

BMI Bath Clinic

Quality Report

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

BMI Bath Clinic is an independent hospital and part of BMI Healthcare Limited. It provides care and treatment to both privately funded patients and NHS funded patients.

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

The hospital has an outpatients department, which provides diagnostic and screening services, including an MRI scanner. There are 67 beds of which 24 were for inpatients, three operating theatres and an endoscopy unit.

We carried out a comprehensive announced inspection of the Bath Clinic on 3, 4 and 5 May 2016 and an unannounced inspection on 16 May 2016.

We inspected and reported on the following three core services:

- Medical care
- Surgery
- Outpatients and diagnostic imaging

We rated the hospital as requires improvement overall. Our key findings were as follows:

Are services safe?

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

We rated safety overall as requires improvement:

- Only 85% of endoscopy staff were up to date with their mandatory training.
- Anaesthetists were not always documenting that they had obtained consent from patients.
- There was one incident of venous thromboembolism or pulmonary embolism in 2015.
- Staff completed care records for patients attending for follow up appointments in the outpatient department, but these were not kept in one folder and were in different locations. This meant there was not a complete record of patients' care and treatment available to clinical staff.
- The fire risk assessment was out of date even though a new service with a potential risk of fire had been introduced. Staff were unsure of evacuation procedures for patients with reduced mobility from the first and second floor of Longwood House, in the event of fire.

However:

- Staff acted upon the principles of the duty of candour. They were open, honest and apologised to patients when things went wrong.
- Staff were trained to recognise and respond to signs of abuse of vulnerable people. The director of clinical services had overall responsibility for safeguarding people, and was trained to the appropriate level.
- There was a good culture of incident reporting, and learning from incidents.
- There was a safe level of both nursing, medical and support staff with a good mix and range of skills and experience. The resident medical officer was available 24 hours a day, seven days a week.

Summary of findings

- There were no hospital acquired infections from January 2015 to December 2015
- The infection control and prevention lead was improving education and learning around infection prevention and control and took a proactive approach to ensure learning was effective for staff.
- Staff recognised and responded quickly to any deteriorating patients.
- The imaging department had efficient restricted access policies and practices, and staff complied with these.

Are services effective?

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

We rated effectiveness overall as good.

- Patients gave valid informed consent where they were able to do so. There were assessments and procedures following legal requirements for patients who might have reduced mental capacity to make their own decisions.
- There were low levels of surgical site infections.
- The hospital monitored all aspects of employment and practising rights for medical staff. These were up to date.
- There were appropriately trained staff to safely care, treat and provide support for patients.
- Patient's receiving chemotherapy had access to a 24 hour, seven days a week support line.
- An enhanced recovery programme was used for patients undergoing hip or knee replacements.
- There was an effective on call rota for imaging staff that ensured emergency screening could take place out of hours.

However:

- There was varied compliance with annual staff appraisals being completed ensuring staff were competent and up-to-date with their professional development.

Are services caring?

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

We rated caring overall as good.

- Patients were given care and compassion that treated them as individuals. Staff respected their human rights including their privacy and dignity.
- There was a high level of patient satisfaction with the service, including the Friends and Family Test results. All the feedback we received from patients about their care and support was positive and highly complementary.
- There was good emotional support for patients, particularly if they were anxious or nervous. Staff recognised and responded to these patients with compassion and kindness.
- People were involved with arranging appointments to suit their needs and circumstances

Are services responsive?

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

We rated responsiveness overall as good.

Summary of findings

- Services were planned to meet local needs and provide timely independent medical care to both private and NHS patients.
- People were treated as individuals. This included taking time to support people living with dementia and meeting different levels of need.
- There was good physical access to and around the hospital for patients and visitors. Parking was available.
- Good bed management led to few cancelled or delayed operations. Surgery services met their referral to treatment times (monitored for NHS patients).
- The hospital was commissioned and established to treat non-emergency patients and provide elective medical care and surgical services. The only excluded patients were children and young people under the age of 16.
- There was an appropriate response to complaints. There was learning and action taken from any complaints.
- Referral to treatment time exceeded targets and meant that 100% of patients were seen within 18 weeks from referral.

However:

- The environment did not always meet the needs of patients with dementia, visual impairment or learning disabilities. Staff were unable to tell us about reasonable adjustments that had been made to the environment to meet the needs of patients with additional needs.

Are services well led?

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

We rated well-led overall as requires improvement.

- Whilst there was an environmental and corporate risk register, there were no clinical risks mentioned.
- There was no departmental clinical risk register, which meant the services could not proactively manage clinical risks.
- The hospital did not have systems in place to make sure all the consultants were aware of updates, changes in practice or general hospital guidelines.
- Issues around quality and risk management were not being identified or addressed in a timely manner.
- There was a lack of continuous monitoring around quality and improvement in the surgical department with infection prevention and control audits.
- There was a lack of understanding amongst staff in relation to their accountability for driving continuous quality and improvement in the surgical department.
- There was no proactive approach, to monitoring the implementation of actions following areas of service performance that required improvement following incidents.

However:

- The staff always strived to make every patient's experience an excellent one. They were supported in doing this through an open and supportive culture within the hospital.
- There were clear governance arrangements in place.

Summary of findings

- Staff at all levels felt support by their line managers and by the hospital executive team.
- There were staff forums which engaged with staff and helped shape the culture and environment of the hospital.
- There was a systematic programme of internal audit used to identify and monitor quality and performance.

We saw areas of outstanding practice including:

- The infection control and prevention lead was improving education and learning around infection prevention and control and took a proactive approach to ensure learning was effective for staff.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure a single patient record is held in outpatients for each patient which contain patients' complete treatment and care histories.
- Introduce a clinical risk register throughout the hospital.
- Ensure the fire risk assessment is reviewed, and actions previously identified are put in place.
- Ensure staff are fully aware of evacuation procedures for patients on the first and second floor.
- Ensure all action points from risk assessments associated with eye laser treatment is achieved.

In addition the provider should:

- The hospital should ensure that anaesthetists consistently complete the anaesthetic chart and document when consent has been obtained.
- The hospital should ensure that there is a service level agreement in place with the local microbiology department at the local NHS trust.
- The hospital should ensure that yearly staff performance appraisals are carried out to ensure staff competence and ongoing development within their role.
- The senior managers should be more visible around the hospital.
- The hospital should ensure the staff understand their role and accountability to ensure ongoing monitoring of performance and quality.
- The hospital should ensure that there is a risk management system in place to address current and future risks to ensure a proactive approach to risk management.
- Review nurse staffing requirements of the outpatient department as there is a high reliance on bank staff and no clear deputy for the manager
- Review opportunities to collect patient outcome measures to help evaluate the effectiveness of services in outpatients and diagnostic imaging
- Continue to ensure regular department meetings are held in diagnostic imaging to facilitate sharing of information and learning.
- Ensure the imaging department develop local standard operating procedures in line with the recommendations set out in the National Safety Standards for invasive Procedures
- Review opportunities to use and display patient feedback to improve outpatients and diagnostic imaging services
- Review practice in the physiotherapy department regarding documentation of obtained consent.
- Increase staff awareness of the WHO checklist for safer surgery in outpatients and diagnostic imaging
- Review compliance with cleaning schedules in outpatients and diagnostic imaging.
- Ensure staff are aware of who the appointed laser protection supervisor (LPS) is and that staff understand their role.
- Review uniform policy to include nurses wearing belts and the effects this may have on infection control and prevention.

Summary of findings

- Increase awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards amongst staff

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Medical care

Good



We rated medical care overall as good because:

- Staffing levels in endoscopy and oncology met the demands of the service.
- Staff knew how and when to report incidents. When this happened they were fully investigated and learning shared across the hospital and within the BMI Healthcare group.
- The endoscopy and oncology units were visibly clean and tidy and the hospital had not had any incidences of hospital acquired infection from January 2015 to December 2015.
- The hospital had a competent workforce with the knowledge, skills and experience to provide effective care and treatment.
- Staff involved patients and their relatives in their care and treatment and helped patients to understand what was happening and what was planned.
- Patients were treated with kindness and compassion and with dignity and respect.
- Patients and their relatives were spoken with in a caring manner and received information in a way that they could understand.
- Services were planned and delivered to meet people's needs.
- People were treated as individuals and received care and treatment tailored for their individual needs.
- Patients were able to raise complaints and concerns with the knowledge that they would be listened to, their concerns investigated and a response provided.
- There were clear governance arrangements in place via different committees to the heads of department meetings and the medical advisory committee.
- Staff at all levels felt supported by their line managers and the hospital executive team.

However,

Summary of findings

- The endoscopy unit did not have accreditation from the Joint Advisory Group (JAG). Although this was work in progress
- Only 85% of staff within the endoscopy unit were up to date with their mandatory training.
- None of the endoscopy staff had received up to date appraisals.
- A corporate and environment risk register was in place, but this did not recognise any clinical risks affecting the Bath Clinic. The environment risk register was not kept up to date.
- The hospital did not have robust systems in place to make all their consultants aware of changes in policy, hospital practices and general updates.

Surgery

Good



- Staff were aware of their responsibility to report incidents and involvement in shared learning across different BMI hospitals.
- Staffing levels and skill mix were planned to meet the needs of the patients.
- Comprehensive risk assessments and reviews were carried out to keep patients safe.
- Treatment was in line with evidence based best practice guidelines.
- The hospital was delivering an effective multidisciplinary approach to care
- Staff were encourage to develop their knowledge and skills to enhance their role.
- Staff treated patients with kindness, dignity and respect and communicated well with the patient to ensure they felt involved with their care.
- There was a clear governance structure in place.
- There was a culture of openness and honesty and staff felt they could approach senior management with concerns.

However

- Anaesthetists were not always documenting when they had gained consent from patients on the anaesthetic charts.

Summary of findings

- There was no service level agreement in place with local microbiology department at the local NHS trust.
- Not all staff had a completed yearly appraisal to ensure competency and planning of ongoing professional development.
- Issues around quality and risk management were not being identified or addressed in a timely manner
- Staff demonstrated a lack of accountability to continue to ensure quality and performance on the absence of leaders.

Outpatients and diagnostic imaging

- Staff completed care records for patients attending follow up appointments in the outpatient department, but these were not kept in one folder and were in different locations. This meant there was not a complete record of patients' care and treatment available to clinical staff.
- The fire risk assessment was nine months out of date. This was despite the recent introduction of eye laser service with a potential increased risk of fire. Staff were unsure of evacuation procedures for patients on the first and second floor in the event of fire.

However,

Requires improvement



- Staff used a range of good practice approaches to ensure the correct patients received the correct treatment and procedures.
- The imaging department had an effective on-call rota that ensured emergency screening could take place out of hours.
- Staff treated patients with dignity and respect and we observed caring and kind interactions between staff and patients.
- Referral to treatment times were consistently better than the 95% target set by NHS England with 100% of patients being seen within 18 weeks from referral.
- Staff told us they felt supported by their managers and managers told us they were proud of their team and the teamwork.

Summary of findings

- The service had not completed action points from a risk assessment carried out in preparation for the new eye laser treatment.
- There was a high reliance on bank staff and no clear deputy for the manager.
- The imaging department did not have standard operating standards for procedures in line with the recommendations set out in the National Safety Standards for Invasive Procedures.
- Compliance with mandatory training was below the hospital's target for compliance in the outpatient and physiotherapy departments.
- There was little evidence that the service collected patient outcome measures and used these to evaluate the effectiveness of care and treatment delivered.
- There was no departmental clinical risk register, which meant the service could not proactively manage clinical risks.

Summary of findings

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Requires improvement 

BMI Bath Clinic

Services we looked at

Medical care; Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI Bath Clinic

BMI Bath Clinic hospital is part of BMI Healthcare Limited. The hospital is located in Bath and serves the local population treating privately funded patients and NHS patients. Surgery and medical services are provided for inpatients, day-case patients and outpatients and the hospital treats young people (aged 16-18) and adults. The hospital did not provide services for children or young people younger than 16 years.

The hospital had 67 beds (24 bed inpatient ward and 43 day beds), three operating theatres, a dedicated endoscopy suite, diagnostic imaging department, day-case unit, oncology ward and outpatient department. Other services at the hospital included health screening, physiotherapy and a travel clinic.

The registered manager and accountable officer for controlled drugs for BMI Bath Clinic is the hospital's executive director.

During this inspection, we looked at the following services: surgery, medicine, outpatient and diagnostic imaging. We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out a comprehensive announced inspection on 3, 4 and 5 May 2016 and an unannounced inspection on 16 May 2016.

Our inspection team

Our inspection team was led by:

Inspection lead: Care Quality Commission inspector.

The team of eight included CQC inspectors and a variety of specialists: a consultant surgeon, three senior NHS nurses specialising in surgery, oncology, theatres and outpatients and a specialist CQC pharmacist inspector.

How we carried out this inspection

We carried out the inspection using a variety of sources of information. The organisation provided us with data, statements and evidence prior to our inspection.

We visited the hospital on Tuesday 3, Wednesday 4 and Thursday 5 May 2016 and again on 16 May 2016. We spoke with patients, their relatives and supporters. We

talked with a range of staff including the executive director (also the registered manager), the director of nursing, the operations manager, the quality and risk manager, and the consultant surgeon who was chair of the Medical Advisory Committee. We held two drop-in sessions for all staff in the hospital to attend.

Information about BMI Bath Clinic

The BMI Bath Clinic saw 4,759 inpatients from January 2015 to December 2015. Out of this number 2,221 patients were seen on the NHS and 2,538 patients were treated privately. The hospital also saw 25,594 outpatients of which 8,293 were NHS patients and 17,301 were private patients. These included 11,943 new referrals and 13,651 follow-up appointments. From

January 2015 to December 2015, the outpatient and imaging departments provided 219 appointments for young people age 16-17 years. The hospital stopped seeing children under this age in 2014.

BMI Bath clinic had a 24 bed inpatient ward and three operating theatres. Theatre one had an ordinary airflow system and was used for general surgery, gynaecology,

Summary of this inspection

ENT, urology vascular and eye surgery. Theatre two and three had laminar airflow systems (systems to circulate filtered air in theatres) to allow for orthopaedic surgery, spine and plastic surgery. There was also a six bedded recovery unit. Theatre lists ran from 8.30am to 8pm Monday to Friday and on several Saturdays monthly.

From January 2015 to December 2015 there were 4,833 surgical operations completed. The five most common procedures performed were phacoemulsification of lens with implant (a modern cataract surgery in which the eye's internal lens is emulsified with an ultrasonic hand piece and aspirated from the eye,) dorsal root ganglion

block (an injection to reduce pain from small swellings that appear on nerves,), diagnostic endoscopic examination of the bladder, multiple arthroscopic operations on the knee(keyholesurgeryused both to diagnose and treat problems with joints) and image-guided injections into joints.

Between January 2015 and December 2015 the diagnostic imaging department performed 4,718 plain film x-ray, 2,046 CT scans, 2,463 MRI scans, 1,698 ultrasound examinations, 200 digital mammography and 197 image-guided injections into joints.

Detailed findings from this inspection






Overview of ratings

Our ratings for this location are:

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

Notes

Medical care

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

Information about the service

The Bath Clinic provided endoscopy services and chemotherapy treatment for cancer patients. These were on a predominantly day case basis, although facilities were available for patients to stay overnight if that was required. The hospital did not provide any services to children and young people under 16 years of age.

The BMI Bath Clinic saw 589 medical inpatients from January 2015 to December 2015. Out of this number no patients were seen on the NHS and 589 patients were treated privately.

During our inspection we spoke with 15 staff (including nurses, doctors, administrative staff and managers), five patients and three relatives. We looked at the medical records of five patients and five complaint files. We visited the oncology suite and the endoscopy unit.

Summary of findings

We rated medical care overall as good because:

- Staffing levels in endoscopy and oncology met the demands of the service.
- Staff knew how and when to report incidents. When this happened they were fully investigated and learning shared across the hospital and within the BMI Healthcare group.
- The endoscopy and oncology units were visibly clean and tidy and the hospital had not had any incidences of hospital acquired infection in the year preceding our inspection.
- The hospital had a competent workforce with the knowledge, skills and experience to provide effective care and treatment.
- Staff involved patients and their relatives in their care and treatment and helped patients to understand what was happening and what was planned.
- Patients were treated with kindness and compassion and with dignity and respect.
- Patients and their relatives were spoken with in a caring manner and received information in a way that they could understand.
- Services were planned and delivered to meet people's needs.
- People were treated as individuals and received care and treatment tailored for their individual needs.

Medical care

- Patients were able to raise complaints and concerns if they need to with the knowledge that they would be listened to, their concerns investigated and a response provided.
- There were clear governance arrangements in place via different committees to the heads of department meetings and the medical advisory committee.
- Staff at all levels felt supported by their line managers and the hospital executive team.

However,

- The endoscopy unit did not have accreditation from the Joint Advisory Group (JAG).
- Only 85% of staff within the endoscopy unit were up to date with their mandatory training.
- None of the endoscopy staff had received up to date appraisals.
- A corporate and environment risk register was in place, but this did not recognise any clinical risks affecting the Bath Clinic. The environment risk register was not kept up to date.
- The hospital did not have robust systems in place to make all their consultants aware of changes in policy, hospital practices and general updates.

Are medical care services safe?

Good 

We rated safety as good because:

- Staffing levels in endoscopy and oncology met the demands of the service. There was 24 hour medical care via the resident medical officer. Patient's individual consultants were also available when needed out of hours.
- Staff knew how and when to report incidents. When this happened they were fully investigated and learning shared across the hospital and within the BMI Healthcare group.
- The endoscopy and oncology units were visibly clean and tidy and the hospital had not had any incidences of hospital acquired infection.
- Staff had good systems in place for the administration of medicines, including making sure special medicines were given at the correct time. Cytotoxic medicines were prepared in a special unit on site keeping them as sterile as possible.
- Hospital records were legible, signed and dated and included the relevant information necessary for the care and treatment of each patient.

However,

- Only 85% of staff within the endoscopy unit were up to date with their mandatory training.

Incidents

- Staff we spoke with were aware of their responsibilities to report incidents. Staff told us they completed a paper incident report form which went to the health and safety and risk manager. Details of the incident were logged on the corporate electronic reporting system. All incident report forms were reviewed by the director of clinical services and allocated to the most appropriate manager for investigation. Staff gave us examples of when they would complete incident forms, this included medication errors, equipment failures and complications due to procedures.

Medical care

- We saw evidence that learning took place when incidents occurred. As an example, a patient was given the wrong dose of chemotherapy because a specific blood result was not checked before the chemotherapy was given. As a result, new systems had been introduced so that the relevant blood results were incorporated into the chemotherapy prescription form and pharmacy would not dispense the medicines if the results were not present.
- We were told that incident and complaint forums had started a few months before our inspection. It was intended that they be held every two months as a forum to discuss incidents and complaints in more detail with staff. We asked to see the minutes of this forum and were told that only two forums had taken place, however, neither were documented.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The staff we spoke with were aware of the duty of candour and when to apply it. They understood the principles of openness and transparency that were encompassed by the duty of candour.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- Safety thermometer information was displayed in the oncology ward. The information included the patient satisfaction scores, staff satisfaction scores, the infection rates and a 'What you said, what we did' section. The staff we spoke with on the oncology unit told us that the information related to the hospital as a whole and was not broken down into the different areas such as oncology.

Cleanliness, infection control and hygiene

- Both the endoscopy and oncology units were visibly clean and tidy.
- The BMI Bath Clinic had not had any incidents of hospital acquired infections from January 2015 to December 2015.

- Reliable systems were in place to prevent and protect people from a healthcare associated infection. The hospital completed monthly infection prevention and control audits to observe whether staff followed hospital policy. Nearly all departments achieved 100%.
- Staff within the oncology unit and endoscopy suite used personal protective equipment (i.e. gloves and aprons) in line with the hospitals policy. Staff were bare below the elbow in clinical areas, washed their hands between patients and used hand sanitizer when entering and leaving each department.
- We spoke with the hospital lead for infection prevention and control who told us monthly audits were completed in the clinical areas to observe if staff followed the hospital policy. The results had shown 100% across most of the departments for 2015. Those that did not achieve 100% would be discussed at their team meeting to raise awareness amongst the staff and improve performance.

Environment and equipment

- The maintenance and use of equipment kept people safe. Systems were in place to report broken or faulty equipment. Staff we spoke with were aware of how and when to report equipment faults.
- Staff in the endoscopy suite performed daily checks on the equipment and we saw evidence that this was completed consistently.
- The hospital kept a medical equipment asset register which detailed when equipment had been serviced and when this was next due.
- Resuscitation equipment was maintained and ready for use in an emergency. The resuscitation trolley was checked daily and we saw evidence that this was completed consistently. The trolley was secured with tamper evident seals. Emergency resuscitation equipment was available between the oncology unit and the day unit.
- The oncology service at the Bath Clinic was awarded the Macmillan Quality Environment Mark in May 2014. This quality award aimed to set the highest standards for cancer care environments through five core principles – accessibility, privacy and dignity, comfort and well-being, choice and control and support. To receive the award, the provider completed a self-assessment

Medical care

tool and submitted supporting evidence directly to the cancer charity Macmillan. An external assessment team then visited the hospital to complete their assessment. An action plan was produced following the external assessment which was to be completed before re-inspection and assessment in April 2017.

- We saw that within one double room, a leak had been detected in the roof. The room was immediately taken out of commission for patient use. At the time of our inspection, the leak had not been fixed, although we were shown evidence that plans had been approved by the corporate provider to fix the roof this financial year. In the meantime, the room remained out of use.

Medicines

- Systems were in place to store medicines appropriately. Medicines were kept in locked cupboards that only staff had access to. Room temperatures were checked to make sure the medicines were stored within appropriate temperature ranges.
- Private prescriptions forms were stored securely and an audit system was in place to track each form. When we compared the audit to the prescriptions, we found it to be accurate and up to date.
- The provider had systems in place to report any errors relating to medicine administration, storage or prescribing. All incidents relating to medicines were reviewed by the pharmacy manager so that appropriate investigation and learning could be undertaken. As an example of this, a patient had nearly been given the wrong Parkinson's (progressive neurological condition) disease medicine. As a result of this near miss incident, the description of these tablets i.e. pink tablets, blue tablets, immediate release, controlled release were added to the patients prescription chart when dispensed from the pharmacy. This reduced the chances of staff potentially giving the wrong medicine again.
- We saw that the pharmacy team had good administration systems. As an example of this yellow stickers were used to highlight medicines for Parkinson's disease where timely administration was important.
- The Bath clinic had a centralised intravenous additive service (CIVAS) unit on site in which it prepared chemotherapy for patients. The CIVAS unit was

inspected by the regional pharmaceutical quality assurance officer (South West) earlier in 2016. The report was not available for our inspection, however, emailed feedback confirmed the service was judged to be low risk and was a service under good control.

- Systems were in place to manage controlled medicines. Stock levels were checked on the wards every day. A pharmacy stock check was completed every week and a full controlled drug audit took place every three months. A robust tracking system was in place for the ordering, delivery and receipt of controlled drugs to the hospital and to the wards. Two staff checked the administration of controlled drugs, which was in line with the BMI policy.
- All prescriptions for chemotherapy were reviewed by the pharmacist and checked against protocols before being prepared and released to the wards. The protocols and prescribing treatments were all based on nationally determined standards for the treatment of cancer.
- The UK National Confidential Enquiry into Patient Outcome and Death report 'For better, for worse?' 2008 recommended the introduction of electronic cytotoxic prescribing to reduce the risk to patient safety. The BMI Bath Clinic introduced this system in February 2016. We asked why it had taken so long to introduce this system and were told it was because of the number of different consultants working within the hospital who were used to different systems in their own hospitals. A training programme had to be agreed and implemented prior to the electronic system going live in February 2016.
- We observed good medicine preparation and administration for cancer patients. Cytotoxic medicines were delivered to the ward in specially labelled boxes. Staff worked in an aseptic (keeping the process as sterile as possible) technique when administering the medicine. Two nurses carried out the necessary checks beforehand, i.e. checking the prescription and the patient details (name, hospital number and allergies). These systems reduced the chance of administration errors taking place.

Records

Medical care

- Inpatient (hospital) medical records were kept for all patients who received treatment at the Bath Clinic. However, those who attended outpatients had a separate set of outpatient records that belonged to the consultant.
- We looked at five sets of medical records for oncology and endoscopy. We found entries to be signed, timed and dated. Nursing assessments were in place together with the patients' personal details. A treatment record was in place and where necessary consent had been taken and documented. The endoscopy care pathway had been completed fully and signed by the nurse completing it.
- There were comprehensive, (patient held) chemotherapy booklets that detailed their care, treatment and chemotherapy received.

Safeguarding

- Staff were aware of their duties and responsibilities to report any suspicions of abuse. Staff were aware of what made a person vulnerable and what constituted abuse, they were also aware of the different forms of abuse. Policies and procedures were in place to provide staff with further information and guidance when reporting suspected abuse.
- Staff had received safeguarding training. There was between 98% and 100% compliance with both adults and children level one and level two safeguarding training.
- The director of clinical services was the hospitals named nurse responsible for ensuring any suspicions of abuse were reported and monitored. Staff we spoke with were aware of the named nurse's role.

Mandatory training

- BMI healthcare had a mandatory training matrix that detailed what training different groups of staff needed to have and the frequency of updates. As an example, all staff had to undergo fire training, whereas only clinical staff completed resuscitation training. Training was provided via e-learning and practical training sessions depending on the subject.
- The staff we spoke with told us they were up to date with their mandatory training.

- Overall within the Bath Clinic, 91.7% of staff were up to date with their mandatory training. This training included areas such as resuscitation, infection control and manual handling. However, we saw that in some departments such as Endoscopy only 85% of staff had completed their mandatory training. The BMI standard indicated that mandatory training had to be above 90% to be considered compliant.

Assessing and responding to patient risk

- The hospital used an early warning score system (which followed the National Early Warning Score (NEWS). This highlighted deteriorating patients. Patients' temperature, pulse and blood pressure were monitored together with pain levels and levels of consciousness. The scores indicated different protocols to follow, such as increased observation by the nursing staff, through to contacting the resident medical officer or consultant.
- Staff knew how to recognise neutropenic sepsis (a type of sepsis that is common with cancer patients). We were shown the protocol and a sepsis tray that was kept ready for staff to access quickly. The staff within oncology were able to explain the actions they needed to take, where the relevant medicines were kept and where to seek additional help if necessary.
- The resident medical officer had been trained in advanced life support.
- A resident medical officer was on duty 24 hours a day and was available if a patient became unwell. An on-call team of theatre staff and anaesthetist could also be called upon out of normal hospital hours. Where a patient needed more care and treatment than the hospital could provide, patients could be transferred to the local acute NHS trust as necessary. A service level agreement was in place with the local NHS acute hospital and their emergency department.

Nursing staffing

- There were safe levels of nursing staffing within oncology and endoscopy. BMI Healthcare produced a nursing dependency and skill mix planning tool in 2015. This was a tool that was used and implemented to have the best levels of nursing to support the patient's needs.
- Within endoscopy there were two registered nurses that represented 1.7 full time equivalents and two health care assistants equalling 1.4 full time equivalents. In

Medical care

In addition, two further nurses worked on the internal hospital bank system. Staff felt that the staffing levels at the time of our inspection were sufficient, they also felt that another full time nurse was needed to cover for annual leave and sickness.

- For the oncology service, two whole time equivalent nurses provided the service, although at the time of our inspection an advert had been placed for an additional chemotherapy nurse for 15 hours a week.
- The manager of the oncology service also provided management support to one other oncology services at another BMI hospital.
- Staffing levels were adjusted to meet the needs of the patients and bank staff would be used to cover sickness and annual leave as necessary. The nursing staff were supported by physiotherapists, pharmacy staff and administration support.

Medical staffing

- The hospital did not employ medical staff directly, however, the Bath Clinic had 161 consultants who had practising privileges at the hospital. Doctors working at the hospital were approved by the medical advisory committee once appropriate checks were had been completed. We saw that 60 (out of 161) consultants had not provided any patient care at the hospital between January 2015 and December 2015.. However, regular checks were made on each consultant each year and we found these to be up to date.
- Each consultant was responsible for their patients 24 hours a day. The consultants attended the hospital to see their patients on the ward, in outpatients or to perform procedures such as an endoscopy. Consultants could also be contacted via the telephone when necessary especially out of normal hours or overnight.
- Constant medical cover was provided by the resident medical officer (RMO) via a long-standing agreement with a specialist agency. The RMO was on duty at all times and involved one primary RMO supported by another RMO who provided cover arrangements under an agreed framework. The primary doctor undertook the majority of the rota and was permanently based on the hospital site. We checked the records for the RMO, these showed that they had been trained in areas such as resuscitation.

- The RMO was available throughout the day and night for any planned or unplanned care or treatment of patients. They were also available to provide guidance for staff.

Major incident awareness and training

- The Bath Clinic was not part of the local NHS emergency preparedness plans. However, the overall provider BMI, had a business continuity policy in place. The staff we spoke with were aware of the policy. The policy had contact numbers for key staff in the hospital and action cards were available covering different scenarios such as a fire or loss of IT infrastructure.

Are medical care services effective?

Good 

We rated effectiveness as good because:

- The hospital had a competent workforce with the knowledge, skills and experience to provide effective care and treatment.
- Patients receiving chemotherapy treatment had access to a 24 hour, seven day a week helpline so they could seek advice when they needed to.
- Medical staff were checked to make sure they were fit to practice and all checks were up to date
- The hospital had good relationships with the local, acute NHS hospital and was able to transfer poorly patients when necessary.

However,

- Whilst the majority of staff had received their appraisals, none of the endoscopy staff had received up to date appraisals.
- The endoscopy unit did not have accreditation from the Joint Advisory Group (JAG).

Evidence-based care and treatment

- The endoscopy unit followed best practice guidance when undertaking procedures.
- The oncology service was developed in line with a number of national guidance such as the Manual for Cancer Services – Chemotherapy (2011 and 2014) and

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the Manual for Cancer Services – Acute Oncology Services (2011). These manuals were developed nationally in line with national NICE guidance and best practice.

- The endoscopy suite had not been accredited by the Joint Advisory Group (JAG) at the time of our inspection. JAG accreditation is the formal validation that an endoscopy service has demonstrated it delivers against a range of quality improvement and assessment measures. Whilst it is not mandatory for a service to achieve this accreditation, it is a sign of good practice. The service was not yet accredited because of the decontamination room had the same entrance and exit. The hospital was seeking to address this by having a central site for cleaning and decontaminating the endoscopy equipment for several, local BMI hospitals, including the Bath Clinic.

Pain relief

- Patients having endoscopy procedures were offered local anaesthetic or sedation depending on the procedure and were monitored for any pain once their procedure had been completed.
- Patients were prescribed pain killers when necessary and administered in a timely way by the nursing staff.

Nutrition and hydration

- Patients were informed when they needed to stop eating and drinking before any procedures. Patients were also advised when specialist bowel preparation for procedures and any dietary considerations that might be needed afterwards.
- The hospital was able to offer a variety of meals, snacks and drinks depending on the patient's needs.

Patient outcomes

- Patient outcomes within endoscopy and oncology were measured in terms of local audits (such as infection prevention and control), incidents, complaints and compliments. Oncology patients were discussed weekly at the multi-disciplinary meetings.
- Once a patient had finished a course of chemotherapy, the nursing staff in oncology would call the patient at

home later that day and the following day to make sure the patient was managing independently at home. These follow up calls were standard for the first cycle of treatment, but would continue if the patient needed it.

Competent staff

- We looked at the appraisal records for staff within the Bath Clinic. These showed that in a number of areas such as pharmacy, oncology and portering 100% of staff had received their yearly appraisal. However, Endoscopy had reported that none of the staff were up to date with their appraisal. We raised this with the managers who told us they knew that it was an area they needed to improve upon and had put plans in place to resolve this in a timely way.
- We saw the training records for staff working with the cancer patients. This showed evidence that staff within the oncology unit had received additional training in the administration of medicines, giving medicines intravenously and the administration of cytotoxic (specialist medicines to treat cancer) medicines.
- Staff working within the endoscopy suite received the corporate induction upon starting at the Bath Clinic. They also had additional competences undertaken before working within endoscopy. Staff received ongoing training and updates and this was evident in their training records. As an example, a member of staff had attended decontamination training for the endoscopy equipment and had visited another hospital to see their processes in action.
- All of the consultants received their appraisals.
- The General Medical Council (GMC) required all licensed doctors to take part in annual appraisals in order to revalidate and remain registered with the GMC. The hospitals made checks on each consultant's registration every year with the GMC to make sure they were still current and able to practice. The hospital had systems in place to check and monitor each consultant's suitability to practice. We saw that for every consultant, the hospital recorded: a self-declaration, indemnity insurance, GMC status, checks made under the Disclosure and Barring Services (DBS), vaccination status, copies of their annual appraisal and professional development plan. Copies of relevant qualifications and proof of development were also held on file.

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- Each consultant had a biennial review with the executive director. This looked at any issues that had arisen and was discussed and approved by the Medical Advisory Committee.
- The hospital had systems to share relevant information with other healthcare providers where a consultant had been suspended from practicing for any reason. This included contacting their responsible officer and other NHS and Private healthcare providers where the consultant practiced. We saw evidence of where a consultant had been stopped from practising at the hospital. The investigation had been well conducted and thorough and the appropriate organisations were informed in line with the sharing of information agreement.
- Any new consultant who wished to practice at the Bath Clinic had to have a substantive contract within an NHS hospital. They had to agree to adhere to BMI policies and procedures and met with the executive director as part of their induction. References were taken and then details were submitted to the medical advisory committee for approval.

Multidisciplinary working (in relation to this core service)

- The oncology team had close working relationships with the local hospice, a specialist cancer support charity, the other local BMI hospitals and the local acute hospitals. This ensured communication about their patients' care and treatment was shared in a timely way when necessary.
- A multi-disciplinary meeting (attended by a manager, nursing staff, pharmacy staff and medical staff) was held each week to discuss any incidents that had taken place, guidelines and protocols for each chemotherapy regime, and any individual patients and their care and treatment plans.

Seven-day services

- The oncology and endoscopy services did not provide seven day services. The oncology service operated Monday to Friday with patients seen in outpatients on the Monday, followed by the administration of their chemotherapy Tuesday, Wednesday and Thursday.
- The oncology service did offer a 24 hour telephone support line which was manned by the oncology staff.

One nurse was responsible for answering this support line for a week at a time on a planned rota. This enabled patients to seek advice if they were worried out of normal hospital hours.

- The resident medical officer provided 24 hour medical cover throughout the hospital, seven days a week.

Access to information

- Patients receiving chemotherapy treatment were given comprehensive record booklets that they could keep with them and bring into to each treatment session. The booklet recorded their chemotherapy treatments and any other relevant information.
- Patients attending for their endoscopy were given information on the procedure before they came into the hospital and we saw in patient records that information was also given on discharge.
- GPs and local NHS acute hospitals were sent details of the treatments their patients had received. This made sure that other health professionals involved in treating that individual patient received up to date details of treatments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw examples where patients were asked to give their consent to specific procedures such as endoscopy. Patients were able to give informed consent because of the information provided to them and discussed with them by the nursing and medical staff. This information included the benefits and risks of the procedure. This showed that staff followed the hospitals policy on consent for examination and treatment.
- Not all consent was obtained in writing, but we observed staff seeking verbal consent from patients for example, to administer their chemotherapy. This was documented in the patients' medical notes.
- Formal consent was documented on consent forms and filed in the medical records.
- The hospital acted in the best interests of patients who could not give valid, informed consent. The hospital followed the requirements of the Mental Capacity Act 2005 in providing care and treatment only in the best

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interests of patients with limited or no capacity to decide for themselves. Patients were assessed by their consultant to determine if they had the capacity to make their own decisions.

- Staff had knowledge of Deprivation of Liberty safeguards, but acknowledged they were unlikely to encounter any patients who needed to be deprived of their liberty to keep them safe. This was due to the hospital's admission policy and or the type of patient who used services at the Bath Clinic.

Are medical care services caring?

Good 

We rated caring as good because:

- Staff involved patients and their relatives in their own care and treatment and helped patients to understand what was happening and planned.
- Patients were treated with kindness and compassion and with dignity and respect.
- Patients and their relatives were spoken with in a caring manner and received information in a way that they could understand.
- Staff provided support to patients and their relatives and maintained their privacy and confidentiality.

Compassionate care

- We observed staff introducing themselves to patients and their relatives at every stage of their journey through the hospital. This included when they arrived at the main reception, to arriving on the ward, and attending the endoscopy unit for their procedure.
- Within the oncology unit, staff had built up relationships with their patients over time and first names were used with the consent of each individual patient.
- All the patients we spoke with talked highly of the care they had received. Their comments included "the staff are just excellent, I could not want for more." "I have been having my treatment here for some time and know

the staff, they are very kind to me and my family and support us all very well." "Attending the Bath Clinic was very easy, the staff put me at ease and reassured me at every step, I am glad I came here."

- We saw that staff treated patients with dignity and respect. As an example, staff always knocked before entering their bedroom, and confirmed if it was convenient to do what they needed to do. The patients we spoke with also told us they were treated with dignity and respect.
- One patient we spoke with told us that they had noticed how calm and peaceful the hospital was when they attended for their endoscopy procedure. They went on to say how well organised and helpful the staff were. "They showed me to my room and around the unit, they explained everything to me and within an hour, I was ready for my procedure. I cannot thank the staff enough."
- The patient satisfaction scores were reviewed constantly across all the hospitals within the BMI group. We were provided with information which showed that the Bath Clinic was ranked 9th out of 60 (1st being the best) hospitals for positive patient satisfaction scores.
- Patient satisfaction scores were displayed in waiting areas and in ward areas. This showed that between January to December 2015, over 1,000 patients completed the satisfaction survey. This showed that 98.7% of patients thought their care was either good or excellent.

Understanding and involvement of patients and those close to them

- Checklists were completed before and / or after admission. These detailed the individual needs of each patient that staff could take into account. Staff and patients told us that staff spent time listening to patients to understand their needs.
- The BMI Bath Clinic worked in conjunction with the cancer charity Macmillan and a wide range of Macmillan cancer information leaflets and booklets were available for patients and their families to take away and read.
- We spoke with a patient who received chemotherapy treatment. They told us that their treatment was explained and to support what the staff had said, information leaflets were given. The patient was also

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given a patient held treatment record which detailed all the treatment that had been received and that was yet to come. The patient felt that they had been given enough information for their needs, but felt reassured at having a 24 hour on-call telephone number that they could ring if they needed help or had any concerns.

- Comprehensive information was provided on the costs of treatment where the patients were self-funding.

Emotional support

- One patient who had been receiving chemotherapy treatment told us how the staff not only supported them, but also their partner. "We have found it hard to come to terms with the diagnosis, but the staff provided such valuable support for us both. It just made it easier to deal with."
- Oncology patients could also be referred to the local hospice for additional support.

Are medical care services responsive?

Good 

We rated responsiveness as good because;

- Services were planned and delivered to meet people's needs.
- There was equitable access to all those who used the hospital.
- People had timely access to the endoscopy and oncology services at the Bath Clinic.
- People were treated as individuals and received care and treatment tailored for their individual needs.
- Patients were able to raise complaints and concerns if they need to with the knowledge that they would be listened to, their concerns investigated and a response provided in a timely manner.

Service planning and delivery to meet the needs of local people

- The hospital met the needs of the local people. Just fewer than half the number of patients seen as inpatients, were NHS patients. This meant that local, NHS patients had additional choice when choosing which hospital to go to for their procedure.
- The hospital benefited from extensive car parking and the hospital was accessible for people with disabilities.

Access and flow

- The patients we spoke with were both privately funding and NHS patients. They told us it had been a quick process to access treatment at the Bath Clinic. This ranged from a few days to a few weeks for planned procedures.
- For oncology patients, appointments were given in line with their treatment plans and chemotherapy was administered twice a week.
- When patients arrived at the hospital they reported to the main reception who confirmed their details and booked them into the hospital. They were then shown to the oncology or day care unit where they were greeted by the staff on the units.

Meeting people's individual needs

- A pre-assessment clinic was available for patients attending endoscopy. Staff told us they found this useful because it allowed them to understand individual patient's needs. As an example, one patient attended the pre-assessment clinic who had already be diagnosed with Parkinson's disease. Staff were able to listen to their specific requirements, especially around the timings of medication and planned their care accordingly.
- Where a patient's first language was not English, staff had access to interpreting support in a variety of languages via a telephone based system.
- Patients and visitors were provided regular drinks and had the option to help themselves to refreshments in the waiting areas.
- The hospital was accessible to people with disabilities.

Learning from complaints and concerns

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- Prior to our inspection, the provider had supplied us with a summary of 28 complaints that had been received from 1 October 2015 to 19 April 2016. The summary detailed what the complaint was about and any resulting action taken by the hospital.
- We conducted a complaints review during this inspection. We picked five complaint files at random and reviewed them against set CQC criteria. We looked at how well people were supported, whether the complaints process was simple, whether risk assessments were carried out, whether the investigation was thorough and formal records were kept, whether the outcome was explained and whether complaints made a difference to how the service was delivered. We found that it was easy for people to complain or raise a concern and that they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with. Complaints and concerns were taken seriously and responded to in a timely way. Improvements were made to the quality of care as a result of complaints and concerns
- Where appropriate, the hospital arranged meetings with complainants to discuss their complaint in more detail and to offer apologies.
- We saw evidence that complaints were discussed at other meetings when appropriate. For example, test results were not followed up for one patient. This was discussed with the staff concerned, and at the medical advisory committee (MAC). At the time of our inspection the process for recording results and notifying GPs was under review by the MAC, to prevent similar incidents from occurring again.
- The provider's complaint's policy stated that complainants should receive their response within 20 working days. The Bath Clinic achieved this 100% of the time consistently from November 2014 to December 2015.

Are medical care services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- There was a local risk register for the hospital which was not kept up to date, but no clinical risk register to identify risks within endoscopy or oncology.
- The hospital did not have robust systems in place to ensure all consultants aware of changes in policy, hospital practices and general updates.

However,

- The hospital had a clear structure for governance and risk management, with information being cascaded via departmental meetings.
- Staff at all levels felt supported by their line managers and the hospital executive team.
- There were staff forums which engaged with staff and helped shape the culture and environment of the Bath Clinic.
- The feedback from patients was predominately very positive and complimentary about the care and treatment they received.

Vision and strategy for this this core service

- The vision for BMI Healthcare was to provide the largest network of quality acute care hospitals in the UK and delivering the best possible outcomes and experiences for their patients. The vision also included consistently delivering quality care, being financially successful and being the leading provider of surgical and medical care in the UK.
- The staff we spoke with were aware of the overall BMI Healthcare vision but could not articulate it fully. They knew where to find information about the vision if needed, but knew their role was to provide the best possible care to their patients.
- The staff and management of the Bath Clinic consistently told us that they were striving to make sure that the patients always had an excellent experience.

Governance, risk management and quality measurement for this core service

- We looked at the hospital's risk register. This contained environmental risks dating back to January 2013. The information contained on the risk register included the problem, potential harm, a risk rating and a review date. However, risks identified were old and there was no evidence of review to demonstrate action had been

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taken to address the risks. As an example, on the 20 April 2015, a risk was added regarding the possible loss of electrical supply in theatres during a power cut, before the generator started. The action was stated to install an uninterrupted power supply and to get a quote.

However, no update had been documented and the issue had not been resolved. We also saw issues on the risk register that were in the process of being resolved but had not been documented on the risk register.

- We asked to see a clinical risk register but were told about the corporate risk register and the local environmental risk register. The managers confirmed that a clinical risk register was not in place. When asked, the managers did not elaborate to any clinical risks.
- The overall BMI group had a risk management plan and risk register. These were corporate risks that might affect any of its hospitals across England. The risks were scored and detailed existing risk controls and any further action that would be required. However, they did not represent local risks specific to the BMI Bath Clinic.
- The overall corporate provider held monthly regional quality assurance meetings which each hospital was discussed. Clinical issues, quality, staffing, health and safety and individual specialties were standard agenda items. Where learning and / or good practice was identified, this was shared with all the hospitals in the BMI group.
- The hospital had a committee structure in place. This showed that all the committees such as the clinical governance committee and the health and safety committee fed through to the heads of department meeting which in turn reported to the regional committee meetings.
- We asked some of the key senior staff what their top three risks were within the hospital. The top risk a double suite that had been taken out of action because of a roof leak. No clinical risk was mentioned by any of the senior managers we spoke with.
- We asked how all 161 consultants got to hear about new policies, changes in practice, new developments etc. that took place within the hospital. We were told that this information was recorded in the minutes of the Medical Advisory Committee which were then emailed to the consultants. We asked for confirmation of this,

however, consultants received an email inviting them to request the minutes of the meeting, of which only 60 consultants took this option. This left 101 consultants unaware of any new developments or risk issues.

Leadership and culture of service

- Staff told us that they felt support by their colleagues and immediate line manager. One of the managers we spoke with told us they also felt supported by their team, but wanted to spend more time clinically on the unit to work and support staff. Staff told us that the managers were both approachable and visible within the ward areas.
- The senior executives had support from their regional colleagues and they met regularly at regional meetings.

Public and staff engagement

- The results of the 2016 staff survey were not available at the time of our inspection, however, the provider was able to share a summary at the end of our inspection. This showed 89% would recommend the hospital to family and friends to have their treatment, and 72% of staff would recommend the hospital as a place to work. Out of the 52 questions in the survey, the hospital scored lower than the previous year in 18 questions. This included 'I am proud to say I work for BMI', 'I feel valued as an employee of BMI', 'BMI recognise achievement'. The hospital did not score well for nine questions. These included 43% of staff not feeling valued as an employee of BMI. However, they scored well in eight questions which included 92% of staff feeling they got the necessary support from their line manager, and 92% of staff saying they received appropriate training to do their job.
- We saw that there were plans to discuss the staff survey results via the staff forums and at the heads of department meetings with a view to developing an action plan to improve the scores for 2017.
- The patient satisfaction scores were reviewed across all the hospitals within the BMI group. We were provided with information which showed that the Bath Clinic had been ranked 9th out of 60 (1st being the best, 60th being the worst) hospitals for positive patient satisfaction scores.
- Patient satisfaction scores were displayed in waiting areas and in ward areas. This showed that between

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January to December 2015, over 1,000 patients completed the satisfaction survey. This showed that 98% of patients thought their care was either good or excellent.

- We were told that the medical advisory committee did not have the influence some of the consultants thought it should have. We asked what was meant by this and were told that the committee were sometimes told what to do by the overall BMI provider rather than being asked for their professional opinion. It was felt that there was a very distant relationship between the MAC and the corporate provider, with little or no input from the corporate medical director.

Innovation, improvement and sustainability

- The endoscopy unit did not have Joint Advisory Group accreditation and BMI Healthcare were aware of the shortfalls of the service. At the time of our inspection work was being planned on a new unit to serve the local BMI hospitals which would clean the endoscopy equipment and help in gaining accreditation. At the time of our inspection, the BMI Bath Clinic together with several other local BMI hospitals were working towards achieving JAG accreditation.

Surgery

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

Information about the service

BMI Bath Clinic provided a range of routine and non-urgent surgery for adults and young people in the population of Bath, North East Somerset, and Wiltshire on behalf of the NHS. The hospital also carried out private work. Both day-case and inpatient surgery specialities were offered at BMI Bath Clinic, including joint replacements (total hip and knee,) primary repair of inguinal hernia, facet joint injection general surgery, gynaecology and cosmetic surgery.

BMI Bath clinic had a 24 bed inpatient ward and three operating theatres. Theatre one had an ordinary airflow system and was used for general surgery, gynaecology, ENT, urology vascular and eye surgery. Theatre two and three had laminar airflow systems (systems to circulate filtered air in theatres) to allow for orthopaedic surgery, spine and plastic surgery. There was also a six bedded recovery unit. Theatre lists ran from 8.30am to 8pm Monday to Friday and on several Saturdays monthly.

From January 2015 to December 2015 the percentage of patients receiving NHS treatment was 35% and private patients was 65%. In the same time period there were 4,833 surgical operations completed. The five most common procedures performed were phacoemulsification of lens with implant (a modern cataract surgery in which the eye's internal lens is emulsified with an ultrasonic hand piece and aspirated from the eye,) dorsal root ganglion block (an injection to reduce pain from small swellings that appear on nerves,), diagnostic endoscopic examination of the bladder, multiple arthroscopic operations on the knee(keyhole surgery used both to diagnose and treat problems with joints) and image-guided injections into joints.

We visited the ward, theatres and recovery unit. We spoke with staff, including nurses, healthcare assistants, theatre staff, operating department practitioners, staff from the recovery unit, consultants and registered medical officers. We also met the management team, including senior managers, ward and theatre managers, We spoke with pharmacy staff, a physiotherapist and an occupational therapist. We met with seven patients and members of staff. We observed care being given to patients and looked at medical records.

Surgery

Summary of findings

We rated surgery services as good because:

- Staff were aware of their responsibility to report incidents and involvement in shared learning across different BMI hospitals.
- Staffing levels and skill mix were planned to meet the needs of the patients.
- Comprehensive risk assessments and reviews were carried out to keep patients safe.
- Treatment was in line with evidence based best practice guidelines.
- The hospital was delivering an effective multidisciplinary approach to care
- Staff were encouraged to develop their knowledge and skills to enhance their role.
- Staff treated patients with kindness, dignity and respect and communicated well with the patient to ensure they felt involved with their care.
- There was a clear governance structure in place.
- There was a culture of openness and honesty and staff felt they could approach senior management with concerns.

However

- Anaesthetists were not always documenting when they had gained consent from patients on the anaesthetic charts.
- Not all staff had a completed yearly appraisal to ensure competency and planning of ongoing professional development.
- There was a lack of monitoring around risk management.
- Staff demonstrated a lack of accountability in the absence of leaders to continue to ensure quality and performance

Are surgery services safe?

Good 

We rated the surgical service safety as good because:

- Staff were aware of their responsibilities to report incidents and demonstrated how learning was shared beyond the affected service.
- There had been no incidences of methicillin-resistant Staphylococcus aureus (MRSA) or clostridium difficile in 2015.
- The new infection, prevention and control lead was driven to improve education and learning around infection prevention and control and took a proactive approach to ensure learning was effective for the receiving staff.
- There was evidence to show the hospital was using National Institute for Health and Care Excellence (NICE) guidance around surgical site infection, there had been one incident of surgical site infection following a knee replacement in 2015.
- There was a good system of monitoring patients and responding to the deteriorating patient.
- There was safe management of medicines and controlled drugs (medicines that are controlled under the Misuse of Drugs legislation).
- There were safe levels of nursing staff on the ward and in theatres which demonstrated a good skill mix and senior support. There was minimal use of agency staff to cover shifts.

However

- Anaesthetists were not always documenting that they had obtained patient consent, though we saw evidence of appropriate documentation of consent by the operating surgeons.
- There was limited continuity of infection, prevention and control (IPC) audits and care bundle audits for the ward and theatres between the original IPC lead leaving and the new lead starting in the role.
- Compliance with mandatory training was variable.

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- There was a lack of storage space for large bulky items in theatres, which posed a hazard to staff.

Incidents

- Staff were aware of their responsibilities to raise concerns and understood the process of how to log incidents. The system used to report incidents was an electronic reporting system. All incidents were sent to the director of nursing to be reviewed, then to the head of department for further investigation. All staff we talked with said the process was straightforward. Staff told us any identified feedback and learning from incidents was cascaded through team meetings, safety briefings and handovers. There were 378 clinical incidents and near misses reported in the period January 2015 to December 2015.
- Staff were engaged in the learning process from incidents to improve safety and quality however, this was not always actioned implemented and monitored for compliance in a timely way. There had been three similar incidents within a short time frame on the ward. These were communication issues after the patient had been discharged. We observed the root cause analysis (a method of problem solving by identifying the main causes or problems) that staff worked through following their involvement with an incident. This enabled the staff to identify the underlying cause of the incident in order to enhance learning and make changes to practice. We were told about the action plan following and changes to processes and pathways of dealing with information once a patient had been discharged and how the incident had been fed through to the clinical governance, senior nurses and health and safety meeting and then onto the medical advisory committee. Despite actions being taken to improve quality and safety around communication following the incident, there was no documented evidence to demonstrate further monitoring to ensure these actions were implemented due to two similar incidents occurring, following the initial incident.
- There had been one surgical site infection during the reporting period January 2015 to December 2015 following a knee replacement. This was reported as a clinical incident and during the time of our inspection, was undergoing a full investigation and root cause analysis. The incident had also been discussed at the clinical governance meeting, corporate governance meeting and had also been escalated to the BMI infection, prevention and control lead.
- Lessons were learnt and actions taken as a result of incidents to improve quality and patient safety. We were given examples from theatre and the ward where actions had been taken to improve processes and practice following incidents. Training sessions were used to ensure learning and improvements were made following incidents. Theatre staff told us of an incident that occurred with a piece of equipment in theatres. As a result of this incident, a training session was carried out to re-train staff in the use of this particular piece of equipment and a quiz and learning session conducted with theatre staff to raise awareness and improve understanding. Staff were also informed of changes to practice at staff meetings and an email was distributed providing staff with information regarding any changes. However, not all staff received this due to not all having BMI email addresses.
- Lessons were shared to ensure action was taken to improve safety beyond the affected team. Staff gave us examples about medication incidents and never events that had occurred at other BMI Healthcare sites. They told us about how learning had been shared across BMI sites and were able to give us examples of how practice and systems had changed at the BMI Bath Clinic. For example, we saw a copy of the standardised briefing checklist that was being used in theatres as a result of learning and improving safety in theatres following never events. We saw a copy of the action plan and a time frame for shared learning across the BMI sites to be implemented at the hospital. Actions were allocated to specific lead roles within the different BMI locations and proposed completion dates for all actions identified.
- The hospital did not hold specific morbidity and mortality meetings or surgical speciality meetings. The hospital had reported no unexpected deaths in the reporting period January 2015 to December 2015. Incidents, concerns or relevant information associated with the surgical department were fed into clinical governance meetings, senior nurses meetings and

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health and safety meetings. Issues could also be escalated to the medical advisory committee if appropriate, for example, the challenges around compliance with the theatre briefs and debriefs.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. This is known as the duty of candour. We saw evidence that the BMI Bath clinic had applied the duty of candour after a patient was found to have had the wrong prosthesis implanted in December 2014. Staff we spoke with were aware of the event and a new system had been put in place to reduce the risk of the incident occurring in the future.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The treatment centre participated in the monitoring of patient care in line with the NHS safety thermometer. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care on one working day a month. This covers areas, including falls, pressure damage, infection control, venous thromboembolism (VTE) and catheter-associated urinary tract infections. Between March 2015 and March 2016, the hospital had recorded two pressure ulcers, no cases of venous thromboembolism (four cases of urinary tract infections and no falls. Between January 2016 and March 2016 the hospital reported between 83.3% and 100% harm free care.
- The hospital had completed risk assessments for venous thromboembolism (VTE) for all patients that required the assessment as set out by the National Institute for Health and Care Excellence QS3 guidance. We reviewed eight sets of patients' records. VTE assessments were part of the surgical pathways. We saw appropriately completed VTE assessments and the assessment being reviewed as appropriate. There had been one incident of VTE or pulmonary embolism

between January 2015 and December 2015. This incident had been investigated and we saw evidence of learning points and action plans put in place following this incident.

Cleanliness, infection control and hygiene

- The ward, theatres and recovery areas were all visibly clean, well maintained and organised.
- Standards of infection, prevention and control (IPC) were monitored and maintained. Monthly audits were carried out and focused on hand hygiene observations and hand hygiene technique. For the month of April 2016, there was variable compliance. Claverton ward and recovery scored 100% for the hand hygiene observation; however, the day centre scored only 50%. The hand hygiene technique audit for recovery was 93%; however the day centre scored 86.6%. We observed an action plan detailing the findings from the audits and the action to be put in place to improve compliance. Feedback on the audits and action plans were discussed at the quarterly infection, prevention and control meetings and the monthly senior nurses' meeting. Only data from April 2016 was available at the time of inspection. This was due to the current IPC lead only being in post for two weeks prior to our inspection. There had been no continuation of audits for the four month period prior to the current IPC lead being appointed.
- Carpets had been replaced in patients' rooms with a hard floor which were easy to keep clean. There were carpeted corridors in the ward areas. The infection, prevention and control lead (IPC) lead told us that the hospital was meeting the infection, prevention and control policy of having no carpet in the clinical rooms but at present there were no plans to change the carpeted corridors until the flooring required changing. When this time came, we were told they would be replaced with hard wood flooring. There was no evidence of stains or wear and tear of the carpet, however, cleaning would be enhanced by having hard wood flooring throughout.
- Processes were in place to protect patients from hospital-acquired infections. Meticillin resistant *Staphylococcus aureus*

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- There had been no incidents of Meticillin resistant Staphylococcus aureus (MRSA), Clostridium difficile (C-diff) or Methicillin-susceptible Staphylococcus aureus (MSSA) during the period January 2015 to December 2015.
- There were systems and processes in place to ensure the hospital followed the National Institute of Health and Clinical Excellence guidelines CG74, around surgical site intervention before, during and after surgery. The individual care pathways required staff to perform checks around the prevention of surgical site infection and to document these. The hospital provided quarterly data to Public Health England about surgical site infections. There had been one surgical site infection following a knee replacement during 2015. At the time of our inspection there was a full investigation taking place.
- There was antibacterial hand disinfectant gel available at the entrance to the ward and theatres and around the wards. Hand washing sinks were available and posters were displayed around the ward reminding staff to wash their hands. Personal protective equipment was available for use throughout the ward and theatre.
- Processes were in place to ensure theatres were deep cleaned. Theatre deep cleans took place on a six monthly basis. Theatres were also cleaned during the night by two members of staff. We looked at cleaning plans and log books for theatres. All entries for cleaning had been completed for March and April 2016, with only two omissions.
- Each department had a link infection, prevention and control (IPC) nurse which had been standardised throughout each department following the recruitment of the IPC lead into post. Prior to this there had not been an IPC link nurse in each department. We saw a copy of the role's profile which had been set out by the IPC lead for the hospital. The IPC lead for the hospital had also set up a quarterly IPC sub group for the link nurses to attend. The meeting agenda included the hospital business around IPC and IPC education. We saw a copy of the minutes detailing conversations about IPC processes and audits and a copy of the education action plan for 2016/2017. The actions from this meeting fed into the IPC committee meeting and then into the clinical governance meetings and senior nurses' meetings.

Environment and equipment

- Daily and weekly checks of equipment were carried out to ensure safety. We saw completed daily equipment checks in the day centre for March, April and May 2016. Staff ensured that equipment checks were up-to-date. We saw that equipment on the ward was clearly labelled, detailing the expiry date in order to keep people safe.
- We saw evidence that equipment in theatres was serviced and maintained. Some medical equipment in theatres was serviced by an external contractor, whilst some was organised and arranged by the EBME lead at BMI head office. The theatre manager ensured that equipment was regularly checked and maintained.
- The hospital had a service level agreement in place to maintain and provide cover for equipment failure for devices such as the urinalysis, pregnancy testing and full blood count testing machines. The agreement gave the company 48 hours to repair the device by telephone conversations with staff in the event of equipment failure. If this was not possible a representative would come out to sort out the problem or replace the equipment.
- There was a system in place to train new staff and maintain existing staff competencies around the use of equipment in theatres. Staff told us there were regular equipment training sessions provided by representatives from the companies that provided equipment for the theatres.
- The hospital had a system for managing clinical waste. Clinical waste was separated into colour coded waste bags. Sharps bins were available around the ward and theatres and were all labelled. The bins and sharps bins we observed were filled to an appropriate level and not overflowing. There were no clinical waste bins in the individual patient rooms. This posed a risk to both staff and patients when staff had to leave a patients room with contaminated waste. Waste was collected from theatres, recovery, the ward and day care by the general porters.
- There were systems and processes in place to ensure that patients and staff were kept safe and these were communicated and available to staff. We saw the risk assessment folder in theatres. The folder contained local health and safety information, minutes from the

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health and safety committee meeting and BMI guidance around health and safety risks. The folder also contained theatre department risk assessments. These included manual handling risk assessments, Control of Substances Hazardous to Health (COSHH) risk assessments and contained a staff signature checklist to demonstrate staff had read the information in the file and were aware of the risks. The COSHH risk assessments were all completed and in date.

- The hospital had appropriate equipment for bariatric patients to keep both the patient and the staff safe. There was equipment available to help transfer and reposition a bariatric patient available in theatres. The ward also had beds that accommodated bariatric patients and there was a bariatric armchair available. Staff told us that if more equipment was required they would contact the physiotherapist and occupational therapist and arrangements would be put in place following pre-assessment clinic. Bariatric surgery was performed at the hospital up to four times a month.
- There was safe provision of resuscitation equipment in all departments. Resuscitation trolleys (which included defibrillators and other emergency equipment and medicines) were tamper-evident, located to be accessible and checked daily. We reviewed the checklist for April and May 2016 and found all checks had been completed. There were checklists for the medicines stored on the resus trolley. This provided staff with information about the expiry date of the medicines on the trolley, which were monitored by the pharmacist.
- Equipment, instruments and implants must comply with the Medicines and Healthcare products Regulatory Agency (MHRA). Theatre staff told us that they were made aware of equipment alerts by information provided by the risk, health and manager.
- There were challenges around the storage of large items of equipment in theatres. There was a large microscope stored in the corridor in theatres. Staff told us that there was no other place to store this due to the item being large and bulky. There was space to manoeuvre a bed/ trolley around the microscope; however, there was a part of the equipment that could pose a trip hazard to staff if they were unaware of the equipment. A risk assessment had not been completed about storage of this piece equipment.

Medicines

- Medicines were stored in a way that kept people safe from avoidable harm. Medicines on the ward were stored in a locked, temperature controlled treatment room. There was a safe containing keys to locked cupboards in the treatment room. Controlled drugs and the controlled drugs book was also kept in a separate locked cupboard in the treatment room. The nurse team lead for the shift would carry the keys for the controlled drugs cupboard.
- Controlled medicines were stored appropriately in locked cupboards in theatres and the ward. Daily controlled medicines checks which were completed in line with national guidance (Department of Health, 2013, Controlled Drugs; Supervision of Management and Use Regulations). We observed one incorrect entry into the controlled drugs book on the ward. We reported this to the pharmacist who stated a clinical incident form would be completed. We observed the morning check of the controlled drugs in theatre. Checks were carried out, completed and signed by two members of theatre staff, the theatre nurse and the operating department practitioner (ODP).
- The hospital provided a pharmacy service five days a week during working hours. There was a medicine supply available over 24 hours. There was an out of hours on call pharmacy service for clinical pharmacy advice.
- Fridge temperatures were checked daily on Claverton ward and in the day centre and were all recorded and within range. We saw completed log books for fridge temperature checks for March, April and May 2016 in the day centre and on the ward. Staff monitored the temperature of the clinical area where medicines were stored. We observed completed checks with no omissions for March, April and May 2016 on the ward.
- Allergies were clearly documented on the front page of the patient's care pathway and highlighted in red. The care pathway also had areas for allergies to be documented at each stage through the patient's journey. We reviewed eight sets of patient notes. Each set of patient notes had allergies clearly recorded.
- Medication errors were reported as incidents. Actions were put in place to improve practice and patient safety. For example, we were told about a trend of incidents

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regarding the medicines that patients took home when they were discharged. The trend was identified and actions to address the trend included staff attending medicines management training and staff writing reflections on practice.

Records

- The BMI group produced specific, standardised care pathways for patients undergoing surgical procedures. We saw completed versions of these pathways documenting the patient journey from pre-operative assessment through to discharge. Patient care plans were kept in the room with the patient. Any other patient information or previous medical notes were stored in a locked room behind reception.
- There was a comprehensive, evidence-based pre-operative assessment recorded. This included pre-operative investigations and assessment, past medical history and medication history. There was also a pre-operative assessment of patients' social, physical and home environment to enable early preparation for discharge planning.
- The care pathways enabled a multidisciplinary approach to record keeping. All members of the team documented their interventions in the same patient record and this provided an accurate and contemporaneous log of interventions without the need for duplication. The care pathway prompted staff to complete specific documentation for each different day following the patient's operation. We looked at eight sets of case notes. They all had with clear, legible multidisciplinary documentation recorded.
- We observed poor documentation and recording of consent on the anaesthetic charts by the anaesthetists. We saw good completion of record keeping processes and procedures around the administration and documentation of the anaesthetic medication on the chart which led us to believe that consent was sought, however, the tick box to identify patient consent was not consistently completed

Safeguarding

- Staff were aware of their responsibilities about safeguarding and understood the processes for reporting safeguarding concerns. There were policies and procedures to help staff with decision- making and

reporting when they had concerns. The hospital lead for safeguarding was the director of clinical services; however when asked, not all staff knew who the safeguarding lead for the hospital was.

- The hospital provided safeguarding training for both adults and children. There was between 98% and 100% compliance with both adults and children level one and level two safeguarding training. The safeguarding lead for the hospital had undertaken safeguarding training for both adults and children at level three.

Mandatory training

- Staff received mandatory training in safety systems and processes to ensure their competence and to maintain patient safety. Mandatory training was carried out via an online system for all BMI staff and there were a combination of e-learning or face-to-face courses provided. Staff and managers were alerted by the system when they were due to update their mandatory training.
- There was variable compliance with mandatory training. The compliance rate with mandatory training as of March 2016 was 100% with pain assessment and management, 90% for registered nurse acute illness management, 100% for equality and diversity. There were lower rates of compliance for other training such as, 77% immediate life support, 72% medical gases training, 79% for documentation and legal aspects.
- Mandatory training for infection, prevention and control for the ward and theatres was 100%. This was a combination of e-learning and a face-to-face workshop. Mandatory training for the aseptic non touch technique was 88%. The competency assessment for the aseptic technique was carried out with the IPC lead. Records provided to us showed infection, prevention and control and high impact interventions had low rates of compliance at 68%. However, during our visit the IPC told us that training compliance with this had recently improved and was now at 86%.
- There was a mixed response from staff as to the ease of access to the training. Some departments found it easier than others to access computers to carry out their e-learning training. Some staff told us that it was difficult to complete face-to-face courses due to a shortage in courses to attend. Staff provided an example of the acute illness management (AIMS) course. The

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compliance for this course for healthcare assistants was just 40%. Staff told us that this course had been cancelled four times due to trainer sickness. Staff told us that when they were not up-to-date with any mandatory training, they received “an unpleasant letter”. The letter that staff received was in accordance with the disciplinary policy. Staff felt this was unnecessary and felt penalised for something that was out of their control. The letter that staff received was in accordance with the disciplinary policy.

Assessing and responding to patient risk

- A specific care pathway was put in place for each patient, to identify potential surgical risks and to identify plans to minimise risk and improve patient safety. The pathway contained documents and risk assessments following the patient journey from the pre-assessment stage through to discharge. The care pathway included information about past medical history, current medications, allergies and the pre-assessment stage.
- The Five steps to safer surgery, World Health Organisation (WHO) surgical checklist was used to ensure patient safety throughout the patient journey. Compliance with the WHO checklist was audited. Between January 2015 and March 2015, the hospital scored between 98% and 100% compliance. We looked at eight sets of patient records and saw completed WHO checklists. There were WHO checklists available in the care pathway, however, many of the checklists had been completed on individual sheets outside of the care pathway and stored with the patient record. Staff told us that there five different care pathways in the Southern region and each had a different version of the WHO checklist, some incomplete with parts omitted. This issue had been escalated to senior management. It was decided to reduce risks and to ensure consistency and safety, the individual WHO checklist outside of the care pathway was to be used. There had been no further actions identified at the time of our inspection.
- The national early warning score (NEWS) (a standardised scoring system that allocates a score to different physiological markers that are taken from the patient and measure how far from normal the score was) was used on the ward to identify a deteriorating patient. All patients were monitored by the nursing staff for a number of clinical and physiological markers, for example, blood pressure, temperature levels, and respiratory measures. If the patients score identified signs that the patient was deteriorating, the observations were increased and the registered medical officer was informed. Patients did not return to the ward until they met the discharge criteria set out in the care pathway.
- Standardised pre-operative risk assessments were completed pre-operatively and updated and reassessed as appropriate to keep patients safe from avoidable harm. These included assessment for venous thromboembolism (VTE), malnutrition screening tool (MUST), pressure ulcer risk score, moving and handling assessment and a falls risk assessment.
- Hourly nursing rounds, known as ‘intentional rounding’ were carried out and recorded for each patient for the duration of their stay to ensure patients were safe. These checks included, whether assistance was required to go to the toilet, pain monitoring, provision of pain medication as appropriate, comfort and repositioning and ensuring personal possessions and water jugs and fluids were in close reach. If the patient was asleep during the hourly round the nurse would document this on the chart.
- The hospital employed a resident medical officer (RMO) who was available on site 24 hours a day, seven days a week to ensure patient safety. The RMO was trained in both intermediate and advanced life support and would support the nurses if a patient started to deteriorate.
- There were arrangements for transferring patients for emergency care. The hospital had a service level agreement with a nearby NHS acute hospital with an emergency department. Patients who significantly deteriorated at any stage in their treatment, would be taken by an NHS ambulance to the local emergency department. Staff were able to tell us the procedure for when a patient deteriorated. This included reassessment by the Registered Medical Officer and the consultant. If a transfer was required, a verbal handover was provided to the hospital by both the consultant and the nurse and a copy of the patients records were taken with them to the local hospital. Nursing staff would continue to call the local hospital daily to enquire about the progress of the patient.

Nursing staffing

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- There were safe levels of nursing staffing on the wards and operating theatres in line with the Association for Perioperative Practice guidelines and the National Institute for Health and Care Excellence Safe Staffing Guidelines. The hospital was using a planning tool provided by BMI Healthcare to ensure that there was the correct number of staff available on each shift and that the skill mix reflected the staff required. This helped to ensure patient safety. Staffing rotas and skill mix was planned up to a week in advance using an acuity assessment to identify the required number of staff for each shift.
- Early planning of surgical admissions enabled staffing levels and skill mix to be planned accordingly to ensure patient safety. We saw staffing plans for March 2016 for Claverton ward and the day centre. We saw that the anticipated staffing levels based upon the patients coming in matched the clinical hours and skill mix that was actually required.
- There was an appropriate skill mix of nursing and theatre staff to ensure patients were safe, received care and treatment from the most appropriate person, and to provide enough support for junior staff. In theatre there was one whole time equivalent (WTE) theatre manager who was supported by 2.9 WTE nurse team leads. There were six WTE scrub nurses, 3.9 WTE theatre healthcare assistants and 5.9 WTE operating department practitioners.
- There were arrangements in place to ensure patients were kept safe by the use of bank and agency staff. Bank and agency staff were given an induction on their first shift in the department. We saw completed induction forms signed by new bank or agency staff working in the department. Agency staff were used infrequently; less than 10% for operating department practitioners, less than 5% for theatre staff in May 2015 and no use of agency staff for theatre healthcare assistants between January and December 2015.
- The ward employed nursing staff who only worked night shifts or day shifts and this posed challenges to staffing flexibility. The ward manager told us that the hospital was looking into trying to change contracts for new staff to enable more flexibility with working patterns.
- Safety briefings took place on a daily basis on the ward and in the day care ward at each staff handover to ensure safety. We saw the safety briefing file which included information about incidents, daily working of the department and administration issues. The day centre manager told us that there were some compliance issues with carrying out the safety brief in the day centre when the manager was not present. Three weeks ago, an alarm had been set in the office. The alarm going off reminded staff to do the safety brief. We were told that this was working well and that the brief was also being carried out prior to the alarm going off. This demonstrated that the safety briefing was becoming embedded into the handover session.

Surgical staffing

- There were adequate numbers of consultants and anaesthetists to meet the needs of patients. The service was consultant delivered. Consultants were responsible for their patients' care 24 hours a day, seven days a week. Consultants were available during working hours and could be contacted out of hours. Staff and the registered medical officer (RMO) told us that the consultants were very supportive. It was the responsibility of the consultant to organise cover for absences with another appropriate consultant. Nursing staff and the RMO told us they felt well supported by the consultants. There was a 30-minute time frame for consultants to come in to review patient if required, however response times were not recorded for compliance with this requirement. We were told that there had been not incidents where consultants had arrived outside of the 30 minute timescale.
- The hospital had a system to ensure that there was an anaesthetist available out of hours and at the weekend as required. The rota was set up eight weeks in advance by the BMI Bath anaesthetic group.
- There was a resident medical officer (RMO) on site 24 hours a day, seven days a week providing medical cover. The RMOs were outsourced to an external contractor who was responsible for the RMO's training, appraisal and revalidation. The RMO had yearly training in immediate life support, and advanced life support (ALS) and European paediatric advanced life support (EPALS) training, which was renewed every four years. Training in

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both adult and children's safeguarding was provided to level two. The RMO's completed routine tasks for the consultants, including blood tests and prescribing medicines, and supported consultants on ward rounds.

- The hospital had a system in place to ensure that consultants working under practicing privileges were competent to carry out their role. Consultants worked under practising privileges and were approved by a medical advisory committee prior to working at the hospital. There were 161 consultants granted practising privileges. Of these, 60 had not provided any episodes of care in 2015. There had been 35 consultants that had carried out over 10 episodes of care, and 61 of these were working regularly, each having delivered over 100 episodes of care. The chairman of the medical advisory committee told us that, despite 60 consultants not having provided any episodes of care in 2015, if the consultant had been signed off as competent during the yearly appraisal, then they could continue to practice at the hospital. The yearly appraisal demonstrated that that staff member had maintained the competence to continue to perform the role they carried, demonstrating their fitness to practice, which ensured patient safety.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents to ensure the safety of patients and staff. There was a corporate business continuity policy and contact numbers for key staff in the hospital were available to staff in the event of an emergency. Action cards were available covering different scenarios and providing staff with useful information, primary action points and follow-up action points to ensure best management of the situation. Action cards were available for a variety of situations such as theatre air flow, loss of electricity and loss of power.
- Staff received fire training annually, provided by the safety and risk co-ordinator. A fire simulation was practiced annually in theatres to ensure staff were aware of the procedure if an event occurred. Ward and theatre staff took part in an annual simulation to train for the event of a patient suffering a major haemorrhage.

- There were plans in place to manage a cardiac arrest at the hospital. There were two bleeps carried by operating department practitioners that would sound if a member of staff pressed the emergency button in the event of a cardiac arrest. These bleeps were tested on a daily basis.

Are surgery services effective?

Good 

We rated effectiveness of the surgical service as good because:

- An enhanced recovery programme was used for patients undergoing hip or knee replacements. Notes from patients whose stay was extended beyond the anticipated date of discharge were reviewed for trends and learning.
- Patients had good access to pain relief.
- There was evidence of good multidisciplinary team working across all departments to ensure effective patient care.
- Discharge planning was started early at pre-assessment to identify and address any potential issues that may prevent patients being discharged on time.
- There was access to seven day physiotherapy cover and an out of hours and weekend pharmacy on call rota for advice.
- There was a system in place to ensure that consultants were up-to-date with relevant employment checks to ensure fitness and competence to practice at the hospital.
- Staff were encouraged to develop their knowledge and skills.

However

- There was varied compliance with annual staff appraisals being completed ensuring staff were competent and up-to-date with their professional development.

Evidence-based care and treatment

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- Evidence-based guidelines and best practice were used to develop how services, care and treatment were delivered. Care was provided in line with guidance from the National Institute for Health and Care Excellence (NICE). For example, routine pre-operative tests for elective surgery (NG45) was followed regarding pre-operative tests and surgical site infection (QS49) was followed regarding surgical site infection.
- An enhanced recovery programme was used for patients who had a total hip or knee replacement surgery. Enhanced recovery is an evidence-based approach that aimed to improve patient outcomes by speeding up their recovery after surgery and to reduce their length of hospital stay. Its aim is to make patients active participants in their recovery process. The average length of stay for a patient at the hospital undergoing orthopaedic surgery was 3.3 days for hip replacements compared to a national average of 4.2 days and 3.8 days for knee replacement surgery, compared to a national average of 4 days. The hospital were performing better than the national average with regards to length of stay for hip and knee replacement surgery. We were shown data from January 2015 to April 2015 where there had been 40 'overstays' which were due to physiotherapists requesting the patient stay an extra night in order to reach physiotherapy goals in order to be safe for discharge. These had been reported as clinical incidents. The deputy physiotherapy manager had been asked to look into these occurrences to establish any trends or causes for the 40 cases of 'overstay' patients. This work was ongoing during the time of our inspection.
- All patients who underwent joint replacement surgery consented to have their prosthesis registered on the National Joint Registry (NJR). This was done to contribute to the ongoing monitoring of the NHS on the performance of joint replacement implants, the effectiveness of different types and to improve the quality of clinical practice
- The hospital participated in the programme of Patient Reported Outcome Measures (PROMs). PROMs. This was a programme established by NHS England to measure patients' health-gain following four common

procedures. The hospital reported on pain and quality of life pre and post operatively for the procedures it performed, namely hip and knee replacement and groin hernia surgery.

Pain relief

- Post-operative pain was managed and assessed on an individual basis. The hospital used a numerical rating scale of zero to three. Zero meaning no pain and three meaning severe pain. Pain was continuously monitored in recovery and continued to be monitored on the ward. We observed completed pain score charts for patients. Patients told us they felt the nurses managed their pain well. We were told that if the prescribed pain medication was not managing the patients pain this would be escalated firstly to the registered medical officer and then the anaesthetist if required. Pain was controlled by the use of spinal blocks, general anaesthetic, patient controlled analgesia (however there was little requirement for its use.). The hospital no longer used epidurals due to the difficulty with the ward nurses and the registered medical officer maintaining their competencies for the use of epidurals.
- A pain nurse was employed by the hospital for 18 hours per week. The pain nurse was a positive addition to the team and provided support by becoming involved with more complex patients and their pain issues. More effective pain management helped to optimise patients' ability to become mobile and to function independently following their hospital stay. During our inspection, there was a patient on the ward with complex pain issues following surgery. The patient told us that staff had worked tirelessly to manage their pain, in order for them to progress with their mobility and rehabilitation
- Pain relief was used to help optimise patient progress following surgery. Physiotherapists told us that they worked closely with the nursing team to plan physiotherapy sessions around the provision of pain medication. This was to optimise the patient ability to mobilise, engage and participate during the physiotherapy session. This would be discussed at the huddle and the physiotherapists would also remind the nurses prior to the session starting.

Nutrition and hydration

- Patients were risk assessed to ensure their nutrition and hydration needs were sufficiently met. The hospital was

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using the widely recognised Malnutrition Universal Screening Tool (MUST) to assess patients against the risks of poor nutrition or hydration which was available in the patients care pathway documentation. We saw examples of well-completed MUST records for patients and fluid intake and output were measured and recorded to ensure a good fluid balance was maintained.

- Patients undergoing operations or other procedures were given appropriate instructions about eating and drinking prior to their procedure. We observed the information booklet sent out to patients prior to their pre-operative assessment detailing what they could or could not eat and/or drink prior to their operation or procedure.
- Patients were assessed for the symptoms of nausea and vomiting in the recovery department and this continued on the ward to ensure nutritional and hydration needs were met. The hospital used a numerical rating scale of zero to three. Zero meaning no symptoms and three meaning severe symptoms of nausea. We observed completed nausea numerical rating charts for patients. Patients told us that they felt the nurses managed issues around nausea well.

Patient outcomes

- Care bundles were completed on the ward to reduce the risk of complication and to keep patients safe. Care bundles were completed for urinary catheter insertion and cannulation.
- The hospital took part in the national Patient Reported Outcome Measures (PROMs) for the NHS patients for the reporting period from April 2014 to March 2015. PROMs are standardised, validated question sets that measure patient's perception of health, functional status and their health related quality of life completed before and after surgery. This was then submitted to a national database which analysed the effectiveness of the care delivered to patients as perceived by the patients themselves. PROMs's audits were carried out on patient who had hip or knee replacements and groin hernia surgery. Both hip and knee replacement surgery scores were within the expect range for the England average. There were too few cases to enable a comparison between groin hernia surgery and the England average.
- The European quality of life five dimensions questionnaire (EQ-5D) index measured responses in five broad areas of mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. For hip replacement surgery, out of 60 questionnaires returned, 95% of patients said they had experienced improvements, and none said their health had worsened. For knee replacement surgery out of 47 questionnaires returned, 82.2% of patients said they had experienced improvements, and 2.1% said their health had worsened. For groin hernia surgery, out of eight questionnaires returned, 50% of patients said they had experienced improvements, and 12.5% said their health had worsened. A high number of patients were reporting improvements to quality of life following surgery.
- The European quality of life visual analogue scale (EQ-VAS) index measured how the patient would describe their general health on the day they completed their questionnaire. For hip replacements, out of 59 questionnaires returned, 79.7% reported their health as improved and 11.9% as worsened. For knee replacements, out of 44 questionnaires returned, 70.5% reported their health as improved and 22.7% as worsened. For groin hernia surgery, out of eight questionnaires returned, 50% reported their health as improved and 37.5% as worsened. More patients reported improvements in their general health following surgery.
- The Oxford hip and knee score was a questionnaire that measured symptoms and function pre and post patient having a joint replacement. For the 64 people who participated in the hip questionnaire for hip replacements, 100% reported an improvement in their function. For the 54 people who participated in the knee questionnaire for knee replacements, 100% also reported an improvement in their function.
- There were low levels of unplanned patient readmissions. There were only five patients readmitted as an inpatient within 29 days of their treatment at the hospital between January 2015 and December 2015. This represented 0.1% of the 4,883 patients treated as inpatients between January and December 2015
- There had been 19 cases of unplanned transfer to the local NHS hospital between January 2015 and December 2015. Each transfer was reported as an

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incident and we saw a copy of the incident log. A root cause analysis was also carried out to identify any trends or learning points that could have prevented the transfer. No trends had been identified in any of the 19 transfers. The transfer of patients to the local NHS trust were also discussed at clinical governance meetings, senior nurses meetings and at the medical advisory committee.

Competent staff

- Staff were provided with appropriate training to meet the needs of the patients. The physiotherapy staff held monthly in-service training sessions to maintain their competencies around treating certain conditions and rehabilitation following surgical procedures. The physiotherapists also took part in peer reviews to share knowledge, feedback and learning about practice.
- Nursing and health care assistants were required to complete yearly competency matrix produced by BMI to demonstrate their competence on their role and to ensure quality and patient safety. We observed the competency matrix for the trained nurses whilst the health care assistants completed a different set of competencies appropriate to their level and role. These were reviewed and discussed at the yearly appraisal.
- Staff were given opportunities to develop their role and enhance their knowledge and skills. We were told that all theatre staff that were capable would be encouraged to complete the first assistant training on BMI learn. BMI learn was the electronic learning system used at the hospital. The training would provide staff with further skills and knowledge and would also enhance their theatre 'scrub role' (nurses who assist during surgical procedures). Four members of theatre staff had also attended an external level one theatre first assistant training course.
- Staff were encouraged and given the opportunity to develop. Staff told us that if they wanted to attend an external course, they had to write a statement to outline the course and its relevance to their practice. Staff told us that applications for external courses were generally approved.
- Theatre staff told us that there was not a programme for department training; however the operating department

practitioners (ODP's) told us that they had recently received training for echocardiogram (ECG) monitoring (heart tracing). This training was organised by the head of department.

- New staff were given the opportunity to develop their roles. There had been a recent recruitment drive in Italy and five nurses had been recruited. Three members of the newly recruited staff were working in the surgical department; two were working on the ward and one in theatres. The staff were, at the time of our inspection working as healthcare assistants but had nursing qualifications. This was to develop their English in order to be able to communicate effectively with patients and to ensure that they were trained correctly and had completed all competencies prior to working in their full capacity as nurses. The new staff were undertaking preceptorship programmes under the new regional South West trainer. The aim was to have the staff working at their full capacity in six months.
- Infection, prevention and control (IPC) training was carried out by the IPC lead. We were shown copies of the evaluation form used to gain feedback from the session from staff. The IPC lead planned to use this information to improve the training that was delivered to staff to ensure that it was more beneficial and useful for future sessions.
- Compliance around yearly staff appraisals to ensure staff were competent in their role and ongoing professional development varied amongst staff. Compliance in theatres was 91% for theatre nurses, 100% for operating department practitioners and 80% for theatre health care assistants. There was low compliance with inpatient nursing staff at 24% and 0% compliance with inpatient healthcare assistant staff appraisals. The ward manager was new in post and prior to this, there was not a manager to complete appraisals. We were told that an informal meeting had taken place between the new ward manager and ward staff to identify any issues that needed addressing immediately. There was a plan in place to ensure ward staff appraisals were completed and the manager of the day centre was undertaking staff appraisals to improve compliance and to support the ward manager in completing the yearly appraisals. Personal development reviews were recorded on a new electronic system that had recently

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been introduced. Staff told us that the system had enabled better communication between the member of staff and appraiser but could be challenging to use. This issue had been raised by staff in theatres.

- There were arrangements in place to support nursing staff with nursing revalidation (a process to renew nursing registration with the nursing midwifery council). Staff told us that drop in sessions were provided and BMI had updated information and advice about the process. A member of staff told us they were developing a user friendly guide to support nursing colleagues with the process as they had recently completed it.
- There was a standardised BMI induction form for bank and agency staff on the ward and in theatres to ensure the competence of new staff working within these areas. We saw evidence of completed induction forms which were kept in the department office. The forms were signed by the member of staff carrying out the induction and the bank, agency or new member of staff on completion.
- Assurance was gained around the experience and qualifications of the first assistants (practitioner assisting the surgeon) in theatre if they came in externally from local hospitals. A form by the first assistant would be completed and checked with the local hospital for accuracy. The form was also signed by the consultant who brought the first assistant. This information was held in the main theatre office.
- Medical staff were employed to work at the hospital under practicing privileges. There were 161 consultants working under practicing privileges at the hospital. It was the role of the medical advisory committee to approve new medical staff to work at the hospital.
- There was a system in place to ensure that consultants only carried out work that they were skilled and insured to carry out. Information including disclosure and barring service (DBS) checks, indemnity insurance, information about appraisals, revalidation, registration with the GMC and self-declaration forms were collected. The system alerted the management office administrator three months before the DBS check was due for renewal and five days before the indemnity insurance was due for renewal. Letters were sent to consultants to advise of the need for renewal of any of the documentation. There was also a spreadsheet in

place for when the management office administrator was away to ensure that other staff were informed about up and coming expiry dates regarding consultants documentation. We were also shown a record of nursing and allied health professionals revalidation and registration details. These were also reviewed and checked to ensure registration by the appropriate body was upheld.

Multidisciplinary working (in relation to this core service only)

- There was a daily morning multi-disciplinary meeting or 'huddle' on the ward at 9am and a board meeting at 8am in theatres attended by members of the theatre staff. All staff groups involved with patient care attended. We observed a morning huddle and a board meeting during our inspection. The huddle and board meeting gave the multidisciplinary teams the opportunity to discuss patients, any concerns, discharge plans, on call rotas and plans for any changes to the working day. There was a book to record important information from the board meeting in theatres which was kept in the theatre manager's office.
- Patient care was delivered in a co-ordinated effective way across different departments. Nurses from the ward collected patients from recovery to bring them back to the ward. A written handover was available in the patients' pathway containing information about the patients' journey and status through theatre and in the recovery department. Staff told us that they also handed over verbally. They felt that this verbal communication ensured a detailed understanding of the patient and enabled staff to provide more effective care. We observed a handover take place on a patient's arrival into recovery. A detailed verbal handover took place between the anaesthetist and scrub nurse and written documentation was also provided in the care pathway.
- Multidisciplinary team working continued when patients were transferred to the local NHS hospital to ensure a seamless transition for the patient's safety and continuity of care. Patients' notes were photocopied and went with the patient to the hospital. A verbal handover was provided consultant to consultant and a

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nursing handover provided from the BMI hospital nurses to the receiving NHS nurse. The BMI hospital nurses would call the receiving ward daily to check the patients' status.

- We attended a team brief for theatre two during our inspection. All members of theatre two staff attended the brief. This ensured that staff were aware of issues that may be encountered during the working day and were updated about new guidance available. We saw a copy of the team brief form used at the briefing to document what had been discussed.
- Staff worked together and in conjunction with the patient from pre admission to discharge and to plan ongoing treatment when patients were transferred between services. If a patient required further physiotherapy after their allocation at the hospital was complete, a referral to the patients' local NHS physiotherapy department was made with information provided about the patients' treatment, progress and goals to the accepting team. This provided a smooth transition of care services and better continuity for the patient.

Seven-day services

- Surgical patients on the ward had access to a physiotherapist seven days a week to provide continuity for rehabilitation and to optimise outcomes and patient discharge. Physiotherapists provided a minimum of two sessions daily and more if required.
- There was access to the pharmacy service five days a week during working hours. The pharmacy team ran an on call rota for outside of working hours to enable staff to call to gain pharmacy advice or support. The on call pharmacy rota was available on the ward at reception and in the pharmacy department.

Access to information

- The hospital had an efficient system to share information with the patient's GP on discharge. This provided continuity of care and ensured the GP was kept well informed of the patient's status, procedure and follow-up needs on discharge. There was a BMI template letter used for writing discharge letter to GPs. The nurses on the ward filled out the discharge letters and gained discharge information to put in the letter verbally from other members of the multidisciplinary team (MDT) or

from the MDT notes in the care pathway. The letter was typed by the nurse and saved on the system. This was then sent to the GP within 24 hours of the patient being discharged. A copy of the discharge letter that was also added to the patient's file and the patient took a copy of the discharge letter home with them.

- There was a system in place for the GP to speak to the registered medical officer. The GP could ring the 24 hour helpline to access support and advice.
- Patients were provided clear evidence-based information about post-operative care on discharge. There was good discharge paperwork and advice to patients and backed up with a telephone call 24 hours post discharge. The pack given to patients to take home included the 24-hour helpline number for the hospital, an information sheet from the consultant who performed the surgical procedure, advice on avoiding the risks from deep vein thrombosis, an exercise letter and information booklet provided by the physiotherapy department and a copy of the discharge letter that was also sent to the patients GP.
- The physiotherapist and occupational therapists reviewed patients at pre-assessment stage to discuss discharge expectations, social circumstances and arrange any equipment that would be required on discharge. We observed the specific information booklet and exercise worksheet demonstrated and provided to patients during pre-assessment providing information to patients to prepare for the operation, what to expect during the hospital stay and information and advice for discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff acted within the legal framework to obtain patient consent for treatment. Consultants always obtained consent from patients and provided information about the operation, outcomes and possible complications. This enabled the patient to make an informed decision. We observed completed and legibly written consent forms. The forms were signed and dated by patients. These were stored in patients' notes.
- There were processes in place which demonstrated and recorded patient consent was obtained for joint replacement surgery. The National Joint Registry looked

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at patient information between January 2016 to March 2016. The treatment centre had carried out 86 joint replacements, 46 hip replacements and 40 knee replacements. The evidence of consent was recorded as 100% which exceeded the NJR target of rate of 95%.

Are surgery services caring?

Good 

We rated this service as good because:

- Patients were treated with respect and dignity.
- Patients told us that staff communicated well and treated each patient as an individual.
- The staff tried to promote independence and encourage normality to optimise progression and improvement.
- Patients told us that they felt involved with their future care and treatment. Staff recognised that some patients required more support and acted upon this in an appropriate way.

Compassionate care

- Patients we spoke with told us that the nurses maintained their privacy and dignity at all times. They told us that staff always knocked before entering their rooms. We were told by a younger gentleman that the staff brought and taken away urine bottles very discretely which he had appreciated.
- Patients we spoke with told us that the staff communicated and interacted well with them. We observed good interaction and communication between the anaesthetist and patients in the anaesthetic room. The anaesthetist took the time to explain to the patient what was happening and all members of staff present in the anaesthetic room were introduced to the patient. We observed a nurse in recovery communicating clearly with a patient and providing support and reassurance to a patient who had woken up from an anaesthetic. Patients described the staff as “very friendly” and told us that the staff “couldn’t be more helpful”. One patient described the ward atmosphere to be “like a family”, while another stated that the staff “treated me like an individual.”

- The staff took steps to promote independence and normality to optimise recovery post-operatively. The physiotherapists worked on patients’ mobility from day one post operatively, whilst the nursing staff encouraged patients to sit out in their chair for meals and during the day to establish a normal routine that would be followed at home. Nursing staff told us that they encouraged patients to wash independently if they were able to and provided support and encouragement to patients who required more help. Nurses told us that they encouraged patients to get dressed on day two post operatively, in order to return to a normal routine as quickly as possible to optimise recovery.
- A patient-led assessment of the care environment (PLACE) was completed for the reporting period of February 2015 to June 2015. The PLACE score for privacy and dignity was 97%, better than the England average of 87%.
- The friends and family test data showed good results. Patients were asked to say if they would recommend the hospital to their friends and family. From July 2015 to December 2015 the percentage of patients who said they would recommend the service to their friends and family ranged from 97% to 100%. During this reporting period the response rate ranged between 23% and 62%. For all months during the reporting period, apart from October 2015, the response rate for the friends and family test was higher than the England average.
- We observed a physiotherapy session with a patient. The physiotherapist maintained good communication throughout the session and provided clear instruction to the patient about how to improve and progress. The physiotherapist was very encouraging, reassuring and supportive.

Understanding and involvement of patients and those close to them

- All patients we spoke with told us that they were fully aware of the future plan for their care and treatment. One patient’s wife told us that her husband was due to go into theatre later and she would not be able to return to see him after his operation. The consultant had called her once her husband had come out of theatre to inform her that the operation went well and her husband was doing well following the procedure.

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- Staff understood when patients and those close to them needed more support to understand their care and treatment. We spoke with a patient and family member who told us about the positive experience they had using the 24 hour helpline. They told us that the nurse who spoke to the patient on the initial helpline call understood that the patient required further information and support. The nurse arranged for the consultant to call the patient and their family. The consultant spent time speaking to the patient and family member to provide advice, support and reassurance. Both the patient and family felt supported and reassured by the extra information and call from the consultant.
- Patients we spoke with told us that staff always took the time to explain what was about to happen and what needed to be done and why. All patients we spoke with told us that staff always gave them the opportunity to ask questions and become active partners in their care.

Emotional support

- Staff understood the impact of patients' care, treatment and condition on their wellbeing and people close to them. A patient told us that their family and friends had limited access due to the hospital being a long distance from where they lived. The patient had been at the hospital for several weeks due to the complexity of their problems. They told us that the ward staff had been very supportive, taken the time to engage in conversation and provided the reassurance they needed whilst being away from their family and friends. Recognising this, staff had arranged for the patient's rehabilitation to continue at a hospital more local to their family. The patient felt this had helped them get through his extended stay at the hospital.
- The ward and theatre staff worked together to recognise and support patients' anxieties. They told us about a recent example where a theatre list was altered so that a very anxious patient could go into theatres first.
- The hospital encouraged patients to maintain communication with their family and friends to support their wellbeing. There was free wifi access on the ward for patients to use and there was a telephone in each patient's room to enable them to call family and friends and receive incoming calls directly to their room.

Are surgery services responsive?

Good 

We rated responsiveness as good because:

- Flow through theatres was improved by support from the central sterile services unit in preparing equipment for theatre.
- Theatre cancellations were reported as incidents and trends monitored to avoid cancellations for avoidable reasons in the future.
- The hospital was meeting its referral to treatment times.
- There was a plan in place and an on call rota to manage unplanned returns to theatres out of hours and at weekends.

However,

- There were issues with delays in transporting patients from recovery back to the ward.

Service planning and delivery to meet the needs of local people

- The hospital was opened in 1983 and was extended in 1992 to add an extension for the day-care centre due to the growth in day-case surgery. Since that time the hospital had taken on an increasing amount of work for the NHS, commissioned by the local clinical commissioning groups and local NHS hospitals. This currently accounted for 55% of the work undertaken. Between January 2015 and December 2015 this had amounted to 10,514 patient spells and around 35% of the services provided. The service enabled NHS patients in the local area to have access to and a choice of where to have a range of elective operations or procedures.
- Facilities in the day care ward were appropriate for the services planned. There were separate male and female changing facilities and waiting rooms with lockers for patients to safely store their belongings whilst in theatre. Each patient on the ward had an individual room and access to a private bathroom with a shower.

Access and flow

- Systems were in place to effectively manage access and flow through the surgical department and ward. The

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admissions team organised admission times for patients. The 'walk in walk out' clinic in the day care ward staggered admission times for patients. Patients also had staggered admission times to the ward, depending upon the time of their surgery. This helped to avoid unnecessary waits for patients at the hospital prior to their procedure.

- The theatre team worked to improve flow through the department and to ensure efficient turnaround in theatres, minimising patient waits and delays. The central sterile services unit (CSSU) supported the surgeon and the theatre team in the organisation and issue of equipment required for theatres. The CSSU staff checked the equipment picked for theatre, saving the theatre staff time and allowing them to concentrate on preparing the theatre for the next patient.
- Patients were able to access treatment at a time to suit them. Theatres were open six days a week, Monday to Saturday and provided a morning and afternoon list. Occasionally, a third, evening list would be arranged in theatres. This gave patients more choice and flexibility for care and treatment.
- There was an appointment system in place supporting patients to access and alter appointments. Patients were provided with an appointment time for their pre-op surgical assessment; however, there was an option to change this for a more convenient time. Staff told us that the appointment system was easy to use. Patients told us that and that they were able to talk to someone immediately and have the appointment changed. Patients felt the staff were very helpful and accommodating. Patients appreciated being able to talk to a staff member, rather than having to use an automated system.
- Theatre cancellations were reported and recorded on the incident reporting system. Between October 2015 and April 2016 there had been 28 theatre cancellations. 17 cancellations had been for clinical and 11 cancellations for non-clinical reasons. Clinical reasons included a patient being unwell on admission or there being abnormal test results requiring further investigation prior to surgery. Some non-clinical reasons for theatre cancellations were investigated due to the situation being potentially avoidable. For example, equipment had not been ordered for two surgical procedures, resulting in surgery being cancelled. An

investigation had been carried out and an action plan identified. More effective systems were set up to ensure better tracking of equipment requisition paper work to avoid similar incidents in the future. A back-up plan was in place to ensure enough staff were trained to enable administration procedures to continue if there was sickness absence or leave. The new system was communicated to staff during the morning safety meeting and, at the time of our inspection, was working well.

- The hospital was treating most NHS-funded patients within 18 weeks of their referral for treatment. The hospital reported on information about treatment times as required for its NHS patients. The treatment centre was meeting its referral to treatment target (RTT) waiting times for all but one month. Between January 2015 and December 2015 the hospital scored better than the 90% target for referral to treatment times, with between 94% and 100% of patients being seen on time. However, the hospital did not meet the referral to treatment 90% target in October 2015, with 88% of patients being seen on time. On average, surgical patients were waiting between seven and eight weeks for their surgical procedure.
- The ward telephoned patients the day before they were due to be admitted to identify any problems or issues that may disrupt access or flow onto the ward and in theatres. Patients were called to remind them of their admission time, to check they were well and were prepared for their admission and procedure. This was to ensure a seamless flow from admission through their journey into theatre and back to the ward.
- The hospital had a plan to manage the provision of unplanned returns to theatre out of hours, at weekends and during public holidays. There was an on call theatre team rota system in place, consisting of a scrub nurse, operating department practitioner and a healthcare assistant. There was also an anaesthetist on call rota for out of hours and weekends. There had been seven cases of unplanned returns to theatre during 2015. It was not clear from meeting minutes if these were reviewed.

Meeting people's individual needs

- Services were planned to take into account the needs of different people to enable them to access care and treatment. The hospital's admission criteria was set out

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so all patients, irrespective of their gender, weight, pregnancy and maternity status, race, religion or belief, or sexual orientation could access services. The hospital treated young people between the age of 16 to 18 years of age however the hospital had strict exclusion criteria excluding children up to 16 year of age to receive treatment at the hospital.

- There were arrangements in place to support patients with complex needs, to improve communication for patients with hearing or communication problems and remove barriers to care and treatment. A hearing loop was available for patients with hearing problems and a visual communication aid book. These items were located in the day care ward but could be used by all departments. Staff told us there had not been an occasion where this equipment had been required to use with a patient recently. We saw standard operating procedures in place for interpreters, hearing impaired patients and visually impaired patients. The hospital had identified and planned effective means to support this patient group if they came into the hospital.
- The hospital did not have any facilities to support or promote independence for patients living with dementia or learning difficulties. There were no facilities in any of the patient rooms on the ward, for example, using contrasting colours to highlight the entrance to the bathroom or the toilet seat. We were told that the hospital very rarely treated patients living with dementia or patients with a learning disability. There was no dementia lead role at the hospital; however, two members of staff had undergone dementia awareness training through Health Education South West. All staff also undertook dementia training. The hospital scored 76% for dementia care against the England average of 87%.
- Patients had post-operative support to maximise recovery. The physiotherapy service provided flexibly, and was based on meeting individual patient's needs. Staff told us each individual session and each course of physiotherapy lasted as long as the patient required to optimise recovery. Staff told us that patients had a minimum of two sessions daily, however, if required, patients' would have more sessions. We were given an example of a patient who had been on the ward recently requiring three sessions daily to maximise potential for progression and recovery. We saw patients' individual post-operative physiotherapy needs and plans were documented in the care pathway.
- Patients we spoke with in the day care ward told us they were provided with a written information pack, along with their appointment letter. We saw the information pack that provided information about the hospital, what to do before coming in for a procedure and what would happen at each stage of their journey. We saw information packs that were provided to patients on discharge. These included, a personal copy of post-operative instructions and information from patients' individual consultants and contact telephone numbers, information leaflets about the management of their procedure post-operatively, a copy of the discharge letter sent to the GP and information about pain medication on discharge.
- There were systems in place to ensure individual patient needs were met and provided a 'personal touch' to patient care. Each room had a call bell which patients could use to call the nurse at any time during the day or night. There was also a separate pink button so that patients could call the pantry to request a drink or something to eat at any time of the day or night. Once the pantry closed at 8pm, the call would be diverted to the nurses. There was a wide variety of well-balanced meal choices and different diets could be catered for.
- The pharmacy department had a system in place to manage complex discharges and to support and empower patients to independently manage their medication. If a patient was prescribed a lot of medicines, the pharmacist developed an individual medication plan for the patient. We saw a plan that had been developed for an individual patient on the ward. This documented the times of day the medicines should be taken and the dose. Patients who were on less medication were provided with an information sheet providing information about the medicines they were taking, how they should be taken, the dose, side effects and important information of note.
- There was a 24 hour helpline for patients that provided access to the multidisciplinary team for advice and support following discharge. Patients were provided with the helpline telephone number on discharge and advised of its purpose. The helpline telephone

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remained with the nurses. We saw the log book that all helpline calls were logged in. The nursing staff also provided a follow-up telephone call to all patients 24 hours after discharge to check that the patient was managing well and had no problems. We saw the log book identifying that patients had received their follow-up telephone call. Staff showed us a card that was sent out to patients if the nurses were unable to get hold of the patient for their follow-up call on discharge. They told us that patients would normally call the ward on receiving the card to inform the staff that they were well.

Learning from complaints and concerns

- Information was available advising patients how to make a complaint. There was a poster in the reception area informing patients how to make a complaint as well as a section in the information pack provided in the patients' room.
- The hospital had policies and processes in place to ensure the appropriate investigation, monitoring and evaluation of complaints. Complaints were shared with staff. During 2015 the hospital received 53 complaints. The hospital reported that 100% of the complaints were resolved by the hospital at stage one of the complaints process. Stage one was when complaint were managed and resolved locally by the hospital. There were four main themes which emerged. There were eight complaints about medical treatment, seven complaints relating to delays or cancellations of outpatient appointments, seven complaints regarding clinical treatment and five complaints detailing issues around financial costs and charges. We saw the hospital report of the actions taken to address each of these complaints themes along with minutes from the senior nurses' meetings where they had been discussed and the actions taken to try and resolve the complaints trend.
- The hospital's complaints policy required that complainants received an acknowledgement of their complaint within three working days and a full response within 20 working days. In 2015 the hospital met this target for 100% of complaints.

Are surgery services well-led?

Requires improvement

We rated well led as requires improvement because:

- There was a continuous monitoring around quality and improvement in the surgical department with the exception of infection, prevention and control audits.
- There was a lack of understanding amongst staff in relation to their accountability for driving continuous quality and improvement in the surgical department.
- There was no proactive approach, to monitoring the implementation of actions following areas of service performance that required improvement following incidents.
- There was no clinical risk register in the surgical department, on the ward or in theatres, to identify the risks associated to the surgical department and how the risks were managed.
- Senior management, being the director of nursing and the chief executive, were not visible in the surgical department.

However,

- There were staff forums which engaged staff in shaping the culture and environment.
- The staff felt confident to approach senior management with problems or concerns.
- There had been an opportunity to develop staff and performance at the hospital through training via Health Education South west.

Vision and strategy

- There was a clear vision and a set of corporate strategic objectives set out for the BMI Bath clinic, with quality and safety being a top priority. Staff we met were fully aware of the vision and their role in delivering it. Most staff we asked talked about the vision and providing the best quality care for patient and providing the best outcomes to patients and high quality services. Staff told us that prior to the CQC visit they had been sent emails and information about the vision which they had found helpful.

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Governance, risk management and quality measurement for this core service

- The hospital did not have a clear structure for governance and risk management, with information being cascaded via departmental meetings. Despite various meetings and sub group committee meetings, issues around quality and risk management were not being identified or addressed in a timely manner. There was no clinical risk register for the theatre or ward, no monitoring of infection, prevention and control audits and risks on the environmental risk register for over one year that had not been reviewed or managed in a timely way.
- Staff did not understand their role and accountability in ensuring continuous quality and performance improvement in the surgical department. There was a BMI corporate plan to improve the enhanced recovery programme delivered at the hospital. Various members of staff were involved with the ongoing project where the aim was to improve patient safety, service quality, effectiveness and efficiency. There had been a steering group working on the enhanced recovery programme (ERP) locally at the hospital. We saw detailed action plans to improve the ERP, however, all ERP meetings and action plans had stopped in April 2015 due to the steering group lead leaving post. There were several other members of staff in the steering group but no accountability from the remaining members to continue to drive the project forwards and implement actions plans to improve quality and performance. We were told that this project would start up again when the new physiotherapy lead started in post.
- There was poor compliance with the monthly audit schedule to monitor quality and performance around infection, prevention and control (IPC), such as hand hygiene and care bundles on the ward and in theatres. The hospital was unable to provide us with information to demonstrate continuous monitoring of quality and performance. There had been a period of time between November 2015 and April 2016 where there had been no IPC lead. We were told that there was no formal documentation of these audits being carried out between November 2015 and March 2016. During this time period no-one had taken accountability or ownership to continue the reporting of the auditing process to feed into the audit schedule to monitor and improve performance where required. This raised questions about how effectively quality and performance was discussed and monitored at governance meetings. From the minutes we reviewed, there had been no discussion at clinical governance meetings or heads of department meetings about the lack of IPC audit work in theatres and on the ward between November 2015 and April 2016.
- There was a local risk register for the hospital, but no clinical risk register was maintained in the ward or theatre department identifying significant risks in each department and how these risks were to be managed. We were told that incident reports were completed when a risk was identified. This indicated a reactive approach to the management of risk. Staff provided us with examples where issues had occurred and actions had been put in place following the incident to reduce the likelihood of the incident occurring again.
- The lack of an uninterrupted power supply for theatres had been highlighted on the hospital risk register in April 2015. A risk assessment had been completed and the risk reduced by the use of a back-up generator and the provision of spare battery packs for all of the equipment in the department. The action plan identified a quote to have this installed with a review date for December 2015. The heads of department meeting minutes from January 2016 identified getting a quote for an uninterrupted power supply. However, there was no follow up discussion of this action recorded in the February 2016 heads of department meeting. The hospital had been slow to address this action despite it being identified and documented on the risk register for over a year.
- There was not a proactive approach to monitoring and implementing actions in response to service performance issues that required quality improvement. There had been three incidents on the ward as a result of a lack of communication after the patient had been discharged from the ward. Whilst actions to improve communication had been put in place after the initial incident occurred, there was no proactive approach to monitoring the actions were being implemented to avoid the event occurring again. The approach to

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monitoring actions that had been implemented was ineffective as the same incident occurred three times, despite actions being put in place following the initial incident.

- Theatre staff had requested new monitors and capnography (equipment to monitor blood gases) equipment for the department in November 2015 to improve the quality of care for patients. At the time of our inspection, the department had not received the new equipment. Staff told us that there had been many challenges to ordering this equipment and a lack of communication about whether or not the request had been approved. The staff felt unsupported by the senior management team in driving forward the request to obtain new equipment for the department due to the lack of communication.
- There was a systematic programme of clinical and internal audit used in each department to monitor quality and identify areas for improvement. We saw the monthly theatre audit schedule using the BMI self-assessment tools. A different audit was carried out each month in relation to different areas of theatres. The department had scored 83% for their steps to safer surgery audit in January 2016. The theatre manager told us that the theatre debrief was the area that required improvement. Action plans in place to improve this issue and how this was to be monitored to improve compliance. We were also told that the issue had been escalated to the medical advisory committee to gain further support with consultant compliance in this area. We saw evidence of this in the minutes from the medical advisory committee minutes.
- Ward and departmental meetings took place and staff were updated on information from the hospital clinical governance meetings. This included information on complaints and incidents. For staff who were unable to attend, meeting minutes were printed and available in each department. Staff told us that if they had any issues, managers would raise these at clinical governance meetings on their behalf.
- An incident and complaints forum had recently been set up for staff at the hospital to make staff aware of issues to improve quality and care for patients. This was a newly introduced meeting and at the time of our inspection only one session had been held. The meeting was held on the alternate month to the staff forum. Staff

had been told that individual department sessions could be held but this would need to be requested by the department. There were no formal minutes of the meeting but we saw information detailing the content of the complaints and incidents that were discussed at the meeting.

- Assurance was gained around the experience and qualifications of the first assistants (practitioner assisting the surgeon) in theatre if they came in externally from local hospitals. A form by the first assistant would be completed and checked with the local hospital for accuracy. The form was also signed by the consultant who brought the first assistant. This information was held in the main theatre office.
- There was a system to ensure that consultants inviting in external first assistants had the appropriate checks in order to work in theatre. The experience and qualifications of the first assistant would be collected and then confirmed by the local hospital that they usually worked in to ensure accuracy. The first assistant was then granted practicing privileges to work in theatre. The information was held in the theatre office.

Leadership / culture of service related to this core service

- Senior management (the hospital director and the head of nursing) were not felt to be visible either in theatres or around the ward during the working day. Staff told us that they had raised this issue with senior management and they became more visible for a short period of time. However, this did not last long.
- The culture encouraged openness and honesty. Staff told us they felt they could approach the senior managers with concerns and felt confident to do so and felt supported by senior management when they had raised concerns. Staff told us that there had been a lot of change to the senior management team which had highlighted very different methods of leadership and had been challenging for staff to get used to new leadership styles.
- Morale had been low amongst the staff working at the hospital. The staff told us that this had been due to staff changes, changes to terms and conditions and also the new method of clocking in and out of the working day. However, staff told us that things had settled down and

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that morale was improving. Senior management had recognised that this had been an issue and that the changes were going to take time for staff to get used to the new ways of working.

- There was variable evidence that teams worked collaboratively, constructively and shared the responsibility of delivering good quality care. Staff told us how they enjoyed being part of their departmental teams but also of how they worked closely together across the different departments to provide efficient and effective care for patients. We were given an example of effective team working between the ward and pharmacy to ensure a patient had the medication they required before pharmacy closed.
- Staff described not feeling respected and valued since the introduction of the clocking in and out system for the working day. Staff told us that the system did not take into account good will or flexibility which had caused some demoralisation amongst staff.
- Staff told us about the 'above and beyond' reward scheme that existed at the hospital, which gave recognition for work and contributions to different departments. Staff felt that this scheme was motivational. Staff told us that if a patient sent a compliment and named a particular member of staff, the hospital director would send out a personal letter to that named member of staff and their name would be displayed in the hospital.
- The staff we spoke with told us that there was no hierarchy at the hospital. Staff told us that they felt comfortable to go and discuss concerns about patients directly with the consultants and found them very helpful. We spoke with a consultant who told us that he valued feedback from the physiotherapists about his patients and gave us an example of working closely with the physio to manage a complex patient to achieve the best possible outcome for the patient.
- The senior management provided patient feedback to the day care ward and ward staff to demonstrate patient appreciation towards staff at the hospital. We saw thank you cards on display in the staff room on Claverton ward and an email on the staff notice board in the day centre which provided positive feedback to staff from patients via the patient satisfaction questionnaire.
- Bi-monthly staff forums were held to engage staff in shaping the culture of the environment. The meeting consisted of two parts, a business meeting about how the hospital was performing and a session where staff could raise concerns and issues. Theatre and ward staff told us that they found it difficult to attend due to their work commitments. However, theatre staff told us how they had called the hospital director to arrange an individual department session. This took place and a further two individual sessions had been held for the theatre department to ensure staff were up-to-date with the hospital business and had an opportunity to raise concerns or discuss issues.
- Staff were actively engaged in working groups to deliver better quality patient care and help to develop more effective service delivery. For example, the medicines management group met quarterly and worked on action plans to improve quality and practice in their clinical areas. Competencies for scrub nurses in theatres had been reviewed locally and the theatre operating department practitioners were looking at ways to improve the working environment.
- There was a clinical supervision group held monthly by an external organisation to support staff from each department at the hospital. The forum was set up to ensure staff wellbeing and to provide a safe place for staff to discuss issues or concerns and benefit from peer support.

Innovation, improvement and sustainability

- The new infection, prevention and control lead was striving for continuous learning and improvement. The 'One Together' assessment tool was looking at the prevention of surgical site infection (SSI). The tool had been initiated as a quality improvement collaborative with the aim of promoting and supporting the adoption of best practice to prevent SSI across the surgical patient pathway. The trial and audit programme was underway during our inspection. We were told that if it was successful then it would be used organisation-wide.
- The hospital had worked in conjunction with Wiltshire Clinical Commissioning Group and Health Education South West to secure places for staff on development

Public and staff engagement






Surgery

and training courses to develop services in the hospital. Staff had attended courses on leadership and innovation, dementia care and care of the deteriorating patient.

- The surgical department were continuing to work on improving compliance with the safer surgery checklist

and the theatre debrief. The theatre manager told us about how they were due to visit another BMI site to learn how things are carried out in different hospitals. This would allow them to develop learning and processes from other hospitals to improve performance and practice.

Outpatients and diagnostic imaging

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

Information about the service

The BMI Bath Clinic is an independent hospital which forms part of the BMI Healthcare Group. The hospital opened in 1983 and referrals are accepted from GPs and local NHS trusts either as private patients or as 'Choose and Book' NHS-funded patients.

Between January and December 2015 the outpatient department held 25,594 appointments of which 68% were privately funded (self-paying or through medical insurance) and 32% were NHS funded appointments. These included 11,943 new referrals and 13,651 follow-up appointments.

From January 2015 to December 2015, the outpatient and imaging departments provided 219 appointments for young people age 16-17 years. The hospital stopped seeing children under this age in 2014.

The outpatients department has 16 consultation rooms on three different floors. Consultations are offered for a range of different specialities including cardiology, care of the elderly, dermatology, general medicine, gynaecology, haematology, neurology, ophthalmology, pain management, respiratory medicine and rheumatology. In December 2015, the hospital added eye laser treatment to the portfolio of services provided within ophthalmology. There is one treatment room on the ground floor, which is used for wound dressings, minor surgical procedures and plasters. The outpatient department offered appointments from 8am to 6pm Monday to Friday with occasional Saturday clinics.

The outpatient department services include phlebotomy, pre-admission assessment unit (PAU), health assessment and a travel clinic. The hospital also had a physiotherapy

department, which provided physiotherapy and occupational therapy services to both inpatients and as part of the outpatient service provision. The department had six treatment rooms and a gym.

The Imaging department was on the ground floor and provided x-rays, digital mammography, imaging or ultrasound guided diagnostic procedures, ultrasound scans, Magnetic Resonance Imaging (MRI) and multislice Computerised Tomography (CT). Between January 2015 and December 2015 the diagnostic imaging department performed 4,718 plain film x-ray, 2,046 CT scans, 2,463 MRI scans, 1,698 ultrasound examinations, 200 digital mammography and 197 image-guided injections into joints.

We visited the departments on 3,4 and 5 May 2016 as part of a scheduled inspection process. We observed clinics in the outpatient department, imaging department, health assessment clinic, phlebotomy and physiotherapy department.

We spoke with patients and their relatives or carers and a range of staff including five consultants, five radiologists, nine radiographers, eight nurses, four healthcare assistants, two physiotherapist, one occupational therapist and five secretaries.

We met with the managers for the outpatient department, imaging department, the acting lead for the physiotherapy department and the health and safety officer.

Outpatients and diagnostic imaging

Summary of findings

We rated the BMI Bath Clinic outpatient and diagnostic services as requires improvement because:

- The outpatient department completed care records for patients attending follow up appointments, but these were not kept in one folder and were in different locations. This meant there was not a complete record of patients' care and treatment available to clinical staff.
- The fire risk assessment was nine months out of date. This was despite the recent introduction of eye laser service with a potential increased risk of fire. Staff were unsure of evacuation procedures for patients on the first and second floor in the event of fire.
- The service had not completed all action points from a risk assessment carried out in preparation for the new eye laser treatment.
- There was a high reliance on bank staff in the outpatient department and no clear deputy for the manager.
- The imaging department did not have standard operating standards for all procedures in line with the recommendations set out in the National Safety Standards for Invasive Procedures.
- Compliance with mandatory training was below the hospital's target for compliance.
- There was little evidence that the service collected patient outcome measures and used these to evaluate the effectiveness of care and treatment delivered.
- There was no departmental clinical risk register, which meant the service could not proactively manage clinical risks.
- Review compliance with cleaning schedules in outpatients and diagnostic imaging.

However,

- Staff used a range of good practice approaches to ensure the correct patients received the correct treatment and procedures.

- The imaging department had an effective on-call rota that ensured emergency screening could take place out of hours.
- Staff treated patients with dignity and respect and we observed caring and kind interactions between staff and patients.
- Referral to treatment times were consistently better than the 95% target set by NHS England with 100% of patients being seen within 18 weeks from referral.
- Staff told us they felt supported by their managers and managers told us they were proud of their team and the teamwork.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement 

We rated safety of the outpatient and diagnostic imaging services as requires improvement because:

- The outpatient department completed care records for patients attending follow up appointments but these were not in one folder and in different locations. This meant there was not a complete record of patients' care and treatment available to clinical staff.
- The fire risk assessment was out of date even though a new service with a potential risk of fire had been introduced. Staff were unsure of evacuation procedures for patients with reduced mobility from the first and second floor in the event of fire.
- There was a high reliance on bank staff across in the outpatient department and no clear deputy for the manager.
- Some parts of the hospital were in need of decorating and repair which was compromising effective cleaning.
- The housekeeping audits for weekly cleaning in the outpatient and imaging departments showed poor compliance

However:

- Staff were aware of their responsibilities to report incidents and there was a good incident reporting culture amongst staff.
- Staff complied with infection control measures, including hand washing.
- The imaging department had efficient restricted access policies and practices, and staff complied with these.

Incidents

- There were no never events reported in the period from January to December 2015. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death.
- In the last 12 months, there was one incident of X-ray exposure to the wrong site and one incident where a

consultant did not review an X-ray report, causing a delay in treatment. We discussed these incidents with the radiation protection advisor and found the ionising radiation dosage was so small, it did not require a notification in accordance with the Ionising Radiation (Medical Exposure) Regulations, 2000. The second incident was still under investigation but staff told us the hospital had already introduced a new process to ensure the error was not repeated.

- Staff understood their responsibilities to raise concerns and reported incidents using the hospital's electronic incident reporting system. Staff told us the system was easy to use and were able to show us the incident reporting policy, which was available on the intranet.
- In the outpatients department staff recorded some incidents in logbooks, rather than in patient records, which the manager reviewed for trends. The manager shared the learning from these trends with staff through daily briefings or via monthly department meetings. The incidents recorded in the logbooks included signs of surgical wound infection or suspected deep vein thrombosis. If a surgical wound infection or a deep vein thrombosis were subsequently confirmed this would then be reported using the electronic reporting system.
- Staff learnt and took action because of incidents to improve quality and patient safety. There had been an increase in reported incidents concerned with wrong labels being placed on patient forms, and wrong notes being placed in patient records. Management had identified this and introduced a new system called the '3 ok rule' to prevent further issues. The rule required staff to confirm name, address and date of birth with patients at different times. All staff we spoke with were aware of this new process, which showed effective learning had been shared with appropriate people. Managers had also set the '3 ok rule' as one of the hospital's safety goals.
- Lessons were shared to ensure action was taken to improve safety beyond the affected team. All physiotherapy managers in the BMI group attended weekly telephone conferences and discussed feedback from incidents. The acting manager gave an example of an incident that had occurred in a physiotherapy department in London where a patient had experienced a cardiac arrest within the physiotherapy clinic. The subsequent investigation had resulted in an action

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plans that included provision of additional equipment for each physiotherapy clinic and a system for monthly checking of the oxygen cylinders. This demonstrated that some learning from incidents was shared across the whole BMI group.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the hospital to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.
- Staff demonstrated awareness of Duty of Candour and we saw posters displayed in staff areas of the imaging department. Staff understood the principles of openness and were aware of when to apply Duty of Candour and what this involved.

Cleanliness, infection control and hygiene

- The hospital had commissioned a patient-led assessment of the care environment (PLACE) audit, carried out between February and June 2015. This audit rated cleanliness in the hospital at 99%, which was above national average of 98%. Consultation rooms in the outpatients and imaging department were tidy and looked clean on the days we visited the departments.
- Processes were in place to protect patients from hospital-acquired infections and the hospital had a good record for infection control. There had been no reports of *Clostridium difficile* or Meticillin-resistant *Staphylococcus aureus* (MRSA) between January and December 2015. There were systems in place to ensure the service screened patients for Meticillin-resistant *Staphylococcus aureus* (MRSA) in the pre-assessment clinic.
- We saw daily cleaning records completed by nursing and radiology staff in most areas. Staff cleaned the equipment in the consultation rooms every morning. There were green stickers attached to equipment with the date of cleaning, and these were up-to-date. Staff told us that any used trolleys or equipment that for an episode of care was cleaned before the next patient was called.
- There was antibacterial hand disinfectant gel available at the entrance to departments. There were hand washing sinks in most consultation rooms and posters displayed around departments to remind staff to wash their hands. Personal protective equipment such as gloves and aprons were visible and available in all the departments. The hospital reported good compliance with hand hygiene practice and technique, which they audited every other month. In their 2015 quality account, the hospital reported compliance was 95% for hand hygiene and 98% for applying the correct technique.
- Staff were mostly seen to be bare below the elbows. However, we observed one consultant who was not bare below the elbows wearing a long-sleeved shirt with cufflinks, when they examined a patient's wound. Their practice was witnessed but not challenged by nursing staff.
- Staff were dressed in clean uniforms and had their hair tied back. We saw some staff wearing belts with their uniforms and we were concerned that these could not be adequately laundered. The Royal College of Nursing (2013) recommend that uniforms are laundered at 60 degrees Celsius and that fabric containing Lycra may not endure thermal disinfection processes. We discussed this with the lead for infection control; they did not feel this was an infection risk because staff could wear an apron and cover the belt. We also reviewed the hospital's uniform policy but found there was no mention of belts.
- The hospital took precautions in the outpatients and imaging department, when seeing people with suspected communicable disease such as tuberculosis. The manager in the imaging department, told us they would be made aware of the risk prior to the patient attending. They would consult with the infection control lead and wherever possible staff planned the scan at the end of the day after all other patients had been seen. This meant the environment could be cleaned as appropriate afterwards.

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- However, the hospital did not always have safe systems and processes in place to monitor and improve practices when required. We reviewed the housekeeping cleaning audits and found that the daily cleaning schedule was not completed every day in any clinical area in the four weeks prior to our visit. The audit also showed that the once weekly cleaning schedule was not completed for any of the four weeks prior to our visit. This meant we were not assured that some cleaning, including spot cleaning of walls, doorframes, ventilation grills and high/low dusting was done and could therefore pose an infection risk to patients.

Environment and equipment:

- There were systems in place for maintenance and use of equipment. For example, an external company serviced all exercise equipment in physiotherapy and records showed this had been completed within the last 12 months.
- The hospital used outside contractors to update and calibrate specialist equipment in the outpatient department. We checked the asset register of all electrical equipment in the hospital and found a good record of appropriately tested and maintained equipment.
- Staff carried out daily and weekly checks to ensure safety of equipment. Staff knew what to do if a piece of equipment was failing. In one of the consultation rooms, we saw an ultrasound machine with a large sign to alert people that it was out of action. Staff told us they had reported this to the engineers and that they usually responded within a couple of days.
- There were processes in place to check resuscitation equipment. Cupboards with airway management aids and oxygen cylinders were in strategic places in Longwood House and these were checked weekly. The resuscitation 'grab' bag was kept in the main reception area and was checked regularly.
- However, the design, maintenance and use of facilities and premises did not always keep people safe. The floors in corridors were generally carpeted and we noticed some areas had stains. This showed that spillages could not always be cleaned effectively and could present an infection risk. In the clinical areas (imaging, phlebotomy, physiotherapy department and in the consultant rooms) the flooring was vinyl which meant they were easy to clean.
- There were holes in the wall in the imaging department's reporting room and there was peeling wallpaper in the eye laser treatment room on the second floor of Longwood House. This meant it would be difficult to keep free of dust and could pose an infection risk.
- Some of the furniture in the outpatient department were not conducive to best infection prevention practice. We saw fabric covered chairs, desks and lampshades that were difficult to clean and keep free from dirt and dust.
- Safe systems, processes and practices were not always monitored and improved when required. There was a potential increased fire risk in the eye laser treatment room. A risk assessment was undertaken and proposed mitigating actions included a fire safe method of covering mirrors and reflective metal surfaces and adding or confirming that blinds to cover the window were laser/fire proofed. However, staff could not confirm that the drape used to cover the mirror or the blind in the room was fire proof.
- The service used the treatment room for both minor surgical procedures and removal of plaster, which could compromise the suitability of the room for both types of procedures. However, staff said removal of plasters hardly ever happened and if it did, it was scheduled at the end of the day and the room would be thoroughly cleaned afterwards.
- We spoke with the radiation protection advisor (RPA) and medical physicist. A local NHS trust provided both these services via a service level agreement (SLA). The RPA was legally responsible for ensuring maintenance of the quality assurance testing, patient dose audits and staff dose audits. We saw records to demonstrate these were all up to date and within acceptable ranges.
- Records demonstrated that the X-ray and scanning equipment was tested for quality assurance every year and the equipment was risk assessed every other year. The risk assessments were all in date and in line with

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recommendations from the Ionising Radiation (Medical Exposure) Regulation 2000. Radiation protection Advisor (RPA) stated he had no concerns regarding the imaging equipment at the hospital.

- There were processes in place to control the area and restrict access to the imaging rooms. The MRI screening room had keypad access only to restrict unauthorised access and avoid accidental access during screening. We saw risk assessments and local rules for all the imaging equipment. Local rules are a summary of instructions for staff to restrict exposure to radiation in areas where diagnostic screening procedures are carried out. This conformed to specifications in the Ionising Radiation (Medical Exposure) Regulation (2000).
- Staff had access to lead coats and these were assessed yearly to ensure compliance with recommendations. Staff carried thermoluminescent dosimeters, which monitored dosages of radiation exposure to staff. These were sent to Health Protection England every two months to be examined. Reports were displayed on a staff noticeboard and confirmed radiation exposure was within safe limits.
- Within the plain film x-ray rooms there were screened off areas from where the staff could operate the machine. For CT and MRI screening there were separate 'control rooms' from where the staff could safely operate the equipment.
- The radiologist consultants spoke of the ability to report remotely and found the equipment at the hospital to be good with an on-going replacement programme. Radiology consultants told us they enjoyed working with up to date, well-maintained equipment.
- The imaging department had no office for the manager to work in and they often had to use the CT control room as an office. This meant there was no secure storage for records, work was constantly interrupted due to the scans taking place and there was poor lighting, which all made it difficult for them to complete tasks.
- The storerooms we looked at were clean and tidy and we did not find any out of date items. Staff were aware of stock rotation processes and no excess stock was stored.

- The hospital had arrangements for managing waste to keep people safe. There were clinical waste bins and domestic waste bins in all rooms and staff segregated waste appropriately. There were sharp bins in rooms as required and these were not overfilled.

Medicines

- Medicines were stored in a way that kept people safe from avoidable harm. Medicines were stored securely and at the right temperature. Medicines were kept in locked cupboards and the keys were securely stored in coded key safes, which only registered nurses had access to.
- We did not find any surplus stock or out of date medicines and there was a pharmacy onsite to help staff with any queries. There were no controlled drugs stored in any of the clinical areas within the outpatient and imaging department.
- An auditable system was in place for the management of blank private prescriptions. Pharmacy staff issued prescription pads in packs of 50 to locations along with numbered audit sheets on which to record usage. The pharmacy department reviewed and managed the prescription pads. The pharmacy manager knew the anticipated number of prescriptions and issued two or three prescriptions at a time to consultants at the beginning of outpatient clinics and any unused prescriptions were booked back in.
- Fridge temperatures were monitored and within safe range. We saw records for daily checking and staff had not identified any concerns. Staff knew what to do if the temperatures were outside of the recommended range and explained the process.
- Emergency boxes, containing medicines to be used in case of severe allergic reaction, were available in the travel clinic and CT scanner room. These were the areas where risks of an allergic reaction were higher due to the intravenous injection of contrast medium and travel vaccinations. Staff knew the signs of an allergic reaction; in the imaging department staff told us about an incident where a patient had an allergic reaction to contrast medium injected for the CT scan. Because of the incident, staff in the imaging department left the cannula in longer to ensure instant intravenous access in case of an emergency.

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- We observed a care episode where a patient attended the pre-assessment clinic, we observed the nurse discussing the patient's medication with her in detail, asking and answering questions.

Records

- Individual care records were not managed in a way that kept patients safe, as the service did not keep single care records for patients attending the outpatients department. Staff completed separate records in different locations; this prevented other staff from reviewing patients' complete care histories. For example, when staff discharged a patient from the surgical ward, the care records was archived. If the patient attended a follow up appointment, the nurse recorded the interventions in a logbook. There were five different logbooks used for different concerns, or to capture care episodes, each containing multiple entries that referred to various patients who had attended. Nursing staff completed a continuation sheet if complications occurred or additional treatment was required. These sheets were stored in a separate ring binder in the outpatient office. However, there was no system for staff to identify if a patient had attended an outpatient appointment previously and therefore retrieve treatment information recorded in the logbooks or in the continuation sheets. On discharge from the outpatient's department, staff filed the continuation sheet in the patient's hospital notes, which were separate from the consultant's notes. This meant there was a risk to patient care and treatment as it was necessary to collect information from more than one source, and this made corroboration of the information difficult and possibly inconsistent. However, all entries were legible, dated and signed.
- Medical records were stored securely in locked cupboards in an office accessible by key-code. It was the responsibility of the consultant's secretary to get the records out and available on the day of the clinic. The consultant wrote up or used digital dictation to write their medical notes. The consultant's secretary transcribed the dictation and stored the consultant's notes securely in the medical secretaries' office.
- The hospital had a guidance document for the safe storage and filing of health records. This guidance stated patient records may only be accessed by authorised clinicians. However, staff did not seem to know whom to

contact in the event that medical records were needed. The guidance also stated that health care records were not allowed to be removed from the hospital unless requested by coroner's office.

- In the radiology department, all patient records were electronic. Staff in the imaging department scanned referrals into a computer programme. This meant the radiologist reviewing the images had access to all required information when reporting on an x-ray image. There was a list of authorised referrers and the referrals were audited to ensure they held the correct information. This was important to enable the radiographer to justify the screening with ionising radiation. This is a legal requirement for safe practice according to the Ionising Radiation (Medical Exposure) Regulations (2000). The electronic system was password protected and computers had screens to prevent others reading confidential information about patients.
- There were systems in place to monitor processes for the safekeeping of medical notes. The hospital carried out annual audits in each department for safekeeping of medical notes. We saw audits carried out for each of the departments once in the period from April 2015 to April 2016. The audits confirmed compliance and highlighted where practice could be improved.
- Documentation audits were not completed for outpatient physiotherapy notes. However, all physiotherapy discharge summaries were completed and were sent to the patient's GP.
- Staff rotas in the outpatient department, were prepared a week in advance to reflect the number of clinics and patients and they were written in pencil as amendments were required frequently. This did not comply with guidance for keeping rotas set out in the Department of Health: NHS Code of Practice: Records Management. It is a requirement to keep documents related to rostering for four years and these should be completed in ink.

Safeguarding

- The hospital had systems and processes in place to safeguard adults. There were no safeguarding concerns reported to the CQC in the period from January to December 2015. The hospital had a safeguarding adult's policy, which incorporated mental capacity, deprivation of liberty and 'prevent' which forms part of the government's counter-terrorism strategy. The clinical

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director was the named safeguarding lead. The policy did not specify the level of safeguarding training for the safeguarding lead or clinical staff. A named lead for adult safeguarding and child protection had undertaken safeguarding training to level 3 for both adults and children. However, there was no policy to cover the protection of children under 18 years of age.

- Staff received training in adult safeguarding and knew how to raise a safeguarding concern with senior managers. The hospital did not submit data specific to each department; however, 98% of staff in the hospital had completed safeguarding training. Safeguarding training was delivered via e-learning. Registered healthcare professionals such as consultants, radiologist, nurses and radiographers had undertaken level two safeguarding training and healthcare assistants and other support staff had undertaken level one safeguarding training.
- The outpatient and imaging department had 219 appointments for young people 16-17 years of age in the period from January to December 2015. The Royal College of Paediatrics and Child Health has published guidance (Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2014)), which sets out minimum training requirements for healthcare professionals working with children and young people. The guidance recommends that all clinical staff, who are in direct contact with a child or a young person, is trained to level two in children's safeguarding and that the named lead is trained to level three.

Mandatory training

- Staff received mandatory training. The training was a mixture of face-to-face and online training via the BMI Learn system. The online training sessions were easy to access and staff found the sessions met their needs.
- Compliance with mandatory training requirements was less than their 90% target compliance rate. Although for hospital the overall compliance was above this target. Compliance with mandatory training in outpatients was just below the hospital's target for compliance at 88.9%. In diagnostic imaging compliance was at 93.98%. However, in the physiotherapy department compliance was 82%. We spoke with the acting head of department

who explained this included some staff who were new and had not been in post long enough to have completed their training. Staff told us staffing numbers made it difficult to access face-to-face training.

- Data provided by the hospital prior to the inspection, showed compliance with fire training was 88% and for basic life support, the compliance was 67%. Staff told us that staffing numbers made it difficult to attend face-to-face training. These figures included staff who had left the hospital, and others who were on maternity leave. The hospital did not have data available that only included those staff required to undertake each topic.

Assessing and responding to patient risk

- There was a daily safety briefing in the outpatient department where the numbers of patients and clinics, staff allocation and any equipment or other safety issues were discussed.
- In the imaging department, there was a service level agreement with a local NHS trust to ensure access to a radiation protection advisor (RPA) for advice. There were three appointed radiation protection supervisors (RPSs) at the hospital covering each clinical area. The RPSs acted as a link between the RPA and the hospital, they were responsible for updating local rules and oversee safe procedures.
- We spoke with staff in different clinical areas about actions to take in the case of a medical emergency. Staff knew how to raise the alarm, access emergency equipment and who they would expect to attend.
- In the imaging department, staff explained the procedure to follow in the case of a patient suffering a cardiac arrest while in the MRI scanner. The imaging department had an emergency bay where the patient would be taken, under the instructions of the MRI scanner staff. This procedure was necessary due to the hazardous environment in the scanner room. There was always a resident medical officer on duty in the hospital who was trained in advanced life support.
- In physiotherapy, there were buzzers that staff could use to call the cardiac arrest team. A life support bag was available in the department and staff checked the equipment weekly.
- Staff carried out comprehensive risk assessments for patients. We observed a care episode in the

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pre-assessment clinic where the nurse identified a possible risk to the patient. The patient had a planned tooth extraction prior to her surgery and the nurse discussed the risk of infection. The nurse explained to the patient she needed to speak with the consultant and arranged for the patient to ring the pre-assessment unit the following morning to find out if her surgery needed to be postponed. The nurse also identified a potential risk associated with a medicine the patient was taking and said she would confirm with the patient via telephone the next day if any additional precautions needed to be taken.

- Nurses had an awareness of actions to take if there were signs of a deep vein thrombosis (DVT). The nurses told us they would contact the resident medical officer or the consultant to review the patient. They would tell the patient to access the accident and emergency department at the local NHS hospital to receive treatment.
- Staff in the pre-assessment unit followed specific care pathway to determine which patients required deep vein thrombosis (DVT) prophylaxis, depending on their surgical procedure. We saw a nurse giving a patient specific post-operative advice about DVT prevention.
- Staff in the imaging department used the 'six ok's' to minimise errors of wrong identity, wrong site exposure or radiation exposure to pregnant women. Staff carried out three further checks to ensure safe exposure to radiation. These were justification of exposure (radiographers would check the clinical reason for exposure and that the patient had not had a recent x-ray in another hospital), monitor optimisation (a term used to capture the lowest radiation exposure to gain the optimal x-ray for safe reporting) and check the referrers signature from an authorised list. We reviewed some of the audits from July 2015 to April 2016 and found good compliance.
- There were adequate signs and information displayed in the imaging department, informing people about areas and rooms where radiation exposure took place. Staff called patients in from an adjacent waiting area this meant that the number of people in the imaging department were kept to a minimum and thus reduced the risk of accidental entry to imaging rooms in use.

- In the physiotherapy department, there were no treatment plans or goals documented and no evidence of a holistic assessment approach. This meant there was a risk that staff treated patients' physical conditions without consideration for emotional needs.

Nursing and allied health care staffing

- There is no recognised tool for managing skill mix in the outpatient department. There was a high reliance on bank staff to run clinics. Managers told us, using bank staff enabled them to respond to varying levels of staffing requirements according to the number of clinics running. Bank staff were from an established pool of nurses and received the same training and appraisals as contracted permanent staff. The executive team told us the aim was to staff outpatients with 80% permanent staff and 20% bank staff. It was difficult to check rotas to confirm this as rotas did not clearly identify who were permanent staff and who were bank staff. However, running the service with a high reliance on bank staff could compromise the efficiency due to potential lack of skills, experience or availability.
- The manager in the outpatient department was the only full time registered member of staff. When we asked who would be able to support or deputise in their absence there was no clear plan. All other members of staff in the department had part time contracts.
- The physiotherapy department could not meet some outpatient commitments due to staff shortages. There was a triage system in place to ensure high priority patients were seen without delay. However, at the time of our inspection, there was a two-week waiting list for routine outpatient physiotherapy.
- There were 6.6 full time equivalent radiographers working in the imaging department and no vacancies. Three of the radiographers had the additional responsibilities of acting as radiation protection supervisors.

Medical staffing

- The hospital had 161 doctors working under the rules of practising privileges in private independent practice.
- A resident medical officer (RMO) provided medical cover at all times via a long-standing agreement with a specialist agency. The RMO was available at all times. There was a primary RMO who undertook most of the

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rota and they were based on the hospital site. The RMOs were trained and competent in clinical emergencies such as advanced life support. The RMOs could also administer contrast agents in the imaging department in an emergency or out of hours.

- There were 18 consultant radiologists working under the rule of practicing privileges. They were all part of a cooperative Bath Radiology Group providing cover for the hospital and working in the nearby NHS trust. They covered on-call rotas and out of hours cover. This meant the entire consultant radiologists were used to working together and the arrangements offered an opportunity to provide cover in unforeseen circumstances so clinics could carry on. The NHS trust ensured their appraisal and development including revalidation, and this fed into the hospital's governance processes around practicing privileges.
- There was a system in place to ensure that consultants only carried out work that they were skilled and insured to carry out. Information including disclosure and barring service (DBS) checks, indemnity insurance, information about appraisals, revalidation, registration with the GMC and self-declaration forms were collected.

Major incident awareness and training

- In the imaging department, there were 'work instructions' for the screening equipment in case of radiation incidents. These incidents could be failure of equipment or unintentional exposure to radiation. There were policies outlining responsibilities and staff were knowledgeable about what to do in the case of an emergency. Staff we spoke with knew how to report and investigate radiation incidents, including notification to outside agencies, in the case of a radiation incident.
- There was a backup generator in case of failure of electrical supply. Engineers tested the generator monthly and staff received warning of the generator test so they could plan imaging procedures around the momentary loss of electrical supply. All imaging equipment could be switched off manually to allow patients to be safely removed in the event of a complete power failure.
- The hospital had a corporate business continuity management policy, which included 19 action cards. These cards provided a framework for staff to take

appropriate action in the event of interruption to services. These interruptions included loss of electrical supply, sewerage services, adverse weather conditions and other environmental disruptions.

- The treatment room for eye laser treatment was on the second floor. There were two flights of stairs or a lift for patients to access the second floor. Staff confidently discussed actions to take in case of a fire and the fire evacuation route, which was down the main staircase as the lift would not be safe to use in the event of fire. We checked that all the doors were fireproof doors and that fire extinguisher were in place and tamper proof. However, there was no alternative fire exit on the second floor and staff were unsure how to safely evacuate people with poor mobility in the case of fire. We raised this concern at the time with the health and safety officer in the hospital.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

The effectiveness of outpatients and diagnostic imaging was not rated due to insufficient data being available to rate these departments' effectiveness nationally. On inspection we found:

- The service delivered care and treatment based on national guidance.
- Multidisciplinary teams worked together in the 'one stop' breast clinic.
- The physiotherapy department covered inpatient care seven days a week
- There was an effective on call rota for imaging staff that ensured emergency screening could take place out of hours.
- Information security audits confirmed records were stored securely.
- Staff obtained consent before treatment interventions however, this was not always documented

However:

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- The imaging department did not have standard operating standards for all procedures in line with the recommendations set out in the National Safety Standards for Invasive Procedures.
- The service did not collect patient outcome data or evaluate the effectiveness of care and treatment delivered.
- We saw examples of assess competence for individuals but a clear overview was not demonstrated.
- Consultants did not consistently issue a discharge letter to patients. This meant that in an emergency other healthcare professionals would not have access to information about a patient's recent health.
- Staff meetings did not happen regularly in all departments.
- Staff had limited knowledge of legislation about Deprivation of Liberty and the Mental Capacity Act.

Evidence-based care and treatment

- The service used evidence-based guidelines to inform how care and treatment was delivered. For example, staff in the pre-assessment unit (PAU) carried out routine pre-assessment tests for elective surgery, in accordance with guidance from the National Institute for Health and Care Excellence.
- Staff in PAU used standardised care pathways for surgical procedures which included an evidence-based enhanced recovery programme.
- PAU staff followed best evidence-based practice in accordance with the Joint United Kingdom Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee, when taking a blood test for cross match in the eventuality a blood transfusion was required.
- Staff in the imaging department, demonstrated how they followed guidance from the Royal College of Radiologists for the prevention of contrast induced acute kidney injury in patients who required contrast for CT scans.
- Staff used a moderated version of the World Health Organisation (WHO) checklist when carrying out minor procedures. The WHO checklist is a nationally recognised tool to enhance safer surgery. We saw the

checklist in the treatment room, in phlebotomy and in the imaging department. However, nurses and managers in these areas did not audit compliance with the use of the checklist and were not aware of why they were brought in. This demonstrated that learning from other departments or corporate learning was not always shared effectively to all members of staff and there was a lack of awareness of best practice. We heard of one manager who had attended 'human factor training' in September 2015. Other staff we spoke with were not aware of what this training was.

- Staff in the imaging department used diagnostic reference levels to optimise radiation exposure. Optimisation refers to the lowest dosage of ionising radiation given to achieve the best diagnostic image. There are nationally recommended dosages for different plain film x-ray; a list of these were on display in the x-ray room.
- In the imaging department, there were standard operating procedures for some procedures although local protocols had not yet been developed in line with the recommendations in the framework for National Safety Standards for Invasive Procedures. The framework recommends that local safety standards for invasive procedures are introduced to enhance patient safety. The department had a box with hand written cards to assist staff in setting up trolleys for procedures. These cards did not include information about best evidence-based practice. This meant that best guidance may not always be followed and patients' safety put at risk.
- At the time of our inspection, the imaging department had started working towards Service Accreditation Scheme (ISAS) accreditation. However, this work had only recently started. Accreditation is not mandatory but helps to improve clinical governance standards, raises the level of competency and enhances the credibility of the service amongst patients.
- The BMI physiotherapy lead had set up special interest groups within physiotherapy. These groups were forums where therapy staff discussed the latest evidence base for specialist aspects of their profession. The occupational therapists attended the BMI occupational therapy special interest group.

Pain relief

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- Staff were rarely required to administer pain relief due to the nature of the clinics. However, nurses asked patients about pain during appointments. Nursing staff informed the consultant if the patient had complained of pain to them.
- During a consultation, a patient described their pain in detail and the consultant gave reassurance that this level of pain was 'normal'. However, no formal pain scale was used to measure the patient's perception of pain.
- We observed a physiotherapist consultation with a patient where pain was discussed in depth and formed part of the review of patient progress however, no standardised scale was used to measure pain.

Nutrition and hydration:

- Patient's nutrition and hydration needs were met. There was provision of free hot and cold drinks in two waiting areas. Where delays in clinics happened, staff offered to collect refreshments for patients.

Patient outcomes

- The service did not collect outcome data routinely. This meant the service could not evaluate how effective treatment was. One surgeon explained that he collected outcome data for every patient however, the data was not used by the hospital or by the BMI group.
- Staff in the physiotherapy department had recently started (from April 2016) to collect data for national audits known as Patient Reported Outcome Measures (PROMs). The specific audit was a standardised measure of health status also known as 'quality of life questionnaire'. Staff used this questionnaire at the initial assessment and again when they discharged the patient, to assess if the treatment had had a positive effect on the patient's lifestyle. It was too early for staff to evaluate the results.
- We observed a physiotherapist considering the vocational needs of a patient during his treatment session. If an outpatient treatment extended beyond six weeks, the physiotherapist conducted a review of the notes in collaboration with a peer in order to determine if the most effective treatment options had been considered.

- Accreditation is not mandatory but helps to improve clinical governance standards, raises the level of competency and enhances the credibility of the service amongst patients.

Competent staff

- At the time of our inspection, all doctors working under practising privileges in the hospital had registration with a professional body, indemnity insurance and an up to date Disclosure and Barring Service check. Patients could search the hospital website for more information about consultants.
- Each consultant had a biennial review with the executive director. This looked at any issues that had arisen and was discussed and approved by the Medical Advisory Committee.
- All staff administering radiation were appropriately trained to do so. The service did not have any students or radiographer assistant practitioners.
- We saw examples of assessed competence for individuals but the manager did not demonstrate a clear overview of competence assessment within the outpatient department.

Data provided by the hospital prior to the inspection showed compliance with training in applying 'aseptic non touch technique' (ANTT) was 68%; however this was for the whole hospital and not specific to each department.

- All staff had received a recent appraisal. Staff were encouraged to undertake development but this was not often supported with study time or paid for (or paid for in parts) by the hospital. This meant that development opportunities were not equitable and staff found it difficult to attend extended learning in addition to their job.
- The physiotherapy team organised monthly in-service training sessions covering a variety of topics, including demonstrations from equipment suppliers and informal 'question and answer' sessions with an orthopaedic surgeon.
- The physiotherapy manager was covering the role in an 'acting up' position and had attended a 'new managers'

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one day course run by BMI. She felt well supported by the physiotherapy lead for the BMI group who had helped her to understand the requirements of her new role.

- An occupational therapist had set up a local continuing professional development group that included all occupational therapists working in the geographical area, i.e. NHS staff as well as other independent healthcare providers.
- In addition to the radiation protection advisor in the imaging department, there were three radiation protection supervisors (RPS) as recommended in the Ionising Radiations Regulations (IRR'99) Guidance. The role of the RPS was to act as link between the hospital and the radiation protection advisor, to offer support and advice, and to ensure that staff adhered to local rules.
- The hospital introduced eye laser treatment to the portfolio of services in December 2015. The health and safety manager and the laser protection advisor carried out a risk assessment in preparation for the eye laser treatment. It is a legal requirement of the Medicines & Healthcare Products Regulatory Agency (MHRA) that there is an appointed Laser Protection Advisor (LPA). The services of the LPA were provided by a local NHS trust via a service level agreement. The MHRA also recommended the appointment of a Laser Protection Supervisor (LPS), however, staff were not aware of who the LPS was. The role of the LPS is to update local rules, ensure safe practice is followed and to act as a link between the LPA and equipment users. Without the knowledge of who the LPS was, it was unclear who would take on this responsibility.
- One registered nurse and three healthcare assistants had undertaken e-learning and passed a multiple choice questionnaire to assist with eye laser treatment. Only four eye laser treatments were performed in the period from December 2015 to end of April 2016; there could therefore be a risk that staff were unable to safely maintain competence in assisting the consultant due to the low number of treatments.
- Resuscitation practice scenarios were arranged approximately every eight weeks. The scenarios were staged all over the hospital grounds, including the outpatient area and the radiology department. While

the resuscitation lead could demonstrate these had taken place regularly not all members of staff were involved. One member of staff had been employed for more than ten years and had never attended one of these events.

Multidisciplinary working

- Care was delivered in a co-ordinated way. For example, staff in the pre-assessment clinic arranged appointments with different healthcare professionals, including consultants, physiotherapy, occupational therapy, phlebotomy and imaging, to ensure a smooth flow and time efficient visit for patients.
- Staff worked together to assess and plan on-going care and treat. Physiotherapists were able to contact consultants to discuss treatment options. They described a proactive approach from consultants who wanted to ensure that patients received the best possible physiotherapy outcomes.
- Processes were in place to establish if patients had had recent X-rays ordered by their GP or carried out in another hospital facility. This process meant the risk of unnecessary exposure of ionised radiation to patients was reduced and formed part of the required justification practices within radiology.
- Two radiographers in the imaging department were responsible for delivering mammography screening. This service was integral to the 'one stop breast clinic' for women with suspected breast cancer. Their service ensured patients could access mammography and ultrasound scans to aid the consultant to make a diagnosis on the same day. Dedicated radiographers would carry out the screening and the radiologist would report on the findings on the same day. These meant women would get a diagnosis on the same day and with the support of the wider support team including a consultant and a special breast cancer nurse

Seven-day services

- The outpatient service did not offer a seven-day service except for occasional Saturday clinics. There had been two Saturday clinics this year so far one in February 2016 and one in March 2016.
- Outpatient physiotherapy and outpatient occupational therapy was provided on weekdays only.

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- The consultant radiologist and radiographers provided on call cover out of hours and at weekends and could report on scans remotely. This meant that emergency scans could be carried out on site and helped inform treatment plans even though there was not a seven-day service in the imaging department.

Access to information

- Medical information needed to deliver effective care and treatment was not always available from consultants in the outpatient department. Staff told us that it was unlikely that access to consultant's notes would be required in emergencies, given that these records were for private outpatients, and it was unclear how and if this was possible.
- On discharge from the hospital, the secretaries sent a discharge letter to all patients' GP with information about care and treatment the patient had received. We learnt that not all consultants provided a discharge letter to patients but sometimes a summary was generated by nurses at the point of departure from the outpatient department at the hospital.
- Consultants were able to view an electronic system that enabled them to access patients test results including tests carried out by GPs.
- To ensure sufficient information was available, nurses in the outpatient department had to access three different software systems to gain information about a patient prior to an appointment. Nurses told us this was a time consuming task.
- Staff in the imaging department scanned all referrals for imaging and attached these to the imaging scan. This meant that the radiologist had all the information they needed when reporting on images or scans.
- There was a good understanding amongst staff on how to maintain confidentiality with written and digital information about patients. Information security audits from June 2015 to April 2016 looked at safe storage and risk that confidential information could be visible to persons who had no right to view the information. Within outpatients and imaging, seven areas were audited on eleven measures and results demonstrated good compliance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- People were supported to make decisions about their care and treatment. We observed a surgeon during an outpatient consultation clearly explaining all aspects of a forthcoming operation in the process of documenting consent.
- There were processes in place to obtain consent in the imaging department. Staff explained verbal consent was obtained before any intervention and in the imaging department this formed part of the 'six ok's'
- In the outpatient department there were processes in place to obtain consent for clinical procedures such as eye laser treatment and minor surgical procedures, the consultant obtained written consent.
- We reviewed eight sets of physiotherapy outpatient records for patients who had completed their course of treatment and been discharged. Consent for all care and treatment interventions should always be obtained before commencement of any intervention. We saw that although staff did document consent gained for specific treatments such as aquatic therapy or acupuncture, staff had not consistently documented consent for more generalised physiotherapy assessment and treatment.
- We asked staff about their awareness of Deprivation of Liberty and Mental Capacity Act; most staff had awareness but stated it was not something they came across at the hospital. Staff showed us a consent form they would use if the patient did not have capacity to consent; they also told us where to find the policy online to follow in these cases.

Are outpatients and diagnostic imaging services caring?

Good 

We rated caring of the outpatient and diagnostic imaging services as good because:

- We observed caring and kind interactions between staff and patients.
- The service had good provision of chaperone services and all chaperones were trained and competent.
- Patients told us they were always treated with dignity and respect.

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- Patients told us that confidentiality was always upheld.
- People were involved with arranging appointments to suit their needs and circumstances.
- Staff discussed questions about fees openly with patients.
- The service gave patients extensive information about their care and treatment so patients could make an informed decision about their care.

However,

- There was not a holistic approach to patient care in the physiotherapy department with regards to emotional distress.

Compassionate care

- Staff took time to interact with people. We observed interaction between patients and different staff groups in all clinical areas of the outpatient and imaging departments. Staff cared for and responded to patient's needs in a kind manner.
- Staff introduced themselves to the patient and obtained verbal consent for us to be present. This meant that despite our presence staff upheld patients' preferences and dignity. Patients told us they were always treated with privacy and dignity.
- Staff told us they enjoyed having time to speak with patients and this made care person-centred. This meant that they could answer questions from patients and offer reassurance.
- Staff ensure dignity and privacy was maintained. For example, they ensured screening with curtains when patients got changed and providing blankets or towels to protect their modesty. However, not all consultation rooms had a curtained area.
- In the physiotherapy department, there were signs on the doors to consultation rooms that indicated the room was in use. There was one lockable room used for women's health physiotherapy.
- There was a chaperone policy, which stated that all patients should be offered a chaperone. We saw posters to inform patients of chaperone services. Nursing staff had chaperone training and a logbook to log all patient

encounters where a chaperone had been present. These details included the patient details, the nature of the clinic attended, who the consultant was and who the chaperone was.

- Some consultants would always ask for a chaperone while other consultants did not think it necessary however; this was appropriate and proportional to the examinations undertaken. For example, there would not necessarily be a chaperone present for the examination of the feet whereas for more intimate examinations or procedures a chaperone would always be present.
- In the imaging department, there were changing areas for patients where they could get undressed behind a locked door and with a lockable locker to store their belongings. However, the patients then had to walk through the imaging waiting area wearing a hospital gown. Staff told us their aim was to reduce the time the patient had to wait in the waiting area after they had put on the gown. The hospital had a policy for 'provision of same sex accommodation' but there were no specific reference to the imaging department.
- Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. A member of staff in the imaging department told us of a patient who had attended for an x-ray. The patient told the staff member that he was a carer for his wife. The staff member was concerned about his welfare so she completed additional checks to make sure he was in receipt of support services he needed.
- Staff respected confidentiality. Patients told us confidentiality was 'first rate'. We found that staff maintained patient privacy and confidentiality as far as possible and consultations were held in single rooms with the door closed.
- The hospital scored high in the family and friends test but the response rate was variable at 23 to 62% in the period from July to December 2015.

Understanding and involvement of patients and those close to them

- Staff communicated well with patients so that they understood their care, treatment and condition. We observed nurses in the outpatient department give clear explanations prior to any intervention and in response to questions the patient asked.

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- In January 2015 the patient assessment unit (PAC) introduced a protocol where all day case patients would attend a 30 minute appointment with a nurse. The nurse undertook pre-operation baseline observations and infection control screen but this also meant that patients had the opportunity to ask questions and receive reassurance.
- Physiotherapists gave clear verbal explanations and demonstrations of their exercise programmes and this was followed up with written instructions that were emailed to the patient. Physiotherapists checked the patients understanding several times during the consultation.
- We asked staff what made care 'person-centred' and staff told us that having the time to explain and answer questions without feeling rushed and ensuring patients had contact details so that they could phone if they had any concerns. Staff also told us that the consultants were supportive and took time to speak with patients.
- We observed a patient consultation with a surgeon. The surgeon offered the patient various options for the timing of their operation that would suit their schedule. The patient made the decision. The surgeon also gave clear verbal information regarding expectations of the recovery period.
- We spoke with one patient's partner who said that she had been involved in all aspects of the patients care. Staff gave her information and support.
- Medical secretaries and staff in the admissions office explained they had sensitive discussions about fees over the telephone prior to patients coming in for their appointments so that patients knew what was included.
- We observed a patient asking the doctor in the health assessment clinic about additional costs of a recommended further investigation. The doctors was reassuring and open about the added cost and explained it would be covered by the patient's health insurance as it was a medical issue that had been picked up in the health assessment. The doctor also encouraged the patient to double check with the insurance company so that they could make an informed decision.
- Staff understood the impact a person's care, treatment or condition could have on their wellbeing and on those close to them. We observed a consultation where the patient displayed some concerns about the result of a health assessment where further investigation was recommended. The doctor gave a detailed explanation of the findings, the possible causes and what it meant for the patient's future health. The doctor offered opportunities to ask questions; answered openly and checked the patient's understanding.
- We observed a consultant and a nurse responding to a patient's use of humour. They used banter to help them cope with the anxiety they were feeling following a recent operation.
- During our inspection, a member of staff from the imaging department attended the funeral of a patient they had seen often and regularly in the department. This showed that staff cared for their patients and their next of kin with real compassion and went the extra mile to show support for the family at a difficult time
- We observed a surgeon giving reassurance to a patient during an outpatient consultation and explaining that she was welcome to contact him again prior to her operation if she required further explanation.
- However, patient's emotional needs were not always met. We saw in a physiotherapy record that a patient had described feeling moderately depressed in their initial assessment, but there was no care plan to address this concern. In another patient's physiotherapy record, a recent bereavement was noted in the initial assessment form, but no further reference was made to this.

Are outpatients and diagnostic imaging services responsive?

Good 

We rated the outpatient and diagnostic imaging services as good for responsive because:

- Reception staff helped patients as required and the waiting areas were bright and comfortable.
- Patients had a choice of appointments to suit their needs.

Emotional support

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- Patients did not wait long on the day of their appointment.
- Referral to treatment time exceeded targets and meant that 100% of patients were seen within 18 weeks from referral.
- The hospital had a complaint policy and handled complaints in a timely manner. There was some evidence the service made changes because of lessons learnt from complaints.

However,

- There was limited evidence and awareness of the environment meeting the needs of individuals with dementia, visual impairment or learning disabilities.
- Waiting time for appointments in the physiotherapy department had increased due to staff shortages.

Service planning and delivery to meet the needs of local people

- The environment was not always appropriate and person centred. The outpatient department was in a building known as Longwood House and spread over three floors. There was a lift to aid patients with poor mobility but the lift was very small and wheelchair access in the lift was very tight. The colours and surfaces were not designed to meet the needs of people with visual impairment and this was made more difficult by poor lighting in these areas. However, consultation rooms were bright and spacious with adequate room for wheelchair access.
- The main hospital reception area was welcoming and bright. It was clean and tidy and had seating areas with magazines, free refreshments and toilet facilities. Reception staff were professional and greeted patients with a smile. They offered help immediately and directed patients to the appropriate area or on occasions escorted the patient. There were also signposts to give direction to different departments. There was a children's play area in the waiting area by the imaging department.
- There were plenty of free parking places. Patients who did not drive to the hospital told us that the reception

staff called a taxi on their behalf. We spoke with reception staff who were knowledgeable about public transport options for patients travelling to and from the hospital by public transport.

- We spoke with patients who told us they were happy with their care and treatment because the hospital had changed appointment to suit their needs and preferences, patients had 'a lot of faith' in the hospital and the staff and they received follow up telephone calls from the consultant, which they 'very much appreciated'.
- The need for alternative format of information sent to patients prior to admission was not assessed, this included the need for information in other languages. The information contained leaflets about infection control and prevention, deep vein thrombus prevention, a guide to pain relief, general information leaflet, a dietary needs questionnaire and a health questionnaire. This meant it could not be assured that patients had access to the correct format of important information.

Access and flow

- People had timely access to initial assessment, diagnosis and urgent treatment. We reviewed the referral to treatment (RTT) waiting times and found that they exceeded target, which meant that between 96% and 100% of patients were seen within 18 weeks of referral in the period from January to December 2015. Most private patients got an appointment within two weeks and NHS patients were seen within six weeks from referral.
- Patients were often able to access care and treatment at a time to suit them. Staff in the booking office explained they were usually able to change appointments to meet patients' preferences for dates/times. Clinics were rarely cancelled, and only in the event of consultant sickness. We observed a consultant discussing preferred time for treatment and the expected recovery time, with a patient during a consultation. Patients told us they received timely information and appointment letters.

Staff in the pre-assessment unit had developed a system where patients had their journey mapped out to reduce the waiting times between different clinical areas and to reflect the number of different pre-surgical assessment the patient needed. For example, appointments would be booked to see physiotherapist,

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obtain ECG, X-ray, have bloods taken and meet with a nurse, prior to attending the pre-assessment unit for an appointment with the consultant. This ensured a smooth and efficient flow.

- The hospital did not record or display how long patients were kept waiting in the departments once they had arrived for their appointment. Staff were mindful of waiting times and ensured explanation was given and offered patients a refreshment while waiting. On the days, we inspected the service; we did not see crowded waiting areas. Most patients we spoke with had arrived early for their appointment and one person told us that their appointment was running ten minutes late.
- 'Did not attend' (DNA) rates were monitored. From October 2015 to March 2016 the average DNA rate was 4 % but it was not clear how the hospital used this information.
- At the time of our inspection, patients requiring physiotherapy outpatient appointment were experiencing a longer wait of two weeks instead of the usual 24-48 hours. This increased wait had developed over two months whilst the service was short staffed. Recruitment was on-going to fill vacancies. .

The physiotherapy department were not able to accept physiotherapy students or employ junior staff because insurance companies often stipulated that only experienced staff provided the physiotherapy input to their clients. This had limited their capacity to recruit.

- Bookings staff sent text messages to patients to remind them of their clinic appointments.

Meeting people's individual needs

- Patients spoke of the relationship they had with the consultant, the ability to have a long consultation and how this made them feel reassured and fully informed of the procedure and the plan.
- The hospital provided appropriate support for bariatric patients. Bariatric equipment could be obtained through liaison with the physiotherapist and occupational therapist. Care and treatment was discussed with the ward manager, theatre manager and the anaesthetic team, this meant that there was a

multidisciplinary approach to meet the needs of the patient. However, the hospital did not carry out surgery on patients with a body mass index (BMI) greater than 40.

- We were told of other examples where the hospital had acquired additional equipment to meet patient needs. For example, a movable compression plate for the breast mammography scanner meant that the scanner could be correctly adjusted to fit patients of all different torso lengths.
- The reception area held an information sheet with information about how to obtain the services of an interpreter (language) or access support for hearing and/or vision impaired patients if required. Staff were aware of this service.
- However, the hospital did not always plan and take account of people with complex needs such as dementia. Staff was unable to give us any examples of reasonable adjustments to make the environment dementia friendly. Staff told us they received dementia training via e-learning. We spoke with one member of staff in the outpatient department who was trying to set up some further dementia training for staff as she had completed a dementia training course.
- Staff told us that there was no specific tool to identify patients with additional needs or learning disabilities. However, in the pre-assessment unit nurses told us they used a 'pre-assessment mini mental test' for patients aged over 75 years or if they had concerns about a patient. The nurses used the test to identify patients at risk of post-operative confusion and the aim was to optimise the patient's safety. If a patient scored less than six out of eleven, the patient was referred to a care of the elderly physician with the agreement of the patient's consultant.
- Children were not treated in physiotherapy and were discouraged from accompanying adults to the clinic. When children did attend, therapists used a checklist to decrease the hazards that were present in the clinic area. This included removal of non-essential equipment, safe storage of remaining equipment, placement of cords and light pulls out of reach,

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unplugging of portable heaters, safe storage of chemicals. The checklist stated it was a requirement that a paediatric nurse was available on site if there were children under the age of three in the department.

Learning from complaints and concerns

- The hospital had a complaints policy and all staff were aware of it and how to support patients who wanted to complain. Staff told us that they would seek to resolve any concerns and de-escalate a potential complaint that way. Complaints were handled effectively and in timely manner. An audit demonstrated that from January to December 2015, the hospital responded to all complaints within 20 working days as outlined in the complaints policy. Patients and carers told us that they had no reason to complain but they knew how to file a complaint if necessary.
- The service learnt from complaints and changed practices. For example the hospital identified a trend in complaints relating to fees. This had led to greater transparency regarding the costs of additional services such as blood tests.
- In April 2016, the hospital introduced a new forum every two months. Staff was informed of clinical incidents and complaints, the outcome of any investigations and the learning taken from these to change practice. Although staff knew of it, we did not speak to any staff who had as yet attended.

Are outpatients and diagnostic imaging services well-led?

Requires improvement 

We rated well-led of the outpatient and diagnostic imaging services as requires improvement because:

- There was limited awareness of the vision and strategy of the hospital amongst outpatient and imaging staff.
- There was no departmental clinical risk register in the outpatients and imaging service, which meant that there was not a proactive approach to identifying and managing clinical risks.

- The imaging department had not yet engaged with the development of local protocols using the National Safety Standards for invasive Procedures framework.
- There was limited evidence and awareness of how patient feedback helped to inform changes and improve the patient experience.

However:

- Staff told us they felt supported by their managers and managers told us they were proud of their team and the teamwork.
- Managers told us that they felt able to 'challenge' consultants if care practices were compromised.
- Consultant radiologists felt the executive team listened to them.
- There were leaflets to encourage patients and their carers to give feedback to the hospital about the care they had received.

Vision and strategy for this core service

- There was a corporate vision to deliver best patient experience, with the best outcomes and be the most cost effective. There was a comprehensive corporate strategy with eight strategic priorities featuring patient quality and care as top priorities. While the executive team spoke of this with enthusiasm, there was little awareness amongst staff when we asked them.
- The managers and staff of the outpatient department and the imaging department did not discuss any vision for developing their services.
- However, the acting physiotherapy manager felt that she was connected to the BMI vision for physiotherapy. There was a strong drive toward harmonising all therapy protocols across the BMI group

Governance, risk management and quality measurement for this core service

- There were limited local arrangements in place to identify, record, manage risks and implement mitigating actions. The service lacked a proactive approach to risk management and there was no departmental clinical risk register in any of the services within outpatients and diagnostics. There was little understanding from staff and department managers of the role of a local risk register.

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- There was a framework and governance structure. Meetings were held regularly for heads of departments, clinical governance and the health and safety committee. The information from these meetings was shared either through display of minutes of the meeting in staff areas, by email or via a daily team brief. Regular staff meetings did not take place which compromised effective sharing of information and learning below senior level.
- There had been 378 incidents reported for the whole hospital between January and December 2015. Clinical managers investigated incidents and fed back in senior nurse's meetings, clinical governance meetings and at the heads of department meetings. Managers told us a new forum, which was open to all staff, had started where the Director of Clinical Services or the health and safety officer presented reported incidents and learning was shared. This forum started in April 2016 and staff we spoke with had mixed awareness of the forum. None of the staff we spoke with had attended. Learning was also shared with staff through daily safety briefs, handovers or team meetings
- In the outpatient department, there was a system to monitor staff had access to and had read standard operating procedures and policies. This system was overseen by a health care assistant (HCA) and required staff to sign that they had read a new policy or standard operation procedure. The HCA would forward compliance sheets to the quality manager once completed.
- The hospital had efficient processes to assure of the competence of consultants working under practicing privileges. The executive team told us there was a process for developing new services, which were discussed at the Medical Advisory Committee meetings.
- At the time of our inspection the imaging department did not have local protocols in line with the recommendations outlined in the National Safe Standards for Invasive Procedures framework. The department had recently started working towards the Service Accreditation Scheme; this project was led a corporate level.
- There was a programme of clinical and internal audits in the outpatients and imaging services. The data from these audits were used to monitor the quality and

compliance. For example, in the imaging department they audited compliance with the '6 ok' rule and actions were taken as required. These audits were presented and discussed in staff meetings and heads of department meetings. However, there was poor compliance with some audits for example around cleaning schedules and it was not clear how this was monitored and escalated to improve practice.

Leadership / culture of service

- The culture encouraged openness and honesty. Staff were aware of who the executive team were but told us that the executive leaders rarely visited the departments during the working day. However, at a senior level we were told there was a culture of good communication including communication with the executive team. There was also a good connection to other speciality leads within the wider BMI group.
- Nursing staff told us they felt supported by their managers. Staff told us they enjoyed interaction with patients, that colleagues were friendly and there was good teamwork. Managers told us they were proud of the teamwork within their departments.
- Bank staff were from an established pool of nurses and received the same training and appraisal processes as contracted permanent staff. This arrangement suited most bank nurses we spoke with but some nurses said they would prefer to have a substantive post.
- The radiologists stated there were opportunities to develop new services and the team within the imaging department was good to work with..
- Managers told us they were able to challenge consultants when patient care was compromised. For example, a recent change in practice had placed greater emphasis on the use of chaperones. This had required on-going discussions with some consultants.
- We asked some managers how they managed poor performance. We were told that there was rarely any issues with anyone who had poor performance. If gaps in knowledge or skills were identified then necessary training such as coaching or one-to-one training would be arranged. There was an efficient 'buddy' system where new bank staff worked with experienced staff until assessed competence was ensured.

Public and staff engagement

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- Staff were encouraged by the executive team to raise concerns. The executive team operated an 'open door' policy and also held forums every two months for staff. This forum consisted of two parts: a business update and followed by a session encouraging staff to discuss any concerns. The executive team acknowledged that discussing concerns about the workplace could be a stressful experience for an individual member of staff and told us there was free access to counselling sessions for all staff; staff could access these without referral and they were confidential.
- There were leaflets in waiting areas encouraging patients and their carers to provide feedback about the care they received. Staff also encouraged patients to fill in feedback forms.
- We reviewed the outcome of a Patient-Led Assessment of the Care Environment (PLACE) audit which is a system used for assessing the quality of the care environment and carried out by local people. In June 2015, this audit showed that the hospital was below national English average in three out of five measures. Whilst issues had been identified in the audit, there had been no staff engagement regarding improvement plans.
- Department meetings in the different clinical areas did not always happen regularly. While teams could show us meeting minutes of a recent department meeting there was little evidence that this was happening regularly; in the imaging department, there had been no department meetings for a year. This meant that staff did not have a formal process to receive information and teams did not have discussions to clarify processes and new initiatives. In some areas where they did happen, the meeting minutes were displayed in staff areas and staff told us they could access minutes electronically.

Innovation, improvement and sustainability

- The changes to the patient journey had delivered a significant improvement in the overall efficiency and flow through the pre-assessment unit.
- Staff in the physiotherapy department told us that they were in the process of negotiating a service level agreement with the local university, to gain access to and offer hydrotherapy treatment to patients.

Outstanding practice and areas for improvement

Outstanding practice

- We saw care and compassion from all staff in outpatients and diagnostic imaging, and a willingness from these staff to 'go the extra mile'.
- Staff in outpatients and diagnostic imaging spoke highly of an ethos of teamwork in all departments.
- The infection control and prevention lead was improving education and learning around infection prevention and control and took a proactive approach to ensure learning was effective for staff.

Areas for improvement

Action the provider **MUST** take to improve

- Ensure notes in outpatients contain a single record of patients' complete care histories.
- Introduce a departmental clinical risk register throughout the hospital.
- Ensure the fire risk assessment is reviewed, and actions previously identified are put in place.
- Ensure staff are fully aware of evacuation procedures for patients on the first and second floor.

Action the provider **SHOULD** take to improve

- Review nurse staffing requirements of the outpatient department.
- The hospital should ensure that anaesthetists consistently complete the anaesthetic chart and document when consent has been obtained.
- Senior staff should monitor any actions plans or changes to practice following learning from incidents to ensure that they are being implemented.
- The hospital should ensure that yearly staff performance appraisals are carried out to ensure staff competence and ongoing development within their role.
- The senior managers should be more visible around the hospital.
- The hospital should ensure that there is a risk management system in place to address current and future risks to ensure a proactive approach to risk management.

- Review opportunities to collect patient outcome measures to help evaluate the effectiveness of services in outpatients and diagnostic imaging.
- Ensure the imaging department develop local standard operating procedures in line with the recommendations set out in the National Safety Standards for Invasive Procedures.
- Continue to ensure regular department meetings are held in the diagnostic imaging to facilitate sharing of information and learning.
- Review opportunities to use and display patient feedback to improve outpatients and diagnostic imaging services.
- Review practice in the physiotherapy department regarding documentation of obtained consent.
- Increase staff awareness of the WHO checklist for safer surgery in outpatients and diagnostic imaging.
- Review compliance with cleaning schedules in outpatients and diagnostic imaging.
- Ensure a laser protection supervisor is appointed in outpatients to meet requirements set out in risk assessments.
- Review uniform policy to include nurses wearing belts and the effects this may have on infection control and prevention.
- Increase awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards amongst staff.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 HSCA (RA) Regulations 2014 Good Governance</p> <p>17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.</p> <p>(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.</p> <p>The service did not keep single care records for patients. Staff completed separate records in different locations, and this presented a risk because there was no record with patients' complete care histories.</p> <p>The fire risk assessment was nine months out of date. This was despite the recent introduction of eye laser service with a potential increased risk of fire. Staff were unsure of evacuation procedures for patients on the first and second floor in the event of fire.</p> <p>The service had not completed action points from a risk assessment carried out in preparation for the new eye laser treatment.</p> <p>The imaging department did not have standard operational standards for all procedures and therefore did not comply with the recommendations set out in the National Safety Standards for invasive Procedures.</p>

This section is primarily information for the provider

Requirement notices

There was no clinical risk register, which meant the service could not proactively manage clinical risks.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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