Circle Health Group Limited

The Harbour Hospital

Inspection report

St Marys Road
Poole
BH15 2BH
Tel: 01202244200

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We carried out a comprehensive inspection of BMI The Harbour on 26 and 27 October 2021. The service was last inspected in May 2017 and was rated as good overall. BMI The Harbour provided the following services: surgery (several specialities to include general, orthopaedic and cosmetic), medical care (for example, chemotherapy and endoscopy) outpatients and diagnostic imaging. We inspected all these service during this inspection.

Diagnostic imaging and outpatients' services were also last inspected in 2017, both services were rated as 'good'. At that time, the outpatient's department and diagnostic imaging was inspected under one inspection framework. The Care Quality Commission (CQC) now inspects diagnostic imaging and outpatients as separate core services.

Before the inspection we reviewed information, we had about the location, including information we received and available intelligence. The inspection was unannounced.

We rated safe as requires improvement in medical care, outpatients and diagnostics imaging. In surgery it was rated as good. Effective was rated as good in surgery and medical care but is not rated in outpatients and diagnostic imaging. Caring, responsive and well led were rated as good in four services inspected.

Our rating of this location stayed the same. We rated it as good because:

- The service mostly had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff mostly assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service mostly managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to health information. Key services were mostly available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs and made it easy for them to give feedback. Patients could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and some community services to plan and manage services and all staff were committed to improving services continually.

However:

- Staff were not always following hospital guidance when wearing personal protective equipment (PPE) to reduce the risk of cross infection during some aerosol generating procedures. Cleanliness audits in some areas were not being completed in line with national guidance.

Summary of findings

- Emergency evacuation drills were not carried out in the MRI/CT department in line with national guidance.
- Staff kept records of patients' care and treatment, but these did not always contain up to date or legible information. Some staff had to use three different record keeping systems which meant not all care was not always clearly documented.
- Staff were not always following their own policy or national guidance when caring for patients when under anaesthetic.
- Qualified staff did not always receive clinical supervision in a timely way to maintain their skills and for managers to make sure they had the required skills. The service had been applying for national accreditation of one of their departments since 2016 and staff were not able to explain the delay.
- Not all staff were aware of the translation service provided or how to access this for patients whose first language was not English.
- Recruitment of some staff did not obtain all the required information prior to them starting work at the service. Not all staff were aware of the Freedom to Speak up Guardian role or who their local member of staff was. Not all staff had frequent staff meetings where information was shared. Some staff did not feel supported or valued in the department they worked. Some services were not always engaging with local networks for the benefit of their patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Good 	Our rating of this service stayed the same. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service mostly controlled infection risk well and managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. • Staff provided good care and treatment, gave patients enough to eat and drink. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

However:

- Not all staff wore COVID-19 personal protective equipment in line with the provider policy in areas where aerosol generating procedures (AGPs) (where small droplets are formed which increase the risk of transmission of airborne viruses) were carried out.
- Patient risk assessments were not always carried out by staff who had received training. It was not clear that consultants had reviewed and made a clinical decision on risks in line with hospital policy.
- The processes for documenting care and treatment delivered in oncology services were not clear. Staff used three different systems and meant care was not always clearly documented. There was a risk errors could be made as staff had to duplicate information into different patient records.
- Cleanliness audits were not carried out as often as they should be to comply with national standards.
- The endoscopy service had not completed the application process to gain national accreditation. This had been an ongoing process since 2015.

Medical services are a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was effective, caring, responsive and well-led, although safe requires improvement.

Diagnostic imaging

Good

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in most key skills, understood how to protect patients from abuse, and managed safety mostly well. The service mostly controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well

Summary of findings

together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week to support in-patient services.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities and most staff felt supported and valued.

However:

- Staff did not receive training in how to recognise a deteriorating patient, sepsis awareness and how to monitor vital observations in the event of a clinical incident.
- Processes to assess and mitigate risks of the spread of communicable diseases such as tuberculosis were not always clear.
- and fire alarm test were not always carried out when they should be.
- The service level agreement with the local trust had not been formally reviewed since 2018 but continued of a rolling term basis.
- Processes to mitigate identified risks were not always shared effectively with staff. Emergency evacuation drills were not carried out in line with national guidance.

Diagnostic services were a small proportion of hospital activity. The main service was surgical services. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

We rated this service as good because it was effective, caring and responsive and well led although safe requires improvement.

Surgery

Good 

Our rating of this service stayed the same. We rated it as good because:

- The service mostly had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
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However:

Summary of findings

- Not all patient prescriptions were written clearly. Not all staff were following their policy and national guidance when checking patients body temperature when they were under anaesthetic. There was no specific audit on sepsis management. Staff did not receive specific training about the mental health, learning disabilities or autism.
- Not all new staff had the required information obtained prior to them starting work at the service. Interview records were not always detailed about any gaps in new staff employment history.

Outpatients

Good

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. They managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well. Staff felt respected, supported and valued.

However:

- Staff kept records of patients' care and treatment but these did not always contain up-to-date or legible information.
- The service did not always ensure staff were given adequate time to complete mandatory training requirements.

Summary of findings

- The service did not always ensure premises and equipment were visibly clean.
- The service did not ensure learning from incidents was shared.
- Team meetings did not always take place.
- Staff were not always aware of, or did not use, translation services for patients whose first language was not English.

Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was effective, caring, responsive and well led although safe requires improvement.

Summary of findings

Contents

Summary of this inspection

Background to The Harbour Hospital

BMI The Harbour Hospital was established in September 1996 and is managed by the provider BMI Healthcare Limited. In January 2020, Circle Health Holdings Limited (Circle) acquired the BMI Healthcare Limited group. Facilities include two operating theatres, X-ray, outpatient and diagnostic facilities and an onsite pharmacy. The hospital provides surgery, medical care, outpatients and diagnostic imaging.

The provider is registered to provide four regulated activities:

- Surgical procedures
- treatment of disease, disorder and injury.
- diagnostic and screening procedures.
- family planning.

The registered manager has been in post since August 2021.

Hospital activity;

From June 2020 to May 2021 there were 2,261 NHS-funded admissions and 1,624 NHS-funded outpatient attendances at BMI the Harbour Hospital.

From 1 April 2020 to 31 March 2021 this organisation provided 1,395 private patient admissions (44.6% of all admissions) and 1,735 NHS patient admissions (55.4% of all spells).

From 1 April 2020 to 31 March 2021 BMI the Harbour Hospital carried out 1,905 private patient procedures and 1,560 NHS patient procedures.

The oncology service provided 368 chemotherapy sessions from 1 October 2020 to30 September 2021. During the COVID-19 pandemic, the service provided some chemotherapy sessions to support the local NHS trust.

The endoscopy service provided 116 gastroscopies (thin tube used to examine the inside of the oesophagus, the stomach and upper part of the small intestine), 115 colonoscopies (thin tube used to examine the large and parts of the small bowel) and 46 flexible sigmoidoscopies in the same period.

From 1 October 2020 to30 September 2021, the diagnostic service provided: 1898 MRI scans, 1242 CT scans, 799 ultrasound scans, 160 mammograms and 1903 X-rays.

Track record on safety for the period from 1 October 2020 to 30 September 2021:

One death had occurred within 30 days of surgery.

One never event had happened - A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Summary of this inspection

No external review or investigations have been undertaken.

There were no incidences of healthcare acquired infections.

The service received 34 formal complaints.

No Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) reportable incidents have occurred.

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 service.

How we carried out this inspection

The team that inspected this location comprised of one CQC manager, four CQC inspectors and three specialist advisors. During the inspection we spoke with staff including the management team. We also reviewed documents and records kept by the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Medical care

- The service must ensure that risk assessments are completed and reviewed by staff who have the qualifications, skills, competence and experience to do so in line with its policy. Risk assessments must also include plans for managing risks. (Regulation 12 (2) (a)).
- The service must ensure staff follow COVID-19 policy guidance in areas where aerosol generating procedures (AGPs) (where small droplets are formed which increase the risk of transmission of airborne viruses) are carried out. (Regulation 12 (2) (h)).

Outpatients

- The service must ensure that patient records are up-to-date and legible. (Regulation 17 (1) (c)).

Action the service SHOULD take to improve:

Surgery, medical care, outpatients and diagnostic imaging

- The service should ensure all prescriptions are written clearly.

Summary of this inspection

- The service should review mandatory training and consider the value and importance of providing staff training to improve awareness of learning disabilities, autism and mental health.
- The service should formally review the service level agreement with the local NHS trust to ensure it is still valid and meet requirements to provide safe care.
- The service should ensure staff have regular clinical supervision to enable them to carry out the duties they are employed to perform.
- The service should review how senior staff record details about any gaps in employment history at interview.

Surgery

- The service should make sure temperature checks are carried out on all patients when under anaesthetic, as per their policy and national guidance.
- The service should consider undertaking a sepsis audit.

Medical care

- The service should complete remedial work to ensure the correct environmental conditions where AGPs are carried out.
- The service should review patient documentation systems to minimise the risk of duplicating information and ensuring records clearly demonstrate the care and treatment they deliver.
- The service should consider including parameters for escalation parameters when vital observations are recorded, in line with national early warning score recommendation
- The service should review the frequency of auditing of cleanliness to comply with national standards.
- The service should review how audit results highlight gaps and are used to make improvements.
- The service should review minutes of meetings to ensure it provides information in a manner that was easily understood.

Outpatients

- The service should ensure that staff are given adequate time to complete mandatory training requirements.
- The service should ensure all premises and equipment are visibly clean.
- The service should consider holding regular team meetings so that important information and learning can be shared.
- The service should ensure learning from incidents is shared.
- The service should ensure that staff use translation services for patients whose first language is not English.

Diagnostic imaging

- The service should consider adding training of how to recognise a deteriorating patient and sepsis awareness to mandatory training and refresher training.
- The service should consider providing training and equipment for radiographers to enable them to monitor patients' vital observations in the event of a patient being taken ill.
- The service should ensure emergency evacuation drills are held regularly involving staff in the CT/MRI scanner, in line with national guidance.
- The service should carry out fire alarm testing as scheduled.
- The service should consider how patients with communicable infectious diseases are managed to prevent the spread of infection.
- The service should consider undertaking local patient safety audits. The service should consider ways to engage with staff to improve morale.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Requires Improvement	Good	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Requires Improvement	Inspected but not rated	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Please also see the surgery report.

Nursing staff received and kept up to date with their mandatory training. Staff compliance with mandatory training in health and safety was 87.4%. There had not been a trainer in post to deliver manual handling, but a new trainer had now been recruited and staff could book onto training again. Staff compliance was 100% across all other mandatory training modules at the time of our inspection. Staff were encouraged to complete all mandatory training (100%) in order to be considered for pay review.

The mandatory training met the needs of patients and staff. Staff accessed most mandatory training online with only a few key modules delivered in face-to-face sessions. Mandatory training included fire safety, conflict resolution, basis life support training and infection prevention and control.

Nursing staff working in the oncology service received immediate life support training, which included training in how to recognise and act on anaphylaxis (a severe and potentially life-threatening allergic reaction). Nursing staff received mandatory training in how to recognise the deteriorating patient and about signs and symptoms of sepsis.

Managers monitored mandatory training and alerted staff when they needed to update their training. Department leads had oversight of training compliance and staff received reminders about when their training was due. This was visible as soon as staff logged into the learning section of BMI intranet, where compliance data and reminders were displayed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Please also see the surgery report.

Good

Medical care (Including older people's care)

Staff received training in adult safeguarding and child protection at the level required of their role. Records showed all staff had received level 2 or level 3 adult safeguarding training appropriate to their role and child protection training at level 2.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information was displayed in staff areas to ensure escalation of concerns were not delayed.

Staff had not raised any safeguarding concerns to the local authority from 1 October 2020 to 30 September 2021.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. They kept equipment and the premises visibly clean. However, staff did not always used personal protective equipment and control measures to protect patients, themselves and others from infection.

Please also see the surgery report for information related to endoscopy services.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning records were not displayed but staff showed us records of daily cleaning schedules. The oncology manager carried out cleaning audits every two months in line with the hospitals audit schedule. However, the frequency of auditing was not compliant with NHSE/I National Standards of Healthcare Cleanliness (2021) which recommends weekly auditing of chemotherapy units.

The manager of oncology services audited staff compliance against 11 standards for hand hygiene and use of personal protective equipment. Audits were carried out quarterly in line with the hospital's audit programme. Records showed 100% between December 2020 and October 2021.

Staff cleaned equipment after patient contact although equipment was not labelled to show when it was last cleaned**.** All rooms had signs which stated how many people could safely be in the room to ensure compliance with social distancing recommendations.

The oncology ward area was clean and had suitable furnishings which were clean and well-maintained. Most equipment and consumables were stored off the floor, but we noted there was a box stored on the floor in the clinical preparation room. This did not allow for easy cleaning of the floor in this area.

Patients attending for chemotherapy were advised to follow specific instructions, which included lateral flow test COVID-19 testing at home three days before their chemotherapy appointment. If this was positive, patients were advised to have a further polymerase chain reaction (PCR) test. If patients tested positive, they were advised not to attend for their appointment and staff liaised with the relevant consultant. All patients were advised to self-isolate three days before their chemotherapy appointment.

Staff undertook twice weekly lateral flow tests to ensure they did not have COVID-19. Staff logged their test results on an NHS COVID app and managers relied on staff telling them if they had tested positive. However, there were no processes for managers to check compliance.

We observed staff cleaned the theatre environment following endoscopy services. Endoscopes (small flexible tubes with cameras) were cleaned following the procedure and packaged and returned to another facility where endoscopes were sterilised in line with national guidance. There were effective traceability systems for endoscopes used in endoscopy. Equipment was labelled and records kept of the equipment used for individual procedures.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). For example, in the endoscopy unit, we observed a gastroscopy procedure (a thin flexible tube is used to look at the inside if the oesophagus, stomach and the upper part of the small intestine) where not all staff who were involved with direct patient care, wore the recommended PPE. Gastroscopy is classified as an aerosol generating procedure (AGP), where small droplets are formed which increase the risk of transmission of air borne viruses. Staff did not wear specific masks and one staff did not wear a gown and a visor. This was not in line with the hospital's risk assessment of AGP procedures (July 2021), which stated specific masks (FFP3), apron, gloves and visor should be applied with recognised 'donning and doffing' processes (process to put on and take off PPE in the correct order to minimise the risk of spread of infection).

Compliance with enhanced PPE for aerosol generating procedures were not audited. We did not see any warning signs indicating aerosol generating procedures were being carried out to restrict or minimise others entering the theatre environment. Patients attending for endoscopy procedures were triaged on arrival for any symptoms and were asked to show/confirm they had had a negative COVID PCR test result within 72 hours prior to their endoscopy procedure. Once confirmed, patients were on the low risk pathway. However, the use of a gown and eye/face protection is recommended where there is a risk of spraying or splashing of bodily fluids.

Staff in the oncology department wore PPE in line with national guidance when they were involved in direct patient care delivering chemotherapy to patients.

Staff disposed of clinical waste safely. There were waste bins segregating clinical waste from other waste. Sharps were disposed of safely in designated labelled sharps bins. These were mostly closed when not in use and not overfilled. There were designated sharps boxes for waste and sharps used to administered chemotherapy. Staff explained the processes for safe disposal of these. We noted there was a first aid kit including eye wash kit in the event of accidental splashing of medicines or other hazardous solutions.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

See also the surgical report.

The design of the environment followed national guidance. Rooms were bright, airy and well-maintained. All rooms in the oncology ward had air conditioning and there were built-in TVs for patients to watch if required. Each room had basic emergency equipment such as oxygen and suctioning.

Staff carried out daily safety checks of specialist equipment**.** Staff in the oncology ward completed daily checklists including checks on medicine fridges and warming cabinets. Fire exits and equipment were clearly labelled and there was free access to fire doors in line with national guidance.

We checked the dates of consumable equipment and found two items that had passed their expiry date in oncology. We brought this to the attention of staff who replaced the equipment immediately.

Endoscopy procedures were carried out in the hospitals operating theatre department. This department had two operating theatres with laminar airflow, one of which was designated to be used for endoscopy procedures as it was bigger and had a smaller minor operations room (theatre three). Staff explained endoscopy procedures would usually be carried out in the minor operation room, but this was currently not being used due to an issue with air flow.

Minutes of the endoscopy user group (a forum for clinicians involved with the delivery and care of endoscopy procedures) referred to endoscopy procedures being carried out in theatre three. This included those procedures that were aerosol generating procedures but recommended a 30-minute downtime for cleaning and restoration of clean airflow. Following the inspection, we asked for information to clarify the number of endoscopy procedures that were carried out in the minor operations room between 1 October 2020 and 30 September 2021. Data showed in total, 46 endoscopies procedures were carried out of which 29 were procedures that involved aerosol generating procedures. However, the service had sought external advice which confirmed they could carry on using the minor operating room provided guidance as set out in their policy was followed. Work was being carried out to ensure the minor operation room met requirements regarding air flow.

Staff disposed of clinical waste safely. Waste was segregated into clinical and non-clinical waste. Bins were emptied regularly.

Substances hazardous to health were stored securely and in line with Health and Safety Executive regulations.

Assessing and responding to patient risk

Staff mostly completed and updated risk assessments for each patient and removed or minimised risks. Staff used tools to identify and act upon patients at risk of deterioration.

Staff assessed patients attending for ambulatory (day admission) chemotherapy to ensure they were fit and able to receive chemotherapy. Staff used a national tool (Eastern Cooperative Oncology Group Performance Status) to assess how a patient's cancer impacted on their daily living abilities. Staff assessed patients for signs and symptoms of toxicity including sepsis, as oncology patients receiving chemotherapy are at high risk of infections due to suppressed immune defence. If one or both assessments highlighted risks, staff informed the patients' consultant before chemotherapy was administered. Staff did not routinely monitor patients' vital signs when they attended for chemotherapy. Staff explained clearly how to escalate concerns about deteriorating patient (clinically unwell) or if signs of sepsis. If patients were required to be admitted, this was arranged by the consultant and patients were transferred to the local NHS trust. This was part of a service level agreement with the local trust.

Consultants reviewed patients before they started their chemotherapy sessions at the hospital. All patients were discussed with other relevant healthcare professionals in multidisciplinary teams in the local NHS trust.

Staff advised patients they could call a 24-hour help line if they were concerned after their treatment. Nurses working in the oncology service were rostered to take home the designated telephone for any such enquiries. They used a triage system to evaluate the information patient shared. If staff had any concerns about patients who called the helpline, they contacted the patient's consultant for advice.

Endoscopy staff assessed patients when they were admitted to the surgical ward before, during and following the endoscopy procedure. During the procedure and in the recovery suite, staff monitored patients' vital observations in line

with national guidance and recorded these in a designated ambulatory care booklet for generic endoscopy. The booklet did not follow national guidance such as the National Early Warning Score 2 (NEWS2), which is designed to help staff identify patients who are at risk of deterioration. However, staff told us they would escalate any concerns to the consultant gastroenterologist who carried out the procedure.

Staff mostly completed risk assessments for each patient on admission/arrival, using a specifically designed booklet representing the patient care pathway. However, risks were not always re-assessed when they should be. In the oncology service, staff completed initial risk assessments which included cognitive ability, activity and exercise, elimination, work and living arrangements, sleep and rest and perception of self. However, we noted the patients' weight was not recorded consistently in the four records we reviewed. This was of importance as chemotherapy dosage may require to be adjusted to ensure it is safe and effective.

Staff knew about and dealt with any specific risk issues. Staff mostly carried out specific risk assessments. There was a designated risk assessment tool to assess the risks of venous thromboembolism (VTE) and bleeding when patients first attended for treatment and regularly thereafter, including if there were any changes in their condition. Once assessed, the form was designed to be reviewed and completed by a consultant to confirm and prescribe prophylaxis as required.

We reviewed four records for patients attending for chemotherapy and found in one case the risks had been incorrectly assessed. However, this did not impact on the risk score as all patients were assessed as being at high risk of VTE because they were receiving active cancer treatment. There was no evidence on the VTE forms that the risks had been reviewed or escalated to the consultant in the four paper-based patient records we reviewed.

Following the inspection, we asked for evidence of effective processes to ensure patient risks were assessed and acted upon in a timely manner. Feedback from the hospital following their review of the patient records, stated a clinical review was not required in three of the four patient notes we reviewed as prophylaxis was prescribed in line with national guidance. However, this was not line with the hospital's policy: Venous Thromboembolism preventions: CHG NURpol06 (2021). This policy stated, "The admitting consultant is responsible for prescribing prophylactic measures or for confirming no prophylaxis is required". We were not assured this was always assessed and clearly documents.

We asked staff if they received training in how to assess patients for VTE. Staff showed us there were two modules available on their electronic learning platform. However, not all nurses had completed this training.

Nursing staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

See also the surgical report for staffing relation to endoscopy services, which was carried out by staff working in the operating theatres.

The oncology service had enough nursing staff to keep patients safe. The clinical service manager told us they had no concerns about vacancy, sickness or turnover rates had low and/or reducing vacancy rates. The service had not used any agency staff since 2017 but covered for each other.

Good

Medical care (Including older people's care)

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. There were two full-time equivalent posts in the oncology service which were made up by one full time and two part time nurses. In addition, the clinical service manager also supported clinical work when required.

It was not clear when the staffing establishment had last been reviewed or if these were reviewed regularly to ensure staffing levels were adequate to provide safe care.

Staff had access to clinical nurse specialists from the local NHS trust if required.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Please see the surgery report for information about medical staffing.

Records

Staff kept detailed records of patients' care and treatment. Records were stored securely. Staff kept records of patients' care and treatment.

Consultants kept their own patient records for patients attending for ambulatory care. There were arrangements to share information with nursing staff and external partners, such as the patients' GP, about the care and treatment patients had received.

In the oncology service, Staff used three different systems for documenting care and treatment. The different systems were used for different purposes. The service recognised there were risks associated with using multiple systems. The service had identified and embedded systems to mitigate the risks of using different systems which overlapped at times. However, some information was only entered onto one system leaving this information out of other patient records.

We noted there was little information recorded in the paper-based nursing notes about how patients' emotional needs were met. Following the inspection, we asked for evidence of how this was recorded. The hospital demonstrated how care was recorded in more detail in the electronic patient care records. There was shared access to these records with relevant staff in the local NHS trust. Staff were aware of this, and this was entered onto the hospital's risk register as a risk in 2018 but the risks had not yet been resolved.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff used an electronic records tracing system to ensure patient files could be easily located. All computers were password protected.

Records were stored securely. Paper-based patient records were stored in locked cabinets and all computer records were password protected. A documentation audit was carried out annually. The result of the last audit from December 2020 showed documentation was 92% compliant against 41 different measures. The audit result shared with CQC following the inspection, did not highlight where gaps were identified, and it was not clear if there was an action plan to make improvements.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Good

Medical care (Including older people's care)

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Patients' chemotherapy was prescribed electronically by the consultant. Staff had access to the electronic system to access information they required to administer the correct medicine to patients.

Medicines and fluids used for intravenous infusions were stored safely under locked conditions. Staff monitored fridge and room temperatures to ensure medicines were kept under the correct conditions. Staff checked medicines to ensure they had not passed their expiry dates.

All medicines administered to patients in the oncology service, was double checked and countersigned by two registered nurses. Chemotherapy medicines were checked and taken to the patient on a designated trolley which also had chemotherapy spill kit and a general kit in the event of the cannula (small plastic tube in a vein used to administer the chemotherapy medicine) becoming dislodged.

Chemotherapy was only ordered when it was prescribed at a pre-assessment appointment 72-hours before the scheduled treatment. This was to ensure medicines were dispensed from an external provider as they were prescribed and in accordance with blood test results and patient weight. Chemotherapy medicines were not prepared on site but arrived as ordered at the main reception desk and then brought straight up to the oncology ward.

Staff had access to policy and guidance to follow in the event chemotherapy was accidently administered into the soft tissue if the intravenous device became dislodged. This included guidance of immediate actions for staff to follow.

Staff working in the endoscopy service had access to guidance about the management of patients requiring conscious sedation. Monitoring of compliance was through review of incidents relating to sedation being given. An audit of 75 cases where conscious sedation had been administered, a reversal medicine was required on just three occasions (4%).

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. The electronic prescribing system used in the oncology service did not integrate with the local NHS trust's pathology service. This meant there was a risk patients' blood test results could be transcribed inaccurately. Staff recognised this risk and had entered this onto the hospital's risk register where it was still under review at the time of our inspection. This had been an ongoing issue since 2018. Actions were identified to mitigate the risks. These included nursing staff who were required to transcribe the blood test results, they did this from a separate office to minimise the risk of being interrupted. The entry was then checked again by another registered nurse. A further check was carried out by the hospital pharmacist. Nursing staff confirmed the actions were adhered to consistently to minimise risks. We were not told of any transcribing incidents.

Staff recorded medicines administered to patients receiving endoscopy services, which was signed by the consultant following the procedure. All medicines were discussed and confirmed with the consultant gastroenterologist before it was administered by registered healthcare professionals. Patients who received sedation was prescribed oxygen in line with national guidance. This was prescribed as a standard medicine and signed for by the consultant gastroenterologist.

Staff followed current national practice to check patients had the correct medicines. The hospital pharmacist reviewed patient records and medicine to ensure patients had the correct and prescribed medicine. Chemotherapy medicines were dispensed on the day of chemotherapy treatment from an external provider to ensure patients were fit and able to receive the medicines. Staff told us there were rarely any delays in getting the medicines and in administering these effectively.

Good

Medical care (Including older people's care)

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were shared with department leads by the Clinical Director of Services, who would share those that were applicable to the service. Safety alerts were also discussed with consultants if these impacted on the treatment, they would usually prescribe.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff told us the electronic incident reporting system was quick, simple and easy to use. Staff confirmed they received feedback when they reported an incident.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff in the oncology service spoke of the incidents they would report on the electronic incident reporting system. For example, staff would report an incident if there was a delay in getting chemotherapy from the local NHS trust meaning patients would have to wait longer for their treatment. Staff stated it was important to report when this happened so issues and barriers to timely administration could be reviewed and improvements made.

Staff received feedback from investigation of incidents, both internal and external to the service. The corporate company had introduced 'hotspots for learning' which were short learning sessions about learning from incidents that had happened across BMI sites.

Staff were aware of duty of candour. Duty of candour is a statutory duty to be open and honest with patients when things go wrong causing or having the potential to cause harm and offer an apology. They understood the concepts of duty of candour and being open and transparent, and giving patients and families a full explanation when things went wrong. We were told there had not been any incidents where duty of candour was applicable.

Are Medical care (Including older people's care) effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff had access to up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were reviewed regularly, version controlled and referenced to ensure they represented most recent evidence-based guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff offered food and drink, including those with specialist nutrition and hydration needs, to patients attending for day case treatment. If patients needs or preferences were not met, patients were encouraged to discuss this with the ward hostess or nursing staff to identify suitable alternatives.

Patients attending the oncology ward for chemotherapy, could also be offered meal supplements if required. Dietitians from a nearby NHS trust reviewed patients and prescribed meal supplements if patients needed these.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff assess risks of malnutrition for all patients attending the oncology services. Risk assessments were carried out when patients first started their chemotherapy. Staff mostly recorded weights for patients each time the attended for treatment. However, we reviewed four paper-based nursing documentation records and patients' weights were not consistently recorded each time they attended.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Staff in the oncology services told us they raised any concerns about patients who were in pain, with the consultant who would review patients' medicine prescriptions as required. Patients could also be referred to a specialist pain team within the local NHS trust if needed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The oncology service had obtained the Macmillan Quality Environment Mark. However, the endoscopy service had not yet achieved Joint Advisory Group accreditation for endoscopy services.

The service collected information in line with relevant national clinical audits. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

Staff in endoscopy services collected information about endoscopy procedures. Patient comfort scores were assessed for patients receiving endoscopy procedures. These scores were reviewed and discussed in the endoscopy user group (a forum for clinical staff involved in the delivery and care of endoscopy procedures) in line with national guidance to monitor endoscopy procedures.

Outcomes for patients were monitored. Information about 30-day mortality (patients who died within 30 days of having received an endoscopy procedure) and readmissions within eight days of endoscopy procedures were discussed in the endoscopy user group as a standard agenda item. We looked at minutes of endoscopy user group meeting from November 2020 and March 2021, which stated there had been no incidents of 30-day mortality or readmissions with eight days of endoscopy reported.

The oncology service obtained Macmillan Quality Environment Mark accreditation in 2019. Accreditation was awarded to cancer services that had gone above and beyond to create welcoming and friendly spaces for patients. This accreditation was last assessed in 2019 in line with a three yearly process to apply to maintain accreditation. The service collated information to prepare for the next accreditation process in four main areas: design and use of space, user's journey, service experience and user's voice.

Good

Medical care (Including older people's care)

The endoscopy service was in the process of submitting information to obtain Joint Advisory Group accreditation for endoscopy services. Staff explained this had been delayed by the COVID-19 pandemic but gaining accreditation was one of the priorities for the service in 2022.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and mostly had the right skills and knowledge to meet the needs of patients**.** There were three registered nurses working in oncology services who had all been supported to complete specialist training to administer chemotherapy. Nurses working in the oncology service who had been supported to complete or were working towards accredited systemic anti-cancer therapy (SACT) training. This training was university accredited and competences were assessed by the clinical service manager annually by way of assessing competence against set against standards for systemic anti-cancer therapy training passports. This training is nationally recognised and delivered and university accredited. Once competent, nurses were registered on a specific SACT register. There were arrangements for peer review of and annual competence assessment of the clinical service manager from a clinical service manager working in another BMI hospital.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff were supported to undertake professional development and could ask for financial support to cover course fees. Staff were also supported to attend conferences and the clinical service manager has been supported to attend an internal conference on cancer care.

Staff did not have regular supervision, but the managers explained staff worked closely together. Staff had one-to-one touch point contacts and wellbeing checks with their managers. We reviewed data for staff working in cancer services which showed the manager met with staff most weeks.

Staff had access to a clinical practice educator. Staff who worked when patients were listed for endoscopy procedures received specific training and competency assessment to ensure they had the right skills and knowledge. Records showed 60% of staff working in endoscopy (theatres) had completed their competencies to support endoscopy procedures. There had been no endoscopy procedures carried out at the hospital from March 2020 to March 2021 which had impacted on opportunities to complete competence assessment. There had also been five new members of staff who had started within the last four months. All staff were working on the completion of competencies and skill mix was carefully planned to ensure there was enough staff working who was competent in endoscopy procedures on the days these were listed.

Managers arranged team meetings and staff had minutes of the meeting when they could not attend. We reviewed minutes two team meetings in oncology services which were held in August 2021 and October 2021. There was a set agenda which included agenda items such as risks entered on the risk register, compliance and learning, policy and document reviews and feedback from other meetings.

Managers identified poor staff performance promptly and supported staff to improve. The managers were aware of how to manage poor staff performance to support staff to improve. Managers had access to corporate human resources support if this was required to ensure policy and procedures were followed.

Good

Medical care (Including older people's care)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff told us they had good working relationships with consultants and was able to call them if they had any queries or concerns.

All patients were discussed in multidisciplinary teams by their consultant. There was a service level agreement with the local NHS trust to access pathology (specimen testing) and histology (tissue specimen investigation) services, nurse specialists, counselling and services specific to cancer patients such as oedema clinics and radiotherapy.

Patients had their care pathway reviewed by relevant consultants. If patients required treatment which was not available at BMI The Harbour Hospital, for example radiotherapy, care was transferred to the local NHS hospital.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted. Staff told us they provided support for any patients who needed to live a healthier lifestyle, but this was not always recorded. We did not see any evidence of an ongoing assessment or of practical support and advice documented in the four patient records we saw.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff received training in how and when to assess whether a patient had the mental capacity to make decisions about their care. Staff were required to complete safeguarding vulnerable adults at level 2. The course was designed to encompass awareness of Mental Capacity Act and Deprivation of Liberty Safeguards. Staff received dementia awareness training as part of their mandatory training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff obtained written consent from patients attending for endoscopy service or to receive chemotherapy.

Consultants discussed treatment and endoscopy procedures at the pre-assessment stage, including benefits and risks of the proposed treatment or procedure. Consent was re-affirmed on the day of the endoscopy procedure.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. There was specific consent form used for patients receiving systemic anti-cancer therapy in line with national guidance. Consent was obtained by the consultant and confirmed with patients at the point of administration of chemotherapy.

Are Medical care (Including older people's care) caring?

Good

Medical care (Including older people's care)

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff build rapport with patients and showed their compassion in the way they spoke and interacted with patients. We spoke with three patients who said staff treated them well and with kindness.

Staff working in the operating theatre during endoscopy procedures took care to maintain patients' dignity. Patients wore 'dignity shorts' which meant they remained covered as much as possible during endoscopy procedures.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff in the oncology ward were aware of the '6C', which is a set of essential values to deliver compassionate care. These include care, compassion, competence, communication, courage and commitment.

The oncology service was accredited by the Macmillan Quality Environment Mark. To obtain the accreditation, assessment was made against 'service experience 'and 'user voice'.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provide patients with details of who to contact if they had any concerns. The oncology service had a 24-hour, 7-days-a-week telephone advice line. Nursing staff were rostered to cover this helpline out of hours and over the weekends. Staff provided advice or signposted them to attend for clinical assessment at the local NHS trust of required.

Patients had access to counselling if required. This service was delivered by the local NHS trust in line with its service level agreement.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. During the pandemic, relatives had been discouraged from coming into the hospital. However, specific arrangement could be made with consultants' agreement or videocalls could be facilitated where patients' next of kin could also be present if required.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Patient's next of kin did not routinely accompany patients into hospital for treatment because of COVID-19 precautions. However, arrangement could be made to ensure patient's next of kin was included if this was requested.

Good

Medical care (Including older people's care)

Staff made sure patients understood their care and treatment. We observed outcomes of endoscopy procedures being explained to patients. The consultant took care not to use medical jargon when they explained the findings of the procedure and checked if patients had further questions. Information was given about next steps in the treatment plan.

Staff supported patients to make advanced decisions about their care. Staff explained consultants discussed decisions about advanced care with patients. Staff explained they listened to patients and provided advice or raised further concerns with the patients' consultant if required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this**.** Patients gave positive feedback about the service. We spoke with three patients during our visit. They were very positive about the care they received. They told us staff were kind and professional and they had no concerns at all about the treatment and care they received at the hospital.

Are Medical care (Including older people's care) responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of the local people

Managers planned and organised services, so they met the changing needs of the local population. During the COVID-19 pandemic, the service had worked with the local NHS hospital to provide chemotherapy services. This had increased numbers significantly, but the team felt proud they had supported patients during a difficult time of uncertainty and worry about attending hospitals. Staff had reviewed and assessed patient flow through the hospital to ensure patients were kept safe and to minimise the risk of transmission of COVID-19. For example, there was a separate entrance for patients attending for chemotherapy or for regular blood tests. During this time, staff were advised to contact consultants directly if they had any concerns about signs and symptoms of infection, including COVID-19.

Facilities and premises were appropriate for the services being delivered. There was easy parking for patients attending the services at the hospital. Patients reported to the main reception desk and were signposted by staff about where to go for their appointment. There was a lift for patients with reduced mobility to access the services which were located on the first floor of the building.

Staff monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. Staff told us it was rare that patients missed their appointments. Staff described the actions they would take if this happened. These included making telephone calls and informing the patients' consultant.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff provided access to specialist equipment for patients who attended the oncology service. For example, staff supported patients to use 'cold caps' (specially designed cold caps which reduced blood flow to the scalp and helped to prevent hair loss) and to obtain wigs.

Good

Medical care (Including older people's care)

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Communication needs were assessed, and staff were aware of how to access interpreters if this was required but these had to be booked in advance. There was also access to a 'loop system' for people with hearing aids to help with effective communication.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

The service had suitable facilities to meet the needs of patients' families. Due to COVID-19 restrictions, families or those close to patients could not routinely accompany patients for their appointments. This was assessed on an individual basis. However, conference calls could be arranged so patients and their next of kin could speak with consultants together.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The hospital had cancelled all endoscopy procedures during the height of the COVID-19 pandemic in line with national guidance. Endoscopy procedures were arranged to fit in with gastroenterologist consultants agreed sessions. Capacity to carry out more procedures would increase when issues with the airflow in the minor operating theatre had been resolved.

We were told there was no waiting list for patients attending for chemotherapy services.

Managers and staff worked to make sure patients did not stay longer than they needed to**.** There were effective processes to support patients when they attended for their treatment procedures. Staff worked with patients to make arrangements for them to be collected if this was required. Arrangements could be made for patients to stay overnight if required following endoscopy procedures but that rarely happened. When patients were discharged, they were given information about what to do if they had any concerns when they were at home.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We were told this rarely happened and only if, for example, the consultant gastroenterologist was unable to attend due to sickness.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Staff understood the hospital's policy on complaints and knew how to handle them. Managers investigated complaints and identified themes and shared feedback from complaints with staff and learning was used to improve the service. There had been four complaints about medical care between September 2020 and August 2021. From the information we received, it was not clear if these complaints related to oncology services or endoscopy services. The hospital shared an example of a response to a complaint in medical services, but this related to care provided from the outpatient department.

We were told managers shared feedback from complaints with staff and learning was used to improve the service.

Good

Medical care (Including older people's care)

Are Medical care (Including older people's care) well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

For our main findings please see the surgery report.

There was a shared clinical service manager for the oncology and surgical ward. Staff stated the manager was supportive, approachable and provided good leadership.

Staff who were trained to work in the operating theatres for endoscopy procedures were managed as part of the surgical team.

Staff told us the senior leadership team was visible and approachable. The director of clinical services visited the departments every day.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

For our main findings please see the surgery report.

Each department had a departmental strategy plan (2021). The strategy plan included four generic themes: communication, induction/recruit/retain, physical space changes and process pathway. Under each theme there was one or more objectives which addressed challenges or looked to how services could be expanded.

The strategy plan for endoscopy services did not include accreditation by the Joint Advisory Group (JAG) accreditation. However, staff told us they were keen to obtain this as soon as possible.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

See also the surgery report.

Good

Medical care (Including older people's care)

Staff working in the oncology service attended staff meetings which were mostly held monthly. We reviewed the information from the meetings held 31 August 2021 and 12 October 2021. The meeting followed a set agenda and demonstrated a range of topics were discussed. The minutes were very concise, and it was not always possible to understand the meaning of what was recorded. For example, under the section 'policy and documents' the following were recorded: "Location and status of any local SOPs".

Clinical managers were proud of the staff they worked with to provide safe and effective care and treatment for patients.

Staff were proud of their personal achievements to complete training course and appreciated the opportunities they had to develop in their role. Staff also stated they were proud to work in the teams they worked in. They described their teams as being supportive and staff felt they were valued in their role.

Both the oncology manager and staff told us they were proud of how the teams had pulled together to continue to provide oncology services during the pandemic.

Staff told us they felt able to speak up and raise concerns without fear of retribution. They were aware of who the freedom to speak-up guardian was and how to contact them.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

See surgery report for our main findings.

Endoscopy user groups (a forum for relevant clinical staff involved with the delivery of endoscopy procedures) and care meetings were held quarterly. We reviewed the minutes of the meeting held in March 2021, which referred to the minutes of the previous meeting held in November 2020. The minutes of the meeting were clear and with enough information recorded for those who were unable to attend, to be updated. There was a set agenda which included submission for accreditation audit reports, consultant validation, comfort score, equipment issues and admissions/schedules.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The level of activity performed in oncology and endoscopy services had been greatly impacted by the COVID-19 pandemic. Oncology services had seen an increase in patients receiving chemotherapy as the hospital had delivered some NHS chemotherapy treatment during the height of the pandemic. However, endoscopy procedures had been paused during the four months during the height of the pandemic in spring 2020. We also received information from the hospital that they had not carried out any endoscopy procedures from March 2020 until March 2021 and this had impact on staff competency assessments. However, a patient satisfactory survey had been carried out in December 2020. There was conflicting information about how long the endoscopy service had been paused and we were unsure how a reduction in procedures had impacted on staff compliance with annual competence assessments.

Staff were aware of risk registered on the hospital's risk register. Risks were discussed in team meetings and updates shared if applicable. The oncology service had one open risk registered relating to the systems they used to record care.

Good

Medical care (Including older people's care)

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

See surgery report for our main findings.

Staff collected data through audits and feedback about care. Information was analysed and discussed in team meetings. Where actions were required, the responsibility was allocated to a member of staff and dates for reviews were noted.

The endoscopy service had been applying for national accreditation since 2016 but had not obtained it at the time of the inspection. It was confirmed that assessment for accreditation had been delayed because not enough procedures were carried out and more latterly the pandemic. At the time of our inspection, the application process had been paused pending and increase in activity levels."

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

See also the main surgery report.

Staff were encouraged to participate in staff surveys. Results were not separated out into different departments. Please see main surgery report.

The oncology service received feedback from patients through the NHS friends and family test. We reviewed the results from January to September 2021. The service was assessed with the surgical care group and scores were consistently high between 96.8% (September 2021) and 98.7% (January 2021).

The endoscopy service sent out questionnaires to patients to obtain feedback. The questionnaire sought to obtain feedback on five themes: pre assessment/care, care on the day of the procedure, the environment/endoscopy unit, privacy and dignity and aftercare. The form also asked if patients would be interested in joining a patient forum group. This group had not been operational during the pandemic as no endoscopy activities had been carried out. The service was working to get the patient forum up and running again.

We reviewed a patient view survey from December 2020, which included 84 patient responses. The results were mostly positive and demonstrated patients felt they had been treated with respect and dignity and most felt well informed. For example, the survey showed most patient (80) felt tests were explained well and 81 patients felt staff understood their needs at each stage. However, 71 patients answered 'yes' when asked if they had experienced any delays and ten patients had not been given information leaflets to support their understanding of the endoscopy procedures they were having. An action plan had been developed with four actions which had all been signed off as completed at the time of our inspection.

The oncology service worked with the surgery care group to obtain patient feedback through the completion of patient satisfactory questionnaires.

Good

Medical care (Including older people's care)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The endoscopy service was in the process of applying for Joint Advisory Group (JAG) accreditation. This had been ongoing since the last inspection of the service in 2017. The application had been paused during the COVID-19 pandemic, but staff were unsure about the reasons for the long process. However, staff were committed to complete the application and prepare for a site visit as soon as this could practically be arranged.

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Diagnostic imaging safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in most key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. There had not been a trainer in post to deliver manual handling, but a new trainer had now been recruited and staff could book onto training again. Staff compliance was 100% across all other mandatory training modules at the time of our inspection.

Radiographers working in the MRI/CT scanning department received immediate life support training, which included training in how to recognise and act on anaphylaxis (a severe and potentially life-threatening allergic reaction). Staff in the imaging department did not receive training in how to recognise the deteriorating patient or about signs and symptoms of sepsis. Staff told us they would inform the resident medical officer if they had any concerns about patients and inform the patients consultant for advice. However, radiographers did not receive training in how to carry out vital observations such as monitoring a patient' blood pressure and there was no equipment available to staff for the monitoring of patient's vital observations in the event of a clinical emergency. Staff had highlighted they thought this would be beneficial as otherwise they had to find a nurse who was free to help them.

Staff received dementia awareness training and were required to complete this once. Staff told us there was no refresher training required.

Managers monitored mandatory training and alerted staff when they needed to update their training. Department leads had oversight of training compliance and staff received reminders about when their training was due. This was visible as soon as staff logged into the learning section of BMI intranet where compliance data and reminders were displayed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training in adult safeguarding and child protection at the level required of their role. Records showed all staff had received level 2 or level 3 adult safeguarding training appropriate to their role and child protection training at level 2.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). For example, staff used an adapted proforma to ask sensitive questions about the possibility of patients being pregnant and to assess risk in patients who may have undergone gender transitioning.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had made a safeguarding referral to the local authority about a vulnerable adult who attended the imaging department.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, cleaning audits were not always carried out when they were meant to be, and it was not always clear how the service managed risks of the spread of communicable diseases.

The department was visibly clean and had suitable furnishings which were clean and well-maintained. We did not find any dust on hard to reach surfaces where we checked.

The service generally performed well for cleanliness**.** Cleaning records were not displayed but staff showed us records of daily cleaning schedules. Staff working in the MRI scanning room completed all cleaning (surfaces, floors and sink). Domestic staff did not have access to the MRI scanning room for safety reasons.

Cleaning audits were carried out as planned and in accordance with the audit programme. Audit results showed between 94% and 100% compliance between December 202 and October 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand hygiene and compliance with PPE was audited and showed 100% compliance against eleven standards. Audits were carried out regularly every two months in accordance with the hospital's audit schedule.

Staff cleaned equipment after patient contact although not all equipment was not labelled to show when it was last cleaned.

There were no specific social distancing arrangements in waiting areas in the X-ray department, but patient appointments were made for most patients who attended the department. This meant patients would not be waiting for long periods and staff met patients promptly to carry out the requested diagnostic imaging procedure.

Staff tested twice weekly for COVID-19 using lateral flow tests and results were logged in the NHS app for this use. The hospital did not record staff testing results but relied on staff to report if they had tested positive. Staff were encouraged to receive COVID-19 vaccinations.

Patients were not required to carry out COVID-19 testing before attending for their appointment. Staff on the reception desk asked patients triage questions about symptoms of COVID-19 when patients booked in. If patients had any of the symptoms, staff would ask them to re-book their appointment.

Good

Diagnostic imaging

There was no specific screening for suspected communicable diseases applied when patients were booked in. However, the appointment details sent out to patients mentioned COVID-19 precautions.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff received training in how to use equipment safely. Staff managed clinical waste well.

The design of the environment followed national guidance. All diagnostic services were accessed on the ground floor meaning it was easy for patients with reduced mobility to access the services. There was one CT scanner and one MRI scanner located in an external building on the site referred to as The Lodge. This building could only be accessed from the main road and as such it was geographically isolated from the main building.

The interior was mostly well maintained. However, records showed the light in the main MRI scanning room was not working. This had been reported and recorded every month between July 2020 and October 2021. It did not impact on patient safety but was something that needed to be fixed. Following the inspection, we received assurance the light had been fixed.

There was restricted access to the MRI/CT building. There was further restricted access to the scanning areas preventing patients from accidentally accessing rooms when scanning procedures were carried out. Relevant equipment was labelled in line with the Medicines and Healthcare Products Regulatory Agency guidelines (2021), which recommends all equipment taken into the MRI environment is clearly labelled as MRI safe. There was a patient weight limit on the MRI scanners and there was a large wheelchair for patients with mobility issues.

Records confirmed staff in MRI monitored helium levels every Wednesday and that these were within recommended levels as part of routine safety checks. Helium is used as a coolant inside the MRI scanner and keeps the magnetic coils in good working order.

In the X-ray department, there was a new X-ray machine, one mammography room and a room used for ultrasound scans. The X-ray suite had been refurbished and the equipment upgraded in January 2021. There was a waiting area, but we did not observe patients waiting for long before their scheduled appointments.

Safety and warning notices were displayed, and equipment was well maintained. We saw records of quality assessment processes to ensure imaging equipment was maintained and working within safe limits of radiation and in line with manufacturer's guidance.

Staff had access to a medical physic expert (MPE) for advice if they had any concerns about imaging equipment. This service was provided through a corporate contract. The MPE visited the service at least annually but had visited more often when the new X-ray suite was installed.

There was a corporate equipment replacement fund to ensure equipment was replaced when required. In the X-ray department, there was new equipment installed and staff had received training in how to use this safely. The CT scanner was showing signs of ageing but remained safe to use and was being monitored closely through daily quality assurance checks. Staff carried out daily safety checks of specialist equipment as required and recorded this using internal processes. Staff understood how to report results which were outside of recommended safe levels and we saw records to show this had taken place.

Good

Diagnostic imaging

Staff could access emergency equipment in the event of clinical emergencies. Staff knew how to access emergency equipment stored in specifically designed resuscitation trolleys. Staff and leaders took action to learn from incidents when they occurred. A recent incident had demonstrated systems to call for assistance to clinical emergencies were not always shared effectively highlighted the challenges of the MRI/CT scanner being geographically removed from the hospital. Systems and processes of how to call for help if the event of a clinical emergency had been changed but communication with staff in the MRI/CT suite had not been effective. This meant that when they called for help, they had not followed the updated procedure. The incident had also highlighted that relevant staff did not have the access code to enter the building potentially causing further delay in help arriving. A designated SWARM process had been held to review the process and promptly to reflect and implement processes to learn from the incident and implement improvements.

Lead aprons were available for radiographers if required and for staff in the operating theatre if imaging was used during surgical procedures. There was an audit schedule to assess lead aprons annually and actions were recorded to ensure any concerns were acted upon. All radiographers carried dosage meters which measured exposure to radiation. These were sent off for analysis every three months.

Fire equipment and escape routes were clearly marked. There were fire extinguishers which were serviced and checked regularly, and staff received mandatory training in fire safety. Fire alarms were mostly tested every week, but we noted there were some gaps in records to confirm the fire alarms were tested as scheduled.

Staff disposed of clinical waste safely. Waste was segregated into clinical and non-clinical waste. Bins were emptied regularly, and sharp boxes were labelled and kept closed when not in use.

Substances hazardous to health were stored securely and in line with Health and Safety Executive Regulations.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, changes to access help in the event of a clinical emergency had not been communicated effectively to staff working in the MRI and CT lounge.

Radiographers knew about and dealt with any specific risk issues. They used safety risk assessments in line with national guidance for patients who attended for diagnostic imaging. For example, radiographers used a 'pause and check' system. This is a six-point checklist, which radiographers must carry out before an image is taken. Radiographers working in the MRI/CT lounge carried out additional assessments to ensure patients were safe to receive the planned MRI scan. For example, patients were asked if they had a cardiac pacemaker. If patients required contrast media for scans, additional safety assessments were undertaken including obtaining blood results for recent kidney function test. We reviewed seven CT contrast screening, consent and scan record forms; two of these patients had required CT contrast and relevant safety assessments had been completed.

There were effective systems to ensure justification of exposure to radiation. All CT scans were reviewed by a radiologist who signed to justify the exposure to radiation. Appropriate checking of associated risks was completed and documented. Staff had access to a folder with authorised referrers. Each consultant was listed with information about to their speciality and this was reviewed and updated annually or as required.

Staff had access to a radiation protection advisor and there were three radiographers who had completed radiation protection supervisor training. There was an annual radiation protection meeting which had been held recently.

Good

Diagnostic imaging

Staff used a local (to BMI) version of the World Health Organisation safe surgery checklist when interventional radiology interventions were carried out such as ultrasound guided biopsies. The local safety checklist was based on national guidance. There was a plan to implement the National Patient Safety Agency checklist in the near future.

Staff shared key information to keep patients safe when handing over their care to others. Staff in the X-ray department explained they had communication books (one for radiographers and one for the administration clerks) to communicate key messages and reminders. We were told the manager for diagnostic services shared information through emails and these were also usually printed off for staff to read. Staff held an informal safety briefing each morning where the booked diagnostic procedures were discussed, including patient safety issues, specific patient requirements, equipment and safe staffing levels. These did not follow a set agenda and were not formally recorded.

There were no regular emergency evacuation drills to provide further assurance that staff knew how to safely evacuate patients from the MRI and CT scanners. However, the service confirmed that the processes for an emergency safe evacuation of a patient from the MRI scanner were contained within a local SOP and Work Instruction. Following the inspection, the service provided assurance that an emergency evacuation drill had been carried out in December 2021.

All staff were required to attend a fire training workshop on an annual basis. This session was tailored to ensure it covers the process outlined in the SOP. All staff in the department had completed this workshop.

Staff spoke of resuscitation training scenarios being facilitated at regular intervals to provide life like emergency drills in various departments in the hospital. Staff told us these were beneficial and offered an opportunity to test their skills and knowledge. However, these exercises had not been completed in the MRI/CT suite for a long time and the incident had demonstrated staff were not well-trained in how to attend clinical emergencies in this area.

Staffing

At the time of our inspection, the service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, mammography was covered by bank staff.

The service had enough radiographers and administration support to keep patients safe and ensure the service ran smoothly. However, it was not clear when the establishment review had taken place to ensure enough staff were employed to provide safe care. The manager told us the turnover rate was stable. The MRI/CT lead was leaving shortly after our inspection. There was a plan for one of the MRI/CT radiographers to act up as lead for this part of the service. They were booked onto relevant courses to obtain radiation protection supervisor competencies. The manager explained the MRI/CT service would be supported by staff from another nearby BMI location.

The manager explained recruitment of radiographers was difficult. The upcoming vacancy had been advertised for two months with limited interest. The BMI had added a ‘golden handshake’ as an incentive to attract applicants. There was a plan to explore working with the local university to offer opportunities for newly qualified radiographers to join the service.

Staff usual worked from 8am to 6pm, when the service was open. Radiographers worked an on-call rota to support X-rays that were required out of hours or over the weekend for inpatients. However, we were told they were rarely called.

Three radiographers worked in the X-ray department but there were no healthcare assistants employed to work there. This meant radiographers had to provide chaperone services for patients undergoing sensitive examinations or treatment as well as managing the booked appointments and any on-the-day referrals.

Good

Diagnostic imaging

There was only one mammographer employed on the bank and this was listed as a risk on the hospital's risk register. The mammographer had worked at the hospital for many years and remained up to date with practice and hospital processes. There was a risk that mammography services would be cancelled if they were off sick. Appointments were managed so that annual leave was considered.

Staff covered for each other when annual leave was booked or in the case of sickness. The manager told us staffing levels were discussed every morning in the hospital's safety briefing. If there was not enough staff to provide safe service to patients, appointments would be cancelled but we were told this had not happened.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Clinical leadership was provided by a consultant radiologist who worked under practising privileges. For more information, please see the surgery report.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Records were stored securely. Paper-based patient records were stored in locked cabinets and all computer records were password protected. Staff used an electronic records tracing system to ensure patient files could be easily located.

Paper based patient records included referral documentation, risk assessments and billing information to ensure the correct charges were made for private patients. Information was entered (scanned) into an electronic system where relevant information about patients and their examination history was stored and shared with relevant clinicians. When imaging was reported, the results were entered onto the picture archiving and communication (PACS) system for the referrer to view. If images were shared with other providers such as the clinicians in the local trust, this was done securely using an electronic platform.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when administering, recording and storing medicines. Staff in the MRI and CT department followed protocols which provided information about the scans required and where medicines (contrast media) was prescribed. Radiographers administered contrast media as prescribed using patient specific directions (PSDs).

Medicines were stored safely in locked cabinets. Staff reported there were no issues with getting medicines they ordered. The department kept a small stock of medicines. All medicines we checked were in date.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were shared with department leads by the Clinical Director of Services, who would share those that were applicable to the service. Safety alerts were also discussed with consultants if these impacted on the treatment they would usually prescribe.

Good

Diagnostic imaging

Incidents

The service mostly managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff told us they raised concerns and reported incidents and near misses in line with provider policy**.** There was an electronic incident reporting system which staff were familiar with. Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff spoke of safety events that had happened at other BMI locations.

Staff were aware of when incidents were reportable in line with Ionising Radiation (Medical Exposure) Regulations (IRMER). Minutes of team meetings confirmed incidents were discussed. The manager confirmed they had not been any reported IRMER incidents in the last 12 months prior to our inspection.

Managers investigated incidents. Managers debriefed and supported staff after any serious incident. Staff told us the hospital had introduced 'Stop the line' which was designed to empower anyone who have any concerns about potential harm to patients, to ask for the activity to be stopped, and any issues would be discussed. The hospital has also introduced a 'Swarm' process where all staff involved with an incident were gathered to discuss an incident or near miss in order to identify how improvements could be made.

There were processes to ensure staff, including radiologists were informed of any patient safety alerts. These were shared in the hospital daily communication meeting and shared with staff in the department.

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate effective

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There were local rules/work instructions for imaging procedures undertaken by staff. These were version controlled and reviewed and updated regularly. Protocols were stored electronically, and staff knew where and how to access them.

The service participated in relevant Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) audits. The service was required to submit data on a monthly basis. Results were reviewed by an external radiation protection advisor (RPA). The service accessed RPA and medical physicist expert (MPE) services through a service level agreement with an NHS trust. This was a corporate level agreement to provide RPA and MPE services to all BMI locations. Staff told us the RPA and MPE were easy to get hold of and visited the unit at least once a year. The service installed a new X-ray suite in January 2021 and the RPA and MPE had been involved in the setting up of the new equipment. They continued to provide close monitoring of the service and staff had access to specialist support from the company who supplied the equipment. All relevant staff had been trained to use the equipment and assessed as competent.

Good

Diagnostic imaging

There were corporate policies which staff were required to read when they were updated. Policies were stored electronically, and version controlled,

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Some patients attended the service to receive medicines to alleviate joint pain. Staff did not routinely manage patient's pain as patients were in the department for a short while.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

There were systems and processes to assure the accuracy of reporting of images. For example, all breast images were reported upon by two radiologists with expertise in interpretation of breast images. This was in accordance with gold standard as defined by Royal College of Radiologists guidance of breast screening and symptomatic breast imaging 2019. If there were any discrepancies, the images were reviewed again before an outcome was reached.

The service used national standards to benchmark the effectiveness and safety of imaging. Audit outcomes confirmed the service was compliant with Ionising Radiation (Medical Exposure) Regulation standards, such as lowest radiation dose to achieve good imaging.

Managers and staff used the results to improve patients' outcomes. For example, an internal audit of required information about patients' recent X-ray was not as good as it should have been. As a result, staff had a specific stamp made to prompt radiographers to check and seek information about previous exposure to radiation. Repeat audits demonstrated an improvement.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a clear audit programme of regular audits that were carried out to monitor the safety and effectiveness of the service. Audits results were reviewed by the radiation protection adviser and discussed in meetings.

One healthcare insurance provider requested specific quality assurance and audits to secure patient imagining process could be funded. This information was collated and shared at corporate level by BMI headquarters.

Managers used information from audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. The manager explained staff were involved in drawing up action plans if improvement was required.

The service did not hold any external accreditation. The manager explained that there was a corporate plan to obtain relevant accreditation but was not aware of how this project was progressing.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance. Staff did not receive supervision to provide support and development.

Good

Diagnostic imaging

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Relevant staff were registered with the Health and Care Professions Council and supported to revalidate their registration as required. The provider had an induction programme for newly appointed staff. The service used a competency assessment framework to assess competence for the imaging procedures they were required to undertake.

Managers supported staff to develop through yearly, constructive appraisals of their work. Records shared with us following the inspection demonstrated when the next appraisals were due.

Staff did not have regular supervision, but the manager explained staff worked closely together. Staff had one-to-one touch point contacts and wellbeing checks. These were not always regularly held each month. Records showed some staff received a 'touch point' check in May, July, August and October 2021 but did not meet with their manager in June and September. Staff working in the MRI/CT service received more regular 'touch point' wellbeing checks. Most of the time, radiographers would work in pairs, which enabled staff to seek advice and to 'challenge' practice or behaviours if this was required. Staff confirmed they worked well together and felt able to raise concerns.

The manager was aware of how to manage poor performance to support staff to improve. Managers had access to corporate human resources support if this was required to ensure policy and procedures were followed.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff knew each other well and worked with multidisciplinary colleagues as required. Images were reported upon by the consultant radiologists and discussed in multidisciplinary teams within the setting of the local NHS trust. The hospital had a service level agreement with the local NHS trust that enabled clinicians to discuss patients with their peers and other members of multidisciplinary teams working in the NHS on a regular basis. This ensured that patient cases were reviewed by all relevant clinicians to meet the needs of their condition. We requested the service level agreement following the inspection and found the express contractual term had expired in 2018. We were advised that the contractual provisions were being continued on a rolling contract basis.

Patients had their care pathway reviewed by relevant consultants. Patient pathways were regularly reviewed to ensure they met the clinical needs of patients and to streamline services. The consultant radiologist for breast screening reported on mammograms following the scan and discussed the results of the scan with patients on the same day. If a biopsy (small tissue sample) was required, this would be done on the same day under ultrasound guidance. There was a specialist radiographer who was trained to perform mammography scans. There was no breast care nurse working at the hospital although the radiographer who carried out mammograms was very experienced. If patients received a possible cancer diagnosis, their treatment was referred to multidisciplinary team in the local NHS trust.

Imaging results were shared with patients' GPs, although there was an option for patients to decline consent to share results with their GP.

Seven-day services

Key services were available seven days a week to support timely patient care.

Radiographers working in the X-ray department covered an on-call rota. This ensured there was X-ray cover 24 hours a day and seven days a week for inpatient care if required. Radiographers were on call every three weeks but told us they were rarely called in.

Good

Diagnostic imaging

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information relating to specific instructions about post-procedure care. For example, staff gave patients advice about the need to drink plenty of fluids following scans where contrast media was used.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They mostly followed national guidance to gain patients' consent.

Staff received training about how and when to assess whether a patient had the mental capacity to make decisions about their care. Staff were required to complete safeguarding vulnerable adults at level 2. The course was designed to encompass awareness of Mental Capacity Act and Deprivation of Liberty Safeguards. Staff received dementia awareness training as part of their mandatory training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent was obtained verbally for X-ray imaging and written consent was obtained for MRI/CT scans, including those that required contrast media to be administered. We asked for compliance with consent training which showed all relevant staff had completed the training.

Radiographers working in the CT scanner department completed a 'CT contrast screening, consent and scan record form' for applicable patients attending for a CT scan, However, the consent forms used did not record any discussion of potential risks associated with the imaging procedures. The format was more a risk assessment checklist rather than to obtain informed consent from patients.

Staff used a corporate consent form for all interventional procedures which included a 'needle to skin' process for patients to provide written consent to planned procedures.

Staff clearly recorded consent in the patients' records. The consent form was a triple carbon-copy format where the top copy (white) was held within the patient health record, the second copy (pink) was kept by the consultant and the third/bottom copy was given to the patient. We were not able to check any copies given to patients to review the quality of the copy to ensure this was legible.

Are Diagnostic imaging caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Good

Diagnostic imaging

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff introduced themselves and interacted with patients. Staff valued the opportunities they had to spend more time with patients to provide information and to answer questions that patients asked.

We observed staff providing patients with information about when results would be available.

There were changing room facilities available for patients who needed to change into a gown for their procedure. This ensured patients privacy and dignity was maintained. The service had effective chaperone arrangements for any intimate examinations or procedures and if patients requested a chaperone to be present. The service had a chaperone policy which set out the responsibilities and training required of staff when they acted as chaperones. Staff documented when a chaperone had been present, and the service kept a register of all chaperone actions they had fulfilled.

Patients said staff treated them well and with kindness. We spoke with four patients who all confirmed staff were professional and kind in their interactions with them.

Staff followed policy to keep patient care and treatment confidential. Patient confidentiality was mostly respected. However, we heard one member of staff asking a patient personal 'check in' questions in the waiting area, when there were other patients waiting.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff discussed how their safety check list as part of 'pause and check' processes had changed to enable them to be sensitive to patients who may have or be gender transitioning. Staff felt it was important to be sensitive and respectful of all patients, including those who may be affected by protected characteristics.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff in the MRI/CT scanning suite took account of and supported patients who may suffer from claustrophobia related to the scanning process. Staff took time to explain the procedure and to settle the patient in, once they were in the scanning room. Staff ensured patients had a call bell and communicated with them at regular intervals during the scanning process, to keep them informed and gain assurance that they were coping well during the scanning. Staff could also arrange for patients to come in to see the scanners ahead of their appointment if they felt this would help them prepare.

Staff gave patients time to ask questions and took time to explain what happened next.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients understood their care and treatment. Staff checked with patients their understanding of the imaging that they were booked in for and to confirm the site to be X-rayed or scanned. This also offered patients an opportunity to raise questions to enhance their understanding of the imaging process.

Good

Diagnostic imaging

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff speak with patients in a manner that they understood. Staff did not use medical jargon but used every day terminology to explain procedures and/or answer questions.

Patient received their scan either through an NHS pathway, self-funded or paid for by private health insurances. When patients were self-funding, staff discussed the costs with patients and gave them an opportunity to think about it and to confirm they wanted to go ahead with the imaging procedure.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged patients to complete feedback cards following their imaging procedures. However, the number of feedback forms (NHS friends and family survey) returned was too low to report patient satisfactory survey results for diagnostic imaging services separately. Instead, they were reported alongside the feedback from patients added to the outpatient department. We looked at the average scores from April 2021 to September 2021, which showed between 93.3% and 100% of patients who returned the questionnaire, thought the service was very good.

Patients gave positive feedback about the service**.** Patients told us they were pleased with the care and treatment they had received in the department.

Are Diagnostic imaging responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people seeking private care.

Managers planned and organised services, so they met the needs of patients paying for private imaging or through private health assurance. The departments were open between 8am and 6pm. Most appointments would be available within 24-48 hours. Most patients were self-funding or funded by health care insurance. However, we were told there was an agreement with the local NHS trust to provide ten NHS X-rays and four MRI/CT scans every day.

Facilities and premises were appropriate for the services being delivered. All scanning facilities were at ground floor level meaning patients with reduced mobility could easily access their imaging appointments. There were enough seats for patients waiting and toilet facilities if required. These had grab rails for assistance and emergency pull cords. There were refreshments for patients waiting in the main reception area. Car parking spaces were at the front of the hospital for patients attending for diagnostic imaging procedures.

Managers monitored and took action to minimise missed appointments. Staff ensured that patients who did not attend appointments were contacted. Staff told us there were very few missed appointments. There were processes for staff to follow if patients did not attend.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. The service worked with multidisciplinary teams in the local NHS trust through contractual agreement.

Good

Diagnostic imaging

Staff understood and took account of cultural, social and individual needs of patients as far as possible. Most imaging appointments were outpatient appointments although staff also carried out imaging procedures for inpatients and for patients having surgery. Most patients stayed in the department for a short while, but staff told us they had enough time to speak with patients about their imaging procedure. This sometimes led to conversations about their conditions or other personal issues. Staff said they would answer questions or signpost patients to their GP if required.

The service had information leaflets available in languages spoken by the patients and local community. Staff and patients had access to information that helped them to identify which was the preferred language for patients. Staff could then access support from interpreters as required and could access support with 200 different languages. Minutes of a staff meeting held in June 2021, confirmed compliance with national guidance: Accessible Information Standards (2015) was discussed. There was an action for all staff to ensure any patient communication needs were flagged and discussed in huddles.

Staff took care to ensure patients were as comfortable as possible. Staff in the MRM/CT service took care to provide reassurance and ensured patients wore ear protectors to reduce the noise during scanning procedures. The ear protectors had built-in two-way communication system which meant staff could communicate effectively with patients during scans and patients could listen to music of their choice during scanning sequels. Staff also ensured patients had a call bell and informed patients that they could stop the scan at any time.

Patients who were anxious about being claustrophobic could be invited to visit the unit ahead of their booked appointment

Access and flow

People could access the service when they needed it and received the right care promptly.

Most patients were referred for imaging procedures by consultants they had seen through private consultation. Some patients received their imaging on the same day of their appointment with consultants.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. We were told there were no waiting lists and patients attended for their imaging procedures as soon as practically possible.

Managers and staff worked to make sure patients did not stay longer than they needed to. Appointments were scheduled to minimise waiting times when patients arrived for their booked imaging procedure. During the inspection, we observed staff attending to patients promptly when they arrived in the department.

Staff told us appointments were rarely cancelled and that this would only be if there was not enough staff to carry out the procedure safely or if there was equipment failure. This had not happened in the last 12 months. If procedures were cancelled, staff sought to re-book them as quickly as possible to fit around the patients' availability as far as possible.

There were effective processes to ensure the reporting on images were carried out in a timely way. Staff organised imaging appointments to ensure a consultant radiologist could report on images in a timely manner. The target time for reporting was 48 hours but occasionally, images required further review by another consultant radiologist which could cause a slight delay to results being available. Staff told us many of the consultants would ring or call in to check if there were any outstanding images that needed to be reported.

Good

Diagnostic imaging

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Feedback cards were available to enable patients to give feedback. These forms were sent to the corporate headquarters to be reviewed and themed before they were shared with staff.

Staff understood the policy on complaints and knew how to handle them. The manager investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Records showed the imaging department had received three complaints from 1 October 2020 to 30 September 2021. Most complaints were about the cost of imaging procedures. To help patients understand the costs, staff discussed these with patients and noted this on specific stickers which were added to the patients' paper records before being scanned into the electronic care records. The cost was quoted in writing and the sticker was signed by the member of staff and the patient as a record of the quoted fee. We observed one patient who enquired about the cost of an imaging procedure. Staff provided the information about the cost and next steps allowing the patient time to consider if they wanted to go ahead with a privately funded scan.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed a complaint response which showed the complaint had been investigated and an apology offered to the patient.

Are Diagnostic imaging well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. The new executive director was visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

All staff we spoke with confirmed the executive management team operated an 'open door' policy and that they would feel confident to raise concerns with managers or senior managers if required. Although staff in the MRI/CT department were aware of who the executive leadership team was, they stated they did not often visit the department. However, they spoke well of the new executive director and stated they had visited the department to interact with staff.

Department leaders were respected. The MRI/CT lead was leaving shortly after our inspection and staff stated they would be missed as they had provided good leadership of the department. Another radiographer had agreed to step up to be the MRI/CT lead. However, with no new recruitment, we were told there would be a gap and scanning activities would have to be adjusted to ensure ongoing safe scanning with enough skilled and experienced staff. Recruitment was ongoing and managers were hopeful they would be able to appoint a new radiographer soon.

Vision and Strategy

The service had a vision for what it wanted to achieve.

Good

Diagnostic imaging

For our main findings please see the surgery report.

Each department had a departmental strategy plan (2021). The strategy plan for the diagnostic imaging department included four themes: communication, induction/recruit/retain, physical space changes and process pathway. Under each theme there was one or more objectives which addressed challenges or looked to how services could be expanded.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

For our main findings please refer to the surgery report.

Most staff said they felt valued and enjoyed working at the hospital, but some staff told us morale was low. There was no specific reason provided for this although the last two years during the COVID-19 pandemic had been difficult. Not all staff had been able to take their annual leave when they wanted it and some staff had their leave cancelled without any reason given.

Team meetings were not always held monthly as planned. Staff told us they had attended a staff meeting in September 2021. However, the last previous meeting was in June 2021.

MRI/CT did not always feel connected to the department; this was not helped by being geographically removed from the main hospital site. The radiology manager was aware of the challenges and visited the department at least once a day or if this was not possible, they would make contact by telephone.

All staff we spoke with were aware of who the freedom to speak up guardian was and of their role. Most staff confirmed they felt they could raise concerns without the fear of retribution.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

For our main findings please refer to the surgery report.

Staff collected data to confirm audits were completed as required under the Ionising Radiation (Medical Exposure) Regulations. Data was collected and submitted as required. Audit results were discussed in meetings with the radiation protection advisors and action plans were agreed if required. Audits included compliance with quality assurance and compliance with diagnostic reference levels for imagining. These audits demonstrated patients received the lowest and recommended exposure to radiation to achieve the best imaging quality, image quality, reporting turn around and reporting accuracy.

The service participated in corporate audit programme as required. Staff had suggested they should audit the success rate of cannulation (insertion a small plastic tube into the vein) for administration of contrast media. However, it seemed there were no mechanism to add local audits into the audit schedule.

Good

Diagnostic imaging

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

For our main findings please refer to the surgery report.

The service did not have its own risk register. All risks were logged on the hospital's risk register. There was one risk logged for diagnostic services. This related to the MRI/CT scanner electrical supply not being on the hospital's generator in the event of a power outage and recruitment.

For each there were identified actions to reduce the risk. Risks were discussed in staff meetings as a standard agenda item. We reviewed the minutes of the team meeting held in June 2021 which included updates on four risks. One risk had been closed, one risk relating to the lack of generator back up was listed on the hospital's risk register in October 2021. However, two risks were not added to the hospital risk register. One risk was about staffing of the mammography service as this was currently covered by an ex-employee who was not working as bank staff. The other risk related to risks relating to the transfer of patients between the hospital and the MRI/CT department housed in an external building known as the Lodge.

Staff could operate the MRI/CT scanning equipment manually in the event of a power outage as the scanner was not directly linked to a backup generator. Electrical power was assured through a substation which was maintained by a regional electrical provider. Following the inspection, the service confirmed the power outage was included in the hospitals' Business Continuity Plan which was reviewed regular. Evidence showed the last review was in December 2019.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of data collected for audit purposes and how this was used to make improvements where this was required.

All radiographers we asked, were knowledgeable about policies, local rules/work instructions and where to find these.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

For our main findings please refer to the surgery report.

We were told the service last carried out a patient satisfaction survey in 2019. However, staff encouraged patients to complete feedback forms which were sent to the BMI head office. Feedback was provided from the head office and shared with staff.

Good

Diagnostic imaging

The service received feedback from patients through the NHS friends and family test which covered both outpatients and the imaging department. We reviewed the results from January to September 2021. The scores were consistently high between 93.3% (July 2021) and 100% (January and August 2021). There were no feedback scores from February 2021.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings were minuted, followed a set agenda and were clear to ensure staff who were unable to attend could read updates from the meeting. We requested minutes of the last two team meetings held. We received and reviewed the minutes of the meeting held 22 June 2022. The meeting was attended by the imaging manager and two other members of the team while apologies were noted from the other five members of the team. Following the inspection, we received assurance team meetings were held regularly although the frequency had been affected during the COVID-19 pandemic.

Staff worked with other nearby BMI hospitals and the local NHS trust.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff told us the last 18 months had been very different because of the COVID-19 pandemic. Staff felt this had impacted on moving forward to develop the service further. However, staff in the X-ray department spoke of the benefits of the new X-ray suite had made to patient care.

Good

Surgery

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

Are Surgery safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

All staff completed mandatory training in key skills and the service monitored this for compliance.

The mandatory training was comprehensive and met the needs of patients and staff. Nursing staff received and kept up to date with their mandatory training. Clinical staff completed training on recognising and responding to patients living with dementia. Training figures provided demonstrated they were at 93% compliance with the 12 mandatory training courses.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received an e-mail to alert them when their training was due. Managers were able to follow up on any training outstanding. For the resident medical officers (RMO) they had to provide evidence of their mandatory training to senior staff who monitored their compliance.

Staff told us there was a policy for sepsis management and staff received training on sepsis management as part of care and communication of the deteriorating patient.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Records showed all staff had completed safeguarding adults training in level 2 and 3 and children level 2.

The RMO completed safeguarding training for adults and children to level 3.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they could refer any concerns to senior staff or the safeguarding lead and these would be reported to the local authority.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service provided flow charts on how to report any concerns for an adult or child. They had made no safeguarding referrals in the last 12 months.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The ward area and theatres were visibly clean and had suitable furnishings which were well-maintained. However, we found some equipment in theatres that had gone rusty for example, stools and bins. These had been identified by the theatre clinical lead and were in the process of being removed and replaced.

The service generally performed well for cleanliness. Due to the pandemic the service had not been inspected by PLACE. PLACE assessments are usually an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors).

This location has signed up to PLACE lite assessments until they re-start the PLACE in September 2022. PLACE Lite is recommended good practice to complement the annual PLACE collection. Staff had started their collection of data for PLACE, and this showed they were at 100% for cleanliness across the whole site. One area on the action plan was how to help patients who were not able to wash their hands prior to mealtime. They were looking to obtain alcohol hand wipes and the completion date for this action was November 2021.

Audits of the cleaning of the environment, both on the ward and in theatre demonstrated 100% compliance with the policy for maintaining safe standards. This was also the same for hand hygiene audits and personal protective equipment (PPE).

Staff followed infection control principles including the use of PPE. We observed staff wearing PPE to safeguard patients and themselves from possible cross infection. We saw the results of hand hygiene and COVID-19 audits which was carried out monthly across the whole location the results were 100% for each month.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed in the sluice area and on other equipment in the ward 'I am clean' stickers which also stated the date they were last cleaned. We did not see these stickers in theatres.

Staff worked effectively to prevent, identify and treat surgical site infections. The Infection Prevention and Control lead investigated all possible surgical site infections. In the last 12 months the service reported four surgical site infections, all were superficial, and no trends were identified. These were for NHS and private patients. As part of national reporting for private patients the service reported from 1 April 2020 to 31 March 2021 one surgical site infection in a primary hip replacement procedure, which was 3.2% of all primary hip replacements carried out. There were no infections reported for revision hip replacements or primary knee replacements.

The service screened new admissions for possible infections including COVID-19, MRSA and Meticillin-sensitive Staphylococcus aureus and Carbapenemase producing entrobacterales (CPE). Carbapenemase-producing Enterobacterales (CPE) are bacteria that are likely to be resistant to most antibiotics. Enterobacterales are a type of bacteria (known as Gram-negative bacilli, such as E. coli and Enterobacter), which live naturally and harmlessly in

people's guts, along with billions of other bacteria. We saw infection prevention control (IPC) risk assessment documents which were completed by at the pre admission clinic appointment and any risks identified would be reviewed. For COVID-19, patients had to undertake a Polymerase chain reaction (PCR) test three days prior to admission and then self-isolate.

Decontamination of surgical equipment was undertaken by a third party off site. Sets of surgical equipment were checked before use to make sure they were sterile and all present.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

All patient rooms were single occupancy to prevent any risks of cross infection.

The PLACE self-assessment for 2021 showed the overall condition, appearance and maintenance was 96.5% for the whole location and for the ward it was 100%. For disability accessibility overall for the whole location it was 87% and for the ward it was 84.6%. An action plan had been devised to meet the areas identified for example, signage for the drop off areas at the hospital. Completion date was December 2021.

The service had enough suitable equipment to help them to safely care for patients.

There were two operating theatres both with laminar flow. Laminar flow, is a system that creates a homogenous flow of air in the operating room with very little turbulence, is used widely in orthopaedic procedures, especially during the insertion of prosthetic graft materials, to minimise contamination of the surgical field with airborne microbes. Facilities and surgical equipment including resuscitation and anaesthetic equipment was available and fit for purpose and checked in line with professional guidance. For example, we saw on the ward the resuscitation trolley was checked daily.

Staff disposed of clinical waste safely.

There were recording systems for documenting details of specific implants, for example the National Joint Register. The National Joint Registry was set up by the Department of Health and Welsh Government in 2002 to collect information in England and Wales on joint replacement operations and to monitor the performance of implants, hospitals and surgeons.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Pre-operative assessments were carried out to make sure patients were fit to have their surgery at this location. We observed a pre assessment clinic for a patient undergoing orthopaedic surgery. A full medical history was undertaken with a list of medication and some physical observations for example, blood pressure and pulse.

The hospital had an admission policy setting out safe and agreed criteria for selection and admission of patients using the service. This was based on medical history and risk of an anaesthetic.

Good

Surgery

Staff completed risk assessments for each patient on admission, using recognised tools, and reviewed this regularly, including after any incident. We saw risk assessments for falls, malnutrition, pressure ulcers, moving and handling, use of bedrails and venous thromboembolism (VTE). There was also a form for reviewing any intravenous cannulas to make sure they were patent and not showing signs of infection.

Staff knew about and dealt with any specific risk issues. Each surgical pathway contained risk assessments for example, pressure ulcer and falls. These highlighted any concerns to staff.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We observed in the surgical pathway documents the staff had access to the NEWS2. NEWS2 is the latest version of the National Early Warning Score (NEWS), which advocates a system to standardise the assessment and response to acute illness. In theatres we saw NEWS was still being used and not NEWS2. This meant they were not using the most up to date tool to monitor patient's condition. All records relating to NEWS and NEWS2 had been completed in full making sure patients were being monitored for deterioration.

Staff monitored patients using the NEWS2 and if they were concerned about possible sepsis, they informed the resident medical officer. They would then make the decision, with advice from the consultant if required, about prompt transfer to an NHS hospital to commence urgent treatment.

Staff shared key information to keep patients safe when handing over their care to others. For example, we observed this in theatres when patients were handed over to recovery post operation.

Shift changes and handovers included all necessary key information to keep patients safe.

There were protocols including a service level agreement (SLA) for the transfer of patients using services to NHS in the event of complications from surgery. From October 2020 to September 2021, five patients were transferred to the local NHS trust for treatment following a deterioration in their condition. None of the five patients who were assessed prior to surgery were identified as being unsafe to have their operation at this location.

The service ensured compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist. We observed staff completing the checklist in theatres, all staff were present, taking part and the checklist completed in full. Monthly audits were undertaken checking compliance with the WHO surgical checklist from records and these were rated as 100% each month.

The service made sure there was access to consultant medical input. The resident medical officer or nursing staff were able to contact the consultant directly if they had any concerns the patient's condition had deteriorated.

The service ensured there were appropriate 24-hour hotline arrangements for patients following discharge. Patient were advised to ring the ward if they had any concerns for advice and support.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Good

Surgery

The service had enough nursing and support staff to keep patients safe. Managers reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with the number and needs of patients. The number of nurses and healthcare assistants matched the planned numbers as displayed on the notice board at the nurse's station.

The ward had low patient numbers as it was school half-term. An additional clinical lead had started working on the ward and a new Clinical Services Manager had also been appointed in theatres, but they had only been in post for short while at the time of the inspection. Bank and agency nurses had been used to fill qualified nurse vacancies on the ward. Some staff had raised this as an issue due to competency of some of the temporary staff. They had reported this to senior staff. Local induction to the ward and to the operating theatres was provided to bank and agency staff. This included for example, where emergency resuscitation equipment was located.

The service had eight vacancies across the ward and theatres. These were permanent positions for trained and untrained staff. In theatres they also had a bank role vacancy for a theatre practitioner.

Guidance on theatre staffing levels was planned to be in line with recognised professional body from next year. The provider will be looking to implement The Association for Perioperative Practice (AfPP) accreditation for staffing. *The Association for Perioperative Practice* are a registered charity working to enhance skills and knowledge within operating departments.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. A resident medical officer (RMO) was on duty 24 hours a day and had access to the consultants if needed in an emergency.

Surgery was consultant delivered and led for both private and 'NHS choose and book' patients.

Consultants reviewed patients on their ward rounds. The RMO would also review patients before surgery and after if required. The RMO was included in the handover of patients in the morning and evening to make sure they were aware of their medical conditions.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We observed patients had a standard surgical pathway, some were for specific operations. Each pathway contained for example, a list of medicines normally taken, risk assessments, NEWS2/NEWS and multidisciplinary records. Records were stored securely.

Documentation audits were undertaken six monthly. We did not see how many patients' records were audited but the result for the last three audits showed they were at 86-88% compliance. This included an action plan for areas that required improvement.

The service ensured appropriate pre operation assessment was recorded. In all the records we examined we saw evidence of a pre operation assessment which took place either via telephone or face to face.

Good

Surgery

Discharge summaries were communicated to the patients GPs. We saw records of discharge information sent to the patients GPs on their discharge.

The service ensured the recording and management of medical device implants for inclusion in the Breast and Cosmetic Implant Registry (BCIR) were completed. The registry records the details of any individual who has breast implant surgery, so they can be traced in the event of a product recall or other safety concern relating to a specific type of implant.

Medicines

The service had systems and processes to safely administer and record medicines use. Staff supported patients to make choices around their medicines by providing clear information. Not all staff received feedback following a medicine incident.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff were aware of how to access medicines advice and supply during opening hours and there were arrangements for out of hours support. During pre-assessment for surgery, there were processes to alert a pharmacy professional for a review where necessary.

Discharges were planned and the provider had a clinical meeting each day to communicate this. Medicines supply and advice on medicines were timely at discharge.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. A member of the pharmacy department attended daily staff meetings about ward activity and patients to help prioritise. Staff provided support to patients to inform them about their medicines, allowing them to raise concerns and ask questions including out of hours. Staff we spoke to were aware of the sepsis pathway and described the actions in accordance with The National Institute for Health and Care Excellence (NICE) guidance which states patients should receive intravenous antibiotics within 60 minutes.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Generally, medicines were prescribed and administered in line with the provider's policy. Medicines training is not mandatory for all staff. Prescriptions were not always clearly written which could lead to errors. Where this was the case, nursing staff would check with the prescriber before administering. The prescriber was always responsive to this and no medication was delayed. Prescribers should ensure prescriptions are written clearly.

Where errors were made, these were reported and investigated. Where staff were given feedback, they were supported and completed reflection. However, the provider should ensure that feedback, learning and improvements from incidents are fed back to all staff involved.

Staff followed current national practice to check patients had the correct medicines.

We looked at a combined medicines reconciliation and missed doses audit completed each month. The provider was over 98% compliant in the last 6 months.

A medicines management committee had been recently set up to share medicines related information and to learn from incidents.

Good

Surgery

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff are asked to sign up to national electronic patient safety alerts when starting employment and urgent alerts were cascaded by the medication safety officer.

We were informed of a clinical newsletter where medicines safety alerts and incidents can be disseminated.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff are asked to sign up to national electronic patient safety alerts when starting employment and urgent alerts were cascaded by the medication safety officer. We were informed of a clinical newsletter where medicines safety alerts and incidents can be disseminated.

Decision making processes ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The provider had a covert medicines policy. Staff ensured patients were comfortable and explored non-medicine options to relief pain such as changing their position in bed. Pain relief was given where necessary.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the providers policy. All staff had access to the incident reporting system.

Staff received feedback from investigation of incidents. The computer system used, automatically sent feedback to the member of staff who reported the incident once it had been investigated.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Investigation reports were shared with patients and their families on their completion.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

The service had reported one never event in surgery and this was wrong site surgery. The surgery had been undertaken in outpatients under a local anaesthetic. This was in the process of being investigated. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

The service had also reported a patient death within 30 days of surgery. This was being investigated.

The provider sent to each of their locations the Medicines and Healthcare products Regulatory Agency (MHRA) alerts weekly. These were then shared with staff by the heads of each of the department. The MHRA National Patient Safety Alerts send alerts that require local executive management level action to reduce the risk of death or serious harm.

Good

Surgery

Are Surgery effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance, however not all guidance was being followed by all staff.

Staff followed up-to-date policies to plan and delivered high quality care according to best practice and national guidance. Staff had access to the providers policies and procedures which were accessible via their computer system.

The provider required locations to complete 37 audits per year and these were linked to national guidance and quality standards and professional guidance. We saw the results of some of these audits and saw compliance was at 100%. Where the service had not scored 100%, action plans were devised to address the areas of shortfall. There was no specific audit for sepsis however, the service told us they received their assurance staff were monitoring patients for sepsis from the antibiotic stewardship audit and the National Early Warning Score (NEWS) escalation audit.

Not all staff were following the National Institute for Health and Care Excellence (NICE) guidance, for example, in theatres we observed they were not always meeting the hypothermia prevention and management of adults having surgery (CG65). In the intraoperative phase the patient's temperature should be measured and documented before induction of anaesthesia and then every 30 minutes until the end of surgery; to help reduce the risk of infection and to monitor the risks of hypo or hyperthermia. The theatre standard operating procedure also reflected temperature to be checked every 30 minutes. We reviewed the records for three patients who had major surgery and found this did not always happen.

The inspection was undertaken during half term and the service had a reduction in planned surgery due to holidays. Most patients who were having surgery were day cases therefore their operations were minor, and they were under anaesthetic for short periods of time and didn't require their temperature to be taken during surgery. Staff we spoke with in theatres were aware of the need to monitor patients having major surgery under general anaesthetic at the 30 minute intervals. Following our inspection, we were sent copies of audits where staff had been recording patient's temperature. However, this audit did not look at monitoring of patient's temperatures during the operation.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients we reviewed during inspection did not require food and hydration levels monitoring. Staff told us they completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patient's risk of malnutrition. As part of the surgical pathway, staff assessed patient's risk of malnutrition using the Malnutrition Universal Screening Tool.

Good

Surgery

Patients waiting to have surgery were not left nil by mouth for long periods. Staff told us patients were advised to have no food for six hours prior to surgery and two hours for water. This was confirmed in the pre-operative assessment manual. Some patients may have different fasting times depending on the surgery, information about this would be given to patients by the consultant.

Following surgery patients had effective management of nausea and vomiting. A patient told us when they required pain relief, they were also given a medicine to prevent them from feeling nauseous.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a pain score, which was included in the NEWS2, and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. For example, Patient Reported Outcome Measure (PROMs). This is a measure of health gain in patients undergoing hip replacement and knee replacement surgery. This is done using questionnaires before and after surgery. Private Health Care Information Network (PHIN) was used. They provide outcome information for private hospitals and consultants in the UK.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The PROM data for NHS-funded patients from 1 April 2019 to March 2020, was similar to other organisations. The same for The Oxford score adjusted average health gain for hip replacements (primary) and the EQ-5D index adjusted average health gain for knee replacements (primary). Private-funded patients from 1 April 2020 to 31 March 2021, following knee replacements (primary); 100% of patients that took part in the PROMs questionnaire reported an improvement in health (compared to 94.8% nationally).

Under the PHIN Data Maturity Model, patient outcome measures were published under Milestones 5 and 7. Milestone 5 is participating in health outcome measures, and Milestone 7 is publishable health outcome measures. BMI The Harbour were compliant with both of these.

In the 2020 National Joint Registry hip and knee audit, 98.8% of patients at this organisation consented to having their personal details included in the audit, which was better than other organisations. For the four other comparable metrics in this audit the organisation performed similar to other trusts. This told us the outcomes for patients were good at this service.

BMI Harbour was due to participated in QPROMs this is the same as PROMS but for cosmetic surgery.

From 1 April 2020 to 31 March 2021, the top private patients' surgical procedures carried out by this organisation were as follows: cataract surgery and knee arthroscopy. For NHS patients it was skin lesion removal and carpel tunnel release.

Good

Surgery

The service monitored patients' outcomes to identify any trends. For example, three patients required re-admission from September 2020 to September 2021, two of these were due to patients needing a catheter insertion due to urinary retention following day case surgery. Patients note were reviewed and no areas of care of concern were identified.

The service monitored the patient's length of stay to make sure they were in line with other services. For example, the longest length of stay was for knee replacements at 3.2 days and hip replacements at three days.

The Commissioning for Quality and Innovation (CQUIN) framework (for NHS procedures) had been put on hold due to the pandemic. This supports improvements in the quality of services and the creation of new, improved patterns of care. This service was currently negotiating their CQUINs with the local Clinical Commissioning Group.

Competent staff

The service made sure nursing staff were competent for their roles. Managers appraised nursing staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. A clinical educator supported the learning and development needs of staff.

Staff had completed their competencies except for two new members of staff. One of whom was in their probation period and one member of staff returned from maternity leave and was in their return-to-work phase.

Managers gave all new staff a full induction tailored to their role. They had a 90-day probation period, during this time they had an induction checklist to complete and support of a buddy (a senior member of the staff team) to assist with orientation and learning.

Following our inspection, we were sent evidence of one- to-one meetings or 'Staff Touch Point Contacts' and 'Wellbeing Checks' for the ward and theatre staff. The time frame was from May 2021 to October 2021. We found that some staff had more frequent contact than others. However, we do not know if all staff who were on this list were still working at this location.

Managers supported staff to develop through yearly, constructive appraisals of their work.

We were told and saw posters advertising the recently introduced 'Tea and Train' short teaching sessions for staff to develop new skills.

Arrangements for granting and reviewing practising privileges had been developed. The provider had developed an approvals list which had to be completed before practising privileges were granted. For example, details of their experience, proof of GMC registration and they had to be interviewed by the medical advisory committee.

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary meeting during our inspection, patients were discussed and plans of care reviewed.

Good

Surgery

Staff worked across healthcare disciplines when required to care for patients. We observed patients being handed over to theatre staff and then back to the ward staff once their operations had been completed. Information was shared between staff.

The resident medical officer received appropriate information about the patients and surgery being undertaken. They attended the ward daily multidisciplinary meeting in the morning and at night they joined the ward handover to the night staff. They told us they were kept up to date with the patient's condition and they could request consultant support if required.

Staff liaised with patients their families/carers when discussing discharge plans and ongoing care and treatment if required. As part of the preadmission assessment, discharge arrangements were considered.

The service ensured relevant information was shared between them and the patient's GP, in order to ensure safety of the patient following discharge.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on the ward for their patients, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors who could arrange some diagnostic tests, 24 hours a day, seven days a week. There was also support from pharmacists and therapists.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service was able to signpost patients to relevant information promoting healthy lifestyles.

Staff at the preadmission clinic assessed each patient's health during their clinic appointment and provided support to live a healthier lifestyle as required and to improve their recovery post-surgery. We observed a preadmission clinic for a patient who was undergoing orthopaedic surgery. Staff asked questions about their lifestyle to include if they smoked and how many units of alcohol, they drank each week. Advice was given about reducing or stopping either or both as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their safeguarding adults training. Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. Staff gave us examples about when they had raised concerns about a patient's ability to give consent; including who they had involved, and the outcomes.

Staff recorded consent in the patients' records. We looked at six patient records, all files contained a consent form that had been signed by the patient and doctor.

Good

Surgery

Staff ensured informed consent was given by speaking to patients at their preadmission assessment appointment. Staff checked their understanding of their surgery, expected outcomes and risks and about post operation recovery. We observed risks had been documented on the consent forms we reviewed.

Staff said they did not have training specifically in relation to the Mental Health Act but said this was covered in their safeguarding adults training. Senior staff said they did not have any patients subject to the Mental Health Act.

Senior managers told us they had not been required to use Deprivation of Liberty Safeguards. Patients had to meet a criteria to be able to have their surgery at this location and they did not have the skills or support to care for patients with mental ill health or those who may require a Deprivation of Liberty Safeguard.

Are Surgery caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. All comments we received were very positive about the staff. Staff knew they had to keep patient care and treatment confidential.

The service sent us feedback from patients they had received in the last 12 months. For example, “very friendly staff who knew what they were doing”, “all needs met. All staff lovely and professional”, “the staff from nurses to catering and physios and domestic to medical, were excellent. They were caring, thorough and professional throughout” and “lovely staff, I felt really looked after”.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. One patient told us how the staff had made sure their pain was under control. The staff also checked on them frequently, offering to change their position to make them more comfortable.

Staff supported patients who became distressed and helped them maintain their privacy and dignity. Staff told us they were aware that some patients had different care needs depending on their culture and religion and they took these into account when caring for them.

Good

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patient feedback provided by the service said for example, "excellent information, everybody was kind, but efficient, they listened but you felt you were in very capable hands, thank you".

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Feedback we received from the providers patients survey included, "all the staff were very friendly and explained everything to me thoroughly. No complaints. Very happy with everything" and "attentive, excellent communication, personable. Always making me aware of the plan for the day 10/10".

Staff talked with patients, families and carers in a way they could understand. Patients we spoke with on the day confirmed they understood what staff had told them and were able to ask questions about their treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw evidence of this during and after our inspection with patient feedback.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

There was a system to ensure patients using the service who were self-paying for their treatment were provided with a statement. This included terms and conditions of the services being provided to them and the amount and method of payment of fees. There was also a breakdown of costs for each individual service. We saw evidence of this in patients' records.

Are Surgery responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. They worked with the local NHS trust and Clinical Commissioning Group to reduce waiting their lists due to the pandemic.

Facilities and premises were appropriate for the services being delivered.

There were staff members trained to aid the delivery of care to patients in need of additional support. For example, they had a dementia lead who could support staff.

Good

Surgery

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with sensory impairment or dementia received the necessary care to meet their needs. For example, during the inspection a patient with complex needs was able to bring in their carer to support them. They had to undertake the same COVID-19 precautions prior to admission.

Each patient room had an en-suite facility of a toilet and shower. Height adjustable beds and other equipment were provided to meet the needs of patients. Patients could reach call bells and staff responded quickly when called.

The service had information leaflets available in languages spoken by the patients and local community.

Patients were able to be given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to arrangements for patients who need translation services.

NHS funded care was provided, and the service complied with Accessible Information Standard by meeting the information and communication needs of patients with a disability or sensory loss. We were shown copies of information leaflets in different languages, in large print and they were able to obtain in braille if required.

Staff had access to training and a dementia lead to help them meet the needs of patients living with dementia.

Access and flow

People could access the service when they needed it and received the right care promptly. Due to the transfer of a small number of delayed NHS patients, some waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed. Not all patients received treatment within agreed timeframes and national targets. The consultant led referral to treatment waiting times in August 2021 showed the organisation treated 9.1% of patients on an admitted surgery pathway within 18 weeks, which was worse than the national average of 74%. However, this was because the service had taken on a contract with the local NHS trust to treat patients who had exceed the 18-week referral to treatment time scale.

Managers and staff monitored their waiting lists. For example, at the time of the inspection there were 26 NHS funded patients and 22 privately funded patients, waiting for an operation date.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. From October 2020 to September 2021, 27 operations were cancelled and of these, six were re-booked within the 28 days national target. However, the remaining 21 all had reasons not to be re-booked. For example, some were due to patients own choice, some patients didn't want to come in during the pandemic and one was cancelled by the consultant due to medical reasons.

Managers and staff worked to make sure that they started discharge planning as early as possible. This was to prevent any unnecessary delays.

Good

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Information on how to complain was available. NHS patients were able to make a complaint via the NHS trust or Clinical Commissioning Group.

Complaints numbers were monitored, for example, the ward and theatres had received 10 complaints from October 2020 to September 2021.

Senior staff told us about the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. No themes had been identified. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of learning from complaints.

The service was a member of the Independent Sector Complaints Adjudication Service (ISCAS) which provides independent adjudication on complaints for ISCAS subscribers. ISCAS is a voluntary subscriber scheme for the vast majority of independent healthcare providers. We saw one complaint had been referred to this scheme and some concerns had been upheld. At this inspection we saw changes had been made to the discharge medicines of some patients undergoing elective orthopaedic surgery due to learning from this complaint.

Are Surgery well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The leaders had the skills, knowledge and experience to manage the service. There had been some recent changes to the senior management team with a new manager (known as the executive director) and the clinical lead. The manager had applied to us to be considered for registration and was successful. They had been in post since August 2021. Previously they were the registered manager at another independent hospital with another provider. They had a background in finance management.

The clinical lead had started in July 2021, and they had a background of working in hospitals.

The provider had a senior management structure at each of their locations with the registered manager (executive director) leading the team. Then the next level of senior management was a director of clinical services, operations director and clinical chair. The clinical chair was a new position for a consultant to have more clinical input into senior management.

The leaders were visible and approachable to staff. All grades of staff confirmed they were aware of who the registered manager (executive director) was. Staff told us the registered manager and clinical lead were approachable and operated an ‘open door’ policy.

Good

Surgery

Staff were able to identify the clinical lead and their roles and responsibilities. Staff told us the clinical lead was visible walking around the hospital during their shift.

The registered manager told us they maintained links and a good working relationship with the local NHS trust and Clinical Commissioning Group. They held weekly meetings with the local NHS trust and were working on some new contracts to help reduce waiting lists at this trust.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a written vision statement and a strategy of how to achieve this. For example, the provider main purpose was to "provide the high quality, safe and compassionate care our patients need and expect". There were four key principles and eight values based on their main purpose. For example, one of their values was to value people and staff. At a local level, the senior management team were working on devising their own vision based on the providers main priorities and then to share it with the staff for their comments.

A realistic strategy for achieving their priorities and delivering good quality sustainable care had been devised. The registered manager told us how they were planning on growing their business to encourage more people to come and use their services.

BMI The Harbour's strategy was aligned to local plans in the wider health care economy, and services were being planned to meet the needs of the relevant population.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt supported, respected and valued. Several members of staff we spoke with had worked at this location for over 15 years. Staff told us they liked working there. We saw in the minutes of some of the meetings that staff had been promoted to more senior roles, as the provider encouraged each location to 'grow their own' to aid retention and increase morale.

The culture centred on the needs and experience of patients who used services. The provider had introduced in March 2021 the Circle Operating System (COS). COS is an established methodology to empower staff to work together to be safe and effective and recognise that everyone has a responsibility to contribute towards this goal. It focused on for example, engagement and performance with six key areas to help achieve this. One being 'stop the line' where if a member of staff feels a situation could cause harm to a patient, they can report this to the member of staff in charge. COS champions worked across the providers locations. Staff were aware of the COS.

Staff told us they felt able to speak up if they felt a situation could cause harm to patient. This was especially in theatres where staff said they would stop the consultant if they had any issues with the procedure.

Good

Surgery

Staff were encouraged to report all incidents as they were a learning opportunity. Staff confirmed they could raise any issues with their line manager, or other senior staff. Staff had access to a freedom to speak up guardian and most staff knew who this was. The provider had a corporate freedom to speak up member of staff and this was the chief nursing officer.

The provider had processes and procedures to ensure it met the duty of candour. We were told they had duty of candour policy. We had seen evidence this had been used for incidents which met the threshold. Staff we spoke with were aware of the principles of the duty of candour.

Managers had access to policies, procedures and support to address behaviour and performance that was inconsistent with the vison and values, regardless of seniority.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Not all information required for safe recruitment of new staff had been obtained.

There were effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services. These were regularly reviewed, and improvements made as required. We saw evidence of the audits and minutes of monthly or quarterly meetings where staff discussed these and other topics. The provider had a total of 37 audits for each location to complete each year at different timescales. The majority of audits demonstrated high compliance.

The provider had introduced in May 2021 a governance framework to demonstrate transparency from locations to board. This showed how each of the committees or steering groups at locations fed into regional teams and them into the provider and board as required and how information was fed back to locations.

We saw all levels of governance and management functioned effectively and interacted with each other appropriately. We reviewed minutes of several meetings, for example, clinical governance meetings and senior leadership meetings. We saw minutes of the medical advisory committee with representation from the consultants who worked at this hospital and other senior staff. Subjects mentioned actions from previous meetings, including complaints, areas of concerns and practising privileges.

Staff at all levels were clear about their roles and accountabilities. The senior leadership team shared information to heads of departments to be cascaded to staff.

The service had a service level agreement with the local NHS trust. This was out of date in 2018 and did not include an agreement which existed to facilitate multidisciplinary working for patients on cancer pathways. Senior staff told us they were aware of this, and it was currently under review with a meeting booked to update and review this. Senior staff met weekly with representatives from the local NHS trust to discuss ongoing working together and to maintain a good working relationship.

The provider ensured surgeons, including those carrying out cosmetic surgery had an appropriate level of valid professional indemnity insurance. As part of the review of surgeons and consultants practising privileges, they had to provide evidence of their insurance cover. The provider had set up a format for each location to follow, which included

information required under national guidance on appraisals for doctors. We reviewed this for several consultants and saw the required evidence had been obtained. This information had to be provided so they could continue to provide treatment. As part of monitoring each consultant who worked under practising privileges each consultant had to have an interview every two years with Executive Director (registered manager). These meeting included scope of practice, review of activity and meeting the requirements of practising privileges. We saw a section on this in the Medical Advisory Committee meetings. Not all consultants had been reviewed using this system as it was still new.

We reviewed four staff records and saw that Disclosure and Barring Service checks (DBS) were completed. However, we found not all pre employment checks were complete. Three of the four staff had gaps in their employment history which had not been followed up with a written explanation. We saw in the interview records, that conversations had happened, however these were very brief and did not state dates or timescales. This was not in line the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, all other recruitment checks as required by the Regulations had been completed. For the staff who had professional qualifications, such as a nursing qualification, we saw that these credentials had been checked. We reported our findings to the registered manager during the inspection who took immediate action to improve record keeping at interviews.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. We were sent copies of minutes of six clinical governance meetings where we saw clinical areas discussed for example, outcome of clinical audits for World Health Organisation (WHO) surgical safety checklist and Venous Thromboembolism (VTE) compliance. Training for staff and resuscitation exercises were also discussed. We were shown a range of audits that had been completed. The outcome of these were discussed as part of several meetings. An action log had been developed for areas requiring improvement. We saw evidence of this where audits were not at 100%.

We saw there were processes to manage current and future performance. These were regularly reviewed and improved. The senior management team told us about their plans to increase the services they provided. We also saw some of the plans had been discussed at meetings for example, in the medical advisory committee minutes.

Arrangements for identifying, recording and managing risks, issues and mitigating actions we were being used. Each risk had been assessed and allocated a score, the higher the score being more of a risk. The risk register was reviewed regularly, and any risks closed were removed. Copies of the risk register were on display in staff areas.

Each core service area had their own meetings for example, oncology and diagnostics. Audits were also completed and these fed into the other meetings for example, clinical governance and then senior management meetings as required.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. This included the use of back up emergency generators in case of failure of essential services.

The senior management team ensured all cosmetic surgery carried out was monitored and reviewed. We saw evidence of a cosmetic surgery audit and actions needed to reach 100% compliance. For example, the cosmetic surgeon needed to record psychological assessments for body image.

Good

Surgery

The provider was registered with the Medicines and Healthcare products Regulatory Agency (MHRA) Central Alerting System (CAS) so they received alerts that may be relevant to the services they provided. These were cascaded down from the providers head office to each location and then passed to staff for any action.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There was a holistic understanding of performance, which included patients views with information on quality, operations and finances. This information was used to measure improvement. Audits provided data on compliance with areas reviewed. These were reviewed by staff and action plans devised when shortfalls were identified.

In the meeting minutes we reviewed, quality and sustainability were covered in the relevant meetings at all levels. Staff had access to information they required to review their service provision. There were clear service performance measures, which were reported and monitored. Each audit was scored out of 100% and a set of performance standards to meet this. When shortfalls were identified, actions were devised to address these.

There were effective arrangements to ensure that data and notifications were submitted to external bodies as required.

The provider had arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, were in line with data security standards. We did not ask to see their policy on data management to confirm the arrangements met the providers standards.

The service ensured surgical cosmetic procedures were coded in accordance with SNOMED_CT. This is a set of clinical codes for cosmetic surgery. This common language can be used within electronic health record systems, to support improved communication and to provide information to support audit and quality improvement.

Data systems were secured and monitored. Staff told us they had a secure log in for each computer and these timed out if they were not used in a set time. Staff told us they logged out or locked the computer when they need to leave the desks.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients' views and experiences were gathered and used to make improvements to the services and culture. We were sent details of the latest patient feedback for three months up to August 2021. Patients were asked a set of questions and these results were collated and percentage score given. The lowest score was 83% for catering and the highest score was 100% where patients felt ready for discharge. This location also scored 98% of patients who said they were 'likely or extremely likely' to recommend.

Friends and family test results for inpatient and day case patients from January 2021 to September 2021, all rated the service as 'good or very good' with between 97% and 98% likely to recommend this service.

A patient forum had been put on hold due to the pandemic, but they had plans to re-start this soon.

Good

Surgery

Staff were actively engaged so their views were reflected in the planning and delivery of services and in shaping the culture. The provider had used an external company to find out staff views. They used the following areas to gauge staff responses, fair deal, my company, my manager, wellbeing, giving something back. The results were compared to other companies, and they were collated at location level to identify areas of improvement, for the provider and location. One example of an area that was identified a positive was wellbeing of staff as this location was 9% higher than the other companies they were assessed against.

Staff in theatres told us they had not had staffing meeting for some time but now a new lead had been appointed plans were underway to have one shortly.

Staff had access to staff forums and leadership walkarounds. Staff we spoke with confirmed they had attended the staff forum and seen senior staff about the location. The registered manager and clinical lead told us they operated a policy where staff could go and talk to them when their doors were open.

Leaders of the service told us they maintained positive and collaborative relationships with external partners to make sure patients received care and treatment safely and to deliver services to meet their needs.

Senior staff told us they ensured patients considering or deciding to undergo cosmetic surgery were provided with the right information and considerations to take account of and to help them make the best decision about their choice of procedure. There was also at least a two week time period between consultation and the procedure, for the patient to be able to make sure this was the right thing for them.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and research.

Leaders and staff strived for continuous learning, improvement and innovation. This included participating in appropriate research projects and recognised accreditation schemes across all specialities. For example, BMI The Harbour was recognised with a National Joint Registry (NJR) Quality Data Provider award. The NJR Quality Data Provider award scheme has been developed to offer hospitals a blueprint for reaching standards relating to patient safety through National Joint Registry (NJR) compliance and to reward those who have met targets in this area. This location had received a 2019/20 award for reaching and maintaining these standards.

The physiotherapist team published an article on shockwave outpatient department treatment. Extracorporeal shockwave therapy is a modality used for the treatment of a variety of musculoskeletal conditions, primarily applied to chronic conditions, particularly those affecting medium to large sized tendons and their insertions on bone

A senior member of staff had completed an article which was due to be published in a professional magazine about a sleep study they had completed. Plans for other studies included the radiology department taking part in a provider review on the use of X-rays 24 hours post implant insertion and the use of these. X-rays were routinely taken following hip and knee replacement surgery after 25 hours to check they were in place. The review was to see if the X-rays were needed or whether they could rely on post operation physical checks.

The provider had an internal review system related to death of patients using the service. The meeting was monthly and senior staff from each location attended. Learning was shared amongst locations to make improvements.

Good

Surgery

Arrangements had been developed for the service to encourage, record and monitor Royal College of Surgeons (RCS) Certification by surgeons who carry out cosmetic surgery. As part of the practising privileges process, this information had to be supplied and verified for them to practice at this location. Cosmetic surgery was stopped during the pandemic and had recently re-started. We were told the cosmetic surgeon was due to attend the accredited masterclass on professional behaviour in cosmetic surgery as recommended by the RCS.

Good

Outpatients

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service did not always make sure staff completed their mandatory training.

Nursing staff received mandatory training which was aligned with the learning outcomes delivered through NHS mandatory training. However, compliance rates were 70% so did not meet their 90% compliance target. Face-to-face training was suspended in line with COVID-19 guidelines and had only just been reintroduced. Therefore, mandatory training had been completed online and some staff felt that online training did not meet their training needs. In the seven days following our inspection we were given evidence to show mandatory training compliance rates increased to 80%.

Staff said they could not always keep up-to-date with their training because they did not have allocated time to do this. They completed training when given allocated time to do so or when the department was quiet. Some staff on sick leave had not been able to complete their training.

Managers monitored mandatory training and recognised that due to staff shortages and sickness staff had not always been able to complete their training. Following our inspection, we were given evidence to show staff had been booked to attend essential training sessions.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff said they knew how to raise a safeguarding concern with their line manager, but staff did not all know who the safeguarding lead was. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples about when they had identified adults at risk of abuse and how they had raised their concerns.

Records showed all staff had received level 2 or level 3 adult safeguarding training appropriate to their role and child protection training at level 2. The safeguarding lead was trained to level 4.

Two safeguarding referrals had been made to the local safeguarding board in last 12 months.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They mostly kept equipment and the premises visibly clean.

Clinical areas were mostly clean and had suitable furnishings which were clean and well-maintained. The service's environmental cleaning audit showed 94% to 100% compliance. However, there was light dust on surfaces in the treatment room and two of the consultation rooms and heavy dust on top of the air conditioning unit in one consultation room. Of the four couches we looked at three had dust and hairs on the base.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore face masks, used aprons and gloves when carrying out medical procedures, washed their hands often and used alcohol hand gel.

Handwash gels were available at sinks along with signage for correct handwashing procedures. The handwashing audit showed 100% compliance. There were supplies of PPE and alcohol gel in every room and at the nurses' station. Staff wiped down and changed the disposable couch tissue in between each patient.

We saw staff cleaned equipment that was not disposable after patient contact and labelled equipment to show when it was last cleaned. The privacy curtains were disposable and were last changed on 9 October 2021.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

We looked at records from 25 January 2021 onward and saw staff carried out daily safety checks of the resuscitation trolley with the exception of five days, when the checks had been missed. The reason the checks had not been completed were not recorded. The contents of the trolley were in-date and the trolley was visibly clean. The trolley was sealed with a tamper-evident tag. Emergency checklists and flowcharts were stored on top of the trolley as a reminder for staff. There were systems to show where the trolley was if it had been moved from the department.

The service had suitable facilities to meet the needs of patients' families. The waiting area had enough seats for chaperones to sit with patients and to remain socially distanced from others. Additional seating had been placed in the corridor to increase capacity at busy times. There was also suitable seating for patients receiving bariatric care.

The service had enough suitable equipment to help them safely care for patients.

We were told an equipment service log was held by the service, but the process for servicing was overseen centrally by BMI Healthcare. The service received regular reports from BMI Healthcare which they cross-referenced with their equipment to ensure it was up-to-date and servicing was booked when needed. Portable appliance testing had been carried out and was clearly documented on electrical equipment.

Good

Outpatients

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. The sharps and pharmaceutical waste bins were stored safely.

A 2021 PLACE (Patient-led assessments of the care environment) report identified areas in need of improvement for condition and appearance in the outpatients department. However, we saw evidence of refurbishment including newly decorated consulting rooms.

Flooring met national guidance.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration

Staff received training in identifying sepsis and used a tool which considered situation, background, assessment and recommendation (SBAR) to strengthen communication between nurses and medics to escalate deteriorating patients. They knew who to call and what to do if there was a medical emergency, they would use the alarm to call the resuscitation team (medical team with special equipment able to be mobilised quickly to treat cardiac arrest) and telephone external emergency services.

Patients attended follow up appointments in the nurse led clinics after minor surgery. Staff knew about and dealt with any specific risk issues relating to their surgery and knew how to escalate their concerns to the resident medical officer in the absence of the patient's consultant.

In the last 12 months two patients were transferred from the outpatients department to an NHS hospital due to clinical deterioration. We were told both patients recovered, and an internal review of their cases showed the transfers to be appropriate.

Nursing staff shared key information to keep patients safe when handing over their care to others. A handover meeting took place when staff on the late shift started at 12 noon.

Staff knew how to access specialist mental health support. Staff told us about a recent incident when they referred a patient to the local mental health crisis team.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix daily.

The service had enough nursing and support staff to keep patients safe. We were told they did not use a formal acuity tool and senior managers adjusted staffing levels daily according to the needs of patients. Staff from other departments were redeployed to provide cover when needed.

The service advertised vacancies as soon as a member of staff resigned. The service had low turnover rates. They reported recruiting to vacant positions was difficult due to a national shortage of nursing staff.

Managers limited their use of contingent workforces staff and did not use agency staff. We were told they had not used bank staff since August 2021.

Records

Staff kept records of patients' care and treatment, but these did not always contain up to date or legible information. Records were stored securely.

Patient records were a combination of paper and electronic systems. Apart from the resident medical officer, none of the doctors were employed substantially by the service. They worked elsewhere and had practicing privileges which gave them the right to see and treat patients at the service. The doctors kept their own patient paper and electronic notes. They brought the patients' paper notes to the service when they were due to see them and logged into their external electronic patient records to make notes and requests tests and treatment. The service kept a smaller amount of paper records for each patient, they called these 'thin files'. There was no consistent approach by doctors to ensure a record of the consultation was retained by the hospital and many doctors did not follow hospital policy. There was no specific audit of outpatient records.

Thin files contained a patient registration document that included the patient's name, address and next of kin, who was responsible for paying for the treatment, signed consent to share information with patients' GPs, and a form that detailed the cost of the consultation or procedure. In addition, if a patient had undergone a minor procedure there was a record of the discussion about the procedure signed by the consultant and signed by the patient as consent. If tests had been requested the request forms were also filed.

We observed two clinics. We saw one doctor use a triple copy carbon paper note pad provided by the service to take notes of the patient consultation. The doctor took the top sheet for their records, the second sheet was for the patient, the bottom sheet was given to the service for their thin file. We saw another doctor who did not use the carbon paper note taking pad, they made electronic notes. Both doctors dictated a letter to be sent to the patient, with copies sent to the patient's GP, that detailed the consultation. These letters were not sent out immediately so would not form part of the thin file straight away. When the carbon paper note pad was not being used this made it difficult for the provider to have accurate and up to date information about patient care.

We looked at 14 thin files. Ten files had a copy of letters to the patient, 11 files had a carbon copy of the doctor's notes. In one file there was not a copy of a letter to the patient and the carbon copy of the doctor's notes was too faint to read, this meant staff could not easily read information about patient care. In three of the files tests had been requested but the results had not been recorded, this meant that there was not always an accurate record of patient care and treatment.

The thin files were stored securely in a locked cabinet in a locked room with a keypad to prevent unauthorised access. The service used an electronic system call E-tracer to locate files. Each file had an individual bar code and could be scanned in or out of a department. This meant staff could find patient records quickly and easily. However, as the audit of this system did not consider the location of the files we could not tell if it always worked.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Good

Outpatients

We saw medical staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines including written information to take home. Prescriptions were issued by doctors who carried their own prescription stationary.

Medicines were stored in a locked cupboard behind a locked door to prevent unauthorised access. The cupboard was clean and tidy, and the medicines were in date. The medicines fridge was locked, and the temperature recording audit showed checks were being completed daily and showed temperatures were in acceptable range. The cupboard for flammable items was kept locked. Medicines disposal was facilitated through the onsite pharmacy.

Incidents

Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents. When things went wrong, staff apologised and gave patients honest information. Managers did not always ensure that patient safety information was shared.

Staff knew what incidents and near misses to report and how to report them, they gave examples of the types of incidents they reported on the electronic risk reporting system.

Staff told us they received feedback on incidents through the electronic risk reporting system but learning from incidents was not widely shared as team meetings were not held regularly.

The service had one never event in May 2021 (never events are patient safety incidents that are preventable and should not occur if healthcare providers are following national guidance and safety recommendations). In response the provider suspended minor surgery in the outpatients department until procedures could be supported by theatre staff. Outpatients staff were provided with offsite training and the practice educator supported the team to ensure the completion of competencies and a pre surgery checking procedure was embedded.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Duty of candour was applied and documented following the never event.

We were told the quality and risk manager assigned an investigator to each incident, typically the lead for the department the incident related to. Once investigated the outcome was discussed at the monthly clinical governance committee meetings and cascaded to staff at team meetings and a copy of the minutes placed on the department staff notice board. We did not see a copy of these meeting minutes on the staff notice board and we saw that two team meetings had been held in the last 12 months. This meant the sharing of learning from incidents was not evident.

Are Outpatients effective?

Inspected but not rated

We do not rate effective.

Evidence-based care and treatment

Good

Outpatients

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Compliance was monitored through a range of audits to ensure staff followed up-to-date policies to plan and deliver high quality care according to national guidance. However, we were not given the compliance rates from all the audits.

Staff said they did not have training specifically in relation to the Mental Health Act but said this was covered in their safeguarding adults training. Staff said they did not recall any patients subject to the Mental Health Act, but they gave examples of how they had raised concerns about patients' ability to consent to treatment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Staff made sure patients had enough to eat and drink. A self-service drinks station providing hot and cold drinks was situated in the waiting area so patients could help themselves. We saw staff making drinks for patients with additional needs who had difficulty making drinks themselves. We were told if patients had to wait in the department for an extended period of time, they would be offered a selection of food from the hospital's canteen snack menu.

Pain relief

If patients said they were in pain staff gave pain relief in a timely way.

Patients received pain relief soon after requesting it. Nursing staff sought support from the resident medical officer to assess and prescribe pain relief for patients who said they were in pain.

Patient outcomes

The effectiveness of care and treatment was not monitored in Outpatients.

We were told that as patients were on a pathway associated with a different department and their outcomes were monitored in the other areas, most often by surgery. Please refer to the surgery report for more information.

Competent staff

The service mostly made sure staff were competent for their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. A clinical educator supported the learning and development needs of staff.

There was a system for assessing staff competencies on a three year basis. Most staff had completed their role specific competencies, but some update assessments had been delayed because of COVID. The remaining competencies were either in progress or staff had been booked to attend training.

Good

Outpatients

Staff were given development opportunities. Healthcare assistants were funded to complete a Level three in healthcare and qualified staff could complete clinical speciality training courses.

Managers gave all new staff a full induction tailored to their role. They had a 90-day probation period, during this time they had an induction checklist to complete and support of a buddy (a senior member of the staff team) to assist with orientation and learning.

Managers supported staff to develop through yearly, constructive appraisals of their work. We were given evidence to show all staff had an appraisal in the last 12 months. However, staff told us they did not always have an annual appraisal.

Managers did not support nursing staff to develop through regular, constructive clinical supervision of their work. Staff said although they did not receive formal supervision, they had frequent informal supervision with their manager.

We were told the manager was leading two departments and had been unable to provide appropriate support, training, supervision and appraisal their staff required because of this. There was a plan to recruit another manager, which would enable outpatients to have a dedicated manager by January 2022. At this point the lead staff member envisioned they would be able to provide monthly supervision annual appraisals and hold regular team meetings.

We were told the service had recently introduced 'Tea and Train' sessions, short teaching sessions for staff to develop new skills.

Multidisciplinary working

Doctors and nursing staff worked together to benefit patients.

Nurses didn't support doctors during their clinics. Some staff told us teams did not always work as closely together as they could, for example with allied health professionals in other departments.

Clinical staff said they got on well with the medical staff, but they had limited involvement with their clinics. Senior managers told us nurses assisted doctors and cleaned down equipment in between patients. Nurses were not present in the two doctors' clinics we observed. We asked one of the doctors if they had support from a nurse, they said they did not but thought this would be very useful. Senior managers told us they had plans to move the nurses' station into the consulting room corridor which would enable doctors and nurses to work together more effectively.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

Details of consultations and minor procedures were shared with patients' GPs although there was an option for patients to decline consent to share this information.

Seven-day services

Key services were available seven days a week to support timely patient care.

The service operated five days a week from 8am to 8pm. If patients needed to be seen by a nurse or doctor at the weekend they could be seen by a nurse from a ward or by the resident medical officer.

Good

Outpatients

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

We were told by the department lead there was not a focus on health promotion through outpatients. However, we saw staff give patients support and advice to lead healthier lives. For example, we saw staff advising patients of practical ways they could improve their health and manage their conditions through exercise.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff receive training in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their safeguarding adults training. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gave us examples about when they had raised concerns about a patient's ability to give consent, who they had involved, and the outcomes.

Staff clearly recorded consent in the patients' records. We looked at 14 patient records and found ten patients had procedures that required consent. All ten files contained a consent form that had been signed by the patient and the doctor.

Are Outpatients caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. We saw staff taking time to interact with patients and those close to them in a respectful and considerate way.

Patients told us staff treated them well and with kindness. We spoke to three patients who said their experiences were "excellent", and "first rate" and the staff were "fabulous" and "fantastic", caring and they felt "really listened to".

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff gave us examples about when they had cared for patients with mental health needs and how they ensured they were treated with dignity and respect.

Emotional support

Good

Outpatients

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff gave us examples about when they had supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw staff demonstrate empathy with patients about their illness and conditions and the impact this had on their lives.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients and their family were given the opportunity to ask questions and were sometimes given additional information to read at home. Different treatment options were discussed, and when possible, the patient could choose their preferred treatment.

Staff talked with patients, families and carers in a way they could understand, and the letters sent to patients did not contain medical explanations, instead used plain English.

Are Outpatients responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

We were told the service had enough staff and space. Additional clinics or procedures could not be booked by consultants if there was not enough room or staff to facilitate these.

Managers planned and organised services so they met the needs of the local, population by focussing on dermatology, orthopaedics and ophthalmology. They created more accessible parking, accessible toilets and used a lift to transport patients from the ground floor to the first floor.

Facilities and premises were appropriate for the services being delivered. Senior managers told us their population had a higher level of elderly people than the national average, so consent needed to be carefully checked.

The service had systems to help care for patients in need of additional support by providing chaperones for appointments.

Good

Outpatients

The service worked with the local commissioners and trust to support the needs of the local population. Outpatient clinics for orthopaedic services had been undertaken at the service. The service relieved pressure on the local NHS trust by taking some of their patients waiting for orthopaedic surgery, including their outpatient appointments.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. Staff gave us examples about times they had helped to support people with additional needs to access the service.

In the minutes from the team meeting held in February 2021 we saw accessible information standards had been discussed. This discussion encompassed people for whom English is not their first language, transgender people, people with a learning disability, and people from different religions.

We saw a poster in reception that people could use to say what their first language was, and the service had access to a telephone translation service. Most staff used the service's language line to provide translation for patients when English was not their first language. However, a few staff told us they did not make use of this service well enough at times.

Access and flow

People could access the service when they needed it and received the right care promptly. The majority of waiting times for patients from referral to treatment were in line with national standards.

The maximum waiting time for non-urgent, consultant-led treatments was 18 weeks. The hospital had 59 patients who had waited over 18 weeks. However, this waiting list included recent transfers from an NHS trust and 90% of these patients had been waiting over 18 weeks prior to transfer.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them within the time frame they set themselves.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed feedback forms in patient areas.

Staff said there had been no or few complaints about the service. However, the service received 14 complaints in the last 12 months which made up 41% of hospital's total. Senior managers told us these complaints had been about the cost of treatment or car parking rather than complaints about care.

Senior managers handled complaints about the service. We were told they would telephone the patient to check they understood the nature of complaint and what outcome the patient wanted before assigning it to a manager to investigate. Patients received feedback from managers after the investigation into their complaint.

Good

Outpatients

Managers said they shared feedback from complaints with the staff involved. However, staff said learning from complaints was not shared.

The service said they needed to work on increasing feedback response rates as patients mainly completed a form following an inpatient stay or surgery and did not complete a separate one for the outpatient part of their care.

Are Outpatients well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff.

Staff told us the senior management team were visible and approachable and their line manager was a good leader. The service lead had proven leadership qualifications.

For our main findings please refer to the surgery report.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services.

Nursing staff had devised a vision and strategy for the department. This included extending staff competencies for clinics, extending ambulatory care and moving the nurse's station into the consulting room corridor so they can be more responsive to patients and doctors.

Not all staff we asked knew what the vision and strategy for the service was.

For our main findings please refer to the surgery report.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they enjoyed working for the service, and they feel supported by the department lead and the senior management team.

Good

Outpatients

The service had a freedom to speak up guardian to encourage staff to raise concerns without fear of reprisals. However, five of the seven staff we asked either did not know what a guardian was or did not know who the guardian was.

For our main findings please refer to the surgery report.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities.

Managers did not hold regular team meetings. Two departmental meetings had taken place in the last 12 months, one in February and one in April. The minutes were brief, so we had no evidence that information or learning was shared with staff who did not attend. Following our inspection, we were given evidence to show 'Staff Touch Point Contacts' and 'Wellbeing Checks' took place with staff between two and four times a month.

For our main findings please refer to the surgery report.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Senior Managers received regular alerts from the Central Alerting System (CAS) (a national cascading system for issuing patient safety alerts, important public health messages and other safety updates) and cascaded information to staff on the day it was received. We were told this information was cascaded to staff verbally to ensure that it had been received rather than by email which may not be read. As this information was given verbally, we do not have evidence that staff had received this information. However, other staff told us key messages were forwarded electronically to all staff, and staff were advised to check their emails when important information has been cascaded that way.

The service did not have its own risk register as all risks were logged on the hospital's risk register. There was one risk logged for outpatients related to low staffing levels and difficulty recruiting to vacant posts.

For our main findings please refer to the surgery report.

Information Management

The system for keeping medical records meant that not all staff had access to an accurate record of patient care and treatment and therefore did not guarantee safe care and treatment.

For our main findings please refer to the surgery report.

Engagement

Good

Outpatients

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had a centralised public experience group and due to the COVID-19 pandemic these meetings had to be held virtually. The participants did not enjoy meeting virtually, so these meetings were paused and following a relaxation of restrictions they were due to recommence in November.

We were told staff were given informal praise and are told verbally or via a handwritten note that they did a 'good job', they were also awarded a voucher for free canteen lunch. They were developing a reward programme so that staff nominated colleagues who would get public recognition of their good work through a corporate newsletter.

Patients and their families could give feedback on the service and their treatment. Feedback forms were on display at the nurse's station, once completed they could be left at reception.

Managers told us the response rate to friends and family test was low but the feedback they received ranked the service as very good.

For our main findings please refer to the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

For our main findings please refer to the surgery report.