legislation, National Institute of Health and Care Excellence (NICE) and Royal College guidelines were regular agenda items. Staff members were allocated policies to review that covered there area of expertise.
- All staff knew how to access policies online, although printed copies were available in folders on the wards and theatres. The folders contained the most up to date

versions of the guidelines and register lists were kept to record which members of staff had read the document. All staff were encouraged to read policies relevant to their scope of practice. A policy co coordinator had been appointed to refine the local policy process.

- BMI The Somerfield Hospital had a comprehensive audit programme in place which supported the care provided against its own policies, work instructions, and standard operating procedures. This audit programme reflected local and national audit requirements and results were used to influence change. However, medication audits were behind schedule due to staffing issues. The senior management team had appointed a short-term contract pharmacist to support the service.
- National audits included the National Joint Register (NJR), Patient Reportable Outcome Measures (PROMs) and National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD). This demonstrated the care delivered was evidence based and regularly monitored to ensure care was meeting national guidelines and recommendations.
- We reviewed the data available and saw the service was compliant with NICE guidance CG 74: Surgical site infections: prevention and treatment in the pre-operative, intraoperative, and post-operative phases of care.
- The National Joint Registry (NJR) collects information on all hip, knee, ankle, elbow, and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery. BMI The Somerfield Hospital submitted data to the NJR.
- Best practice guidance advises the use of enhanced recovery programmes (ERP) for certain types of surgery. ERPs were in place within the care pathways used on the wards for knee and hip replacements and we saw these were fully completed in the records we reviewed. One patient told us they had received information regarding the ERP.
- Venous thromboembolism (VTE) assessments and prophylaxis were embedded in pre-operative care planning. This was routinely audited to measure quality and risk. The audit data and the medical records we viewed demonstrated compliance during the inspection.
- BMI The Somerfield Hospital did not have Joint Advisory Group (JAG) accreditation for their endoscopy services. JAG is a quality improvement and service accreditation programme for gastrointestinal endoscopy. By having accreditation patients and commissioners would be assured the endoscopy unit was meeting and maintaining JAG standards.
- We reviewed a recent medical records audit undertaken by the ward nursing staff. Of the 25 sets of patient notes, it was highlighted that consultants in eight cases had not completed daily progress notes. To address this, the RMO was to visit all patients daily to formally review the patient and ensure individual concerns are identified and appropriately actioned. In three sets of notes, we found no documentation about the medical care delivered on a daily basis. The reviewing of patients was not following hospital policy
- The theatre manager was able to demonstrate the audits undertaken within the theatre suite. These included audits in anaesthesia (94%), anaesthetic room (100%), immediate pre-operative (95%) and theatre recovery (100%).This meant there was a continuous cycle of quality improvements across the service.
- Blood supplies were available in theatres. We saw protocols for the blood fridge and major haemorrhage. Both protocols were in date and were based on national and professional guidance.

Pain relief

- At the beginning of the surgical pathway, patient information was sent to the patient which included pain control guidance. A medical questionnaire completed by the patient was reviewed at the pre-assessment clinic where individual concerns regarding pain were reviewed and documented. Any concerns identified would be placed on the pre-assessment information sheet, which was reviewed by the anaesthetist. We saw evidence that patients had their pain needs assessed at their pre-operative assessments.
- During the admissions process the control of pain post-operatively was explained to patients. We saw patients had regular analgesia prescribed on their Medical Administration Record (MAR), as well as “as required” (PRN) medication for breakthrough pain.

Good

Surgery

- Pain relief for surgical patients was managed by the anaesthetist, who prescribed regular and 'as required 'analgesia to be administered post-operatively. The RMO on the ward would review the painkillers if the patients' pain was not controlled.
- The pharmacist pro-actively supported pain management at ward level providing advice and support to the patients and the clinical teams. All medications given on discharge were communicated to the General Practitioner on the discharge letter.
- The patient satisfaction questionnaires routinely asked patients how well their pain was controlled. We saw on the September 2016, questionnaire that pain management achieved 95.3% compliance which was an increase of 2.2 % from September 2015.
- In recovery all patients had the National Early Warning Score (NEWS) completed which reviewed pain scores. A pain chart was available which used a stepped process to monitor pain following surgery. The scoring system of 0-3 was used where 0 was no pain and 3 was severe pain. Escalation protocols were in place.
- The ward manager told us when the observations were taken any worries including pain management issues would be escalated to the RMO who would discuss with the anaesthetist or consultant.
- The service provided a range of analgesia options to patients including oral, intravenous and Patient Controlled Analgesia (PCA). Guidance on the use of PCA was available for staff. If a patient required a PCA pump these were attached in recovery. Patients undergoing joint surgery will have spinal anaesthetics. Pain control and anti-coagulants will be written up before the patient leaves theatre.
- The ward manager told us no recent pain audit had been undertaken recently. However, pain was reviewed every six hours on drug rounds, in-between these times the nurses would review pain during their comfort rounds.

Nutrition and hydration

- Nursing staff assessed nutrition on admission using the Malnutrition Universal Screening Tool (MUST) and we saw the MUST was completed in the nine records we reviewed.
- Any patients identified as being at risk of getting dehydrated will have all fluid intake and output recorded on a fluid balance chart. A 24-hour balance will be reviewed and appropriate action taken to address any concerns.
- The hospital did not have a dietician or a speech and language therapist (SALT). However if one was required they would contact the director of clinical services for guidance.
- Any dietary requests would be discussed at the pre-assessment clinic and the catering manager would be informed to ensure dietary requests were in place for the patient on admission. A variety of menus and foods were available to support the needs of patients. One patient told us the food was enjoyable and a variety of food was offered.
- Pre-assessment and ward nurses advised patients of fasting times before surgery. In the care pathway we saw it was 6 hours fasting prior to surgery. This was in line with the Royal College of Anaesthetists (RCOA) guidelines.

Patient outcomes

- Between July 2015 and June 2016, there were four cases of unplanned transfer of an inpatient to another hospital in the reporting period. The assessed rate of unplanned transfers (per 100 inpatient attendances) is not high when compared to a group of independent acute hospitals, which submitted performance data to CQC. There were no trends, with regards to types of surgery, or concerns with individual surgeons, identified.
- When a patient was transferred to a neighbouring NHS Trust, the RMO would regularly phone the trusts for updates of the patient's condition. On discharge, the patients received follow up care at BMI The Somerfield Hospital or the local trust depending on whether the patient was a private or NHS patient.
- There had been two cases of unplanned readmission within 28 days of discharge in the reporting period (July 2015 to June 2016). The assessed rate of unplanned readmissions (per 100 inpatient and day case attendances) is not high when compared to a group of independent acute hospitals which submitted performance data to CQC. We reviewed the data

provided by the hospital and no trends were identified. There were four cases of unplanned returns to the operating theatre in the reporting period (July 2015 to June 2016).

- The medical records we reviewed during the inspection demonstrated that patients had their VTE risk assessed and addressed on admission with a 100% compliance screening rate. Data showed that no incidents of VTE's or Pulmonary Embolism (PE) had occurred between July 2015 and June 2016.
- The hospital submitted data to Patient Reported Outcome Measures (PROMS). PROMs scores were similar to the England average for groin hernias. Primary Knee Replacement was significantly higher than the England average for the following measure: the Oxford Knee Score - Out of 32 modelled records 100% were reported as improved. However, Hip Replacements could not be calculated as there were less than 30 modelled records.
- EQ-VAS or EQ-5D indexes, both of which are additional measures of patient health outcomes, showed health gains for primary hip replacements for NHS patients. Out of 19 modelled records 100% were reported as improved and out of 16 modelled records 81.3% were reported as improved and 6.3% as worsened. Oxford Hip Score - Out of 21 modelled records 100% were reported as improved in the period April 2014 to March 2015.
- BMI The Somerfield Hospital reported no deaths at the hospital in the period July 2015 to June 2016.
- The theatre manager told us a recent Infection control audit was undertaken in theatre. We saw evidence of the action plan and discussion regarding the finding in the minutes of the Clinical Governance and Theatre meeting. A senior consultant who attends the MAC and Clinical Governance meeting feeds back to the consultants, the actions and findings of audits to ensure all staff are actively supporting the process.
- Data was provided regarding surgical site infection rates. In the reporting period (July 2015 to June 2016) four surgical site infections were reported. We saw the SSI's were discussed at the Clinical Governance meetings.
- The theatre manager told us consultants would submit to the National Breast Implant Register. The registry was designed to record the details of any individual, who has breast implant surgery for any reason, so that they can be traced in the event of a product recall or other safety concern relating to a specific type of implant.

Competent staff

- We saw data that confirmed all inpatient nurses and health care assistants have had their appraisals completed in the current appraisal year so far (October 2016 to September 2017). More than 75% of other staff having had their appraisals completed in the same appraisals year with less than 75% of theatre nurses. ODPs and healthcare assistants having had their appraisals completed in the same appraisals year so far.
- Patients were cared for by staff with the right knowledge, experience and qualifications to support their needs within the surgical team.
- Recovery from anaesthesia can be a life threatening process and requires prompt intervention by adequately trained staff in the post-anaesthetic period to ensure a safe outcome for patients. The theatre manager told us staff she was assessing the skills of the staff and making sure the skills matched the range of work undertaken in theatres. Recent training included hover mattresses, difficult airways training, epidural and PCA .Theatre staff had recently been allocated lead roles including infection control for endoscopy, resuscitation, fire, and pain management.
- A study day had been set up for staff around patients with hearing impairment. In theatre, a list was available of the staff that performed sign language.
- The theatre manager told us competency frameworks were in place around the scrub role, anaesthetics, and the recovery area. Medical devices competencies were just released and were now in use. Competency frameworks were uploaded to 'BMI Learn' along with performance reviews. We saw evidence staff underwent training and competency based assessments prior to working independently.
- All new staff including agency staff were inducted into their area of work. We were shown completed induction checklists, which outlined department orientation and familiarisation with specific policies.

Good

Surgery

- Surgical staff competence was scrutinised by the medical advisory committee before practicing privileges were granted. Practising privileges were routinely reviewed at the MAC meetings and this was evidence in the meeting minutes we viewed.
- There was a process for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations. This ensured all staff were fit to practise.
- The hospital had a competency based training programme for nurses and HCAs. We saw each staff member had a personal competency and mandatory training folder where they stored their certificates and recorded evidence of learning and development.
- Staff told us they were encouraged and given opportunities to develop their skills. The theatre manager told us two staff have been identified as WHO champions.
- Staff spoke positively about the resident medical officers (RMOs) and their support in delivering care and treatment to patients. The consultants provide professional and peer support.
- All new staff including agency staff were inducted into their area of work. We saw a corporate checklist was in place. We were shown completed induction checklists, which outlined department orientation and familiarisation with specific policies.
- The theatre manager told us all new consultants undergo an informal induction around the theatre suite and if the theatre manager has any concerns about their practice, this was be escalated.
- The theatre manager told us all bank staff would meet with the theatre manager monthly and yearly appraisals will be undertaken. Agency staff were reviewed by their employing agency.

Multidisciplinary working (related to this core service)

- It was evident there was a functional multidisciplinary approach to the care delivered in the surgical department. The documents we reviewed and the staff we spoke with confirmed this. We saw input from pharmacists and physiotherapists in the medical records we reviewed.
- There were no formal multidisciplinary meetings held for surgical patients.
- During the inspection we observed good team working between nurses, theatre staff, pharmacist and RMO.
- We found throughout the hospital, staff worked collaboratively to promote the health and well-being of the patients. It was a small hospital and all staff groups knew each other and were fully involved with improving patients' health and recovery both before and after surgery.
- We observed positive interactions and collaborative working between the ward and theatre staff and in theatres between the surgeons and theatre staff.

Seven-day services

- Consultants provided on-call cover for the duration of their patient's hospital stay. RMOs were available on site 24 hours per day, seven days per week. They were expected to review patients whenever needed and complete day-to-day tasks on the wards.
- The hospital had an on call rota for pharmacy and radiology. If theatre lists were running over the weekend, radiology staff would arrange to come in to support the list. This included Saturday or Sunday working.
- An on-call theatre team were available for emergency returns to surgery out of hours. The team comprised of two theatre scrub practitioner and an anaesthetic practitioner. The anaesthetist was generally the person completing the theatre list.
- Physiotherapist would arrange to come in during the weekend support patients This ensured that patients who required physiotherapy at the weekend had access to the service.
- Patients were advised to contact the ward staff if they had any concerns out of hours.
- Senior managers had an on call rota and were available to staff 24/7.

Access to information

Good

Surgery

- There were systems in place to ensure that staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner. This included test results, risk assessments and medical and nursing records.
- There were paper-based records for each patient; one for medical notes and one for nursing notes; nursing records including observation charts were accessible in the patient's room. This enabled consistency and continuity of record keeping whilst the patient was on the ward, supporting staff to deliver effective care.
- Staff showed us how to access key policies and standard operating procedures on the hospital's intranet.
- Communication from senior management was usually cascaded to staff via team meeting, emails or through the hospital and BMI newsletters
- We found the department provided information, which supported patients and their relatives to make decisions about their care and treatment. At the pre assessment clinic, all the necessary patient information leaflets were given to the patient prior to the procedure.
- Following patients' discharge, their medical notes stayed on the ward until post discharge checks were completed. Once completed, records were taken to an on-site medical records storage room. If clinical staff needed to access medical records administrative staff could retrieve them in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- BMI The Somerfield Hospital had a consent policy in place. In the nine patient records we reviewed, all patients had been consented for their surgical procedure. Consent forms fully described the procedure completed as well as risks associated with it and full signatures from the consenting clinician and patient
- Staff we spoke with, both in theatres and on the wards were aware of the consent policy and the correct procedures to ensure patients gave valid consent prior to any treatment or surgical intervention.
- One patient we spoke to told us they had received lots of written and verbal information and time to make a decision regarding the surgical procedure. A second consultation was arranged to confirm, they were happy to proceed. Consent was then undertaken after the period of reflection on the morning of the procedure.
- All staff received training in the requirements of the Mental Capacity Act 2005 (MCA) as part of their mandatory training. We saw the Mental Capacity policy and documentation to undertake mental capacity assessments were in place.
- Staff we spoke with had received training and were aware of Deprivation of Liberty Safeguards (DoLS) principles. However, staff explained they did not have experience of completing a DoLS application. A DoLS policy was in place.

Are surgery services caring?

Good

We rated caring as Good.

Compassionate care

- We observed the staff on Gordon ward being very kind, caring, and compassionate towards their patients. All patients and relatives we spoke with told us, staff always introduced themselves, were polite and treated them nicely.
- One patient told us they were treated, "so well by everyone and really enjoyed their stay at the hospital"; "it's a lovely happy place." Another patient told us the staff had been, "helpful and very kind" and in the pre-assessment clinic a third patient told us the staff were, "friendly, efficient and informative."
- On Lister ward we saw thank you letters from patients. Comments included 'thank you for all the tender loving care', 'thank you for making my stay a comfortable one' and 'the care was wonderful.'
- All patients were encouraged to complete Patient Satisfaction Questionnaire's on discharge. The questions in the questionnaire included 'did we do everything to control your pain' and 'did staff tell you about medication side effects'. We reviewed the results

of the September and October 2016 questionnaire and saw the hospital achieved above 85% patient satisfaction. BMI The Somerfield Hospital was ranked 32nd out of 55 BMI hospitals.

- The PLACE assessment for the period of February to June 2016 showed the hospital scored 83% for privacy, dignity and well-being, which was the same as the England average of 83%. The place assessment for privacy, dignity and well-being, focuses on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also includes the practicality of male and female services such as bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.
- The hospital reported consistently high (above 99%) Friends and Family Test (FFT) scores for the reporting period January 2016 to June 2016. There was no differentiation of service between NHS and privately funded patients. The FFT is a simple test that asked patients whether they would recommend the hospital to their friends and family.
- Patient's privacy was maintained by ensuring the doors were closed during personal care or whenever patient needed some privacy with their relatives. We observed that staff always knocked before entering the room.
- The hospital had embraced the 'hello my names is' campaign. This encouraged and reminds healthcare staff about the importance of introductions in healthcare. We saw staff greeting patients in this way.
- Patients felt pleased and respected as they were involved, supported, and encouraged to be partners in their care and decision making. This commenced at the consultation meeting with the consultant and continued through pre-assessment and discharge planning. Support was available across the whole of the surgical pathway.
- Every patient we spoke with was extremely complimentary about the care they received. Patients described the continuity of care as good, as they saw the same team of medical and nursing staff at each appointment. Patients informed us that they saw their consultant daily and the nursing staff were always in and out of their room to check how they were feeling.
- We observed one patient in the recovery area. The nurse looking after the patient was seen to be kind and caring and accompanied the patient back to the ward with the nurse who collected the patient from the ward.

Understanding and involvement of patients and those close to them

- We observed staff being caring and respectful to patients and their loved ones. They explained treatments in a way patients and relative could understand and kept them informed about their care.
- The patients we spoke with on the ward knew the names of the staff and who to ask for if needed. They all told us they felt able to ask questions and ask for help if required.
- Patients told us they had received information from the hospital on the type of surgery they were admitted for and they fully understood the care, treatment, and choices available to them. One patient told us that after reading the information they had a few questions. The patient was able to contact the consultant who was able to answer the questions to the patient's satisfaction.
- All the patients we spoke with were aware of what to do if they felt unwell during admission and when discharge home.
- Patients were informed of the cost of the procedures prior to attending the pre assessment clinic. The hospital has a self-pay lead that puts together a quotation that had been agreed with the consultant. This information was sent to the patient with all the relevant information including a patient agreement form, information booklet on the procedure, pain control guide and infection control leaflet.

Emotional support

- The nursing staff on the ward mainly provided emotional support. Support included reassurance from nursing and medical staff, and referrals to the appropriate professional.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Patients we spoke with informed us staff were supportive and reassuring and gave them and their family the reassurance to ease their anxiety before and after their procedure.

Good

Surgery

- The hospital did not provide counselling services. However, the ward manager told us that if support was required they would consult with the clinical services director for guidance.
- No chaplaincy service was available. Staff told us they would usually contact the nearest place of worship for the patient's religion and arrange for a visit if this was required.

Are surgery services responsive?

Good

We rated responsive as Good

Service planning and delivery to meet the needs of local people

- All surgery carried out at the hospital was elective. Operating theatre lists for elective surgery were available in advance and patients could select times and dates to suit their family and work commitments.
- Sixty percent of the patients attending BMI The Somerfield Hospital were NHS patients who were referred to the hospital from two local NHS Trusts via 'choose and book'. Work performed included knee and hip surgery. BMI The Somerfield Hospital would deliver the pre and post-operative care. The patient would be referred back to local trust for follow up care.
- We found there was active collaboration with local (Clinical Commissioning Groups (CCG's) to respond to requirements for NHS funded patient services to ensure the Somerfield hospital were delivering care to NHS Standards and fulfilling the contract in place.
- Private patients were generally referred to a consultant by the GP or via another consultant although a small number of patients were self-referrals.
- Day case patients who required admission had immediate access to overnight facilities, should they require them. For patients whose stay had to be extended for clinical reasons, the facilities were extended and no extra costs were incurred.
- The ward and theatre staff told us they had good teams in place who could work flexibly if circumstances needed. Extra staff could be brought in if the workload was extra busy although this rarely happened. All patients needed to be admitted and full risk assessments were undertaken prior to surgery.
- All surgical patients discharged from the hospital, including those who had day case procedures, had a telephone follow-up call two or three days post discharge, to ensure no issues had developed. A standard checklist was completed by the HCA; any issues raised would be discussed with a member of the nursing staff, which may result in the patient being booked in for an outpatient review with the consultant or a review on the ward. On reviewing the clinical incidents, we saw patients were called back if any issues developed post discharge.

Access and flow

- Patient access and flow was found to be good at this hospital. Theatres had recently introduced a live system around the usage of the staff and facilities.
- The majority of the hospital's inpatient activity was surgical cases. There were 3,205 inpatient and day case episodes of care recorded at the hospital in the reporting period (July 2015 to June 2016). 18% of all NHS funded patients and 22% of all other funded patients stayed overnight at the hospital during the same reporting period. There were 3,090 visits to theatre in the reporting period.
- BMI The Somerfield Hospital could demonstrate compliance with the 18 week pathway for NHS funded referrals. The hospital NHS team monitor patient wait times and help facilitate admissions to ensure no breeches occur. Below 90% (ranged from 79%-99%) of patients were admitted for treatment within 18 weeks of referral in Sep 15 of the reporting period (Jul15 to Jun 16).
- All other (non-NHS funded referrals) access services were subject only to consultant availability. Once a decision to operate was made in clinic, the bookings team worked closely with the consultant, ward staff, and the patient to agree a suitable date for surgery.

- Patients were offered a choice and staff strived to meet individual surgeon's and patients' requirements. One patient told us the surgery was booked in around their work commitments, which meant they were happy with the service being provided.
- The theatre manager described patient booking system, which was undertaken by the admissions office. Rotas were planned 4 weeks in advance. No extra booking were accepted unless the '5 day rule exception form was completed to ensure the correct staff and equipment were available for each case. No paediatric work was undertaken in theatre since December 2016.
- A discharge pathway for patients was in use on the ward. The patient was provided with appropriate verbal post-operative and written instructions. This meant that staff could ensure that patients had all the relevant information they needed before their discharge.
- BMI The Somerfield Hospital reported they have cancelled 25 procedures for a non-clinical reason in the last 12 months; of these 40% (10 patients) were offered another appointment within 28 days of the cancelled appointment. Reasons for cancellations include staff sickness and equipment failure. All cancellations were discussed at the clinical governance meeting.

Meeting people's individual needs.

- The hospital had a range of patient information leaflets. Patients were sent information regarding their surgery prior to the pre-assessment clinic, so patients could read the information before they attended the hospital. The patients also received a booklet on 'General information for surgical admissions'.
- All patients had individual rooms with en-suite facilities that promoted privacy and dignity. Staff completed care round throughout the patients stay. During pre-operative care rounds patients would be kept up to date about the time they were due in theatre and post operatively they would ensure the patient was not in pain and water was close by.
- Patient needs were identified at the initial pre assessment stage of care. If specific needs were identified, they were communicated to the ward, catering, and theatre staff to ensure appropriate planning before admission.
- All patients had a comprehensive risk assessments carried out at their pre-assessment appointments and on the day of admission. We reviewed nine sets of patient records and saw all risk assessments were carried out at pre assessment and on the day of admission.
- Patient Led Assessment of the Care Environment (PLACE) for February to June 2016 showed the hospital scored 79% for dementia, which was worse than the England average of 80%. The place assessment for Dementia was included for the first time in 2015 and focuses on key issues such as flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- The ward manager told us very few patients with a diagnosis of dementia were admitted to the hospital for treatment as all of the patients were risk assessed prior to admission to ensure the hospital provided a safe environment. Within the knee and hip care pathway information around the needs of the patient are documented however, no other dementia environmental tools were available to support any patients with a dementia diagnosis. However we were told a dementia strategy was being developed.
- In theatre we saw specialist equipment including a special table, blood pressure (BP) meters and larger gowns were in place to support bariatric patients. Bariatric patients would walk down to theatre and be returned to the ward on their beds.
- During our inspection, we observed call bells were answered immediately and staff were attentive to patient needs.
- Patients were offered a choice of food and drinks from a 'Day case' and 'Overnight stay' menu. The catering manager could access 'the source' were a variety of menus were available including any special dietary requirement such as pureed food. In the September 2016, patient satisfaction questionnaire the quality of the food achieved 91.9% and the variety and choice of food achieved 87.4%.Staff told us they provided refreshments for relatives and loved ones.
- In the ward kitchen, we saw a white board which discreetly identified any allergies or dietary requirements of the patient and their room number. If

there were any amendments the nursing staff would inform the catering staff. The catering staff told us they would support patients when delivering the food if they were unable to do it for themselves for example following eye surgery.

- Staff had access to language line to assist communication with non-English speaking patients. However, there were no systems in place to provide literature in other languages.
- Information on special cultural, religious, or dietary needs was gathered at the pre-assessment stage and this information was passed onto the ward, catering department and theatre teams.
- No pain control tools were available for patients suffering from dementia however, 'the loop' was available if patients were hard of hearing.
- The PLACE assessment for the period of February to June 2016 showed the hospital scored 76% for disability, which was worse than the England average of 81%. The place assessment for Disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.

Learning from complaints and concerns

- There were systems to ensure patients comments and complaints were listened to and acted upon effectively. Patients could raise a concern and have it investigated and responded to within a realistic timeframe. The executive director (ED) oversees the management of complaints, which were entered onto a complaints data base and we were able to view during the inspection. For all the complaints we reviewed the provider met the target response times.
- Copies of complaints were sent to the relevant head of the department or consultant for investigation. The final response was provided from the ED, with support from the Director of Clinical Services. BMI The Somerfield Hospital follows corporate BMI Healthcare guidelines (P3 Complaints Policy) for managing complaints. This was a three stage process. Any learning from complaints were cascaded to the appropriate department and shared at heads of department meetings. Management to improve the quality of the service provided used comments and complaints.
- The hospital received 19 complaints between July 2015 and June 2016. No complaints have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period. The assessed rate of complaints (per 100 inpatient and day case attendances) was similar to the rate of other independent acute hospitals we hold this type of data for.
- Learning and actions identified from complaints were discussed with staff members involved. Any learning for a particular member of staff was handled by the head of department.
- The ward manager told us that if a patient was unhappy with any aspect of their care, they would try to resolve the issue verbally for example if there was a delay in the time of surgery staff would give regular updates. Recent complaints included the loss of personal property, post operation concerns, and communication issues. The ward manager was able to explain how changes in practice had addressed these concerns raised through the complaints process.
- Patients were given information about how to raise concerns or make a complaint. BMI have an information leaflet ''Please tell us'' which provides guidance on how to raise concerns and was available throughout the Hospital.
- Patients are able to speak with heads of departments and ward managers during their visit/admission to hospital to discuss any issues they may have. All patient rooms have a 'Patient Information Guide', which includes a section outlining the formal complaints procedure. Patients and their relatives were supported to make comments and raise concerns if they were not happy with the care they received and staff were unable to answer their concerns.
- All complaints were recorded in the incident reporting system and were discussed at the senior complaints review and monthly clinical governance meetings and included in the clinical governance report. We saw minutes of meetings which confirmed the nature, response and outcome of the complaints.

Good

Surgery

Are surgery services well-led?

Good

We rated well-led as Good.

Vision and strategy for this this core service

- BMI The Somerfield Hospital was part of the BMI corporate strategy as well as a local vision for the hospital. The BMI corporate strategy included a governance frame work to support the delivery of excellent services and minimise risks across all areas of the business, superior patient care by providing the highest quality clinical care and striving to be an employer of choice attracting the best consultants and staff. The BMI vision was to provide the best patient experience and outcomes, the most cost effective way.
- The executive director told us the corporate strategy was a five year plan, which had three years to run. A recent BMI 'national launch of the year' discussed the year ahead which included the responsibilities of the of the senior management team. BMI The Somerfield Hospital annual business plan, which incorporates the risk register, has been updated and sent to BMI for approval.
- A BMI corporate clinical strategy was in place, which was made up of six key themes. This included putting patients at the heart of their work, people were their most important attribute, and quality should underpin everything they do. Staff we spoke to during the inspection demonstrated to us that the clinical strategy was embedded across the hospital.
- The senior management team told us information around the strategy and vision were cascaded from the executive team to the heads of department (HOD) meetings, which were held monthly, the daily 'huddle', and departmental team meetings. This approach was supplemented by frequent one to ones with individual members of the HODs team. Consultants would learn about the vision and strategy through the Medical Advisory Committee (MAC) which meets quarterly.

Governance, risk management, and quality measurement for this core service

- BMI have implemented a National Committee structure, which allows information to be effectively cascaded. This consists of monthly regional meetings, monthly hospital senior management team meetings, which include heads of departments meetings, governance committee and MAC meetings. A standard agenda template was used to ensure a coordinated approach to each meeting. Reports were provided by the relevant leads and presented for review at the governance committee meeting, management team meetings, and risk meeting.
- Governance committee meetings were held monthly and the minutes we saw showed these meetings were structured and well attended. Discussions at these meetings were focused on quality and risks and we saw areas such as incidents, complaints, risk register and the audit calendar were discussed. We reviewed the theatre risk register and saw this was regularly updated and discussed. We saw two red rated risks, seven yellow/ amber risks and four green rated risks. The management of risks was the responsibility of the senior management team who oversee both high level and departmental risks.
- The executive director told us there were robust systems in place around quality benchmarking. This included health and safety audits supported by the regional health and safety manager, fire assessments constantly being re visited and business continuity planning which includes table-top scenarios using corporate expertise. Clinical quality was monitored through Key performance indicators (KPI's) and regular meetings with the Clinical Commissioning Groups (CCGs).
- The senior management team have systems in place to assure themselves the hospital was delivering on its values, which includes 'doing the best for their patients'. Various sense checks were in place including reviewing patient satisfaction surveys, complaints, and incidents, which were all discussed at the governance and health and safety committees. The executive director told us of a service that was identified as being under pressure. A detailed look of the service took place, which resulted in a change of profile of the service to provide a more efficient and appropriate service.

Good

Surgery

- Senior staff from the surgical services were engaged with governance activities at the hospital and represented theatres and the wards at various meetings, including infection control, resuscitation, heads of departments and governance committee meetings.
- We saw the Business continuity plans had been reviewed and updated and the Risk Register was treated as a live document and amended when necessary.
- The hospital had a schedule of audits performed throughout the year, which were the mechanism to ensure there were a cycle of continuous service improvements and good care was being delivered. A wide variety of audits were undertaken including infection control, resuscitation and medical records audits. The recent appointment of the operations manager has resulted in the introduction of environmental audits, which has given assurance around the challenges that exist around the hospital building. Audit results were reviewed at governance committee and the Medical Advisory Committee (MAC) meetings. Following that, results were shared with clinical departments. Action plans were put in place to ensure audit findings were actioned.
- The MAC meetings took place quarterly and practicing privileges, quality assurance and new national guidelines were discussed along with key points from the Governance meetings. The hospital had an effective system in place to ensure that practising privileges were updated with the relevant information.
- We observed the senior staff daily huddle, which was attended by ward leads, estates and facilities, catering, physiotherapy, imaging, theatres, hospital director and the operational director. We saw the meeting was focussed, each area of the hospital was briefly discussed which included staff levels and any relevant issues affecting any department. During the huddle we attended the group discussed the physiotherapy project was due to start, out patients air conditioning being serviced and the replacement sink programme had commenced. This ensured all HODs were aware of what was happening in the hospital. This information was then cascade to all staff across the hospital. We observed good inter-professional communication during the huddle.
- Hospital policies, standard operating procedures and work instructions were reviewed regularly by the senior management team who would identify policies needing updating and send these to the relevant heads of departments. All policies were allocated a named owner with a review date. We reviewed a variety of policies including the resuscitation policy; safeguarding policy and saw the majority were in date.
- We saw infection control and resuscitation meetings took place regularly. Agenda items included policy updates, audit schedule, accidents/incidents, training, and medicine updates. All incidents discussed had outcomes documented and actions taken.
- Feedback from hospital wide meetings was disseminated to staff at local team meetings. Information feedback included learning and development, building updates, any theatre issues and health and safety. Team meeting minutes were shared with staff unable to attend. We reviewed the theatre team meetings and saw

Leadership / culture of service

- We found there was a team of suitably qualified heads of department with managerial responsibilities. The hospital's executive director reports to the BMI regional director for London and the South East. We were told the regional director has visited BMI The Somerfield and leads the executive meetings where all the executive directors meet and discuss the business of the day. Other support was available through the BMI chief operating officer.
- Between April 2015 to March 2016 BMI The Somerfield Hospital had 11 Consultants who had their practising privileges removed on personal requests. One consultant retired. The 140 current and practising consultants were continually reviewed in line with regulatory requirements. This was due to expire and the usual annual and biannual reviews will be undertaken by each speciality. Systems were in place to review the consultants who do not regularly practice at the hospital or undertake any practice at all but continue to retain practising privileges.

Good

Surgery

- The senior management team retained a practising privileges folder with all the up to date information regarding the consultants that practised at BMI The Somerfield Hospital. We saw the information was relevant and up to date.
- There was a weekly mandatory meeting for all heads of department to attend. We reviewed the minutes of a recent meeting and saw the Quality and Safety improvement plan were discussed. Other areas discussed included policy updates, patient feedback and complaints, the governance action plan and health and safety or infection control issues.
- Morale across the departments we visited appeared to be high and staff described they enjoyed working as part of the hospital team. Ward staff told us they worked well together and had good relationship with the theatre team and consultants they worked with regularly.
- The medical director was the chair of the MAC and a member of the governance committee. All new policies were disseminated to the consultants at the MAC meeting along with the clinical governance minutes. At the last meeting we saw the Consent policy had been discussed. Two senior staff members meet with the consultants on a one to one basis, through emails and through the chair of the MAC.
- Regular walkabouts by the senior management team encouraged discussion and comment. Staff on the ward felt able to feedback any issues straightaway. Staff confirmed that members of the senior management visited the ward daily.
- The pharmacist met quarterly with the director of clinical services. We reviewed the minutes of the June and September 2016 meeting and saw that any changes in prescribing are discussed along with incidents and complaints. This demonstrated good practice.
- Staff told us they received training and were empowered to acquire new skills. The ward manager told us an HCA was being supported to undertake national vocational qualification (NVQ) level 3 training.
- The sickness rate for theatre nurses and inpatient nurses were 0% or lower than the average of other independent acute hospitals we hold this type of data for in the reporting period (July 2015 to June 2016) except for four and two months respectfully.
- Sickness rates for theatre and inpatient HCAs were 0% or lower than the average of other independent acute providers in the same reporting period, except for four months.
- The rate of inpatient nurse turnover was above the average of other independent acute hospitals we hold this type of data for in the reporting period (July 2015 to June 2016).The rate of inpatient healthcare assistant turnover was below the average of other independent acute hospitals we hold this type of data for in the same reporting period.

Public and staff engagement

- The executive director held staff forums which were designed to be informal and to encourage a high level of staff engagement with an opportunity to share the vision, results, and future strategy for the hospital. An open door policy was in practice within the hospital for members of staff to discuss ideas and concerns.
- Patient survey questionnaires were undertaken by the hospital. We saw that in the last quarter of 2015/16 compliance was at 98% and in the first quarter of 2016/17 97% of patients rated overall care as good/very good with 100% saying they would recommend the hospital.
- BMI The Somerfield Hospital participates in the annual PLACE audit to ensure we can respond to patient feedback, the results are published and areas for improvement identified. The senior management team have developed an ongoing refurbishment programme because of this.
- The consultant's medical secretaries were employed directly by the consultants and were located off site.
- All patients were actively encouraged to provide feedback. We saw examples of positive feedback and how changes suggested by patients had resulted in a change to the service delivered.

- The hospital was involved in a variety of charitable events, which included breast awareness week, British heart foundation week, jumpers for a day and ice bucket challenge.

Innovation, improvement, and sustainability

- The evidence based Enhanced Recovery Programme was in place for all patients undergoing joint replacement. Staff told us of plans to apply the principles of enhanced recovery to other surgical procedures.
- BMI The Somerfield Hospital has an Infection Prevention and Control programme led by an experienced IPC nurse supported by the Director of Clinical Services and a Consultant Microbiologist. Data for the 12 months including August 2016 confirms no cases of meticillin-resistant staphylococcus aureus (MRSA), meticillin sensitive staphylococcus aureus. (MSSA), Escherichia coli (E.coli).
- The senior management team told us that staff were encouraged to develop. All identified staff had completed Acute Illness Management (AIMs) training with two on site AIMS trainers. AIMs is a course that teaches staff to recognise and initially manage an acutely ill and deteriorating adult patient and aimed at preventing a cardiac arrest. All HCAs have completed their self-assessment for the care certificate and those identified have enrolled in the programme. We have three members of the senior management team completing their ILM level three training.
- BMI The Somerfield Hospital were due to open a Patient Discharge Lounge so that clinically discharged patients had a safe, comfortable area to wait for their escort home.
- A daily communications Huddle takes place with a representative from each department attending; this enables the wider hospital population to understand the daily tasks and challenges as well as communicating the presence of Contractors or visitors on site.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as Requires Improvement

Incidents

- The hospital followed their corporate 'Incident Policy, including Serious Incidents' (dated February 2016).
- A paper-based system was in place for staff to report incidents that were unexpected or untoward. However, staff told us the hospital was changing to an electronic system and staff were waiting to undertake their training and receive a password for the new system.
- Staff were aware of the system and felt it was easy to use. They received feedback at the department team meetings or individually if it was more appropriate. Staff told us, they felt it was their responsibility to actively seek feedback from incidents they reported and they also told us, this was what they did.
- The hospital did not report any 'never events' between July 2015 and June 2016. '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.
- Data received from the hospital showed between July 2015 and June 2016 there had been 308 clinical incidents reported across the hospital, and 67 incidents (22%) occurred within outpatients and radiology The rate of clinical incidents was higher than the rate of other independent hospitals we hold data for.
- All the staff we spoke with in the radiology department told us they were encouraged to report incidents using the paper reporting system, this including both radiation and non-radiation related incidents. A service level agreement (SLA) with St Georges Hospital Medical Physics and Engineering department oversee any radiation related exposure incidents as well as providing expert Radiation Protection support and advice.
- The hospital reported no Ionising Radiation (medical exposure) Regulations (IRMER), 2000 incidents to the Care Quality Commission (CQC) in the last 12 months. A radiation protection adviser (RPA) based at a local NHS trust was available for advice if required.
- A Radiation Protection Supervisor (RPS) was employed by the BMI The Somerfield Hospital to ensure compliance with the Ionising Radiation Regulations 1999(IRR '99) and Ionising Radiation (Medical Exposure) Regulations 2000.The RPS was the first point of reference in the investigation of all radiation related incidents.
- There was a yearly radiation protection committee, where radiation incidents and actions were discussed. The most recent radiation protection committee was June 2016. We saw in the minutes that during routine quality assurance (QA) checks in room one, the dose levels were above the base line. The room was taken out of action until engineers came and repaired the

problem. The RPA confirmed the dose levels were within an acceptable range, before the room could be used. This meant the hospital could be confident the hospital had robust QA system in place.

- Data received from the hospital showed between July 2015 and June 2016 there had been 163 non-clinical incidents reported across the hospital with one incident (1%), occurring within outpatients and radiology The rate of non-clinical incidents was lower than the rate of other independent hospitals we hold data for.
- All incidents and adverse events were discussed at the bi-monthly Medical Advisory Committee (MAC) and the monthly Clinical Governance Committee (CGC) and Heads of Department (HoD) meetings. We saw the minutes of the MAC, CGC, and HoD confirmed this.
- Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened**.** We spoke to one healthcare assistant (HCA) who gave us an example of duty of candour following and incident they were involved in. They explained how they contacted the patient, explained what had happened and apologised.

Cleanliness, infection control, and hygiene

- Staff followed their corporate 'Hand Hygiene Policy' (dated May 2016), which included training, types of hand hygiene, soap and water and wearing of jewellery. Staff in all the departments we visited were observed adhering to 'bare below the elbow' guidelines.
- There were sufficient hand washing sinks and alcohol hand sanitising gel within the departments we visited. Overall staff cleaned their hands in accordance with the WHO 'five moments for hand hygiene'. Data received from the hospital showed that the outpatient department hand hygiene compliance rate for May 2016 and the physiotherapy department for August 2016 to be 100%. This means, the hospital can be confident all staff are cleaning their hands as per corporate policy.
- We saw sinks throughout the departments we visited, which were non-compliant with the Department of Health HTM Health Building Note 00-09: Infection control in the built environment Hospital building note, (3.31-3.32) which says clinical hand-wash basins should not have plugs or overflows (a plug may allow the basin to be used to soak and clean equipment, and overflows are hard to clean). However, staff told us this has been highlighted as a risk, and the hospital informed us there was a programme of work to replace the sinks in the outpatients department.
- The outpatients department undertook flexible cystoscopes (procedure used to examine the inside of the bladder), in one of their minor procedure rooms. We were unable to observe the process of endoscope cleaning, during our inspection.
- We spoke with staff at length and they explained the procedure of safe transfer of the cystoscope to and from minor procedure room to the endoscopy department. Staff put used endoscopes into a red plastic bag, and then placed into a silver tray for transfer. This was important to retain moisture and prevent endoscopes drying out before cleaning, which could make soil more difficult to remove. This was in-line with guidance from the Department of Health's "Choice Framework for local Policy and Procedures 01-06 – Decontamination of Flexible Endoscopes: Operational Management". The red colour of the bag showed the endoscope had been used and needed cleaning. The outpatient department used green bags to cover clean endoscopes to differentiate between the clean and dirty.
- Once the scopes, arrived in the endoscopy department a trained member of the outpatient team would manually cleaning the scope prior to placing into an endoscope washer-disinfector for cleaning. The machine printed a receipt providing assurance it had performed complete cleaning after every cycle. Staff told us the printout alerted them if the machine had not worked correctly. This allowed staff to resolve any faults and re-process the endoscopes to ensure complete cleaning.
- The endoscope washer-disinfector had a barcode tracking system. This enabled the hospital to track the cleaning of endoscopes used by individual patients for quality control.

Good

Outpatients and diagnostic imaging

- The outpatient department also undertook examinations of patients using nasendoscopes (procedure for looking at the roof of the mouth and throat). We were unable to observe procedures during out inspection.
- However, we spoke with staff that walked us through the process of cleaning the scopes. Staff showed us nasendoscopes were cleaned between each use with a triple cleaning system. At the end of each of the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff had used. The records showed each time a probe was cleaned with the three stages completed. We saw records were complete.
- However, there was no designated area for cleaning of the nasendoscopes and they used a desk in one of the main corridors. Patients and staff use this corridor to access the outpatient consulting rooms; in addition, there may be a medical secretary at the second desk in the corridor. Staff told us they would bring alcohol hand sanitising gel and place a bin nearby.
- During our unannounced inspection, we raised this with the Director of Clinical Services who was aware cleaning of nasendoscopes took place in the corridor. We advised this practice was not in line with guidance and needed to be rectified.
- This does not comply with Code of Practice on the prevention and control of infections and related guidance (the code), Criterion 2 that describes the requirement to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. This includes a specific requirement for effective arrangements for the appropriate decontamination of instruments and other equipment. It further explains, “decontamination of reusable medical devices takes place in compliant facilities that are designed for the process of decontaminating medical devices through validated processing systems and controlled environmental conditions to ensure all potential environmental, cross-infection, handling and medical device usage risks are minimised."
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety and reduce risks of cross infection when performing procedures.
- However, staff told us when they undertook cleaning for nasendoscopes; they only wore gloves, and did not wear an apron to protect their uniform, or masks or visors to protect their nose and mouth. Staff did say they wore masks if they found the chemical fumes to strong. epic 3: ‘National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England’ (epic 3), says disposable plastic aprons must be worn when close contact with the patient, materials or equipment that pose a risk that clothing may become contaminated with pathogenic microorganisms, blood or body fluids. Furthermore, fluid-repellent masks and facial protection should be worn when there is a risk of blood or body fluids splashing in the face. The code also says there should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This meant, as staff were not wearing aprons and face protection they were not adequately protecting themselves against infection. This meant the endoscopy policy and Health Technical Memorandum 01-01 Decontamination of medical devices within acute services was not being adhered to as both documents recommend staff should wear PPE during the decontamination process.
- There was a dedicated infection control link nurse for the department. Link nurses are members of the department, with an expressed interest in a specialty; they act as link between their own clinical area and the infection control team. Their role is to increase awareness of infection control issues in their department and to motivate staff to improve practice.
- We saw rotas showing named staff, who were responsible for cleaning designated consulting rooms, which indicated the rooms had been cleaned. The infection control link nurse developed these cleaning rotas as part of their role.
- The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.
- We saw waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations

Good

Outpatients and diagnostic imaging

- The PLACE assessment for cleanliness for the period February to June 2016 was 100%, which was better than the England national average of 98%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings. However, during our inspection we found areas of the outpatient department and minor procedure rooms, were not clean. We raised this with the Executive Director, Director of Clinical Services and Operations Manager, during our inspection.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance.
- Some areas of the department (corridors) had carpet, which could not be as easily cleaned as the laminated flooring when spills occurred. Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment states 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. However, the carpets we saw were visibly clean, we also saw regular deep cleans of carpets had taken place.
- We also saw carpets in the consulting rooms and the physiotherapy main treatment area. This did not comply with the Department of Health HTM Health Building Note 00-09: Infection control in the built environment, Hospital building note (3.82) which states that carpets should not be used as this area has a high probability of body fluid contamination. However, the hospital was aware, and had replaced half the flooring in the consulting rooms, so there was only carpet present under the desk area of the room. We saw there was a planned programme of works to change the flooring in all other appropriate areas.

Environment and equipment

- The outpatient service had eight individual consulting rooms, and minor procedure rooms, used for minor operations such as lumps and bumps and treatment, and an outpatient waiting area.
- The consulting rooms were tidy and equipped with a desk and chairs for discussions with patients, and a couch area for procedures. There was a trolley in the room, which contained sterile disposable items, such as syringes, needles, and gauze swabs, all these items were in date. Disposable curtains were in place and had been changed within the last six months.
- There were 'sharps' bins available in all the consultation rooms and we noted the bins were correctly assembled, labelled, and dated. None of these bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures.
- The radiology department consisted of two X-ray rooms, an ultra sound room, a mammography and an interventional radiology room and an X-ray department waiting area. The imaging department was located on a connecting corridor, between the outpatient department and the main corridor for the hospital.
- The imaging rooms and equipment were visibly clean. 'Clean and ready for use' labels were on equipment which were dated and signed. The mammography room had mood lighting available, these lights are used to establish a particular feeling or mood within a room, and assist staff to make patients feel comfortable during the procedure.
- The radiology department had changing cubicles available for patients to prepare for an examination. The cubicles did not have lockable doors, but disposable curtains, which could be pulled to maintain privacy. The curtains had been changed within the last six months. We saw lockers available for patients to use to store their belongings in whilst they had an examination.
- However the changing cubicles were located in the main corridor area, staff told us they encouraged the patients, when they were able, to change in the imaging rooms, to limit the use of the cubicles.
- We saw ultrasound probes were cleaned between each use with a triple cleaning system. At the end of each of

the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff had used. The records showed each time a probe was cleaned with the three stages completed. We saw records were complete.

- In the radiology department, staff were able to show us a copy of the most recent risk assessment, which was undertaken in November 2016. This was a comprehensive risk assessment that covered occupational, environmental and radiation safety; this includes risks to people using the service, staff, and the public. The Radiation Protection Supervisor carried this out.
- In the radiology examination rooms we visited, we observed the correct storage of specialist PPE including lead aprons, thyroid shield, and gloves. We observed each item was labelled with the thickness of lead and we were told by the radiographer that visual examinations take place regularly and screening of the PPE will take place annually to ascertain if any cracks or folds have appeared. This complies with Regulation 9 (3) of the Ionising Radiation Regulations 1999 (IRR'99). In the last annual check, the theatre aprons were damaged and removed from use, this meant the hospital could be confirmed that staff are adequately protected from radiation.
- Staff were seen wearing personal radiation dose monitors and these were monitored in accordance with the relevant legislation.
- The radiology manager told us that there were systems and processes in place to ensure the maintenance and servicing of imaging equipment. Across the department, we saw that a quality assurance (QA) programme was in place for all radiographic equipment requiring all checks to be performed at regular intervals on all equipment, as required by current legislation. We reviewed the quality assurance records of one of the X-ray units and found that these were generally being completed on a regular basis.
- Staff carried out, QA checks for all x-ray equipment. These were mandatory checks based on the IRR '99 and IRMER 2000. These protected patients, staff, and the public against unnecessary exposure to harmful radiation.
- Records of all equipment faults were recorded and the actions taken to mend any faults that develops during the working day. We saw the necessary QA checks for specialist equipment had been completed following equipment repairs before use. We saw the relevant documentation had been completed in line with legislation and was available in the Radiology office.
- The physiotherapy department consisted of an area with four cubicles with couches, and a private room, a small gym where group rehabilitation sessions could be held following joint replacements, and a waiting area. The department was tidy and well equipped; the cubicle area had disposable curtains, which had been changed within the last six months.
- We saw that staff in the physiotherapy department had competency documents to show they were trained in the use of specialist medical equipment, this meant the hospital ensured staff were safe and competent to use medical equipment on patients.
- We saw two resuscitation trolleys in radiology and outpatient areas. All trolleys were locked. Records indicated that the trolleys were checked daily on days when clinics operated. All drawers had correct consumables and medicines in accordance with the checklist. We saw consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator worked and suction equipment was in order.
- Single use sterile instruments were stored appropriately and were within their expiry dates. The Sterile Services Department (SSD) has been taken off-site to a corporate hub to ensure compliance with regulatory requirements for cleaning (decontamination), Health Technical Memorandum (HTM) 01-01: management and decontamination of surgical instruments (medical devices) used in acute care. There was local 'Instrument Tracking for Minor Procedures' policy (dated December 2016), that staff followed.
- None of the staff we spoke with had concerns about equipment availability and if anything-required repair, they reported that it was fixed quickly. Staff were aware of the process for reporting faulty equipment.

· We saw stickers on equipment, which indicated it had been serviced regularly.

- The Patient Led Assessment of the Care Environment (PLACE) for the period of February to June 2016, which showed the hospital, scored 94%, for condition, appearance, and maintenance, which was better than the England average 93%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.

Medicines

- Staff followed their corporate 'Safe Management of Medicines Policy' (dated August 2014), which included, roles and responsibilities, storage of medicines in hospital departments, dispensing, controlled drugs and preparation of medicines.
- Emergency drug packs for cardiac arrest, anaphylaxis (allergic reaction), and deteriorating patients were available and standardised across the service. This meant staff were familiar with them as they were the same throughout the hospital. Records of locations and expiry dates were kept in pharmacy.
- Medicines were stored appropriately in the minor operations room within the outpatients department. We saw that appropriate medicines were stored in dedicated medicines fridges. We saw records, which showed daily checks were undertaken. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range.
- Staff had access to appropriate information related to medicines such as the British National Formulary 72 and online access to an intravenous medicines guide.
- We reviewed the hospitals prescription pad records and these were recorded correctly. All prescription pads were kept in a locked cupboard. We saw evidence of the prescribing pad log, which was up to date, showing serial number, date and time when the prescription pads were last used.
- The pharmacy department supplied patients' with supporting information with their medication.
- In the radiology department, we saw contrast media and other medications were stored securely in a locked medicine cupboard in the interventional radiology room. An emergency drugs box was available for use when the Computerised Tomography (CT) scanner was on site. All medication was checked weekly. We saw records to confirm regular checks had taken place and all medication was in date. A contrast media extravasation kit was available in the radiology department. This was due to expire in February 2017.

Records

- All the hospital's own medical records were kept on site, or recalled from a medical records store in time for the patient's outpatient appointment. The consultants' secretaries, whether internal or external, provided the consultant's own notes prior to any outpatient appointment. The individual consultant's secretary created patient record files for private patients seen for the first time in outpatients department (OPD).
- The consultants' secretaries brought their own notes with them for their clinics and took them back to their consulting rooms once the clinic had finished. This meant the hospital did not maintain an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided.
- Outpatient data supplied by the hospital confirmed that 79% of patients were seen in clinics without all the relevant notes present for medical and nursing review, which meant that staff could not always easily review patient history and investigations.
- Medical staff, who used their own private patient records during the outpatient consultation, took responsibility for ensuring the records were available. It was a requirement of their practising privileges that they registered as a Data Controller with the Information Commissioner's Office. Any breaches in information security were reported through the incident risk management system. The hospital had taken steps to reduce the risks for any patient records managed off site by consultant secretaries. This included security checks for secretaries visiting the hospital and a request that they attend information governance training and sign a data protection disclaimer.
- Outpatient records were maintained for all patients seen by the nurses in clinic for treatment such as wound

dressings or clip removal. We saw the consulting suite clinical pathways of 10 patients. All pathways were tidy legible, dated, and signed, which was in accordance with the hospitals documentation policy.

- Radiology staff scanned radiology referral forms and consent forms onto the computerised radiology information system (CRIS); this included imaging request form, record of the procedure, WHO checklist and consent form. This meant that radiology staff could access imaging information in a timely manner. Hard copies were stored securely in the department. We reviewed four records and found them to be comprehensive and well managed.
- The Picture Archiving and Communications System (PACS), a nationally recognised system used to report and store patient images, was available and used across the hospital. The radiology department also had access to an image exchange portal for images held on other systems. This access meant staff could view patients' existing x-rays instead of exposing them to unnecessary repeat x-ray procedures.
- Data received from the hospital indicated that 95% of the required staff had completed their mandatory training in documentation and legal aspects and 99% of required staff completed information governance training, which was better than the target of 90%. This meant the hospital could be confident staff were aware of their roles and responsibilities to keep patients information safe

Safeguarding

- There was an up to date corporate 'Safeguarding Adults Policy Incorporating Mental Capacity and Deprivation of Liberties and PREVENT For England and Wales' (dated May 2015) and 'Safeguarding Children Policy' (dated March 2016) with defined responsibilities at national, regional and hospital level.
- Staff received mandatory training in the safeguarding of adults and children, as part of their induction followed by safeguarding refresher training undertaken every two years.
- There had been no safeguarding concerns reported to CQC between July 2015 and June 2016.
- All staff we spoke with knew who the lead was for safeguarding. We saw that there were posters displayed in each department for example, 'Procedure for managing a disclosure of suspected/actual child or vulnerable adult safeguarding incident'. These posters contained flow charts and actions to be taken and who to contact in the event of adult or child safeguarding issues arising. Staff told us the actions they would take if they suspected a safeguarding incident; this was in line with policy.
- Safeguarding of vulnerable adults training was undertaken every two years for levels one and two. Data indicated, 98% of required staff had completed level one, and 93% of required staff had completed level two, which was better than the BMI Healthcare target of 90%. Level three safeguarding of vulnerable adults training is undertaken every three year; data indicated 100% of required staff had completed this training.
- Safeguarding of children training was undertaken every two years for levels one and two. Data indicated, 98% of required staff had completed level one, and 96% of required staff had completed level two, which was better than the BMI Healthcare target of 90%. One-hundred percent of required staff had completed level three training for safeguarding of children, which is undertaken every two years.
- We saw that systems were in place to ensure the right person, gets the right radiological scan at the right time. This included the justification of the request forms on receipt of the request by the modality Radiologist or radiographer who could re direct to another imaging modality if it was felt the requested examination was not appropriate.
- On arriving in the Magnetic Resonance Imaging (MRI) department, we observed patients completing a safety questionnaire followed by checks performed by the radiographer prior to the scan being performed. This ensured the patient had been adequately checked and was medically safe to enter the MRI scanning room.
- The Director of Clinical Services (DCS) was the hospital safeguarding lead for both vulnerable adults and children, and trained to level three. The DCS had access to the BMI regional safeguarding lead trained to level four. This was in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.

- Children aged three and above were seen in the outpatients department. In order to undertake procedures on children and young people, a paediatric nurse must be present. However, the paediatric nurse is currently on long-term leave, so procedures are no longer being undertaken.
- Between July 2015 and June 2016, 608 (3% of overall attendances), children between the ages of 3-15 years attended the outpatient department. One hundred and twenty-five young people between the ages of 16-17 years (1% of overall attendances), were seen in the outpatient department. As of December 2016, the hospital no longer provides outpatient services to children, until they can recruit a paediatric nurse.
- Staff complete an on-line learning module for PREVENT, (protecting people at risk of radicalisation) training. The prevent strategy is the Government's response to help counter the extreme ideologies that recruit vulnerable people and to offer guidance and support to those who are drawn to them. The data request showed 97% of the required staff had completed this training. PREVENT training was undertaken every three years.

Mandatory training

- Mandatory training for all staff groups was comprehensive with many modules accessed through an on line learning system. Mandatory training modules included fire safety in a hospital environment, information governance, Infection prevention and control awareness, safety, health and the environment. Other training was role specific for example patient moving and handling, medical gas training, and acute illness management.
- The BMI Healthcare target for mandatory training compliance was 90%. Figures provided to us showed between July 2015 and June 2016, staff working at the hospital exceeded this target with 95% of staff having completed their mandatory training hospital wide.
- We saw records, which showed 100% of radiology and physiotherapy staff and 96% of outpatient department staff had completed their mandatory training, which was equal or better than the BMI corporate target of 90%.
- The resident medical officers (RMO) were required to undertake their mandatory and statutory training with the agency that supplied them as part of their contract.
- Consultants had to complete mandatory training with the trust they worked for as part of their appraisal process.

Assessing and responding to patient risk

- We observed good practice for reducing exposure to radiation in the Radiology department. Local rules were available in the areas we visited. All rooms that perform radiographic examinations had all the necessary warning notices on the doors and illuminated boxes outside the rooms that light up when a radiographic exposure is made. The warning signs are checked every six months to ensure they are working correctly, we saw evidence of these checks. This was in accordance with present legislation.
- There were emergency procedures in place in the OPD including call bells to alert other staff in the case of a deteriorating patient or in an emergency. The hospital allocated staff to respond to an emergency with the resident medical officer (RMO).
- The hospital always had access to a resident medical officer (RMO), provided by external provider, on duty, who was trained in advanced life support and advanced paediatric advanced life support (APLs). The RMO provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would be transferred to the local acute NHS Trust in line with the emergency transfer policy. Staff reported this rarely happened.
- Staff we spoke with gave us an example of an incident where a patient had become unwell in the department, and had to be transferred to the local NHS trust. Staff told us the process they followed, including how they had followed up with the local hospital for an update on the patient after transfer. The hospital followed the corporate "Adult Resuscitation Policy" (dated March 2015).
- Staff completed a workshop and assessment for acute illness management (AIMs). AIMs are a course that teaches staff to recognise and initially manage an acutely ill and deteriorating adult patient and was

aimed at preventing a cardiac arrest. The data request showed 92% of required trained nurses and 100% of required HCA's had completed this training. AIMs training was undertaken every three years.

- In the radiology department, we saw they used a modified version of the World Health Organisation (WHO) Safety Checklist. This included checks such as patient identify, allergies and ensuring the consent form has been signed. The radiologist and radiographer completed these checklists, in the room with the patient present. We saw four WHO modified checklists, all were fully completed.
- To comply with IRMER, departments have to establish the pregnancy status of a patient prior to any relevant medical exposure. We saw signs prompting women to inform staff if there was a possibility they could be pregnant. In addition, staff asked women if they could be pregnant and recorded this on the electronic records system. Departmental policy states that all patients between the ages of 18-55 years must be asked about their pregnancy status. We looked at four sets of patient records, which identified patients had been questioned and who said they were not pregnant.
- We observed systems were in place to prevent contrast-induced nephropathy. Radiology staff were able to describe the process they would follow in order to check blood results of patients before contrast media injections were administered, therefore reducing the risk of radiation-induced nephrotoxicity.
- Nursing staff within the OPD and the RMO confirmed that if a patient's condition deteriorated then the RMO was available and would attend the department. If further treatment were required then the patient would be transferred to the local NHS trust.

Nursing staffing

- There are no set guidelines on safe staffing levels for outpatient department. Outpatient department staffing levels and skill mix were planned and reviewed on a daily basis to ensure the correct number of staff required to be on duty to ensure safe care and treatment of patients at all times.
- Unqualified staff members including healthcare assistants (HCAs) and reception staff supported clinical staff.
- The use of bank and agency nurses in the outpatient department was higher than the average of other independent acute hospitals we hold this type of data for, between July 2015 and June 2016. However, in December 2015 and June 2016, when the use was lower, than the average.
- The use of bank and agency HCAs in the outpatient department was higher than the average of other independent acute hospitals we hold this type of data for, between July 2015 and June 2016.
- Between April 2016 to June 2016, there were no unfilled nursing shifts.
- As of 1 July 2016, there was 3.2 full time equivalent (FTE) outpatient nursing staff employed and 2.3 FTE HCAs for outpatients. The outpatient department had a ratio of nurse to health care assistant of 1.4 to 1.
- There are no vacancies in the outpatient department, as of 1 July 2016.

Allied Health Professional Staffing

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

Radiology staffing

- The radiology department consisted of three full-time radiographers; one of the radiographers was the radiology department manager. One part-time radiographer and one administration support who worked 22 hours a week.
- There is no administration cover for annual or sick leave of the administration support officer, the radiographers would cover these clerical duties in their absence.

Medical staffing

- We were unable to speak with any consultants during our inspections. However, all staff we spoke with told us they had very good relationships with clinicians.
- There were 141 consultants who had been granted practicing privileges at the hospital. Practicing privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these also worked at other NHS trust in the area.

Good

Outpatients and diagnostic imaging

- There was a corporate BMI 'Practicing Privileges Policy, including consultants medical and dental practitioners' (dated November 2015), which included granting and maintaining practising privileges, and roles and responsibilities. The Executive Director and Medical Advisory Committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.
- The hospital had a resident medical officer (RMO) onsite 24 hours a day, seven days a week, on a rotational basis. The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support.
- Staff in the outpatient department told us they rarely had any issues with clinicians not arriving for clinic. They told us in the event a clinic had to be cancelled at the last minute, the outpatient staff would ring every patient and where possible stop them from attending. They would rebook them onto the next available appointment.
- There was sufficient consultant staff to cover outpatient clinics.
- No medical staff members were subject to fitness to practice hearings at the time of inspection.

Emergency awareness and training

- The hospital would not receive emergency patients following a major incident. The hospital had an emergency incident and business continuity plan in place if there was a power cut or loss of communications.
- The hospital ran exercises such as fire drills throughout the year to ensure staff were trained in the requirements of emergency incidents. Data received from the hospital indicated that 92% of the required staff had completed their mandatory training in fire safety in a hospital environment and 100% of required staff completed fire safety in a non-hospital environment, which was better than the target of 90%. This meant the hospital could be confident staff were aware of their roles and responsibilities to keep patients safe.
- Scenario based training was held regularly, this ensured staff responded appropriately to emergencies. For example, staff told us they had recently responded to a scenario based on a patient who had collapsed in the corridor and required resuscitation

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

Evidence-based care and treatment

- The Ionising Radiation (Medical Exposure) Regulation 2000 (IRMER), stipulate the basic measures that need to be in place to provide radiation protection of persons undergoing a medical exposure. Across the imaging modalities we visited, we observed the regulations were being actively implemented.
- We saw evidence of standard operating procedures, clinical protocols; local referral guidelines based on the Royal College of Radiologists guidelines, justification policy to ensure all medical exposures were justified prior to the exposure being made. We saw evidence that systems were in place for the hospital to report 'much greater than intended' incidents to the Care Quality Commission (CQC). This is a statutory requirement and the hospital actively engaged with the CQC.
- The Ionising Radiation Regulations1999 (IRR '99) aims to protect the public and the health of the staff who work with ionising radiation, by specifying the duties of the hospital to ensure compliance to the regulations. We were able to observe compliance to the regulations within the department through the carrying out of risk assessments, QA programmes and the provision of PPE, the development of local rules for each modality and the employment of a RPS. Radiation protection policies, including Local Rules, were available within clinical areas.
- National Diagnostic Reference Levels (DRLs) were available together with the local rules. In one of the X-rays rooms we visited the radiographer was able to show the levels set which enables the patients dose to

be calculated at the end of the medical exposure. These were derived from the DRLs and with input from the medical physics expert. Staff told us that the Medical Physics expert monitors the 'DRL' as part of the rooms Quality Assurance Programme that was scheduled regularly. The outcome of the exposure must be recorded together with data to permit a patient dose to be measured. If the DRL is exceeded, a note was made of the reason and recorded in the radiology management system.

- The department had a variety of clinical protocols in place. We observed that guidance from the Royal College of Radiologists was used as a basis to develop local policy.
- We saw minutes of the Clinical Governance Committee, which reviewed recent NICE guidance monthly.
- Staff in outpatients, radiology, and physiotherapy had a good awareness of and had read local policies. They were able to give us examples of how to find policies and when they had used them.
- The OPD undertook a variety of local audits. They were to check equipment, medicines management, electronic records, hand hygiene, and monthly spot check audits. We saw examples of these audits, along with action plans arising from them.
- The hospital was in the process of developing a dementia strategy based on the National Institute of Health and Care Excellence (NICE) guidance, such as NICE CG42 Dementia: supporting people with dementia and their carers in health and social care.

Pain relief

- During out inspection we did not find any patients who were in pain, and required pain relief.
- The Physiotherapy department offered acupuncture and electrotherapy (electrical stimulation used to directly block transmission of pain signals along nerves) were available to provide pain relief, which they offered to the appropriate patients.

Nutrition and hydration

- In the outpatient waiting area there was a hot drink dispenser, and a separate cold water dispenser, which patients could access free of charge.
- There was also a hospital restaurant available for patients and staff to be able to buy hot and cold food.
- The hospital took part in the Patient Led Assessment of the Care Environment (PLACE) audit February to June 2016, which showed the hospital scored 92% for organisational food which was better than the England national average of 91%. However, for ward food the hospital scored 82%, which was worse than the England national average of 92%, and 90% for food, which was worse than national average of 91%. The assessment for food and hydration covers organisation questions looking at the catering services provided such as choice of food, 24-hour availability, mealtime, and access to menus. It also includes an assessment of food services at ward level, looking at areas such as the taste and temperature of food.
- On reviewing a patient information letter sent to patients prior to attending for an interventional radiological examination, guidance was given to patients around nutritional and hydration requirements, prior to the investigation. For example patients who may be diabetic, were placed first on the list and requested to ensure the patient's health was not compromised prior to the examination.

Patient outcomes

- BMI The Somerfield Hospital had a contract to undertake Knee and Hip imaging without the provision of a radiologists report. In order to comply with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) the referrers (orthopaedic surgeons) had to sign a statement that they would comply with IRMER and record a clinical evaluation of the outcome of the X-ray in the patient's notes. Radiology department to ensure compliance to IRMER was auditing this. However, one orthopaedic surgeon had not signed the agreement and required reports on knee and hip X-rays.
- During our inspection, we saw this process was regularly audited; one consultant was audited each month. Five patients were randomly selected; the department contacts the consultant's secretary and requests the letter with the radiology examination reported. The radiologist, along with the radiology examination to confirm the diagnosis, reviewed this to confirm diagnosis.

- Physiotherapy staff asked all patients to complete a patient reported outcome measure (PROM). This enabled staff to measure the effect of treatment on each patient. See the main surgery report for a breakdown of the PROMs data.

Competent staff

- The hospital had systems in place for supporting staff with learning and development. The hospitals appraisal year runs from October to September. Between October 2016 and September 2017, 90% of nursing staff and 80% of HCAs, had received an appraisal. This meant the service was able address any potential staff performance issues.
- Staff who had, had an appraisal told us they were undertaken yearly. They felt it was useful and managers discussed performance and opportunities for training and progression.
- All staff working in the outpatient, radiology and physiotherapy department completed competency assessments to ensure they had the skills and knowledge to carry out the roles they were employed to do. Staff were also encouraged to undertake continuous professional development (CPD) and were given opportunities to develop their clinical skills and knowledge through training relevant to their role. For example in physiotherapy, we saw competencies were undertaken in electrotherapy, the treatment for pain. Competency assessments were completed before staff could undertake the specific procedure. This meant the hospital could be confident staff were safe and competent to use medical equipment on patients.
- However, we saw competency assessment of staff who undertaken cleaning of cystoscopes, these were dated 2009. The "Choice Framework for local Policy and Procedures (CFPP) 01-06 – Decontamination of Flexible Endoscopes: Policy and management", says all staff, including new staff, who will be involved in the decontamination process are specifically trained in their role and in the broad context of endoscope management, decontamination and recontamination prevention, and that this training is kept up-to-date. This meant the hospital could not be confident all staff were up to date in the decontamination process for cleaning reusable equipment, such cystoscopes.
- One hundred percent of nurses and allied healthcare professionals, such as physiotherapists and radiographers who worked within the outpatient and radiology services for six months or more, had recorded validation of professional registration. This meant the hospital conducted annual checks to ensure all the nurses were registered with the Nursing and Midwifery Council (NMC) and ODP's were registered with Health and Care Professionals Council (HCPC).
- A Service Level Agreement (SLA) was in place to support the hospital with access to a Radiation Protection Advisor (RPA) as required by IRR ('99) and a Medical physics expert (MPE) as required under IRMER. Both roles being undertaken by a registered physicist. The RPA's duties include producing Diagnostic Reference Levels, writing Local Rules in collaboration with Radiation Protection Supervisor (RPS), advising the RPS and attending the Radiation Protection Committee on matters of dose limit/ dose excesses/incidents.
- All Radiographic staff were trained by the Society and College of Radiographers (SCoR) and held either a Diploma of the College of Radiographers (DCRR) or a BSc (Hons) in radiology. All staff were registered on a two year basis with the Health and Care Professionals Council (HCPC).There are codes of Practise for both the SCoR and the HCPC which must be followed, any breaches will result in a radiographer being reported. No staff had been referred to either professional body for misconduct.

Multidisciplinary working

- Collaborative working between the radiology and surgical department meant each area knew the number and type of patient that would be receiving treatments and may need interventions.
- There was a strong multidisciplinary team (MDT) approach across all of the areas we visited. Staff of all disciplines, clinical and nonclinical, worked alongside each other throughout the hospital. We observed good collaborative working and communication amongst all members of the MDT. Staff reported that they worked well as a team.
- Staff told us they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another.

- There were a number of service level agreements in place with nearby organisations, which involved teamwork to ensure continuity of care for patients. For example, the hospital had a service level agreement with the consultant microbiologist at a local hospital for 24-hour access to an infection control doctor.

Seven-day services

- The outpatient department ran clinics between 8am and 8pm, Monday to Friday. Staff cover was provided between these times. Rooms were scheduled on a weekly basis to ensure clinic space available.
- The radiology department was open between 8am and 8pm, Monday to Friday. A 24-hour a day, seven-day a week service for urgent examination requests.
- There was a pharmacy service available at the hospital, Monday to Friday from 8am until 5pm. Either a pharmacist or pharmacy technician (with phone access to a pharmacist) provided an on-call service 24 hours a day seven days a week. Patients could also contact the on call pharmacy service at any time.

Access to information

- Outpatient consultations within the hospital were consultant-led. All NHS patients attending outpatients would either have an enclosed GP referral letter or their current medical records from a previous appointment or admission would be available at the hospital.
- 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.
- GP referral letters would also be available for private patients, unless self-referring. In each of the outpatient, consulting rooms there was secure access to the hospital's digital imaging records, NHS imaging reports, as well as cellular pathology and blood sciences reports systems.
- Images from other hospitals could be accessed via a secure computer network in the radiology department. Staff could see what previous scans or tests had been undertaken. This enabled staff to ensure patients did not receive repeat examinations and receive a higher dose of radiation than required. The consultants and RMO had access to these as required.
- Clinical and quality communication boards displayed the hospitals compliance with key clinical indicators and were shared within patient areas around the hospital.
- The hospital had daily 'huddle' meetings attended by representatives from all departments in the hospital, including outpatients, radiology, and physiotherapy. These meetings allowed for escalation of concerns or shortfalls in staffing. All departments of the hospital were represented at this meeting. During our inspection, we attended one of these meetings.
- The Picture Archiving and Communication System (PACS) link all the patients' examinations and reports together, which mean the Radiologist, can access all examinations and reports during the reporting process. The PAC's system links in with other systems across the BMI Healthcare services, which means if a radiologist not available on site, a global request across BMI group of hospitals can be made requesting an urgent report, from a radiologist at another site. This ensures that there is timely reporting of urgent examinations.
- The Radiology manager told us that an Image exchange portal (IEP) which connects to other hospitals including two local NHS trust was in place to transfer images of their patients who have either received treatment at BMI The Somerfield Hospital or at the two NHS trusts.
- The Computerised Radiology Information System (CRIS) is a workflow management system that used by radiology staff only. All images and patients history can be accessed for comparison and consistency. The information included, patient identifiable information, such as name and date of birth, safety questionnaires, imaging request forms, protocol used and doses and drugs administered, along with the consent and the WHO checklist. This meant the radiologist had all the relevant information available prior to reporting an examination.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Outpatients and diagnostic imaging

- The hospital followed their corporate 'Mental Capacity Policy' (due for review January 2016), which included responsibilities and duties, training, key principles assessing capacity, best interest and refusal to be assessed.
- Data provided by the hospital showed 98% of required staff had undertaken Dementia awareness training, which meant staff was aware of their roles and responsibilities for dealing with patient who are living with dementia.
- Staff in outpatients and physiotherapy told us they rarely encountered patients with dementia or who lacked capacity. They were able to describe the process they would follow if they suspected a patient lacked capacity and knew who to contact for further support or advice on this. We saw there was a list of leads on display in the nurse's office, for staff so they know who to contact if they have any concerns.
- During our inspection we looked at seven, in total, consent forms, three consent from the outpatient department and four from the radiology department. Of the three consent forms from the outpatient department, all had the benefits and risks completed, however, two were not fully completed. We found the sex, age, responsible health professional; job title and patient identification number to be missing, as well as the consultant did not print their names. Of the four we reviewed in radiology, we found them to be fully completed.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as Good

Compassionate care

- Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) QS15.
- We observed staff interactions with patients as being friendly and welcoming. We observed some instances where patients attended clinic regularly had built relationships with the staff that worked there. We saw examples of caring interactions by staff. For example, friendly greetings, getting down to a patient level to interact with them and maintaining eye contact. We observed consultants introduce themselves and shake patient's hands when called in for their appointments.
- We saw enquiries made at the reception desks were responded to in a polite and helpful manner. We saw patients being redirected to other clinic locations with a clear and reassuring approach.
- We saw that staff always knocked and waited for permission before entering clinic rooms.
- A patient told us, "all staff were pleasant to deal with." Patients we spoke with were very positive about the way staff treated them. Patients told us staff were, "fantastic", "friendly", "efficient" and "reassuring."
- The PLACE assessment for the period of February to June 2016 showed the hospital scored 83% for privacy, dignity, and well-being, which was the same as the England average of 83%. The place assessment for privacy, dignity and well-being, focuses on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also includes the practicality of male and female services such as bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.
- Patient's privacy and dignity was always respected in the care we observed. The outpatients department provided an accompanying or chaperone service during physical or intimate care. This person acted as a safeguard and a witness for patients or healthcare professionals during intimate medical examinations or procedures.
- We saw chaperones were available. The hospital followed their corporate "provision of chaperones during examination, treatment and care" policy (dated September 2015), which outlined roles and responsibilities, training and best practice guidance. We also saw there was a chaperoning register, we reviewed the chaperoning register, and it was up to date and in line with the hospitals policy.

Good

Outpatients and diagnostic imaging

- We saw posters informing patients that chaperones were available on display in the waiting areas and in all the consulting and treatment rooms. Patients were given the opportunity to accept or decline a chaperone during their appointment with a consultant. The decision to accept or decline was recorded in the chaperoning register.
- Staff were expected to keep patients informed of waiting times and reasons for delays. We observed during our inspection clinics were running on time. However, staff told us, if delays occurred, they would inform the patients when they arrived at the hospital of the delay and the reasons for this.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction they have received. The test data for all patients between January to June 2016 showed the hospital had consistently high scores (99% and above) and the response rates varied between 36% and 81%. The response rates for this period were or better than the average England response rates for NHS patients, except for January where the response rate was lower. This showed that the majority patients were positive about recommending the hospital to their friends and family.

Understanding and involvement of patients and those close to them

- Staff responded positively to patients' questions and took time to explain things in a way the patient could understand.
- All patients we spoke with told us that their care was discussed in detail with them. Patients told us they were given time and were able to ask questions, and felt included in the decisions that were made about their care. One patient told us, "I was given all the information I needed." Another told us, "I felt like I could ask any anything, and didn't feel rushed."
- Clear and concise information was provided to patients prior to their appointment. They told us the reception staff treated them with kindness.
- We observed consultants behaving in a friendly and respectful manner towards the patients in their care. Consultants came out to the waiting area to greet and show patients to their consulting room.
- Patients' families or carers could accompany them for their consultation as long as the patient agreed. However, they respected the decision of patients when they chose not to involve their loved ones.
- We saw patients and people close to them being consulted prior to radiology procedures and staff were attentive to the needs of the patients. There were no delays evident to patients care and treatment during the course of our visit to the radiology department.

Emotional support

- All treatment and consultation rooms were private and could be used to deliver any bad news, which may adversely affect a patient's future. Staff told us the consultants would inform them if they were about to break bad news to a patient so they would be available to support them. They spent as much time as was needed with the patient and those close to them. They provided support and gave them guidance on where to get further help and support.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as Good

Service planning and delivery to meet the needs of local people

- The main reception desk was enclosed and provided privacy for patients booking into Radiology. This allowed patients conversations with staff to be confidential.
- A range of outpatient clinics were available to meet the needs of the client group. According to data provided by the hospital, this included cardiology, dermatology, ear, nose and throat, general medicine, endocrinology, general surgery, haematology, gynaecology, pain control, podiatry, rheumatology, urology, neurology, orthopaedic, ophthalmology and dietitian. Orthopaedics, general surgery, general medicine and ophthalmology had the highest attendance rates.
- There were no waiting times for physiotherapy treatment and staff saw NHS as well as private patients.

Good

Outpatients and diagnostic imaging

- Patients could access hydrotherapy and exercise classes as part of their physiotherapy management plan.
- The waiting areas were comfortable and uncrowded; there was plenty of seating available.
- Outpatients and imaging departments coordinated activities to provide a 'one stop breast clinic', which enabled patients to undergo breast assessment, specialised breast scanning including mammography and feedback in one convenient appointment.
- Staff could access the hospitals policies and procedures via the BMI intranet page. During our inspection, staff showed us how they did this.
- The outpatient and radiology department was open from 8am until 8pm Monday to Friday. Evening appointments allowed patients who work Monday to Friday 9am to 5pm to access healthcare at a time that suited their needs.
- There was sufficient consultant staff to cover OPD clinics. OPD clinics were timetabled to suit each specialist's availability and obligation as part of the consultants practicing privileges contract.
- The hospital had sufficient space and flexibility for the current number of patients being treated. All patients said their appointment slots gave sufficient time to discuss their conditions.
- There was sufficient free parking to meet patients' needs. However, the hospital recognised the car park was in a poor state of repair, and was a managed risk for patients, visitors, and staff.
- If an inpatient required an MRI scan, this was situated at the back of the car park in a static MRI unit. This would mean the patient would have to be transferred across the carpark, walking, either in a wheelchair or on a bed or trolley, in any weather condition. Although radiology staff told us this rarely happens, there was no provision for safe transfer across the carpark, and in inclement weather conditions.

Access and flow

- There were 2,768 NHS funded patients who attended the outpatient and radiology department for their first appointment from July 2015 to June 2016. There were 2,634 NHS funded patients who attended the outpatient and radiology department for follow up in the same period.
- There were 4,299 patients who were funded either from insurance or self-pay schemes who attended the outpatient and diagnostic department for their first appointment from July 2015 to June 2016. There were 7,318 attended the outpatient and radiology department for follow up in the same period.
- One hundred percent of patients started non-admitted treatment within 18 weeks of their referral in the reporting period from July 2015 to June 2016.
- The provider met the target of 92% of patients on incomplete pathways waiting 18 weeks or less from time of referral in the reporting period (July 2015 to June 2016).
- Access to outpatient appointments was fast and patients told us they were more than satisfied with the amount of time it had taken, to get the appointment. Patients also told us they were able to get appointments at times that suited them.
- Care and treatment was only cancelled or delayed when necessary. We were told the outpatient department did not routinely monitor clinic delays. The clinics we saw during our inspection ran on time.
- Patients reported to the receptionists who logged them in via an electronic booking system and directed them towards the appropriate clinics and waiting areas.
- We were told outpatient department did not routinely monitor clinic delays. The clinics we observed ran to schedule. Staff told us if there were a delay, the reception staff would inform the patients on arrival.
- Staff managed patients not attending clinics (DNAs) by text reminders. The hospital had very low 'did not attend' (DNA) rates. All patients who missed their appointment were followed up and offered a second appointment. If they DNA on the second appointment the hospital would contact the referrer who would be notified of the non-attendance, and would need to re-refer the patient.

Meeting people's individual needs

Good

Outpatients and diagnostic imaging

- Hearing loops were available in the waiting area, along with portable hearing loops, which helped those who used hearing aids to access services on an equal basis to others.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.
- Patients had access to a variety of information leaflets in the hospital. All information leaflets were in English, however staff told us they could access written patient information in other languages through an electronic system and obtained when required.
- There were procedures in place to make sure patients who were self-funding were aware of fees payable. Staff told us they would provide quotes and costs, and ensure that patients understood the costs involved. There were posters on display in the waiting area and in the consulting rooms, advising about fees. Leaflets were available that explained the payment options, and procedures and gave advice of who to contact if there were any queries. The hospital website also clearly described the different payment options available.
- Patient Led Assessment of the Care Environment (PLACE) for February to June 2016 showed the hospital scored 79% for dementia, which was worse than the England average of 80%. The place assessment for Dementia was included for the first time in 2015, and focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- The PLACE assessment for the period of February to June 2016 showed the hospital scored 76% for disability, which was worse than the England average of 81%. The place assessment for Disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.
- The outpatient, radiology, and physiotherapy departments were accessible to patients with a physical disability, as it was all on one floor. There was ramped access to the hospital and we saw there were wheel chairs in the front entrance for patients to use, along with wheelchair accessible toilets.

Learning from complaints and concerns

- The hospital received 19 complaints between July 2015 and June 2016. No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISACS). The Care Quality Commission (CQC) had assessed the level of complaints was similar to the rate of other independent hospitals we hold this type of data for.
- The hospital had a clear process in place for dealing with complaints, including and up to date 'Complaints Policy' (dated October 2015). Staff we spoke to were aware of the complaints procedure. We saw complaints leaflets were available and saw the hospital website had a section detailing how to make a complaint.
- A senior manager had overall responsibility for responding to all written complaints. The hospital acknowledged complaints within 48 hours of receiving the complaint with an aim to have the complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining why. During inspection, we reviewed three of the complaints relating to surgery and saw they had been answered within the specified time frame.
- Staff told us complaints were discussed at the team meetings. We saw evidence in the minutes of team meetings that complaints were a regular agenda item.
- We saw a patient information guide on was available on both the wards, that included a section on the formal complaints procedure. The BMI leaflets 'Please tell us' were located throughout the hospital and contained information on how to raise any concerns.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as Good

Vision and strategy for this this core service

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

Governance, risk management, and quality measurement

- The hospital had clear governance in place. The hospital held meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Heads of Department (HoD) meeting, Infection Control and Medicines Advisory Committee.
- The hospital followed their corporate 'Clinical Governance Policy' (due for review June 2016), which included clinical governance leadership and monitoring and compliance.
- The clinical governance committee (CGC) was responsible for ensuring that the appropriate structure, systems, and processes were in place in the hospital to ensure the safe delivery of high quality clinical services.
- The Clinical Governance Committee (CGC), met every two months and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, risk register review. There was also a standing agenda item to review external and national guidance and new legislation, such as National Institute of Health and Care Excellence (NICE) guidance, such as NICE CG24, Blood Transfusion. This ensured the hospital implemented and maintained best practice, and any issues affecting safety and quality of patient care were known, disseminated managed and monitored. During out inspection we saw the minutes of the CGC held in November 2015, January, March, and June 2016.
- The MAC met quarterly and the minutes of the meetings held in May and September 2015, and January and May 2016 were reviewed. The minutes showed key governance areas such as never events and incidents, practising privileges, and feedback from the CGC were discussed.
- The HoD met monthly and the minutes of the meetings held in May, June, July and August 2016 were reviewed. The minutes showed items discussed included complaints, clinical governance, audit results, and key departmental feedback. These meetings also shared staff experiences and information was shared back with staff in the departments.
- The hospital have a Radiation Protection Committee (RPC), which meets every year and was an important part of the radiation clinical governance process. The radiology manager chaired the group but attendees included the RPA, a consultant radiologist, and the hospital executive director.
- On reviewing the minutes of the last RPC, we saw radiation audits, the QA programme; risk assessments incidents, new legislation, and radiation staff training were all discussed. This gives assurance that radiation safety was a high priority across the hospital and the appropriate systems were in place to monitor radiation safety.
- An annual radiological protection report was produced by the RPA, which gives a summary of the radiation protection for ionising radiation across the Somerfield hospital. The report gives an update on areas including equipment surveys, radiation incidents, radiation protection, and new legislation. There were no specific recommendations from the report. The department was to maintain its high standards of radiation protection.

Leadership and culture of service

- Outpatient staff reported to the outpatients' manager, who reported to the director of clinical services (DCS). Radiology staff reported to the radiology manager, who reported directly to the DCS. Physiotherapy staff reported the lead physiotherapist, who reported to the DCS.
- Many staff had worked at the hospital for a long time, and said they enjoyed working there. Staff spoke positively about their relationships with their immediate mangers.
- Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to. Staff said any inappropriate behaviour would be dealt with immediately.

Good

Outpatients and diagnostic imaging

- Managers encouraged learning and a culture of openness and transparency. They operated an 'open door policy' and encouraged staff to raise concerns directly with them. We saw senior managers visiting the outpatients and diagnostic managing department during our inspection. Staff told us this was a normal daily occurrence.
- We saw that the culture of all the area we visited during our inspection centred on the needs and experiences of the patients. For example, if a mistake happened this was handled in a sensitive and open way.
- The sickness rate for nursing staff working in the outpatient department for the period of July 2015 to June 2016, were 0%, this was lower than the average of other independent acute hospitals we hold this type of data for. However, between February to May 2016, the sickness rates rose to between 5% and 30%.
- The sickness rates for healthcare assistants working in the outpatient department for the period of July 2015 to June 2016, were 0%, this was lower than the average of other independent acute hospitals we hold this type of data for. However, in August 2015 and December 2015 the sickness rates rose to between 10% and 20%.

Public and staff engagement

- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. We saw there were boxes throughout the hospital to place completed form. The hospital also gathered patient opinion from the friends and family test (FFT), and patient led assessment of the care environment (PLACE). Departments used the results of the survey to improve the service.
- There were rewards for staff that had been outstanding, for example, there was an 'Above and Beyond' award scheme in place, where staff could nominate colleagues or patients could nominate a member of staff. Successes were awarded in categories such as; outstanding care, innovative thinking, amazing support, true inspiration, brilliant leadership. No staff we spoke with had received recognition through this scheme, however a member of staff told us they recently nominated an individual, who was always willing to help, and nothing was too much trouble.
- Other staff recognition schemes, included service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years. We saw staff wearing their long service badges with pride, a member of staff told us they were attending the next long service dinner and would be receiving a badge for 30 years' service.

Innovation, improvement and sustainability

- The hospital was currently undergoing a programme of refurbishment, and there was a plan in place to upgrade all the consulting rooms. This included, removing carpets, where they were still present and installing laminate flooring and upgrading all the sinks to clinical hand washbasins. For the carpets in the corridors, they were to be deep cleaned, with a view to replacing at a future date.
- Staff we spoke to in the departments were unable to give any examples of innovation or service improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that staff decontaminating endoscopes must ensure they use personal protective equipment (PPE) and this must be monitored.
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to area where decontamination of reusable medical equipment takes place, to ensure compliance with the Code of Practice on the prevention and control of infections and related guidance.
- The provider must take prompt action to ensure staff are up to date with competencies in relation to decontamination of reusable medical devices, to ensure compliance with the CFPP 01-06.
- Review the retention of out-patient records at the hospital to ensure that a complete record for each patient attending the hospital as outpatients is maintained.

Action the provider SHOULD take to improve

- Ensure dedicated hand hygiene sinks in patient bedrooms are included when carrying out refurbishment in accordance with the Department of Health's Health Building Note 00-09.
- Ensure carpets are removed from clinical areas in accordance with Department of Health's Health Building Note 00-09.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (c) Safe Care and Treatment. Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; **How this regulation was not met:** Not all staff had up to date with competencies in relation to decontamination of reusable medical devices, to ensure compliance with the CFPP 01-06.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (d) Safe Care and Treatment. Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. **How this regulation was not met:** There was no designated area for cleaning of the nasendoscopes, a desk in one of the main corridors was used. Patients and staff use this corridor to access the outpatient consulting rooms; there is at times a medical secretary at the second desk in the corridor.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15(1) 15(2) Premises and Equipment The provider must ensure the safety of staff by ensuring they have the correct equipment and are using it to carry out their work. **How this regulation was not met:** Staff we spoke to were able to describe the decontamination process however, it was unclear if personal protective equipment (PPE) was worn during the decontamination process. This meant the endoscopy policy and Health Technical Memorandum 01-01 Decontamination of medical devices within acute services was not being adhered to as both documents recommend staff should wear PPE during the decontamination process.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (c) Good Governance The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. **How this regulation was not met:** The provider did not have complete outpatient records for all patients.