BMI Bath Clinic

Quality Report

Claverton Down Road
Bath
BA2 7BR
Tel:01225 835555
Website: www.bmihealthcare.co.uk

Date of inspection visit: 15 May 2018
Date of publication: 31/07/2018

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI Bath Clinic is operated by BMI Healthcare Limited. The hospital has an outpatients department, which provides diagnostic and screening services, including an MRI scanner. There are three operating theatres and an endoscopy unit.

The hospital provides surgery, medical care including oncology, outpatient and diagnostic services. Specialties include general surgery, orthopaedic surgery, ear, nose and throat procedures, gynaecology, oncology treatment, ophthalmology and urology services.

We previously inspected this hospital in May 2016 and gave it an overall rating of requires improvement. We inspected this service, unannounced, on 15 May 2018 using our focused inspection methodology. This inspection focused on specific parts of the service that were identified as needing improvement at our last inspection.

The key questions we asked during this focused unannounced inspection were, was it 'Safe' in outpatients and diagnostics and was it 'Well Led' in medicine, surgery, outpatients and diagnostics.

We were not able to change the overall rating of this hospital as this inspection only focused on the specific areas that were identified at the last inspection as needing improvement.

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 also apply to other services, we do not repeat this information but cross-refer to the surgery core service.

Services we rate

We have rated this hospital overall as Requires Improvement.

We found good practice in relation to outpatient and diagnostics care:

- The service managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- Outpatients and diagnostic environments were visibly clean and well maintained and there were measures to prevent the spread of infection.
- Systems had been implemented to keep patients safe and to learn from serious incidents.
- There was a comprehensive system for the management of quality and governance and managers were aware of the risks and challenges they needed to address.
- There was a designated lead for safeguarding children and vulnerable adults. Staff were trained appropriately to recognise and report suspected abuse.
- Patient records were maintained in one place, up to date and stored securely.
- Medicines were managed safely and stored securely.
- Risks were identified and managed with ongoing monitoring and review.

We found good practice in relation to medicine and surgery:

- There was a comprehensive system for the management of quality and governance and managers were aware of the risks and challenges they needed to address.
- Risks were appropriately identified, recorded, monitored and actions taken to minimise these.
- There were systems to keep patients safe and to learn from serious incidents and complaints.
- For surgery an enhanced recovery programme had been reviewed and changes made to meet the needs of patients.

We found areas of practice that require improvement in outpatients and diagnostics.

Summary of findings

- Not all staff were aware who the safeguarding lead for the hospital was.
- Feedback to staff from simulation events of patient emergency did not always take place.
- There was no system that enabled leaders to obtain evidence from staff when they had completed mandatory training with other health care providers.
- Not all staff were up to date with fire awareness training.

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

Amanda Stanford

Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	Where arrangements were the same, we have reported findings in the surgery section. We inspected the well led domain only and this was rated as good.
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We inspected the well led domain only and this was rated as good.
Outpatients and diagnostic imaging	Good 	Where arrangements were the same, we have reported findings in the surgery section. We inspected safe and well led domains only and these were rated as good.

Summary of findings

Contents

Requires improvement

BMI Bath Clinic

Services we looked at were outpatients and diagnostic imaging, surgery and medical care.

Summary of this inspection

Background to BMI Bath Clinic

BMI Bath Clinic is operated by BMI Healthcare Limited. The hospital opened in 1982. It is a private hospital in Bath, Somerset. The hospital primarily serves the communities of the local population and accepts patient referrals from outside this area. Surgery and medical services are provided for inpatients, day-case patients and outpatients. The hospital treats adults and young people aged 16-18. The hospital did not provide services for children or young people younger than 16 years.

The hospital has 65 beds (not all of these are in use). There are 24 bed inpatient rooms, 14 day care rooms, and two ambulatory care rooms. One of these is for one male and one for female patients. Each has four chairs and are used for day case surgery, including eye surgery and spinal injections. There are also three operating theatres, a dedicated endoscopy suite, a diagnostic imaging department, a day-case unit, an oncology ward and outpatient department. Other services at the hospital included health screening, physiotherapy and a travel clinic.

The hospital has had a registered manager in post since October 2016. They are also the accountable officer for controlled drugs.

The hospital also offers cosmetic procedures such as Botox, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

We last undertook a comprehensive inspection at this hospital in May 2016 when we inspected surgery, medicine, outpatients and diagnostic imaging. The hospital received an overall rating of requires improvement. At that time, we looked at five key questions;

- Are they Safe?
- Are they Effective?
- Are they Caring?
- Are they Responsive?
- Are they Well led?

We judged the hospital to be good for effective, caring and responsive in all three services. Surgery and medicine were rated as good in safe. However, all three were rated as requires improvement for well led. Outpatients and diagnostics were also rated as requires improvement in safe.

We re-visited the hospital and carried out an unannounced focused inspection on 15 May 2018, where we looked at all three services. We focused our inspection on whether outpatients and diagnostics imaging were safe and whether all three services were well-led. We found at this inspection the hospital had addressed all the requirements of our last inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in surgery. The inspection team was overseen by Marie Cox, Inspection Manager and Mary Cridge Head of Hospital Inspection.

Information about BMI Bath Clinic

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited the ward, theatres, outpatient and diagnostic imaging. We spoke with 28

Summary of this inspection

staff including; registered nurses, health care assistants, patient administrators, medical staff, operating department practitioners, and senior managers. We spoke with three patients and one relative. During our inspection, we reviewed 13 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 inspected seven times, and the most recent inspection took place in May 2016, which found that the hospital was not meeting all standards of quality and safety it was inspected against.

Activity for year January 2017 to December 2017

- There were 1,147 inpatient episodes of care recorded at The Hospital; of these 514 (45%) were NHS-funded.
- In this same reporting period there were 3,719 day cases and of these 1,645 (44%) were NHS funded.
- There were 30,815 outpatient total attendances in the reporting period; of these 14,697 (44%) were NHS-funded.

Thirty nine surgeons, 34 anaesthetists, seven physicians and 22 radiologists worked at the hospital under practising privileges. Two regular resident medical officers (RMO) were employed via an agency and rotated on a week on, week off rota. The hospital employed 30 registered nurses, 10 health care assistants and 20 patient administrators, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety from April 2017 to April 2018

- No Never events
- Clinical incidents 355, there were 252 with no harm, 89 low harm, 12 moderate harm, 1 severe harm, 1 death
- one serious injury
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Fifty six complaints.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision
- Security

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Outpatients and diagnostic imaging only

We found the following areas of good practice:

- The service managed staffing effectively and had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- The environment in outpatients and diagnostic imaging was visibly clean and well maintained. Changes had been made following our last inspection to prevent the spread of infection.
- Learning took place following incidents to keep patients safe and to meet their needs.
- There was a designated lead for safeguarding children and vulnerable adults and staff were trained to recognise and report suspected abuse.
- Changes to the patient records system meant that each patient had just one set of records.
- Medicines were managed safely and stored securely.

However, we also found the following issues that the service needs to improve:

- Not all staff were aware of who the lead person was for safeguarding.
- Feedback from simulation events of a cardiac arrest did not always take place.
- Not all staff were up to date with fire awareness training.

Are services well-led?

Good

We found the following areas of good practice:

- Staff were aware of the vision and strategy of the provider.
- There was a comprehensive system for the management of quality and governance and managers were aware of the risks and challenges they needed to address.
- Risk were appropriately identified, recorded, monitored and actions taken to minimise these.
- There were systems to keep patients safe and to learn from critical incidents and complaints.
- For surgery an enhanced recovery programme had been reviewed and changes made to meet the needs of patients.

However, we also found the following issues that the service needs to improve:

Summary of this inspection

- There was no system that enabled leaders to obtain evidence from staff when they had completed mandatory training with other health care providers.

Good

Medical care

Well-led

Good

Are medical care services well-led?

Good

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

Leadership

Please see the surgical section of this report for main findings that also cover this service.

- The provider ensured that they complied with the Competitions and Marketing Authority (CMA) Order that came into force in April 2015. This relates to the prohibition of persuading a referring clinician to refer private patients to, or treat private patients at, the facilities. The BMI group had a legal statement to make sure all of their services complied with this order. The registered manager was able to share some examples of how they complied with this order. All consultants were transparent about their fee structure.
- There were no incentives for consultants to bring patients to them, all staff had to complete bribery and corruption training and they contributed data to the Private Healthcare Information Network (PHIN). This is the independent, government mandated source of information about private healthcare, working to empower patients to make better-informed choices of care provider. The mission of PHIN is that all patients considering private healthcare will have access to trustworthy, comprehensive information on both quality and price to help them make their decisions.

Vision and strategy

Please see the surgical section of this report for main findings that also cover this service.

Culture

Please see the surgical section of this report for main findings that also cover this service.

Governance

Please see the surgical section of this report for main findings that also cover this service.

- There were no additional governance arrangements for the chemotherapy service. This was included in the governance of the hospital. Multi-disciplinary meetings took place involving all staff included in the chemotherapy service. Any incidents were reported via their computer reporting system and investigated as required.
- The sepsis lead for the hospital was also the infection prevention control lead. The registered manager told us all staff undertook mandatory training on sepsis. Any event of sepsis would be recorded as an incident and investigated.

Managing risks, issues and performance

Please see the surgical section of this report for main findings that also cover this service.

- As part of their monitoring of patient outcomes, deaths of patients were investigated. Medicine reported one unexpected death in 2018, this was also investigated.
- The infection prevention control lead told us as part of their monitoring of the service they checked all blood cultures results weekly to see if any were positive. They also checked microbiology results from wounds to make sure none were showing signs of potential sepsis.
- NEWS 2 was embedded with staff and monthly audits took place to make sure scores were completed. NEWS 2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system, for example, respiratory rate and temperature. The results of these were shared with their local Clinical Commissioning Group (CCG). The last audit they scored 100%. NEWS 2 was used to help staff identify deteriorating patients who may be at risk of sepsis. There had been no confirmed cases of ward-based sepsis. All oncology patients diagnosed with neutropenic sepsis would be reviewed, treated and transferred within the hour to the local NHS trust hospital, if they could not be treated at this hospital.

Managing information

Good

Medical care

Please see the surgical section of this report for main findings that also cover this service.

Engagement

Please see the surgical section of this report for main findings that also cover this service.

Learning, continuous improvement and innovation

Please see the surgical section of this report for main findings that also cover this service.

- The service had not achieved the Quality Mark for Elder Friendly Hospital Wards. This is a voluntary improvement programme established in Autumn 2012.This programme is run by the Royal College of Psychiatrists and its aim is to improve lives of people with mental illness. The hospital was not aware of this scheme but had made some changes to support patients living with dementia. These included specialist boxes which contained 'fiddle mitts" and dolls to help reduce anxiety.
- At our last inspection the endoscopy unit was not Joint Advisory Group (JAG) accredited. This is a quality improvement and service accreditation programme for gastrointestinal endoscopy. JAG support and assess endoscopy units to meet and maintain their standards, offering patients and commissioners a badge of quality. BMI Bath Clinic was working towards this accreditation at the time of our inspection.
- BMI Bath Clinic was working hard to introduce patient pathways in preparation for the admission of general medical patients. This included the appointment of a junior sister with a background in general medicine, staff training and development.

Good

Surgery

Well-led

Good

Are surgery services well-led?

Good

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

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

Leadership

- Leaders had the skills, knowledge, experience and integrity to manage the service provision. The registered manager (who was also the executive director for this location) had many years' experience of management in health care settings. They were appointed after our last inspection and were registered with CQC in October 2016.The registered manager was part time at this hospital as they were also the manager for another hospital for this provider.
- There was a senior management team which consisted of the registered manager, quality and risk manager, director of clinical services and operations manager (which was vacant at the time of our inspection). The Director of clinical services was in charge of clinical services and reported directly to the registered manager. There was a ward manager and theatres manager and staff were aware of the lines of accountability and who they could report concerns or issues too.
- At our last inspection some staff reported that senior leaders were not visible. They were also the executive director of another BMI hospital, which meant they split their time between each location. The registered manager told us they made themselves available to staff either whilst they were at the hospital or by telephone. Other senior staff held weekly drop in sessions and a staff forum was held monthly. Some staff felt it would be better to have a fulltime registered manager on site but said they were supported by other senior leaders.
- Staff could identify the emergency surgery medical/ nursing lead and their roles and responsibilities. At each shift, a member of staff was appointed as the lead on the ward and for day services. A Resident Medical Officer (RMO) was available to support staff with any medical emergencies and they had access to consultants for support. An emergency call system was in place for staff to use if a medical emergency took place.

Vision and strategy

- The stated vision for BMI Healthcare was to provide the largest network of private quality acute care hospitals in the UK and deliver the best possible outcomes and experiences for their patients. This vision also included consistently delivering quality care, being financially successful and being the leading provider of private surgical and medical care in the UK.
- There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. The registered manager told us part of their strategy included providing good quality care to all patients. This would help maintain a good reputation and encourage more patients to come to them for treatment. Other aims included obtaining the best prices for consumables, maintaining compliance with regulations and meeting the obligations of contracts with the local Clinical Commissioning Group (CCG).
- Staff had an understanding of the vision, values and strategy and their role in achieving them. As part of their induction programme all new staff were informed of the vision and how they should promote this. Copies of the vision were displayed around the hospital for staff to see. At staff forums we were told presentations were undertaken that were based on the visions. Staff had access to these through the computer system.
- The registered manager told us how the strategy was aligned to local plans in the wider health and social care economy, and how services had been planned to meet the needs of the population. This included patients being offered the chance to come to the BMI Bath Clinic through a 'choose and book' system. They were in the process of building relationships with the local NHS trust to look at ways they could offer assistance during busy periods.
- Progress against delivery of the strategy and local plans were monitored and reviewed. The registered manager demonstrated patient outcomes were monitored

through a number of ways, for example, patient feedback, complaints and incidents. As part of the contract with the local CCG the service submitted reports to demonstrate they were compliant.

Culture

- Staff told us they felt supported, respected and valued. A number of staff had worked at BMI Bath Clinic for a number of years. They told us they felt positive and proud to work there. Staff said they did their very best to meet the needs of patients who used the service.
- The registered manager told us they had a number of policies and procedures they could use to address behaviour and performance that was inconsistent with the vison and values. They told us they would first look to speak to the member of staff before using the HR processes to try to address their behaviour and performance.
- The culture encouraged, openness and honesty at all levels within the organisation, including with patients who used services. Staff told us they could approach their manager or another manager with their concerns. The registered manager told us staff were encouraged to report any incident, as they operated a no blame culture and wanted to learn from any incidents or complaints.Learning from incidents was shared with staff in a number of ways, including face to face and via e-mail/notice boards. Staff were encouraged to remember the saying 'see something, say something'. This could relate to a positive or negative incident or observation.
- There were cooperative, supportive and appreciative relationships among staff. Staff told us they worked well together and supported each other especially during busy times.
- A freedom to speak up guardian had recently been appointed and posters were available to inform staff of this.
- There was a system to ensure patients using the service were provided with a statement that included terms and conditions of the services being provided and the amount and method of payment of fees. The registered manager confirmed this took place.
- The provider was meeting the requirements related to Duty of Candour. This included mandatory training for staff. The registered manager told us they were there to provide support and advice to staff. We saw evidence of where duty of candour had been used.

Governance

- There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improvements made as and when required.
- The registered manager told us they operated on an eight week cycle of governance arrangements. Sub-committees met first and then fed into other governance meetings. These included the Medical Advisory Committee (MAC), the hospital governance committee and head of departments meeting. We were shown minutes of these meetings. The sub committees were non decision making and any decisions were referred to the senior governance meetings.
- The registered manager said that all minutes for the sub committees needed to be completed before the other meetings.These could then be discussed by senior staff and decisions needed actioned. All followed a standard agenda and were laid out in a clear and easy to follow format. We saw that risks, incidents and complaints were discussed. It was clear how information flowed from senior level through to all departments. A slide presentation was also in place with each set of minutes for staff who were unable to attend and for other staff to read.
- The sepsis lead for the hospital was the infection prevention control lead. The registered manager told us all staff undertook mandatory training on sepsis. Any event of sepsis would be recorded as an incident and investigated. The infection prevention control lead told us as part of their monitoring of the service they checked all blood cultures results weekly to see if any were positive.They also checked microbiology results from wounds to make sure none were showing signs of potential sepsis.
- National Early Warning Scores (NEWS 2) was embedded and monthly audits were undertaken to make sure scores were completed. The results of these were shared with their local Clinical Commissioning Group (CCG). The last audit showed a compliance rate of 100%. NEWS 2 was used to help staff identify deteriorating patients who may be at risk of sepsis. There were no confirmed cases of ward based sepsis.
- The registered manager told us how they ensured the safety of patients if consultant surgeons invited external first assistants, NHS staff or others into theatres. To be

able to do this they had to meet a number of requirements. This involved checks required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. For example, evidence of a recent Disclosure and Barring Service check (DBS) and other checks included indemnity insurance and their General Medical Council (GMC) registration number. Evidence of these checks were held in a register in theatres. We did not ask to see this register during our inspection.

- All surgeons, including those carrying out cosmetic surgery, had to demonstrate to the hospital they had an appropriate level of valid professional indemnity insurance in place. All cosmetic surgeons needed to be on the Specialist Register for Plastics managed by the GMC. Records of these were maintained and checked to make sure they were in date. Surgeons also had to undergo appraisals and maintain evidence of their performance in line with national guidance. We saw that copies of this information was kept by the hospital and was up to date.
- The roles and responsibilities of the Medical Advisory Committee (MAC) were set out and available. We were shown copies of minutes of recent meetings of the MAC.These showed they were well attended with representation from all specialities. There was a set agenda but other topics could be added as required. For example, in the February 2018 minutes the hand washing audit for outpatients was shared as they had failed to meet the pass rate due to concerns with consultants. Minutes of these meetings were available for all consultants to read. A consultant microbiologist also attends the MAC to provide advice and support about infections etc.
- Governance procedures were implemented for managing and monitoring any Service Level Agreements (SLAs) the hospital had with third parties. A service-level agreement (SLA) is the commitment between the service provider and client where particular aspects of the service such as quality, availability and responsibilities were agreed. For example, the hospital had an SLA with the local NHS acute trust for deteriorating patients. The registered manager told us this was reviewed at set meetings and any changes made as required.
- We found at our last inspection the post operative enhanced recovery programme had stalled as the member of staff leading this had left. After our last inspection a team was formed to review post-operative recovery.The team included a physiotherapist, occupational therapist, nurse etc. They looked at ways of improving the patient pathway from pre admission clinic to discharge. They monitored patient feedback and took some actions to include where some patients felt their discharge process was rushed. They also looked at ways of discharging patients quicker than their planned discharge date if they had recovered sooner.The team were in the process of monitoring all the action they put in place at the time of our inspection.

Managing risks, issues and performance

- There were arrangements for identifying, recording, managing risks, issues and mitigating actions. There was also alignment between the recorded risks and what staff said was 'on their worry list'. The hospital used their designated computer system to record all risks to their service.This also included recording of all incidents. At our last inspection there were no clinical risk registers, which meant each service could not proactively manage clinical risks. At this inspection we found that the three services we inspected (surgery, medicine, outpatients and diagnostics imaging) all had risk registers in place with risks documented and evidence of review.
- The registered manager was able to show us the risk register for the whole hospital as they had oversight of all risks. We looked at their main risk which related to insufficient investment in facilities and equipment. Actions were in place to minimise this risk with evidence of documents to support this. This was an improvement from our last inspection.
- There was a calendar for clinical and non clinical audits that were required to be undertaken by the hospital. These audits were also shared centrally for the results to be monitored and action plans tracked. We were shown the calendar and types of audits, for example, Venous thromboembolism (VTE) and World Health Organisation surgical safety checklist (WHO). The tracker managed by the provider showed this hospital had one action for monitoring, this related to consultants using pathology laboratories that were not part of the hospitals contract for specimens.
- A monthly report was completed by the quality and risk manager which included an overview of incidents, complaints and compliments. This report included a

brief guide into investigations into certain incidents and evidence of actions taken. We were sent a copy of the report for April 2018 which contained all of this information.

- At our last inspection the WHO safer surgery checklist audits was 83% for Jan 2016. The World Health Organisation (WHO) published the WHO Surgical Safety Checklist in order to increase the safety of patients undergoing surgery. At this inspection we found there was an improvement on this figure with audits recorded at 95%. We saw copies of the audits for theatres.These audits were from October 2017 to April 2018. The format of the auditing tool had altered since October but the information was the same. We saw it was documented that if a question was answered with 'no' the reason was entered at the bottom of the form.
- The registered manager told us and showed us how they monitored and reviewed the surgery carried out. This included their participation in the National Joint Register (NJR) and Patient Reported Outcome Measures (PROMs). The NJR was set up by the Department of Health and Welsh Government in 2002. Its role is to collect information on all hip, knee, ankle, elbow and shoulder replacement operations and to monitor the performance of joint replacement implants. It also looks at the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. PROMs are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patient themselves. PROMs are a Department of Health led programme. The BMI Bath Clinic collected data pre and post operation for hip and knee replacements in relation to health gains. This was above the national average.
- Unplanned readmissions within 28 days and unplanned theatre readmissions were also monitored. Readmission rates for 2017 and 2018 (until April 2018) were well below the national average with a total of four patients. These were all treated and suffered no further harm. Deaths were also monitored and investigated. There were no deaths in surgery for 2017 and 2018 (until April 2018).
- The service had a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance. At our last inspection we found there were no audits for infection control. At this inspection we found that improvements had been made.
- We were told by a senior member of staff hand hygiene audits were completed monthly. A new system had been introduced but staff felt this did not demonstrate the compliance rate. This was a corporate policy looking at each department taking on self-assessments. At the time of our inspection they were experiencing some issues. The previous system was still in use to provide assurances that infection control and prevention actions were taking place. We were shown the graphs from April 2017 to March 2018 for hand hygiene results for the whole hospital. Where issues were found these were dealt with.
- Other audits being completed included the use standard precautions, which was the use of personal, protective equipment and the management of waste management and sharps. Compliance for the period April 2017 to March 2018 for these audits was recorded at 85% and above for all areas except outpatients, as they had not taken part. This had been due to a change in staffing.
- Patient satisfaction for cleanliness was also monitored. For room cleanliness they received 90% and bathroom cleanliness was over 90%.
- Surgical site infection rates were monitored. From April 2017 to March 2018 for hip and knee replacements there were no reported surgical site infections.
- The management team had oversight of performance regarding antimicrobial prescribing. Twice yearly audits examined for example the appropriateness of the antibiotics prescribed and whether the use had followed national guidelines. A pharmacist checked on patient prescriptions on their medication administration records daily to make sure they were also following national guidance.
- The hospital demonstrated they were meeting the National Safety Standards for Invasive Procedures (NatSSIPs). These were published in September 2015 to help NHS organisations provide safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur.The NatSSIPs cover all invasive procedures including those performed outside of the operating department. BMI Bath Clinic had completed an analysis of their compliance with this using their corporate

template. This asked each hospital to assess themselves against a set of statements. For example, looking at skill mix for elective theatre sessions and using the appropriate policy and procedure. At the last inspection there was no system for notifying consultants of changes in practice, policy and updates. At this inspection the registered manager told us that all consultants had access to minutes of meetings on their computer systems, they were sent e-mails along with other staff and they were sent copies of the MAC meeting minutes by their representative. A plan for the future was to make a newsletter for all consultants so they could be kept up to date on all changes in one place.

- The registered manager told us they were in the process of developing collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. This included the local NHS trust to see how they could assist them with surgery during challenging times where demand on their service was very high. Patients were able to use 'choose and book' to request to come to this hospital under the NHS.

Managing information

- There was a holistic understanding of performance, which covered and integrated patient's views with information on quality, operations and finance. This information was used to measure and improve assurance. We were shown details of how the provider rated each of their individual hospitals based on patient feedback. The BMI Bath Clinic was rated in the top three of their hospitals. This rating system was completed by a service independent of the provider. We saw that this hospital had been scoring over 9 (scored for each month with 10 being the best score and one the lowest score) since April 2017.
- Finance was discussed at the Head of Department meetings along with other topics relevant to the hospital. The purpose was not to compromise patient care due to financial issues but to combine them both to provide quality care to patients and to meet their financial commitments to remain viable.
- Quality and sustainability both received sufficient coverage in relevant meetings at all levels. For example, we saw the hospitals dashboard from March 2017 to March 2018 where there had been a 'dip' in scores for the arrival of patients at the hospital. The staff were in the process of reviewing the arrival procedure to make changes to improve this for patients and to look at ways of sustaining this improvement. We saw this was discussed at the Heads of Department meetings and then it was to be shared at the other governance meetings. Staff had access to the minutes of these meetings.
- There were effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate,valid, reliable, timely and relevant. The system used for risk management allowed staff to track their incident reports and view the feedback received. This system also managed the risk registers and enabled staff to monitor, review and amend these.The tool used for audit allowed managers to record audit outcomes and manage hospital's audit action plan.
- Robust arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards. The registered manager told us the hospital was aware of the data protection changes coming into force for the General Data Protection Regulation (GDPR). Information about this was sent to all staff to make them aware. Work was underway on the asset register. Where any data protection breaches had been made this had been reported via their incident reporting system.These were investigated and actions put in place. This included a system for checking three points of data to triangulate it was the correct patient before sending any information to them either by post or e-mail.

Engagement

- Patient's views and experiences were gathered and acted on to shape and improve the service and culture. This included patients from a range of equality groups. The service had identified an issue with patients' arrival and were looking to address this at the time of the inspection.
- To enable all patients to provide feedback the service had access to hearing loops, and could provide any literature in large print and had access to interpreters.
- Staff were actively engaged to share their views about the planning and delivery of services and in shaping the culture.Systems had been implemented to make sure staff had access to information about the service. For

example, staff newsletters, e-mails, monthly staff forum and weekly drop ins. A daily communication huddle took place where all senior staff met to discuss any issues/concerns and to update all staff. We attended one during the inspection and observed discussion of a potential issue with the car parking that may have affected staff and patients during that day.

- Staff had access to minutes of meetings from their computer system. Staff involved in the meetings were able to feedback to staff in their locations.
- The service ensured people considering or deciding to undergo cosmetic surgery were provided with the right information to help them make the best decision about their choice of procedure and surgeon. A patient liaison officer was in place to support people and they were given a cooling off period before deciding if going ahead.

Learning, continuous improvement and innovation

- Leaders and staff strived for continuous learning, improvement and innovation.There were a number of initiatives ongoing at the time of our inspection. For example, a falls prevention campaign following an increase in patient falls. Patients were being encouraged to 'please use your bell to keep safe and well'. A falls group had also been established with multi-disciplinary attendance to champion a falls prevention program and develop patient information to optimise mobility pre- and post-admission. We were shown evidence of learning from internal and external reviews of incidents. For example, following increased incidents at night two registered nurses now checked calculations on fluid balance charts to make sure they were correct. Learning was shared with the ward staff on this. Following feedback from patients about communication a new pricing information leaflet was to be sent to patients by medical secretaries with appointment letters, and also given out on main reception at the point of registration. The purpose of this was to be transparent in their charging structure so patients could make an informed choice.
- For external incidents a corporate tracker was used and sent to each location detailing the incident and the learning that each hospital needed to implement and share with staff.This had to be signed off and then shared with the provider to ensure compliance.
- There were systems to reward staff. These included staff nominations at each daily communication meeting and these were added to the e-mail with all the information about each staff member.
- Each year there was an offsite professional development dayfor all ward staff. They were taken off-site for full day of education training, clinical updates, and group work.
- The service had implemented arrangements for monitoring cosmetic surgeons. This involved making sure they were on the General Medical Councils (GMC) specialist register for plastics. Following discussions with the registered manager they planned to write to all their cosmetic surgeons to urge them to consider accreditation with the Royal College of Surgeons (RCS) certification in cosmetic surgery. RCS Cosmetic surgery certification was launched in spring 2016. It was expected that by summer 2017 all surgeons currently practising cosmetic surgery in the private sector would have applied for certification in the areas in which they practice.This scheme however is voluntary and at the time of our inspection 17 surgeons across the country had registered.

Good

Outpatients and diagnostic imaging

Safe	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

At our last inspection we rated outpatients and diagnostic imaging services as requires improvement in the safe domain. This inspection covered this domain. We found that the required actions from the previous inspection had been completed and improvements made.

We rated safe as **good.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. This ensured staff had the necessary skills to keep patients safe and provided the appropriate treatment.
- At our last inspection mandatory training was not up to date as staff said they were not always able to get to face to face training due to staffing numbers. At this inspection we found that improvements had been made. Completion was monitored by the outpatient manager. We saw the most recent record, which showed completion was at 83%. While many staff were at 100% the manager explained the figures had been brought down by sickness, absence and also staff who worked for NHS trusts, where they would have had completed the required training. However these records were not transferable and the service could not therefore be assured the training had been completed. Staff received reminders that their training was due. Staff told us that the training covered the essential areas required for their job roles. This was an improvement from our last inspection.
- The radiology manager was not available at the time of our inspection so we spoke with their deputy and other staff. All staff we spoke with could access their mandatory training record electronically. We saw completion rates stood at 92.47 %. Email reminders were sent to staff when subjects needed updating. The records we saw showed any overdue modules and dates booked for staff updates. Staff told us they received training in a range of subjects including basic life support, safeguarding adults and children and patients with mental health needs. Future dates for mandatory training sessions were displayed in the department for staff to view.

Safeguarding

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Nursing staff working in the outpatients and physiotherapy departments completed safeguarding training level 3 in adults and children.The records for this showed that all staff were up to date.The managers took the lead for safeguarding in their departments, and there was also a lead in the hospital available for advice or support. The safeguarding lead for the hospital was the director of clinical services and they were trained in level 3 in both children and adults. They planned to complete safeguarding training in level 4 and 5 in the near future. The director of clinical services linked in with the local safeguarding boards from the local council on a regular basis. There had been no safeguarding referrals in the previous twelve months. Staff were clear about the process to follow and where to go for advice and support when this was needed.
- Diagnostic imaging staff told us they had completed mandatory safeguarding training but were unsure to what level. We saw the records following the inspection and found all staff had been trained to level 2 in adults and children. One member of staff had completed level 3 in children. This was in line with The Royal College of Paediatrics and Child Health guidance (Safeguarding Children and Young People: Roles and Competencies for Health Care Staff 2014), which sets out minimum training requirements for healthcare professionals working with children and young people. The guidance

recommends that all clinical staff, who are in direct contact with a child or a young person, is trained to level two in children's safeguarding and that the named lead is trained to level three.

- One staff member we spoke with from diagnostic imaging told us there was a safeguarding lead for the hospital but did not know who it was. However, if there were concerns they were confident they could find the person they needed and would report any concerns to their line manager.
- At our last inspection we found there was not a safeguarding policy for children or young people. Following this inspection we were sent a copy of their corporate safeguarding policy for children and young people. This policy mentioned types of abuse, each staff members responsibilities based on their role and where to obtain additional advice.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.
- All staff completed training in infection control as part of their mandatory training within the outpatients and physiotherapy departments and all staff were up to date. The clinic had a link nurse for infection control, who staff could contact for advice and information. We saw that one incident had been recorded after a recent audit. This related to a staff member not correctly washing their hands prior to patient contact. This issue was followed up by the manager of the department.
- We observed staff following the provider guidelines for infection control in clinic areas, washing their hands prior to patient contact and being bare below the elbow. We observed staff regularly using the handwashing gel dispensers that were located around the hospital when moving from one clinic area to another.
- We looked at the patient areas in physiotherapy and outpatients, including waiting areas, treatment rooms and toilets. We found all were visibly clean and hygienic. Infection control audits were being regularly completed and cleaning schedules were being audited. At the last inspection there were concerns raised around a lack of compliance with cleaning schedules.This had been addressed at this inspection. Managers and staff told us that any urgent cleaning was completed quickly.
- All areas in the radiology department had logs of equipment with the dates and signature of person who had cleaned it. Equipment was cleaned daily when the department was open, and between patient use. We saw staff cleaning radiology equipment with specialist surface wipes and replacing fresh paper covers for the next patient to use. Equipment used for intimate ultrasound procedures was decontaminated using sterilising solutions.
- All staff we saw were bare below the elbow and cleaned their hands between patients. Sanitising gel was available throughout the department and sinks were provided with elbow taps in each area. We saw staff using aprons and gloves when inserting vascular access devices.
- The radiology department also had an infection prevention and control link member of staff. Hand hygiene audits were undertaken monthly until March 2018. Audit results were shared with the department manager and fed into the infection prevention and control monitoring. Results were also fed back to staff with any needs for improvement shared with individuals. Previous audits had shown staff compliance as being between 95% and 100% for the previous six months. A revised system of auditing hygiene practices had been introduced in March 2018.The plan was for this to be completed using an electronic spreadsheet but this was in paper format at the time of our visit. Staff were finding it lengthy and difficult to use but expected that the electronic system would improve ease of use when it was fully implemented.
- Staff would assess patients before their appointment for radiological procedures. Any patient suffering with a communicable disease such as flu, for example, would be asked to postpone their appointment to a time when they were infection free. In cases where this was not suitable staff would seek advice from the infection prevention and control lead for the hospital.
- At our last inspection we found some fabric on the chairs used by patients was not easy to clean. At this inspection we found all chairs were visibly clean and with no evidence of staining.

Environment and equipment

Good

Outpatients and diagnostic imaging

- At the last inspection we found shortfalls in relation to the managing of the environment and some aspects of equipment maintenance. All these issues had been addressed. The service had premises and equipment that were suitable and looked after them well.
- Carpets at our last inspection were found to be dirty and stained. We saw that in some communal areas carpets had been replaced with easy to clean flooring. The registered manager told us they had been given funding to replace some carpets in the building. During our tour we found no dirty or stained carpets. The staff were able to demonstrate cleaning of these.
- At our last inspection we found the fire risk assessment was nine months out of date. This was despite the recent introduction of eye laser service with a potential increased risk of fire. Staff were unsure of evacuation procedures for patients on the first and second floor in the event of fire.The service had not completed action points from a risk assessment carried out in preparation for the new eye laser treatment. The action plan we received following this inspection stated they had addressed all the issues we had identified.
- We saw at this inspection that the premises fire risk assessment was up to date and all appropriate testing had been completed and recorded.The hospital had a fire risk assessment that had been completed by an external consultant, and then reviewed regularly by the provider's health and safety manager. Clarity had been provided to staff about evacuation procedures and a new specialist evacuation chair for the stairs purchased. Staff confirmed they had received the appropriate training for this equipment. This was an improvement from our last inspection.
- The potential risk posed by the acquisition of an ophthalmic laser had been reviewed by an external consultant and an appropriate alteration made in the fire risk assessment.
- Training records for outpatient staff showed they had all completed fire safety training; however 25% of staff at the time of our inspection were due to complete their refresher training.
- Equipment used by staff and patients was well maintained ensuring the safety of patients. We looked at maintenance records for equipment used in the physiotherapy and outpatient departments. All testing had been completed and was recorded and all routine maintenance was up to date. Managers told us that repairs, when reported, were dealt with promptly. This was from both the hospital maintenance staff and also when external companies were contracted to carry out repairs or servicing.
- Staff in diagnostic imaging had access to resuscitation equipment which was kept in the theatre department. This was located on the same floor as radiology and physiotherapy but staff needed to go through two doors to get to the department. Equipment to treat patients experiencing anaphylaxis (anaphylaxis is a severe, potentially life-threatening allergic reaction) was readily available in the radiology department.
- Personal protective equipment was available for radiology staff to use.This included radiation proof aprons and collars if staff or carers needed to be with the patient who was undergoing radiation procedures.These were scanned annually for any rips, tears or holes which would reduce their effectiveness and we saw records detailing how an apron had been destroyed due to a tear in the fabric. Radiation proof screens protected staff and carers who were observing the procedure. Staff wore tags which measured how much radiation they had been exposed to over a period of time. These were sent to Public Health England for monitoring and feedback letters showed staff had consistently been below levels of risk.
- All equipment in the diagnostics imaging department was monitored for safety in line with national recommendations. We saw documentation that a quality assurance programme was undertaken to ensure equipment was safe and reliable.This included checking equipment for sensitivity and consistency of image, radiation dosage emitted and that equipment was safe to use. Annual checks of equipment were carried out by external organisations.The MRI scanning machine was constantly monitored by an external organisation who would arrange for an engineer to visit if they noticed any fault or reducing of essential levels such as helium or water pressures.
- Rooms where ionizing radiation exposure occurred were clearly signposted with warning lights to prevent people from entering inadvertently, during a procedure.
- The window blind used in the laser treatment room was labelled as compliant with safety requirements in this area and was laser/fire proof. This was identified as an issue at our last inspection where they were not able to find evidence that the window blind was laser/fire proof.

- A team of staff ensured radiology had access to a stock of frequently used equipment. This was checked and replenished weekly with expiry dates of equipment checked. We looked at five items which were within their use by date and packaging intact. The stock room was organised and appeared visibly clean.
- The laser protection advisor was based in a local NHS trust. We saw audits had been undertaken to assess equipment safety, the most recent being March 2018. Staff trained in laser procedures met with the laser protection advisor annually. The outpatient department manager maintained records of training in laser procedures. These had been developed in collaboration with the laser protection adviser.
- The hospital had a Patient Led Assessment of the Care Environment (PLACE) assessment in April 2018. At the time of our inspection they were awaiting the report but the registered manager told us the feedback was very positive.

Assessing and responding to patient risk

- Staff were able to identify and respond appropriately to changing risks to patients who used the services, including deteriorating health and wellbeing and medical emergencies. The hospital had an emergency call system where the Resident Medical Officer (RMO) and other senior staff would attend. Resuscitation equipment was accessible to the outpatient and diagnostics imaging departments.
- A Service Level Agreement (SLA) existed in the event of a deteriorating patient requiring a blue light transfer to the local NHS Trust. This would include services for treatment of young people aged between 16-18 years old. The registered manager told us this was reviewed at regular intervals.
- Radiology staff used risk assessment tools to protect patient safety. Radiographers used the "6 OK" rule for checking that patients were receiving the appropriate investigation. This system included three part patient identification (name, date of birth and postcode) previous imaging, presence of referrer's signature and clinical information to justify the investigation. Staff used a questionnaire to assess any patient risk presented before the planned procedure took place. If a risk was identified staff followed a protocol to reduce this risk. This would include contacting the radiologist in the department for advice. We listened to the radiologist advising a radiographer about a patient appointment that needed to be delayed. Other reasons for changing a procedure were if a patient had some metal fixings in their body that were due for an MRI (Magnetic Resonance Imaging) scan. This had been changed to a CT scan instead to reduce the risk of the metal becoming dislodged in the MRI.
- Patients who attended for surgical procedures were assessed by nursing staff preoperatively. We saw records where a comprehensive health assessment was made before the patient was admitted to hospital. This included screening for MRSA, risk of developing deep vein thrombosis (DVT), previous history and base line observations of temperature, heart rate and blood pressure.
- Patients who had contrast media used for their procedure were warned of how they might feel during the procedure and the cannula was left in for 30 minutes after the procedure. This was to allow access to a vein if the patient were to react to the solution and become unwell in this time. An emergency box to treat patients suffering with anaphylaxis (severe and life threatening allergic reaction) was readily available for staff to use and a radiologist was always available at each session.
- There had been a training session in the radiology department which simulated a patient undergoing cardiac arrest in the MRI scanning room. Staff told us this had been scored as achieving four out of five marks. However, they had not been involved in any debrief and did not know where they needed to improve.
- The World Health Organisation (WHO) surgical safety checklist had been adapted for use in radiology. Staff completed the checks for patients undergoing interventional radiology such as using contrast media. These checklists were audited for compliance each month. Results for the previous three months had shown a high level of compliance of between 99.9% and 100%. However, we were told these audits were not reported to senior hospital staff for their review.The audit results we reviewed in the department were not clear that they were reviewed regularly at a senior level. However, we were told these audits were seen by the quality and risk manager. If any issues were seen these would be followed up and actions plans requested. The results from these audits fed into to the governance arrangements for the hospital.
- The radiation protection advisor had recently changed from being provided by a local NHS trust to a more

regional NHS trust further away. The radiation protection supervisors were able to contact them for advice and had annual meetings to update on any changes to procedures and regulations.

- GPs and referring doctors were kept informed of plans of care for patients promptly. Of five records we reviewed all had letters prepared to be posted within two days of the appointment.
- The hospital treated patients from 16 years of age upwards. All staff we spoke with were clear they did not treat children below the age of 16 years. Staff told us that any booking of patient appointments was undertaken by regular secretarial staff that were familiar with age limits. Radiographers who booked appointments were also clear about this rule. We were told the patient age would flash up on the computer screen to alert them. Staff were able to demonstrate how this operated.
- A member of nursing staff in outpatient department was trained in children's nursing as well as adult nursing. If a young person attended who was between 16 to 18 years of age they would be assessed by a children's trained nurse and an adult trained nurse for suitability of being cared for using an adult pathway.
- At our last inspection the imaging department did not have standard operational standards for all procedures and therefore did not comply with the recommendations set out in the National Safety Standards for Invasive Procedures (NatSSIPs). NatSSIPs are intended to provide a skeleton for the production of Local Safety Standards for Invasive Procedures (LocSSIPs) or standard operating procedures. These are created by multi-professional clinical teams and their patients, and are implemented against a background of education in human factors and working as teams. We saw standard operating procedures had been developed for invasive procedures in radiology had been implemented. This included the administration of contrast media. This was an improvement from our last inspection.

Nurse staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The manager of the outpatients department explained how they planned their staffing in advance to ensure they had the right skills for the clinics that would be running. The outpatients department had implemented the use of a staffing tool to ensure that the correct levels were in place. This was done by the occasional use of agency staff and the hospitals own bank staff. This was an improvement from our last inspection, as at this time we found the department had a high reliance on bank staff.

Medical staffing

- Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The hospital had 102 consultants and doctors working under the rules of practising privileges in private independent practice. We saw the rotas that showed two regular resident medical officers (RMO) were employed via an agency and rotated on a week on, week off rota.
- A system had been implemented to ensure that consultants only carried out work that they were skilled and insured to carry out. Information including disclosure and barring service (DBS) checks, indemnity insurance, information about appraisals, revalidation, registration with the GMC and self-declaration forms were collected.
- Radiologists working at the hospital had a rota of when they needed to attend the hospital to offer support and advice to staff. This rota usually required them to attend once every two weeks. We were told this was sufficient to meet the demand.
- Radiographers were employed on a mixture of part time and full time basis and worked flexibly to cover the shifts. Radiographers reviewed planned lists of procedures and organised staff to cover the sessions. If there were inadequate staff to cover these sessions they would prevent any further booking of procedures.

Records

- Patient's individual care records were written and managed in a way that kept patients safe. This included ensuring patients records were accurate, complete, legible, up to date and stored securely. At our previous inspection a requirement was made that improvements were needed in relation to patient records. The action plan we received following our last inspection told us that changes were going to be made to the records system so that patients would have one set of notes. This was due to be completed by January 2017. We

found that improvements had been made with the introduction of a new patient records systems. Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.

- All patients registering at the hospital had a single, full care record commenced at the initial appointment, with additional treatment notes being added as appointments were attended. The hospital now had a bespoke medical records department that oversaw all records.
- Records were paper based, but were tracked electronically so they could be located throughout the hospital. Radiology recorded some patient information electronically. Nursing and administration staff we spoke said that whilst there were occasional problems, generally the new system meant they were able to locate records easily and quickly.
- We looked at a sample of 13 patients' records in total and found that they contained the required information, including recording of consent, details of the next appointment and any additional information that needed to be recorded by the consultant.
- We found that improvement had made in relation to the recording of consent. In the physiotherapy outpatients department an audit was done of patients' records every two months.The most recent audit showed that records were 100% compliant in the recording of consent.
- The patient record in the diagnostic imaging was raised at their first appointment. Risk assessments were completed in a pre-assessment clinic before their planned surgery. We saw recommendations were made on patient records for ward staff to follow up when the patient was admitted to the hospital.
- Radiology kept patient records securely in electronic format. Referrals were provided in paper and scanned on to the patient record. Referrals were accepted from a list of authorised referrers.
- We reviewed seven sets of patient records who attended outpatients. All of these had relevant medical patient history including previous surgery, allergies, present complaint and plan of care documented.
- Radiology results were automatically uploaded and were able to be viewed immediately by the leading consultant for that patient.
- To maintain patient's confidentiality and security of records computer screens had an additional film which prevented people in the vicinity from being able to view the screens. These were also password protected.

Medicines

- Medicines were prescribed, stored, administered and recorded safely. Records indicated that patients received the right medicine at the right dose at the right time. A medications management meeting was held every two months. We saw the minutes from the most recent meeting. Information was shared from the pharmacy manager and a full update was provided to the meeting of any ongoing issues around medication. This related to internal matters in the hospital and national directives.
- We saw examples of action being taken by the pharmacy to improve their practice. For example, the team decided that they would stop selling gift cards, as they had proved to be a distraction at times to the dispensing process. The pharmacy manager explained how this had also helped to slow down certain pharmacy activities, meaning the likelihood of near misses or incidents was further minimised.
- Prescription pads were available for radiologists to use and the system used enabled them to be traced. Pharmacy supplied blank prescription pads with a log of each prescription's unique number. These would be signed out by the member of staff writing the prescription and a log being kept of the patient, prescription, consultant and radiographer. This complied with current practice guidelines.
- Medicines and contrast media were kept in locked cupboards secured to a wall. We checked five items which were within their use by date and stored correctly. Temperatures of the rooms were monitored daily and the log showed how the temperature remained within required limits for the medicine stored. Staff told us if they were outside of these limits they would inform pharmacy who would advise on best action.
- The CT scanning room had an emergency medicine box which was clearly dated for when it should be used by. This was securely stored and checked regularly by the pharmacy team.
- Radiology prevented over ordering of medicine stock by assessing what they would need for the following two weeks.

Good

Outpatients and diagnostic imaging

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and support.
- Incident reporting was done electronically and was an integral part of the new risk register system. The provider had put this into place following the previous inspection. Staff were clear how to use the system and we heard of examples where feedback and learning had been disseminated. One example followed a concern from a patient about a perceived lack of post-operative advice. Another was a reported incident regarding the arrival of a sample from the pathology lab without the correct labelling. We saw that these were both discussed at heads of department meetings and appropriate action taken and recorded.
- Patient safety was promoted by the sharing of incidents from other hospitals run by BMI. The new electronic system allowed for incidents and concerns to be escalated and the learning shared across the organisation.
- Radiology staff were aware of what they would report as an incident and received feedback on any actions that were taken in response to the reported incident. Any allergic reaction experienced by a patient would be reported as an incident.

Are outpatients and diagnostic imaging services well-led?

Good

At our last inspection we rated outpatients and diagnostic imaging services as requires improvement in the well led domain. This inspection covered this domain. We found that the required actions from the previous inspection had been completed and improvements made.

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

Leadership

Please see the surgical section of this report for main findings that also cover this service.

- Staff in the outpatients and physiotherapy department were provided with leadership from their managers.Staff were clear about the lines of accountability and told us they were well supported and valued by their managers. The outpatient manager, the pharmacy manager and the physiotherapy manager had regular daily contact with the director for clinical services and a formal catch up weekly meeting. They were kept informed of any ongoing issues, concerns or developments within the hospital. There was also a brief daily morning heads of department meeting where information was shared.
- The radiology manager was not available at the time of our visit but we spoke to a member of staff who deputised for this role if needed. Radiology staff were clear who their manager was and felt they could approach them with any concerns or ideas for improvement. Staff articulated that patient safety was a priority and they would question any practice that presented a risk.

Vision and strategy

Please see the surgical section of this report for main findings that also cover this service.

Culture

Please see the surgical section of this report for main findings that also cover this service.

- Staff we spoke with were positive about working for the provider and told us they felt valued and respected. They were proud of the positive feedback from patients and felt supported by their colleagues and their managers.
- Staff communicated effectively between the different departments which ensure continuity of care and treatment for patients. For example, in the physiotherapy department the staff communicated regularly with ward staff in preparation for the start of the enhanced recovery programmes that some patients were on.
- Radiology staff had not had a team meeting recently due to work pressures. A staff member did, however attend the daily communication meeting. We saw team meetings had been held on alternate months. The most recently held was three months before our visit in February 2018. Minutes of these meetings included new procedures, results from audits and comments from staff.

- Staff were clear about their roles, what they were accountable for and their limitations. Staff described how they followed hospital protocols and would seek further advice if they were unsure of a procedure.

Governance

Please see the surgical section of this report for main findings that also cover this service.

- There was an effective governance framework which supported the delivery of good quality care. There was a clear framework for the meetings and the direction that information needed to be communicated. We saw the minutes from the clinical governance meetings that showed they happened regularly and with good attendance. Staff were clear about their roles and who they were accountable to.
- We saw evidence that the information from performance and patients outcomes was shared at a regional level within the organisation.
- Staff said they were able to approach managers with ideas or concerns and they were listened to. Whilst some staff commented that sharing a registered manager with another hospital had its drawback at times in term of accessibility, staff did not think there was a problem with the visibility of the senior managers. The registered manager and other senior staff were responsive to emails and requests for meetings or information.
- Radiation protection committee meetings were held yearly. We were sent minutes of the last meeting which took place in April 2018. These mentioned for example, any issues or updates that were needed to meet the regulations.
- One of the radiation protection supervisors had recently attended an update with the regional radiation protection advisor.Their plan was to discuss this and the updates to the regulations with their department manager.

Managing risks, issues and performance

Please see the surgical section of this report for main findings that also cover this service.

- The provider had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. At the previous inspection there had been a shortfall in the recording and identifying of risks across the clinical areas. These issues had been addressed with the introduction of a new risk register. This was connected to, and integral to, a new electronic incident reporting system. This was an improvement from our last inspection.
- We saw examples in the outpatient and physiotherapy department that risks were identified and recorded. This information was shared across the hospital and also across the provider organisation if this was appropriate. For example, we saw one recorded risk around certain medication dispensing concerns that were shared with other hospitals within the organisation. The action taken to mitigate this risk was also recorded. Staff were clear how to use the system and were aware how risks were reviewed at the governance meetings. We saw that potential issues identified by the managers, staffing for example, had been identified and recorded. This ensured that the line management were aware of any concerns identified.
- Staff were able to access the risk register for their department. Radiology had their top risks displayed for staff information. Staff were aware how they had performed in a variety of audits however; radiology staff were unsure what improvements they should make following an emergency scenario for training purposes.
- At our last inspection the diagnostic imaging department did not have standard operational standards for all procedures and therefore did not comply with the recommendations set out in the National Safety Standards for invasive Procedures. We saw standard operating procedures for invasive procedures in radiology had been implemented. This included the administration of contrast media. This was an improvement from our last inspection.

Managing information

Please see the surgical section of this report for main findings that also cover this service.

Engagement

Please see the surgical section of this report for main findings that also cover this service.

- The hospital provided feedback or comment cards to all patients to complete. These could also be provided to relatives.The BMI organisation rated all its hospitals in terms of patient satisfaction. At the time of the inspection BMI Bath Clinic was rated as their third highest out of fifty five hospitals. We spoke with three

patients who were attending the hospital for a second spell of treatments.They confirmed they had been provided with the feedback questionnaires. We were told they were happy with their treatment and the service they received and that they had not felt the need to offer any criticism to the provider.

- Radiology staff were able to feed back their views about new policies and procedures at their team meetings.

Learning, continuous improvement and innovation

Please see the surgical section of this report for main findings that also cover this service.

- We spoke with staff that had learning and development needs identified at their appraisals. This included using the corporate offer of leadership training modules to develop skills. The local manager had agreed to support a member of staff in developing their skills by leading on Magnetic Imaging Safety.
- A newly appointed member of staff was undertaking training in laser procedures and their skills in paediatric nursing were being used to develop standard operating procedures for children between16 and 18 years of age who attended the hospital.
- The service did not have links with the Operational Delivery Networks (ODNs). These were launched in April 2013 following the publication of the NHS England strategy to sustain and develop clinical networks. ODNs are focused on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise. Success factors for ODNs are: improved access and egress to/from services at the right time, improved operating consistency, improved outcomes and increased productivity. At the time of our inspection this hospital was not involved in ODNs. However, they maintained links between themselves and their commissioners.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider ways to ensure all staff are aware of who the lead person is for safeguarding.
- The provider should make sure they provide feedback to all staff following simulation events of cardiac arrests.
- The provider should consider ways of better obtaining evidence from staff that have completed their mandatory training with other health care providers to help improve compliance rates.
- The provider should make sure all staff in outpatients undertake their fire refresher training.