BMI The Lincoln Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This was the first comprehensive inspection of BMI The Lincoln Hospital, which was part of the CQC's ongoing programme of comprehensive, independent healthcare acute hospital inspections. We carried out an announced inspection of BMI The Lincoln Hospital on 9 February 2016. Following this inspection an unannounced inspection took place on 12 February 2016.

The inspection team inspected the core services of surgery and outpatients and diagnostic imaging services.

Complex diagnostic investigations such as magnetic resonance imaging (MRI) and computerised tomography (CT) scans were provided by an external provider. There was a service level agreement (SLA) in place for these complex diagnostic imaging services. We did not inspect these services as part of our inspection.

Overall, we have rated BMI The Lincoln Hospital as good. We found surgery services were good in all five of the key questions we always ask of every service and provider relating to safe, effective, caring, responsive and well led. Outpatients and diagnostic imaging services were good in the four key questions relating to safe, caring, responsive and well led. We inspected but did not rate the key question of effective in outpatient and diagnostic services.

Are services safe at this hospital

We found services provided at BMI The Lincoln Hospital were safe.

- Patients were protected from avoidable harm and abuse.
- There was a good incident reporting culture throughout the hospital.
- Staff were supported to be open and transparent and they understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an open and honest culture at all levels within the hospital. Staff were aware of the duty of candour regulation. [This regulation requires providers to be open and transparent with people about the care they receive in particular circumstances and especially where things go wrong].
- Incidents were investigated and learning from incidents was shared throughout the hospital and where appropriate at a corporate level.
- Safeguarding of patients was given sufficient priority. The hospital had a safeguarding lead and staff were supported to take a proactive approach to safeguarding. All staff knew who the safeguarding lead was and told us they would always approach them for guidance. The safeguarding lead at the hospital had good links with the safeguarding lead at the local authority.
- Risks to patients and people using the service were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. The hospital had appropriate processes and agreements in place to transfer patients to a nearby acute hospital if their condition deteriorated.
- Staffing levels and skill mix were planned, put in place and reviewed to keep people using the service safe at all times. Nursing and medical staffing was managed effectively to deliver appropriate care to patients.
- A resident medical officer (RMO) provided 24 hour cover seven days a week for all patients. 99 consultants had been granted practising privileges at the hospital, 87 of whom had been undertaking work at the hospital for over 12 months.

Summary of findings

- There were effective arrangements and processes in place to support the handover of appropriate patient information between the RMOs, consultants and other clinical staff such as nurses and allied healthcare professionals at the hospital.

Are services effective at this hospital

We found services provided at BMI The Lincoln Hospital were effective.

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Local policies and procedures, alongside National Institute for Health and Care Excellence (NICE) guidelines were discussed the Medical Advisory Committee (MAC) meetings.
- Patients received care and treatment in line with national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges.
- The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to national averages and other independent hospitals.
- The hospital participated in national audit programmes such as performance reported outcomes measures (PROMs) and the National Joint Registry. Results showed patient outcomes were in line with the national average. Audit findings were reviewed and monitored at routine clinical governance and MAC meetings.
- Consultants working at the hospital were employed under practising privileges (authority granted to a physician by a hospital governing board to provide patient care in the hospital) that were monitored by the Medical Advisory Committee (MAC). Any changes to policies were reviewed by a consultant with the relevant expertise and discussed and ratified during MAC meetings.
- The location had appropriate arrangements in place for checking qualified doctors, nurses and allied health professionals had renewed their registration on an annual basis.
- Consent to care and treatment was undertaken in line with guidance. Staff were aware of the legal requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.

Are services caring at this hospital

We found services provided at BMI The Lincoln Hospital were caring.

- All staff we observed, without exception, treated patients with compassion, dignity and respect.
- Patients were kept informed and were involved in every stage of their care and treatment.
- Staff demonstrated pride in the care they delivered and spoke about patients in a respectful manner. Patients we spoke with confirmed that staff were kind, considerate and treated them with dignity and respect.
- Emotional support was provided by staff at the hospital. We saw staff providing reassurance for patients throughout their treatment and care.
- Patient experience was reported through local patient surveys and the NHS Friends and Family Test (FFT). Patient satisfaction was high. Between September 2014 and November 2015 between 98% and 100% of patients being treated at BMI The Lincoln Hospital would recommend the hospital to their family and friends as a place to receive treatment and care.

Are services responsive at this hospital

We found services provided at BMI The Lincoln Hospital were responsive.

Summary of findings

- People's needs were met through the way services were organised and delivered. Patients accessed services provided by the hospital via an NHS referral, via self-referral and self-funding or via their health care insurer.
- Services were flexible and choice and continuity of care was reflected throughout the service. For example weekend appointments could be made for some outpatient clinics. The needs of all patients were taken into account throughout the planning and delivery of services.
- Waiting times, delays and cancellations were managed appropriately. Referral to treatment times (RTT) for both admitted and non-admitted patients were consistently above the national average of 90%.
- Occupancy rates on the ward meant that any day case patients who needed to stay overnight because they were not fit to go home could do so.
- The hospital had a policy, which outlined the inclusion and exclusion criteria for patients. Patients with an American Society of Anaesthesiologists (ASA) physical status score of three or greater were excluded.
- All patients were screened pre-operatively to determine whether the hospital could meet their needs. Where a patient was identified as living with dementia or a learning disability, a person-centred approach was adopted to ensure the person received the right care in the right place at the right time.
- There was sufficient capacity to provide care and treatment for patients undergoing surgery at the hospital.
- In line with the provider's policy, all complaints were responded to in a timely manner.

Are services well led at this hospital

We found services provided at BMI The Lincoln Hospital were well led.

- The leadership, governance and culture promoted the delivery of high quality person-centred care.
- There was a clear corporate vision and strategy in place which was driven by quality and safety. The vision and values were visible throughout the hospital. The mission statement for the hospital was 'passionate about care.' Staff were aware of this and they demonstrated this mission statement through the care they provided to people who used the service.
- There was a clear governance structure in place which enabled heads of department to feed into the medical advisory committee (MAC) and the hospital executive management team.
- There were effective systems and processes in place to check that all new and existing executive and senior team leaders were and continued to be of good character and had the necessary qualifications, skills and experience for their role. The Executive Director and the Director of Clinical Services had supplied specific information such as a disclosure and barring service (DBS) check and a full employment history to demonstrate their ability to be a fit and proper person [The fit and persons requirement (FPPR) for directors was introduced in November 2014. The FPPR intends to make sure senior directors are of good character and have the right qualifications and experience].

Our key findings were as follows:

- Although the hospital had a relatively new senior leadership team, they all displayed the skills, knowledge and experience required to lead. This was demonstrated through their attitude, values and commitment to ensure staff felt valued and involved in decision making throughout the hospital.
- There were clearly defined and visible local leadership roles at hospital wide and local levels. Senior staff provided clear leadership and motivation to their teams. The leadership team were known to staff and were visible throughout the hospital on a daily basis talking with patients and observing clinical practice including attendance during theatre lists.

Summary of findings

- Staff morale and motivation were good and staff enjoyed working at BMI The Lincoln Hospital. There was supportive management at all levels, effective team-working and an open culture in which staff were able to raise concerns and make suggestions.
- All clinical areas were clean. The hospital had reported no incidence of MRSA, clostridium difficile (C.diff.) or methicillin-sensitive staphylococcus aureus (MSSA) in the reporting period between October 2014 and September 2015.
- Patient-led assessments of the care environment (PLACE) audits for 2015 showed the hospital had achieved 100% for cleanliness. This was above the national average of 98%.
- All the areas we visited were visibly clean and tidy. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- The hospital had employed an infection control link nurses to provide training and to liaise with staff so patients who acquired infections could be identified and treated promptly.
- A Resident Medical Officer (RMO) provided 24-hour medical and surgical cover for all patients. Consultants and anaesthetists could be contacted 24 hours a day.
- There had been no unexpected inpatient deaths in the hospital in the 12 months preceding our inspection. If deaths did occur then these would be reviewed and discussed at the clinical governance and Medical Advisory Committee (MAC) meetings.
- Patient records included an assessment of patients' nutritional requirements.
- Staff followed guidance on fasting prior to surgery which was based on best practice. For healthy patients requiring a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- The areas we inspected had a sufficient number of trained nursing and support staff with an appropriate skills mix to meet patients' needs.
- Staffing levels were monitored using the BMI Healthcare nursing dependency and skill mix tool. The theatres did not have a full establishment of permanent staff. However, staffing levels had been calculated on the basis that the two operating theatres would be supporting patients with general anaesthetic. Gaps were maintained through the use of regular long-term agency staff.
- Patients were screened at the pre-assessment stage using a screening tool to identify any risks prior to admission. Where appropriate actions were taken to ensure patients were given every opportunity to have their treatment at the hospital.
- Vulnerable adults, such as patients with a learning disability and those living with dementia were identified at the referral stage; steps were taken to ensure they were appropriately cared for. This included an appointment time during less busy periods, continuity of staff and informing carers or representatives of the plan of care.
- The Director of Clinical Services had taken the lead on environmental changes to ensure people with dementia were fully supported. In 2015 a patient-led assessment of the care environment (PLACE) audit highlighted carpets as being a risk for patients living with dementia. This was identified as a risk on the hospital's risk register and this was addressed as part of a refurbishment programme where carpets were replaced with laminate floors. There were also plans to discuss appropriate dementia friendly signage throughout the hospital.

Summary of findings

- Local patient questionnaires were available and themes were collated and used for patient experience planning. Patients received follow up calls within 48 hours following discharge which provided patients with an opportunity to feed back on their experience.

There were areas of practice where the provider should make improvements.

The provider should:

- Ensure seating is washable in patient areas.
- Audit the imaging reporting turnaround times.
- Continue to prioritise the recruitment of staff to theatres.
- Ensure references are obtained for all doctors working at the hospital under practising privileges.
- Ensure training for all staff in relation to caring for patients living with dementia is completed as soon as possible.
- Consider purchasing a ventilator to mitigate risks to staff when using paracetic acid for endoscopic processes.

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
Surgery	Good 	Overall, we rated surgical services at BMI The Lincoln Hospital as good. Patients were protected from avoidable harm and abuse. Staff knew how to report incidents and incidents were shared and lessons were learned. All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked regularly. Medicines were stored and administered safely and records were held securely. Patients had access to medical and nursing care in a timely manner and were very positive regarding the care they received and their involvement in it. Patients were supported, treated with dignity and respect, and were involved as partners in their care. Evidence based care and treatment was delivered to patients following national guidance by competent staff. Patients received individual care although only 58% of staff had received dementia training. Patient's needs were met through the way services were organised and delivered. Complaints about services were responded to within the hospital's timelines. Any actions required as a result were put in place. The leadership of the service was good. The provider had a clear vision and robust governance and risk structures were in place. Feedback from staff and patients was used as instruments for change within the service.
Outpatients and diagnostic imaging	Good 	We rated the Outpatients and Diagnostic Imaging service at BMI The Lincoln hospital as good overall. Systems were in place for keeping patients safe. Staff were aware how to report incidents, safeguarding issues. Staff were aware of the Mental Capacity Act 2005 and the Duty of Candour processes. Sufficient equipment was available, well maintained and appropriately checked. Records were securely stored, legible, signed, dated and up to date. Staff completed mandatory training courses with good compliance rates. Staffing levels were sufficient to meet the needs of patients.

Summary of findings

Patients received care and treatment in line with clinical care pathways and local and national guidance. Patients were assessed for pain relief and provided with medication or treatment where appropriate. Staff confirmed they had received yearly appraisals. We observed effective multi-disciplinary working and staff sought consent from patients in accordance with policy.

Staff were enthusiastic and caring. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received regardless of how they were referred or funded.

Waiting times for outpatient appointments were within the national guidelines. Staff were flexible in their working day to accommodate patients for scans and x-rays at short notice. Interpreters could be booked for patients whose first language was not English, if required. Wheelchair access was available throughout the hospital.

The BMI The Lincoln Hospital strategy and vision was embedded in the departments and staff embraced the values in the work they undertook. There were clearly defined and visible local leadership roles in each speciality within the outpatients and diagnostic imaging areas. Team leaders provided visible leadership and motivation to their teams. The services were represented at executive level and there was appropriate management of quality, governance and risks at a local level.

Summary of findings

Contents

Good

BMI The Lincoln Hospital

Services we looked at:
Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The Lincoln Hospital

The site on which BMI The Lincoln Hospital stands has been providing healthcare to the people of Lincoln and its surrounding areas since 1887. The hospital was originally built as a memorial to its founder, Mrs Bromhead, and the Bromhead Maternity home was opened in 1927. The Bromhead Maternity Home was taken over by the National Health Service in 1948, but in 1981 it became The Bromhead Hospital, run by an independent charitable trust. It was sold to another provider in 2001 and in 2009 passed on to the BMI Healthcare Group when the hospital became known as BMI The Lincoln Hospital.

The hospital has an Executive Director, who was also the registered manager, who registered on 22 September 2015.

BMI The Lincoln Hospital is registered to provide the following Regulated Activities:

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

Healthcare is provided by staff at the hospital to patients with private medical insurance, those who self-pay and through National Health Service (NHS) contracts.

BMI The Lincoln Hospital provided a wide range of specialties including neurology, gynaecology, dermatology, cardiology, orthopaedics, ear nose and throat (ENT), physiotherapy, urology, gastroenterology, cosmetic surgery and general surgery. The diagnostic and imaging department carried out x-rays and ultrasound scans.

The hospital provides outpatients, inpatient and day case care and treatment for adults over the age of 18. The service is registered to provide adult inpatient care to 24 patients at any time, but at the time of our inspection, the provider had taken steps to reduce its number of inpatient beds to 18. The provider had also made a decision to remove all paediatric and young person's services to patients aged less than 18 years from January 2016.

There were two operating theatres including a four bedded recovery area. All of the single bedrooms had en-suite facilities, Wi-Fi, television and telephone.

The outpatient department comprised seven consulting rooms, a pre-assessment room and ambulatory care room, two treatment rooms for minor procedures and cardiology and an eye clinic. The outpatient department offered appointments from 8am to 9pm Monday to Friday with some additional clinics on Sundays.

The physiotherapy department had a gymnasium area with fitness equipment and exercise classes.

The diagnostic and imaging department carried out x-rays and ultrasound scans. However, more complex investigations such as magnetic resonance imaging (MRI) and computerised tomography (CT) scans were provided by an external provider. There was a service level agreement (SLA) in place for this service and this service was not inspected as part of our inspection.

We inspected the core services of surgery and outpatients and diagnostic imaging services at BMI The Lincoln Hospital as part of our ongoing comprehensive inspection programme of independent healthcare hospitals. This was the first comprehensive inspection of BMI The Lincoln Hospital.

Our inspection team

Our inspection team was led by:

Inspection lead: Fiona Collier, Inspector, Care Quality Commission

The team included three CQC inspectors, an assistant inspector and a specialist advisor who was an anaesthetist.

Summary of this inspection

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection on 9 February 2016 and an unannounced inspection on 12 February 2016. We spoke with a range of staff in the hospital, including nurses, consultants, administrative, ancillary and clerical staff. During our inspection we reviewed services provided by BMI The Lincoln Hospital in the ward, the operating theatre and outpatients department.

During our inspection we spoke with 31 members of staff, including consultants who were not directly employed by the hospital, 19 patients and 2 relatives from all areas of the hospital, including the ward, operating theatre and outpatient department. We observed how people were being cared for and talked with patients. We reviewed the personal care or treatment records of four patients in surgery and 13 patients in outpatients and diagnostic imaging. We also reviewed three medication administration charts for three patients in surgery.

Information about BMI The Lincoln Hospital

BMI The Lincoln Hospital was registered for 24 overnight stay beds but had taken the decision to reduce facilities to 18 inpatient bedrooms, each with its' own private en-suite facility. They had two operating theatres, one of which was laminar flow where operations under general anaesthetic were performed. The second theatre was used as an endoscopy suite and offered minor procedures under local anaesthetic.

BMI The Lincoln Hospital provided an outpatient service which comprised of seven consulting rooms, a pre-assessment room and ambulatory care room, two treatment rooms for minor procedures and cardiology and an eye clinic.

The hospital had 99 doctors and working under the rules of practising privileges, 87 of whom have had practising privileges for over 12 months. The hospital employed 57.8 full time equivalent staff including nurses, operating department practitioners, care assistants, allied health professionals, administrative and clerical staff and, other support staff. The largest number of staff employed were administrative and clerical staff.

The majority of patients attending the hospital for surgery were privately funded (insured and self-paying). Approximately 40% of patients in the year October 2014 to September 2015 were funded by the NHS.

In the reporting period October 2014 to September 2015 there were 3,137 procedures undertaken in the operating theatres for overnight stay and day-case patients. The five most common procedures performed were cataract surgery (386), arthroscopic (keyhole) knee surgery (313), complex primary total knee replacement (210), primary total hip replacement (147) and primary repair of inguinal hernia (128).

Between October 2013 and September 2015 the OPD saw 2,106 NHS funded patients for their first appointment and 2,104 follow up patients. During the same reporting period, the OPD saw 4,643 self funded patients for their first appointment and 6,164 follow up patients who were self funded.

The Executive Director was registered as the Controlled Drugs Accountable Officer (CD AO) on 29 July 2015.

Detailed findings from this inspection

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients.

Good

Surgery

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

Information about the service

Surgical services at BMI The Lincoln Hospital included day and overnight facilities for adults undergoing a variety of surgical procedures. The majority of patients attending the hospital for surgery were privately funded (insured and self-paying). Approximately 40% of patients in the year October 2014 to September 2015 were funded by the NHS through the 'NHS e-referral' service system. Previously known as 'Choose and Book' the NHS e-referral service is a national electronic referral service which gives low risk patients a choice of place, date and time for their first out-patient appointment in a hospital or clinic and subsequent surgical procedure. The hospital offered general surgical, ophthalmology and orthopaedic procedures only through this system.

BMI The Lincoln Hospital was registered to provide adult inpatient care to 24 patients at any time, but at the time of our inspection, steps had been taken to reduce the number of inpatient beds to 18. The provider had also made a decision to remove all paediatric and young person's services to patients aged less than 18 years from January 2016.

Surgical facilities at BMI The Lincoln Hospital included 18 individual patient rooms and two operating theatres including a four bedded recovery area for patients recovering immediately post-surgery. Diagnostic endoscopy procedures were also undertaken in one of the theatres. There was also a treatment room in the outpatient department which was used for minor procedures.

In the reporting period October 2014 to September 2015 there were 3,137 procedures undertaken in the operating theatres for overnight stay and day-case patients. The five most common procedures performed were cataract surgery (386), arthroscopic (keyhole) knee surgery (313), complex primary total knee replacement (210), primary total hip replacement (147) and primary repair of inguinal hernia (128).

The hospital did not have a sterile supplies department, but has a service level agreement with a private provider to ensure reusable equipment is cleaned, sterilised and packed for further use.

Before our inspection we reviewed performance information from and about BMI The Lincoln Hospital. During our inspection we visited the ward area, operating theatres and recovery area. We observed the care of patients on the ward, during operative procedures in theatre and in the recovery area. We spoke with 11 patients and two accompanying relatives. We also spoke with 15 members of staff including nurses, medical staff, anaesthetists, therapists, supporting staff and senior managers.

Good

Surgery

Summary of findings

We judged the service provided safe, effective, caring, responsive and well-led services.

The hospital had systems in place to keep patients safe. Staff knew how to report incidents and lessons were learned.

All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked regularly. Medicines were stored and administered safely and records were held securely.

Patients had access to medical and nursing care in a timely manner and were very positive regarding the care they received and their involvement in it.

Patients were supported, treated with dignity and respect, and were involved as partners in their care. Evidence based care and treatment was delivered to patients following national guidance by competent staff. Patients received individual care although only 58% of staff had received dementia training.

Patient's needs were met through the way services were organised and delivered. Complaints about services were responded to within the hospital's timelines. Any actions required as a result were put in place. The provider had a clear vision and robust governance and risk structure were in place with feedback from staff and patients being the instrument for change within the service.

Are surgery services safe?

Good

We have judged the safety of surgical services to be good. Patients were protected from avoidable harm and abuse. We found:

- The hospital had systems in place to keep patients safe.
- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. They also demonstrated good knowledge of the learning that had taken place from incidents.
- Formal and informal processes were in place for auditing the five steps to safer surgery checklists. For each patient's procedure, the checklists were followed and completed in full. [The five steps to safer surgery is a process recommended by the National Patient Safety Agency (NPSA) for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors].
- All patient areas and theatres were visibly clean. Infection prevention and control processes were in place and equipment had been checked in line with the hospital's policy.
- The hospital monitored patient safety on a day-to-day basis and patients were safeguarded from harm.
- Medicines were stored and administered safely.
- Staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.
- Records were fully completed and stored safely when not in use.

However we also found:

- Difficulties had been encountered recruiting permanent staff for theatres.

Incidents

- The hospital's policy for the reporting and investigation of incidents was comprehensive and outlined staff responsibilities.
- All the staff we spoke with were aware of their responsibilities and reported incidents and near misses using the hospital's paper reporting system.

- Staff were able to give examples of incidents where lessons had been learned and where practices had changed as a result.
- Staff told us there was a 'no blame' culture in the service and they felt empowered to report incidents without fear of reprisal. Issues raised included infections, leaking wounds and wrong medicines.
- There was an incident list which was available for all staff to view. This was updated on a monthly basis. Actions taken were also evidenced with shared learning.
- All clinical incidents were monitored and actioned by the Director of Clinical Services.
- There were 263 clinical incidents across the hospital within the reporting period October 2014 and September 2015. Between 1 October 2015 and 31 January 2016 there were 96 recorded incidents and one serious incident (SI). The SI related to a fire in one operating theatre following a power surge which caused disruption to the service from 4 December 2015 to 7 December 2015. A root cause analysis (RCA) was undertaken and five recommendations made by the provider's chief engineer including the installation of an isolated power supply. This would protect the theatre electrical sockets from external power influences. A business case was being submitted for this work to be to be undertaken.
- We spoke with one patient who told us they had not had anything to drink from the night before they had surgery. This meant the patient was at increased risk of becoming dehydrated. We spoke with a senior manager about this who stated they would raise it as an incident and investigate it. Following our inspection the Director of Clinical Services Shared the outcome of the investigation with us. The investigation indicated the patient had not followed the guidelines given to them and had electively chosen to stop eating and drinking the night before their surgery. However as the patient was admitted early in the morning and did not go to theatre until the afternoon staff should have spoken with the anaesthetist to change the time when clear fluids could be taken until. This was reported as a clinical incident and learning from this incident was shared with the wider clinical team to prevent reoccurrence. As a result of this incident changes were made to practice to ensure surgical lists were split into morning and afternoon admissions so that patients listed for the afternoon could have a light breakfast the morning of their surgery.
- Overall, the rate of clinical incidents per 100 inpatient discharges across the hospital was constant in the same period, apart from April 2015 to June 2015 when it peaked to 13 incidents compared to an average of between seven or eight per month. This was following training received by staff and an increased awareness around reporting incidents.
- There had been no unexpected deaths in the hospital in the 12 months prior to our inspection.
- There had been no incidents of surgical sepsis in the 12 months preceding our inspection. Staff were aware of the importance of recognising sepsis quickly and treating it appropriately within a clear pathway.

Duty of Candour

- Staff were familiar with the term 'duty of candour' (meaning they should act in an open and transparent way in relation to care and treatment provided) and told us they would apologise and inform the patients or their carers if incidents of avoidable harm had occurred.
- The Director of Clinical Services shared with us an example where they had applied duty of candour when a patient was denied fluids for longer than was necessary prior to their operation.

Safety thermometer

- The hospital had monitored performance through a series of assessments to reduce risks to patients. These included, falls, pressure ulcers (damage to the skin caused by a patient being in the same position for too long), and venous thromboembolism (VTE). VTEs, also known as blood clots, can form in a vein of a patient and have the potential to cause severe harm. We saw safety data displayed on the ward for staff to see.
- Two pressure ulcers had been recorded as incidents; these occurred in July 2015 and October 2015 and had been investigated. Equipment for the prevention of pressure ulcers had increased as a result of these incidents and staff had received further training from the tissue viability nurse.

- The VTE screening for all patients was consistently 100% in three of the quarters during the reporting period between October 2014 and September 2015. They had scored 93% for one period however 95% is the targeted rate for NHS patients.
- Two patients had developed a hospital acquired VTE or pulmonary embolus (PE) in the reporting period between October 2014 and September 2015. A PE is a blockage of an artery in the lungs. The most common cause of the blockage is a blood clot. Both patients had been risk assessed for VTEs as part of their pre-admission assessment.
- A report completed in November 2015 by the East Midlands commissioning support group, rated the hospital for harm free care against all the providers in the local area including NHS trusts. This included pressure ulcers, falls and urinary tract infections. The hospital achieved 100%.

Cleanliness, infection control and hygiene

- The ward area had been refurbished prior to our inspection. Carpets in all areas of the ward and en-suite bedrooms had been replaced with laminate flooring for ease of cleaning.
- All areas of the hospital were visibly clean, uncluttered and tidy.
- Cleaning schedules had been introduced in December 2015 for all areas of the hospital and copies were available in the most appropriate location dependent upon the area.
- Patient-led assessments of the care environment (PLACE) audits for 2015 showed the hospital had achieved 100% for cleanliness. This was above the national average of 98%.
- The hospital had a service level agreement (SLA) in place with an external provider for the disposal of all waste materials including clinical waste and sharps waste.
- An infection control nurse was in post to provide training and liaise with staff.
- An infection prevention and control work programme was in place for the year 2015/2016 relating to the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. The hospital audited itself against nine identified criteria. It included such items as the environment and information on infections to service users and their visitors.
- The hospital undertook monthly meetings of the infection prevention and control internal staff group with consultants attending every quarter. We saw minutes of the December 2015 meeting when the audit of the Health and Social Care Act 2008, Code of Practice was discussed. Any actions that were required were dated for completion by a named individual.
- The hospital had documented five incidents of wound infection between June 2015 and October 2015; all had been following orthopaedic surgery although were not attributable to any particular surgeon and did not follow any trends.
- The hospital had reported no incidences of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C Diff) or Methicillin-sensitive Staphylococcus Aureus (MSSA) in the reporting period between October 2014 and September 2015. MRSA, MSSA and C.Diff are all infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection that is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. (C.Diff is a form of bacteria that affects the digestive system and commonly associated with people who have been taking antibiotics).
- High risk patients were screened prior to their procedure for MRSA and MSSA as part of their pre-operative assessment. These included patients scheduled for orthopaedic procedures, those who had been in hospital within the previous twelve months and all NHS patients. In addition, any patient who had travelled abroad was screened for carbapenemase-producing enterobacteriaceae or CPE. (Carbapenems are one of the most powerful types of antibiotics. Carbapenemases are enzymes (chemicals), made by some strains of these bacteria, which allow them to destroy carbapenem antibiotics and so the bacteria are said to be resistant to the antibiotics).
- Anti-microbial stewardship was in place in the hospital to ensure the use of antibiotics was controlled and used appropriately.
- The hospital used 'I am clean' stickers to identify equipment that had been cleaned and was ready for use. These were clearly visible and appropriately dated and signed.
- The hospital had an up-to-date policy and procedure for the scrubbing, gowning and gloving of staff prior to surgical interventions. We observed staff following the procedure to ensure infection risk was minimised.

- The hospital had effective processes and procedures for the management, storage and disposal of general and clinical waste, disposal of sharps, such as needles and scalpels, environmental cleanliness and the prevention of healthcare acquired infection. Clinical waste bags and sharp bins were closed effectively and identified with a unique number.
- Sanitising gel was available in each room; patients and visitors were encouraged to use it. There was access to hand washing facilities and supplies of personal protective equipment (PPE), for example gloves and aprons. We observed staff using PPE appropriately.
- All staff were observed to be compliant with the bare below the elbows policy.
- One of the two operating theatres had higher levels of air filtration (laminar flow) in place; this was particularly important for joint surgery to reduce the risk of infection.
- The provider had a wound care management policy and procedure in place which was in use in the hospital. Staff were aware of this and followed it.
- Patients were given written information regarding wound management before discharge. This was supported by verbal discussion; the information included what the patient should do if they were concerned. Patients were provided with telephone numbers of the hospital should they require help or support post discharge.
- Equipment that had been used for endoscopy procedures was cleaned and sterilised on site. An endoscopy washer was used for this purpose with a reverse osmosis unit linked into it. The endoscopy washer was sanitised every night to ensure it was completely clean.
- New equipment had been ordered for endoscopic procedures, for example a new scope, flush system and double sink. The use of this equipment is recognised as good practice. All piping had been changed to stainless steel.
- A designated area was available for the cleaning of endoscopic equipment. Other equipment used for surgical procedures was cleaned and sterilised off site by a private provider.
- Hand hygiene audits in theatres for February, April, August and December 2015 showed 100% compliance for all levels of staff. Audits were available for staff and if they fell below 100% managers brought this to the attention of staff.

Environment and equipment

- Not all rooms on the surgical ward were appropriate for caring for patients who had undergone major surgery in that they were not big enough to accommodate additional equipment and did not have piped oxygen or suction. However, portable oxygen and suction was available for post-operative transfer and admissions of patients requiring major surgery were arranged to ensure appropriate facilities were available for such patients.
- It had been acknowledged by the provider a ventilator was required for endoscopic processes because of the high concentration of an acid that was used. However to mitigate the risk, occupational health checks were undertaken by the provider on all staff involved. A risk assessment had been undertaken which indicated staff should wear personal protective equipment (PPE) to mitigate risks. PPE such as gloves, apron and face masks were available for staff to use. Staff were exposed for very short periods of time and staff rotation was in place to ensure staff were not over exposed to the high concentration of acid.
- Storage facilities for equipment within the ward was well organised. Staff informed us they always had access to equipment they required.
- A hoist was available for patients requiring to be moved. Although the manufacturers recommended a daily check of the hoist there was no documented evidence this was being undertaken. The hoist was however serviced in line with Lifting Operations Lifting Equipment Regulations (LOLER) 1998.
- The first floor theatre suite comprised two operating theatres. We found they were visibly clean and organised and were fully equipped to undertake major surgical procedures. Only one operating theatre was used for general anaesthesia; the second operating theatre was used for endoscopy procedures. We were informed there were plans in place to upgrade the second theatre so it could also be used for patients requiring general anaesthesia.
- The hospital was not equipped to care for high dependency patients. Any patients requiring additional care were transferred to the local acute trust.

- Resuscitation equipment was available in both the ward and theatre areas. Daily checks were undertaken to ensure equipment was present and in working order and consumables were in date. This meant the equipment was ready to be used in an emergency.
- A daily check was undertaken to ensure the emergency alarm was in working order. We observed the testing of the alarm as part of our inspection.
- Anaesthetic machines were checked daily and we saw documentation that supported this. We saw an anaesthetic machine in use during our inspection, which was in full working order
- Ward staff had access to equipment for patients requiring it, for example walking aids.
- All equipment for patient care was visibly clean and ready for use.
- A designated member of staff was the hospital lead for medical devices. They had links to the maintenance department with regard to contracts for certain devices.
- There had previously been issues with the lift in the main building resulting in regular breakdowns. We saw evidence the lift had been repaired and this was no longer a concern.
- Oxygen was available in ward areas, either piped directly or in portable cylinders. Cylinders were stored securely outside the building and were always available when required.
- All equipment belonging to the hospital had an asset number assigned to it which was placed on a database.
- Portable appliance testing (PAT) was undertaken on electrical equipment and we saw PAT stickers on pieces of equipment indicating when this had taken place. This ensured equipment was safe to be used. New equipment that had been purchased was not PAT tested for a year until its warranty had expired.
- Intravenous pumps were available and had been serviced appropriately.
- An external contractor was used for the servicing of all equipment.
- Staff informed us commodes were taken apart for cleaning; we observed two that had been cleaned on 7 February 2016 and 8 February 2016 and were dated appropriately.

Medicines

- The hospital had access to pharmacy support twenty-four hours a day, seven days a week through a virtual pharmacy model with another BMI hospital. The pharmacist was employed for eight hours per week and a pharmacy technician for 25 hours a week. If medicines were required, virtual cover was provided via an on-call service provided by a sister BMI hospital in Nottingham.
- The hospital pharmacy had a secure locking system. Take home medicines were always checked by two members of staff.
- Medicine stock levels were topped up twice a week and levels of stock medicines were reviewed twice a year to ensure the amounts of medicines stored were adequate.
- If any new medications were requested to be stored at the hospital, the request went through the medical advisory committee (MAC) for approval.
- Pharmacy staff had a robust auditing system in place which included for example, controlled drugs and medicine errors. Between 1 August 2015 and 31 November 2015 there had been six incidents involving medication errors. Two related to prescribing errors, two related to medication being unavailable and two related to dispensing errors. Staff were aware of the audits and additional training in relation to medicine management was provided for staff. All relevant staff were required to refresh themselves with BMI's medication management policy and signed an accountability document to acknowledge their responsibilities when handling medication.
- The hospital used a prescription and medication administration record chart for patients which helped to guide staff in the safe administration of medicines for all patients.
- Nursing staff were not permitted to administer medicines until deemed competent to do so.
- We looked at three prescription and medication administration record charts on the ward and saw appropriate arrangements were in place for the recording of medicine administration. Records were clear, fully completed and patients had received their medicines when prescribed. Patient allergies were recorded on their prescription chart.
- Medicines were stored securely including controlled drugs. Controlled drugs are medicines which are stored in a designated cupboard and their use recorded in a special register. Medicines requiring cool storage were stored appropriately and temperatures monitored daily.

Medication room temperatures were also checked daily. All temperatures were within acceptable ranges; this helped to ensure medication did not deteriorate or become less effective.

- Patients were responsible for completing their own pre-admission questionnaire. This included information about the medicines they were currently taking. If necessary, additional information could be obtained from the patient's GP.
- All patients were given information about the medicines they were prescribed, how to use them and any side effects they may have.
- If required, blood was ordered prior to surgery for major procedures, for example hip replacement, and stored in a designated fridge. Additional blood was always available. If further supplies were required they could be obtained within 20 minutes from the local acute trust. Daily temperature checks were undertaken and a cleaning schedule was adhered to for the blood fridge.
- Intravenous fluids (fluids that are given directly into a vein) were available and stored appropriately.

Records

- Patient records within surgical services were paper based and kept securely when not in use.
- Staff were aware of their responsibilities relating to the safekeeping of records and confidentiality.
- We reviewed four sets of medical and nursing records for patients who had undergone different types of surgical procedures.
- All notes were filed in one place. This included assessments, planned pathways of care, consent forms and operation notes. This meant they were easy to locate.
- Planned pathways of care included risk assessments, five steps to safer surgery check lists, operating notes, observations and recovery records.
- All the records were complete, signed by the appropriate health care professional and up to date. Each patient had the appropriate pathway in place for the procedure that had been undertaken, for example knee replacement or cataract surgery. Variations to the expected pathways could be documented including extended periods of hospitalisation. Evidence was available showing discharge was planned and physiotherapy had been arranged when this was necessary. Pathways could be personalised to reflect patient's individual needs
- Risk assessments were completed in each record. These included pressure ulcers, malnutrition and a home environment assessment; this was particularly important for patients undergoing joint replacement surgery. All clinical risk assessments followed national guidance, for example, the use of a recognised score for the prevention of pressure ulcers.

Safeguarding

- A named lead nurse was in post to support staff if they raised any safeguarding concerns. This person had undertaken level 3 safeguarding training. All staff knew who the safeguarding lead was and told us they would always approach them for guidance. The hospital safeguarding lead had good links with the safeguarding lead at the local authority.
- All staff had access to the provider's adult safeguarding policies and procedures via their intranet. A safeguarding resource folder was available on the ward which included flow diagrams to assist staff in following the safeguarding process.
- Staff we spoke with had a good understanding of how to protect patients from harm and abuse. They understood the process and who to refer concerns to.
- Staff who supported patients through gynaecology procedures were aware of how to report female genital mutilation (FGM) incidents.
- Staff undertook an on-line electronic safeguarding adult training module as part of their mandatory training programme. Safeguarding training was undertaken every two years. All staff were required to undertake Level 1, any staff member in a management role, Level 2 and any Directors, Level 3. At the time of our inspection between 80% and 100% of staff had completed adults and children safeguarding training. We noted there had been three new members of staff who had recently started employment at the hospital. This accounted for those staff who had not yet undertaken the training. We saw there were plans in place for these staff to undertake this training as part of their induction and mandatory training.

Mandatory training

- Mandatory training was completed, in the main, using an on-line electronic system, although moving and handling was a face-to-face module taught by the hospital's trainer.

Good

Surgery

- Mandatory training included information governance, infection prevention and control, safeguarding adults and children, dementia awareness, conflict resolution, acute illness management, fire training and health and safety. Basic life support was also included within mandatory training.
- There was an expectation that all staff completed their annual mandatory training. Information provided by the hospital showed that up to February 2016 approximately 71% of staff in theatres and 85% of staff on the ward had completed their mandatory training. This was lower than the hospital's target of 100% but was due to the fact that new staff had started at the hospital and were scheduled to attend and complete their mandatory training.
- Processes were in place to ensure clinicians working at the hospital with practising privileges undertook their mandatory training with their primary employer as part of their appraisal system. Practising privileges related to the consultant surgeons who also worked for the NHS at an acute trust. The hospital monitored this as part of their bi-ennial review of consultants employed at the hospital under practising privileges. Between August 2015 and February 2016 45 bi-ennial reviews had taken place and following our inspection the service shared with us that a further 24 bi-ennial reviews had taken place. There was a plan in place to undertake the remaining bi-ennial reviews between April and August 2016.
- New staff to the hospital underwent a comprehensive induction process which included for nursing staff, completing competency assessments. Induction was tailored to the role and the needs of individual members of staff.
- The resident medical officers (RMOs) who worked in the hospital 24 hours a day were required to undertake mandatory training with the agency that supplied them as part of their contract. This included health and safety, fire training and equality and diversity. There was a service level agreement in place and quarterly reviews were shared with the agency that supplied the RMOs. As part of the contract performance, the Director of Clinical Services at BMI The Lincoln Hospital met with the Directors of the agency to discuss performance, any human resource issues and review training.

Assessing and responding to patient risk

- Patients saw their named consultant at each stage of their patient journey. Patient's needs were assessed throughout their stay and in line with their care pathway.
- A resident medical officer (RMO) was on duty 24 hours a day, seven days a week to respond to any concerns staff may have about a patient's medical condition.
- Surgical procedures were only performed on patients who had been assessed as low risk. Anaesthetists calculated the patient's American Society of Anaesthesiologists (ASA) grade as part of their assessment of patients about to undergo a general anaesthetic. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels with level one being the lowest risk. The hospital only undertook procedures for patients graded as levels one to three.
- The hospital had a service level agreement (SLA) with the local NHS acute trust. This meant that patients could be transferred to the nearby acute trust for care and treatment should their condition deteriorate with the emergency ambulance service providing transport. In the reporting period from October 2014 to September 2015 the numbers of unplanned transfers of inpatients to the local acute trust hospital was four. This demonstrated a consistent low rate of unplanned transfers (per 100 inpatient discharges) over the same period. Each transfer was reported as a clinical incident and was subject to review by the clinical team in order to ascertain whether the transfer could have been avoided or whether the transfer was in the patient's best interest. No preventable issues were identified for the patients being transferred out over this time period.
- BMI The Lincoln hospital was part of the Mid Trent Critical Care Network. If a patient required transfer to a level two or level three facility for critical care this would be undertaken using the Mid Trent Critical Care Network transfer protocol. At the time of our inspection, this facility had never been accessed.
- There was a standard operating procedure (SOP) in place should a patient experience a major haemorrhage (a major haemorrhage is an excessive blood loss which can be life threatening). Staff we spoke with were aware of the SOP and knew what to do in the event a patient haemorrhaged.
- The hospital used a system to record routine physiological observations such as respiratory

(breathing) rate, blood pressure and pulse in order to monitor patient's physical condition. This was used as part of a national early warning score (NEWS). If the score increased nursing staff were alerted to it and a response was instigated. This ranged from increasing the frequency of observations to an urgent review by the patient's consultant or their anaesthetist.

- Patient records we reviewed showed the NEWS charts had been completed. All patients had been stable and escalation was not required.
- All staff at all grades and the RMOs were involved in regular scenarios for cardiac arrest procedures. The scenarios were analysed following their enactment and anyone not performing as well as they should were given additional training. This ensured all staff could respond quickly and efficiently to such situations.
- Goals and actions were in place in patients' care plans dependent upon the post-operative day. They included interventions such as pain management, pressure area care and fluid balance. Staff were required to sign each time these were checked.
- Nursing staff felt confident in contacting consultants by telephone when necessary. Consultants could attend the patient within a short space of time.
- The hospital followed the five steps to safer surgery checks in the operating theatre to ensure any risks to patients were reduced. The five steps to safer surgery are a set of safety checks, for improving performance at safety critical time points within a patient's time in the operating theatre. The nine records we reviewed showed these were completed fully in each case and signed. Those who had not been compliant with the check-list in previous audits had been spoken with; this had been resolved.
- A programme of monthly audits was in place for the five steps to safer surgery checklist. Ten percent of patients notes were audited on a formal basis; this amounted to approximately 26 sets of notes per month. However, an informal check by two members of staff was undertaken of all patients undergoing surgery when clinical records were checked whilst patients were in the recovery area of theatre. This provided immediate feedback to all concerned if a problem was identified.
- A review of ten patient forms for the five steps to safer surgery for February 2016 showed all records were complete with no omissions. We were therefore assured the hospital was taking appropriate steps to ensure patients were safe.
- The hospital predicted blood loss for patients undergoing major surgical procedures. A supply of blood was available in the hospital for use in an emergency. If more blood was required this was available quickly though a SLA with the local NHS acute hospital.
- The hospital undertook endoscopies for private patients only. Although not Joint Advisory Group (JAG) accredited for the endoscopy procedures it was undertaking, the hospital was working towards accreditation. The JAG Accreditation Scheme is based on the principle of independent assessment against recognised standards. It was developed for all endoscopy services and providers across the UK in the NHS and Independent Sector.

Nursing staffing

- BMI The Lincoln Hospital used a validated nurse dependency and skill mix planning tool when planning staffing. The tool was updated daily and in advance to ensure patient dependency and workload was taken into consideration. The ward establishment was stable and could flex to the needs of patients.
- BMI The Lincoln Hospital provided placements for student nurses during their training; at the time of our inspection there were no student nurses working in surgery.
- The surgical ward in the hospital could care for up to 18 patients. Patient numbers were known a week in advance and nursing rotas were undertaken and uplifted into an electronic labour monitoring tool which ensured staffing numbers were calculated according to the number of patients. The labour tool however could be overruled when demand for staff was higher; for example when a high number of major surgical procedures were being undertaken. In those cases additional qualified members of staff were placed on duty to ensure staffing levels were safe and patient needs could be met.
- The base number of qualified staff was two on both day and night duty. A health care support worker was also on duty during the day. At the time of our inspection an additional qualified member of staff was on duty when either of two overseas nurses was working to ensure appropriate support and supervision was available at all times. We observed this during our inspection. This process carried on until the overseas healthcare

professionals received their United Kingdom (UK) professional identification number (PIN) from the Nursing and Midwifery Council (NMC) and they were able to practice independently.
- Staff were allocated to patients to be responsible for when they came on duty and qualified staff were responsible for tasks they had requested health care support workers to undertake.
- Staff we spoke with told us they had enough staff on duty at all times to deliver good individualised care to all patients even though they could sometimes be very busy.
- There was a ratio of 1:4 nurse team leaders to nurses and a ratio of 1:0.3 of nurses to health care support workers.
- Three overseas healthcare professionals had been appointed to theatre duties permanently in January 2016 on a development programme.
- Staff knew what to do if they were concerned about staffing levels. Bank staff were available as and when it was necessary.
- There had been no use of agency nursing staff on the surgical ward between October 2014 and February 2016. Staff told us it was much better using bank staff they knew to support them if required rather than agency staff as it gave staff and patients continuity.
- Handover between shifts was undertaken in a small office on the ward to ensure privacy of confidential information.

Surgical staffing

- There were 99 consultants who had been granted practising privileges at the hospital. Of those 99, 87 had been granted practising privileges for over twelve months. The term 'practising privilege' refers to medical practitioners being granted the right to practice in a hospital after being approved by the medical advisory committee (MAC).All the consultants worked at local NHS trusts. They included those with specialties such as orthopaedics and ophthalmology.
- Consultants visited in-patients at least once every 24 hours and were available via telephone 24 hours a day, seven days a week whilst they had patients in the hospital. If they planned a period of absence a fellow consultant would be identified to cover and the hospital informed at least six weeks in advance.
- Nursing staff informed us they had no difficulties in obtaining help quickly if it was needed to review a patient's care.
- Three resident medical officers (RMOs) provided medical cover 24 hours a day, seven days a week for all patients. Working hours were alternated to ensure one doctor was always on duty. RMOs liaised with consultants to ensure care reflected individual patient needs. BMI The Lincoln Hospital always used the same group of RMOs to ensure continuity of service and to minimise potential risk.
- The operating theatre used for surgical procedures requiring a general anaesthetic was generally in use between 8am and 8pm Monday to Friday and 8am until 4pm on a Saturday. Operations on a Sunday were also undertaken when required.
- The operating theatre used for local anaesthesia and endoscopy procedures was in use between 8am and 8pm Monday to Friday.
- The hospital worked within the recommendations of the Association for Perioperative Practice with regard to numbers of staff on duty during a standard operating list. This comprised two nurses, an operating department practitioner (ODP), a consultant surgeon and an anaesthetist.
- If a patient was required to return to theatre out of hours because of complications, an on-call system was in place to notify staff quickly.
- A newly appointed theatre manager had been in place since December 2015 and although the hospital had advertised for permanent theatre staff, difficulties had been encountered recruiting to such posts. As a result, long term agency staff were in place to ensure safety and continuity of service.
- We were informed by the provider the hospital was a priority in terms of recruitment.

Major incident awareness and training

- BMI The Lincoln Hospital did not have a designated role or responsibility in the nearby acute trust's major incident policy.
- There was a comprehensive business continuity plan in place dated October 2015. It detailed how staff should respond to, for example loss of heating, loss of gas, adverse weather conditions and a bomb threat. The document contained useful contacts with telephone numbers.

Good

Surgery

Are surgery services effective?

Good

We have judged effectiveness in surgical services in the hospital to be good. Patients using the service were receiving effective care and treatment, which met their needs. We found:

- Evidence based care and treatment was planned and delivered to patients in line with current evidence based guidance, standards and legislation.
- Staff were competent to deliver good quality care.
- The hospital provided a seven day a week service with patients having good access to information.
- Pain relief was discussed with patients and administered when required.
- Food and fluids were available in sufficient quantities to ensure patients were safe and comfortable.
- Multi-disciplinary procedures were in place to ensure patients' on-going care was well managed.
- Patients were supported to make decisions. They were well informed about surgical procedures.

However we also found:

- The hospital was not achieving any improvement of the antimicrobial stewardship commissioning for quality and innovation (CQUIN) requirement. The provider informed us this was due to the way the CQUIN was set and at the time of our inspection there was no target set for this CQUIN.
- Nursing staff on the ward informed us they were not always informed by the anaesthetists if patients were going to be late going to theatre.
- Appraisal rates for qualified nurses in theatres equated to 25% due to large changes within the workforce which resulted in appraisal dates for many members of the team falling outside of the calendar year.

Evidence-based care and treatment

- Delivery of day surgery was consistent with the British Association of Day Surgery (BADS) guidelines. BADS promotes excellence in day surgery and provides information to patients, relatives, carers, healthcare professionals and members of the association.
- Care and treatment was delivered to patients in line with the National Institute of Health and Care Excellence (NICE) and Royal Colleges guidelines, for example the Royal College of Surgeons. For example the national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50. Staff assessed patients for the risk venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE guidelines [CG92]. The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines [CG74]. Following discharge, the hospital had implemented a 48-hour follow up call for all hip and knee patients as part of the 30-day SSI audit.
- Surgeons only performed operations they were used to performing at the acute trusts where they were employed. This ensured they were competent and confident in undertaking the procedures.
- Only light sedation was used for patients undergoing endoscopic procedures; this meant their recovery time was quicker.
- Reducing the risk of venous thromboembolism (VTE) was part of the care pathway for major operations. This included the use of anti-embolism stockings and medicine prophylaxis. Prophylaxis is a treatment or medicine designed and used to help prevent a disease from occurring. Patients who had received a planned hip or knee operation for example had this in place.
- During 2015-2016, four commissioning for quality and innovation (CQUIN) requirements had been identified by the Clinical Commissioning Group (CCG) for NHS patients treated at the hospital. Two of the CQUINs related to antimicrobial recording and prescribing. These were selected to seek reassurance that surgical site infections were being identified, recorded in accordance with Public Health England's criteria and BMI policy and where appropriate antimicrobials were being prescribed accordingly. At the time of our inspection there was no target set for this CQUIN. There was on-going discussion with the CCG about this.
- The third CQUIN related to venous thrombosis prophylaxis and the advice that was documented on discharge paperwork. This was chosen following the root cause analysis (RCA) where a patient developed a pulmonary embolism and it had been identified that nursing staff had not documented what advice or precautions had been given to the patient on discharge.

The fourth CQUIN had been selected to provide internal reassurance that correct codes were being used on medication administration charts for medications that had been omitted.

- Regular updates from the Director of Clinical Services were sent to the heads of departments to update them on the outcomes of the audits. Results for quarter three (October to December 2015) showed the hospital had achieved 90% for CQUINs three and four. Targets had been 70% in quarter one and had increased over the following two periods. Each time the hospital had achieved and exceeded the target.
- Good practice alerts were evidenced in the care plan documentation relating to new guidance on particular issues. For example how long patients had to be without clear fluids prior to theatre.
- Comprehensive care pathways were in place for all patients undergoing either local or general anaesthesia. These included anaesthetic assessment and plan, post anaesthetic recovery score (PARS), theatre notes and post-operative care.
- A comprehensive audit of the endoscopy service had been undertaken at the BMI Lincoln Hospital in January 2015. Six issues had been raised as requiring attention. These included automatic endoscope washer testing and staff training. A comprehensive action plan had been put in place. The hospital had either completed all the actions required or were due to complete them by the end of April 2016.

Pain relief

- Patients were given written information relating to pain relief as part of their pre-admission assessment. It included the importance of informing staff about pain and the ways in which pain relief could be given, for example by mouth or via a drip into the blood stream. This meant that patients were empowered to communicate with staff about their pain and obtain the correct pain relieving medicines.
- Staff held conversations with patients prior to discharge about pain relieving medicine.
- The theatre care pathway identified pain as a trigger and prompted staff to assess pain on a regular basis.
- Patients we spoke with immediately following surgery and in their recovery period, informed us they had been given pain relief as soon as they required it and that they had not been in any distress. The hospital used a pain scale to do this which meant staff could give appropriate relief based on the severity of the pain.
- Patients were followed up after 48hrs following discharge via a telephone call and enquiries were made regarding their pain management. Plans to control pain were made if they were in any discomfort.

Nutrition and hydration

- Patients were screened for malnutrition, or the risk of malnutrition, prior to surgery. Patients who had a body mass index under 20 or who had unintentionally lost more than six kilograms of weight in the preceding three months had a more detailed assessment undertaken using the malnutrition universal screening tool (MUST). This ensured patients who were at risk were identified quickly and plans made to mitigate the risk.
- Staff followed guidance on fasting prior to surgery which was based on best practice. This permitted healthy patients requiring a general anaesthetic to eat up to six hours prior to their surgery and to drink water up to two hours before. Nursing staff on the ward informed us they were not always informed by the anaesthetists if patients were going to be late going to theatre; this meant some patients could have had water for longer than was previously arranged. This issue had been raised with anaesthetists who were asked to address it. The location did not routinely audit these delays.
- Water jugs were available to all patients in their rooms. We saw and patients told us these were changed regularly.
- Day case patients were offered a light meal and a drink following their procedure and prior to discharge.
- Patient-led assessments of the care environment (PLACE) dated February 2015 to June 2015 scored 99% for food. This compared to 93% average for all independent sector acute hospitals.
- Care plans included prompts for nursing staff to assess patients' nutritional and fluid intake and to take action where appropriate.
- Fluid charts were maintained until patients had a good fluid intake and urinary output following their surgical procedure.
- Medication was prescribed for patients to ensure the effective management of nausea and vomiting should this occur post operatively.

Good

Surgery

Patient outcomes

- Under a service level agreement with a local acute NHS hospital, there had been four cases of unplanned transfer in the reporting period October 2014 to September 2015.In the same period there had been two cases of unplanned readmissions within 29 days of discharge. CQC had assessed this to be a reduced rate of unplanned readmissions (per 100 inpatient discharges) in that period.
- BMI The Lincoln hospital took part in national audits focusing on patient outcomes; such as the National Joint Register (NJR) and where appropriate the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- The National Joint Registry (NJR) collects information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. Outcome measures data from 344 completed operations had been submitted to the NJR for 2015. The hospital's consent rate was higher than 95%, which met the NJR requirements for 2015. Between April 2014 and February 2015 BMI The Lincoln Hospital had not been identified as a potential outlier for primary procedures.
- The service had recently enrolled in The National Audit Project on perioperative anaphylaxis run by the Royal College of Anaesthetists. The project will look at anaphylaxis before, during and after operations. No results were available at the time of our inspection.
- Results of patient outcomes were compared within the provider as a group through the clinical dashboards. The clinical dashboard data was sourced from the incident and risk management system currently used by the provider. Similar sized hospitals were grouped together and we saw an example where four measures were compared. These were clinical incidents, severe incidents, inpatient falls and transfers out. BMI The Lincoln Hospital had not been an outlier for any of these measures.
- The provider was also working with Private Healthcare Information Network (PHIN) to improve reporting of patient outcomes across the independent sector. The information shared should improve transparency and be comparable with data supplied by the National Health Service (NHS).
- The hospital submitted results based on a national safety thermometer tool which were compared and contrasted with other local providers of care.
- Patient reported outcome measures (PROMS) for hip and knee replacements (NHS patients only) for the period April 2014 to March 2015 were within the expected range of the England average.
- Patient reported outcome measures (PROMS) for groin hernia repair (NHS patients only) for the period April 2014 to March 2015 were within the expected range of the England average.
- The hospital wrote letters to patients' GP's on their discharge. This ensured GPs were aware of a patient's admission and the treatment they had received. This was documented in the patient's care pathway.

Competent staff

- The provider had systems in place to ensure qualified doctors and nurses' registration status had been renewed on an annual basis.
- All nursing staff undertook internal rotation. This meant that nurses worked a combination of night and day duty and ensured their skills were up to date.
- Information from the provider showed high levels of staff appraisal rates, equal or greater than 75%, in 2015 for some of the staff working in inpatient departments, for example qualified nurses equated to 92%. However, appraisal rates for qualified nurses in theatres only equated to 25%. This was because of large changes within the workforce which resulted in appraisal dates for many members of the team falling outside of the calendar year. The provider informed us this would improve throughout 2016.
- Applications from consultants to obtain practising privileges were assessed by the Medical Advisory Committee (MAC) (The term practising privileges refers to consultants being granted the right to practise in the hospital). The process involved checking their suitability to work at the hospital and checks on their qualifications as well as references and any disclosures

under the Disclosure and Barring Service (DBS). For consultants with practising privileges, the hospital kept a record of their employing NHS trust together with the responsible officer's name.

- All consultant surgeons and anaesthetists were required to maintain current practising privileges in line with the BMI practising privileges policy. The personal assistant to the Executive Director monitored information stored for each consultant to ensure practising privileges were reviewed in a timely manner. Each individual consultant was responsible for keeping their information up to date and current. Records were closely monitored. Any delay in submission of evidence of appraisal and revalidation was flagged and where necessary practising privileges were suspended until the required information had been obtained.
- We reviewed the personal files for 11 consultants working at the hospital under a practising privileges arrangement. All 11 files demonstrated arrangements for granting and reviewing practising privileges were appropriate and staff were competent and skilled to carry out the care and treatment they provided. However six of the 11 files did not contain two references. We raised this with the Executive Director who took immediate steps to complete an analysis of all consultant files to establish how many of the files did not have two references. This analysis identified that 44 consultants did not have two references on file. This was because these consultants had had been awarded practising privileges over ten years ago when the hospital was run by a different provider and references had not been consistently filed. This was escalated to the BMI Group Medical Director who clarified there was no need to seek references from those consultants who had been granted practising privileges in excess of ten years.
- BMI The Lincoln Hospital had appropriate procedures in place to review practising privileges on an annual basis and issues related to performance were dealt with as they arose.
- There was a robust process in place to ensure doctors had undergone revalidation. 100% of the consultants working at BMI The Lincoln Hospital had undergone revalidation.
- There were processes in place for all staff working for the provider to ensure issues were dealt with effectively. The responsible officer for medical staff at the employing NHS trust would be contacted if concerns were raised with regard to a consultant's working practices.
- A formal and comprehensive induction system was in place for all new members of staff. It included role specific training but also incorporated core elements of infection prevention and control, basic or intermediate life support and safeguarding. Competency programmes were in place for new members of staff, for example venepuncture for nurses. (Venepuncture is the process of obtaining intravenous access for the purpose of intravenous therapy or for taking blood samples of venous blood). The programme included both a practical and knowledge assessment. We reviewed a competency document for qualified nurses and spoke with a newly recruited overseas member of staff who was waiting for their professional identification number (PIN) from the Nursing and Midwifery Council (NMC). They told us they felt well supported by their mentor and were not permitted to practice unsupervised until they had received their PIN number and completed their training.
- Health Care Support Workers (HCSW) were being supported to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers need to adhere to in their daily working lives.
- The hospital had specialist nurses in place for tissue viability and infection prevention and control. Staff on wards informed us they took guidance from the specialist nurses when they requested it and found them extremely useful and knowledgeable.
- Staff were able to access additional training to keep up to date and acquire additional skills to ensure patients received good quality care.
- Training was undertaken either on site or at external venues, the majority of which were at other hospitals within the provider group.
- Members of staff we spoke with told us there was always a lot to learn but felt supported by senior members of their team and were able to ask for advice if it was needed.

Multidisciplinary working (in relation to this core service only)

- A multidisciplinary team (MDT) approach was evident throughout the service. There was effective daily

communication between multidisciplinary teams within the ward and theatres. Staff told us they had a good relationship with consultants and the resident medical officer (RMO).

- Patient records showed that there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.
- Consultants reviewed their patients every day and where necessary a MDT meeting was arranged with appropriate members of the team.
- Referrals to social services were undertaken to arrange for intermediate care. A senior member of staff informed us patients would not be sent home until it was safe and appropriate to do so.
- Physiotherapy was offered to patients both prior to and following joint surgery and patients we spoke with told us they felt this benefited them greatly. The hospital ran 'joint schools' for patients about to undergo surgery to discuss the importance of physiotherapy in their recovery and the exercises they would need to undertake. Patients received physiotherapy within 12 hours of surgery.
- From November 2015 a hospital-wide safety planning meeting had been taking place on a weekly basis with staff from theatres, imaging, physiotherapy and pathology to enable planning for patients due to be admitted within the following seven to ten days. Consultants and anaesthetists were involved when this was necessary.
- Any specialist staff that were required, for example an oncologist, would be approached as and when necessary. This meant patients received timely access to the services most appropriate for their needs.
- When patients were discharged, the hospital worked well with external services. A letter was sent to the patient's GP to inform them of the treatment and care that had been provided.
- There were a number of service level agreements in place for services required to support the hospital for example the provision of Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scans by an external provider.

Seven-day services

- The hospital had two operating theatres, one of which was used for endoscopy procedures and operations not requiring a general anaesthetic. Plans were in place to upgrade the theatre so it could be used for patients requiring general anaesthesia. The theatres were generally used during the hours of 8am and 8pm six days a week and were closed on Sundays.
- On-call arrangements were in place to ensure patients had rapid access to services if required.
- Physiotherapy services were provided seven days a week.
- Consultants were responsible for the care of their patients from pre-admission consultation until the conclusion of their episode of treatment. Patients were seen daily by their consultant, including at weekends.
- The resident medical officer (RMO) was available 24 hrs per day seven days per week.
- Imaging and x-ray facilities were available from 8am until 6pm Monday to Friday. On-call radiology staff provided a weekend and out of hours service if required and a consultant radiologist was able to report on any images taken out of hours.
- A virtual pharmacy service was accessible seven days a week.

Access to information

- Patients were required to complete a comprehensive pre-admission questionnaire prior to their surgery. This included their past medical history and their current medication.
- For some patients, referral notes from a GP were available with comprehensive patient information prior to their initial consultation, for example NHS e-referral patients. This ensured the hospital had all the information required to make informed judgements about patient care.
- Prior to surgery, patients were required to attend an assessment clinic run by a qualified nurse. The booking form and NHS letter were available at the clinic for NHS patients. For self funded patients the nurse obtained the information at the clinic.
- Any electrocardiographs (ECGs) that were required for patients were read by the resident medical officer (RMO) at the end of the day and any concerns raised with an anaesthetist.
- Further information was gathered during the assessment to judge whether a patient was suitable for surgery, for example height, weight and blood pressure. Appropriate blood tests were also undertaken.

Good

Surgery

- There were paper based records for each patient. All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- Information such as audit results, performance information and internal correspondence were displayed in all the areas we inspected. Staff could access information such as policies and procedures from the hospital's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a consent policy in place and staff we spoke with were aware of it.
- Different types of consent forms were available for different people involved in the process and when different types of anaesthetic were used. For example patients, health professionals and those requiring a general or local anaesthetic.
- Where an interpreter had been used there was a place on the consent form for their signature to state they had relayed the information to the patient correctly.
- The consent forms explained what staff must do if patients could not make an informed choice about consenting to treatment. Staff knew what to do in those circumstances and how to document it.
- Staff we spoke with had received training about consent and the Mental Capacity Act 2005 (MCA). Staff stated if they had concerns about a patient's capacity they would refer the issue to a senior member of staff. Senior members of staff were aware of their responsibilities under the Mental Capacity Act 2005.
- We reviewed five consent forms, all had been completed and signed appropriately.
- Patients we spoke with informed us they were given as much information as they required from their consultant prior to their operation, to enable them to give informed consent to the procedure. Any risks with regard to the operation or procedure had been explained to them.
- In the past twelve months, the hospital had not referred any patients for a Deprivation of Liberty Safeguard (DoLS) assessment. [DoLS is part of the Mental Capacity Act 2005. This aims to make sure that people in such places as care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom].
- BMI The Lincoln Hospital had an up-to-date adult resuscitation policy which clearly identified the process for decisions relating to 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders. A Unified DNACPR form was used at BMI The Lincoln Hospital. The form took into account the person's capacity to make decisions.
- At the time of our inspection there were no patients with a DNA CPR order in place. Patients' resuscitation status was assessed and documented both pre and during their admission. We saw there was a space within the health questionnaire and within the provider's admission pathway booklets.

Are surgery services caring?

Good

We have judged the caring in surgical services to be good. We found:

- Feedback from patients and those important to them was extremely positive about the care they had received and the way staff treated them.
- All staff treated patients with dignity and respect as well as helping them to cope emotionally with their treatment and care.
- Patients were supported and involved as partners in their care. Staff explained care and treatment in a way patients understood.
- The provider had achieved high scores in patient feedback from both the NHS Friends and Family test and the hospital's satisfaction survey.

Compassionate care

- All patients and relatives we spoke with were very complimentary about the staff, giving us positive feedback about the care they had received. One patient we saw had returned for a second operation in the hospital and wanted to return there because of the good care they had received. Another patient told us they could not fault the attention they had received.
- Staff spoke with patients politely and in a friendly manner.

Good

Surgery

- Staff we spoke with told us they enjoyed working in the hospital because of the high quality care they could deliver and took pride in the standards they could achieve.
- Patients told us the care they received was timely and very good. Patients told us staff treated them with dignity and respect. Patients were cared for in individual rooms; we saw staff knocking on doors and waiting for a response before entering.
- For the 15 months between September 2014 and November 2015, the hospital in-patient survey had scored between 98% and 100% of patients recommending the service. Of those months, 11 of them had scored 100%. The sample size for this reporting period was 2831 patients.
- The NHS Friends and Family Test is a satisfaction survey that measures patient's satisfaction with the care they have received and asks if they would recommend the service to their friends and family. For the period between April 2015 and September 2015, 100% of NHS patients who completed this survey said they would recommend it with a response rate of between 38% and 51%. It can therefore be seen the two surveys produced similar results.
- Patients told us they felt the staff treated them 'like family' and did not hesitate to ask questions. One patient told us, "They always have time; it's wonderful."

Understanding and involvement of patients and those close to them

- Patients and relatives told us they had felt completely involved with their care and had received explanations of the procedures they would have, with the care and support they would need following their operation.
- Patient records we reviewed showed completed pre-admission assessments that included additional space for dietary requirements and sleep and rest patterns.
- We observed staff explaining exactly what was happening to patients both in the surgical ward and in theatres.
- We saw written information in the form of leaflets given to patients to take home to ensure they had the details to hand.
- Discharge planning was discussed pre-operatively and with patients and relatives to ensure appropriate post-operative caring arrangements were in place prior to discharge.

Emotional support

- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive about their admission and procedure.
- One patient informed us about how they had been encouraged to mobilise following a knee operation. This had made them feel much less worried about it.
- A quiet room was available to discuss bad news with patients and relatives if this was required.
- Leaders of different religious faiths could be requested to visit at short notice if this was necessary.

Are surgery services responsive?

Good

We have judged responsiveness in surgical services to be good. Patient's needs were met through the way services were organised and delivered. We found:

- Services were planned and delivered in a way which met the needs of the local population.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients were admitted on a planned basis for elective surgery, this included self funded patients and NHS patients.
- Staff provided care in a timely way and NHS and private patients' experienced the same quality of care.
- Complaints about services were responded to within the hospital's timescales. Any actions required from complaints to improve the service were completed.
- The needs of different people were taken into account when planning and delivering services, for example those who had a learning disability or those living with dementia were identified at the earliest stage of the referral process. A senior manager took responsibility for assessing whether their needs could be met by the service and steps were taken to ensure they were appropriately cared for.

However we also found:

- Only 58% of staff had undertaken training to care for people living with a dementia.
- Patients undergoing endoscopic procedures did not have any dedicated recovery area for their use.

- There was no clear written policy or treatment criteria for patients living with dementia or patients with a learning disability.

Service planning and delivery to meet the needs of local people

- Whilst the core of patients were self funding patients, 40% of patients in the year October 2014 to September 2015 were funded by the NHS through the 'NHS e-referral' service system. This has resulted in local people who are deemed to be low risk receiving timely interventions for their required procedures. The admission process and care provided was the same for self-funded patients and NHS patients.
- Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative assessment. Where a patient was identified as needing surgery, staff could plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- The provider was able to meet the needs of local people whose diverse needs were increasing and addressed the different cultures of its staff group.
- The provider had equality and diversity policy in place which stated it was committed to ensuring that no one should have negative experiences when receiving a service. In addition it stated that the hospital must make reasonable adjustments to cater for the needs of disabled staff, patients and service users according to the requirements of the Disability Discrimination Act (DDA) 1995.
- The national target time for 'referral to treatment time' for NHS patients is 18 weeks and it is expected that 90% of patients are seen within this timescale. The hospital had achieved in excess of this for seven of the nine months between April 2015 and December 2015. In the months of October 2015 and December 2015 they had achieved 87% and 88% respectively.
- Patient-led assessments of the care environment (PLACE) between February 2015 and June 2015 were the same or higher than the England average for six of the assessments and lower at 75% for the dementia assessment. In October 2015 light fittings were replaced to improve lighting and prior to our inspection carpets were replaced with laminate flooring. BMI The Lincoln Hospital was liaising corporately to ensure they could procure signage that was dementia friendly. Following our inspection, the Executive Director told us that proposals were being designed to upgrade patient rooms to ensure they were 'dementia friendly'.

Access and flow

- Our inspection did not highlight any concerns related to the admission, transfer or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- The national standard for referral to treatment (RTT) time states that 95% of patients should start consultant led treatment on admission to the hospital within 18 weeks of referral. Data showed that between April 2014 and October 2015 the provider achieved 95% or above for eight of those months.
- Occupancy rates on the ward meant that any day case patients who needed to stay overnight because they were not fit to go home could do so. Between January 2015 and January 2016 there had been between two and eight patients out of 100 per month who had converted from a day case to an overnight stay.
- Only qualified staff, who were competent to do so, undertook pre-operative assessments of patients prior to their procedure being undertaken.
- All pathways stated the average length of stay that patients should experience for their procedure, for example, three days for a knee replacement. Staff informed us this was usually achieved with good care and treatment. However, if complications occurred the time could be extended. Between October 2015 and the end of March 2016 the average length of stay for hip or knee surgery was 3 days.
- Information from the provider showed cancellations for procedures amounted to 14 between April and December 2015. The highest level of cancellations, amounting to five in total, was in July 2015.Seven of these related to cancellation on the day due to patients being clinically unfit for surgery when assessed by the surgeon or anaesthetist, three were due to unplanned staff absences in theatre and two related to environmental factors, one related to failure of a surgeon to attend and one related to failure of a surgeon to provide a first assistant to help with the procedure. All National Health Service patients were rebooked within 28 days and self funded patients were offered surgery at the next available convenient date.

- Discharge planning was covered during pre-assessment to determine how many days patients would need on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.

Meeting people's individual needs

- Information leaflets were given to patients regarding their planned procedure or treatment. They were generally handed to patients during their assessment or sent to them with their outpatient appointment letter.
- Information leaflets given to patients were written in English only. If leaflets were required in different languages an external company was used to translate the information.
- Staff used both telephone and face to face interpreting services for patients whose first language was not English. Staff who worked at the hospital could also be used to translate if this was appropriate. However, family could not be used when clinical matters were discussed; this was not considered as good practice.
- If relatives wished to stay with their loved ones this was facilitated after discussion with a member of staff.
- Staff told us that equipment could be ordered to meet the needs of bariatric patients. Bariatric patients are those who are termed as obese.
- Patients undergoing endoscopic procedures were recovered in the same recovery area as patients who had undergone a general anaesthetic.
- Patients with a learning disability or those living with dementia were identified at the earliest stage of the referral process. A senior manager took responsibility for assessing whether their needs could be met by the service and steps were taken to ensure they were appropriately cared for. We were informed that patients with a learning disability did not present very often because those patients were usually treated at the local NHS acute trust.
- Dementia awareness training had been introduced as an e-learning module as part of mandatory training from December 2015. At the time of our inspection the compliance rate was 58%.
- There was no clear written policy or treatment criteria for patients living with dementia or patients with a learning disability. However staff shared information with us about a patient who had been assessed pre-operatively who had a diagnosis of dementia. The focus was on whether the hospital was equipped to meet the needs of the patient. It was decided to bring the patient into the hospital for a trial to see how they coped in the hospital environment. The patient coped well and the planned operation successfully went ahead. We saw documentation within the patient's medical records that supported what we had been told. This meant the hospital did not exclude patients purely on the grounds that they had a condition such as dementia.
- All patients over the age of 65 years were screened for dementia at their preadmission assessment using a dementia screening tool. If the referrer indicated concerns and a patient was younger than 65 they would also be screened for dementia. If there was any indication that a patient was developing dementia, a letter was sent to their GP for appropriate care, treatment and onward referral.
- Because BMI The Lincoln Hospital was a private hospital patients who wanted to convert from being a day case patient to being an inpatient were able to do so. The Executive Director told us there had been occasions where elderly patients who lived alone had chosen to leave the hospital the following morning rather than the same evening.
- The hospital provided three meals a day for all in-patients and choices were varied. The service used a private contractor for their food delivery service. Menus were offered depending upon patients' personal, medical or religious needs, for example Halal, vegan, vegetarian and Kosher foods.
- Staff demonstrated an awareness of the religious needs of patients and staff. Facilities were available for patients and staff following the Islamic faith.
- Physiotherapy was offered as group post-operative exercise sessions or one to one; this depended upon patient preferences.
- Patients with specific needs, for example poor mobility, were individually assessed and their needs documented.
- Signage in all areas was small and only in English. This did not take into account patients with poor eyesight or whose first language was not English.
- The hospital had a chaperone policy in place during examination, treatment and care issued in September 2015. It stated that patients had the right to request a

chaperone when undergoing any procedure or examination to safeguard the patient and the healthcare professional. Staff we spoke with were aware of this.

Learning from complaints and concerns

- A comprehensive complaints policy was in place which stated all staff working in the service must adhere to the policy. The policy was based on recommendations made within national reports and inquiries, in particular the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), the Francis Report and the Berwick Review, both of which focused on patient safety.
- The hospital had four complaints in 2015 relating to the surgical ward and one relating to theatres. Of the four relating to the ward, two related to discharge processes and another complained about inattentive staff. The complaint relating to theatres concerned the cancellation of a procedure because of staff shortages. A summary of all complaints are shared with staff each month and complaints were displayed on the clinical governance board along with any learning outcomes to prevent future reoccurrence. Complaints were also discussed at the Medical Advisory Committee (MAC) meetings and clinical governance meetings. Following our inspection the Executive Director informed us that the first experience focus group meeting had taken place where complaints were discussed.
- Information about how to raise a complaint was displayed throughout the hospital.
- The Executive Director undertook responsibility for responding to all written complaints.
- In line with the provider's policy, all complaints had been acknowledged within 48 hours and responded to in full within 20 working days. This demonstrated that complaints were handled effectively within the provider's complaints policy timeframe.
- Information from the provider showed themes and trends from complaints related to pricing, payments for procedures and delay in GPs receiving letters. Detailed actions were taken to address all the identified issues.
- We were given examples of learning from complaints such as changes to the pricing structure so patients knew exactly how much their operation was going to cost regardless of where they had their operation around the country.

Are surgery services well-led?

Good

We have judged well-led in surgical services to be good. The leadership, governance and culture promoted the delivery of high quality person-centred care. We found:

- There was a clear vision with strategies in place; staff were aware of these.
- There was a clear and robust governance and risk management structure in place.
- There were clearly defined and visible leadership roles in place with senior staff providing motivation to their teams.
- Changes had been made to service delivery following feedback from staff, patients and consultants.
- Local patient questionnaires had been used for patient experience planning. Patients received calls within 48 hours following discharge which provided patients with an opportunity to feed back on their experience.

However we also found:

- There had been low levels of staff stability, (less than 60%), for health Care Support Workers working in the theatre department in the reporting period October 2014 to September 2015.

Vision and strategy for this this core service

- The service had a clear corporate vision in place to be achieved by 2020. This was underpinned by eight strategic priorities including superior patient care, an employer of choice and continual updating of facilities.
- All staff we spoke with had an understanding of the hospital strategy and were aware plans were in place to re-commission the second theatre in order to offer general anaesthesia and increase capacity at the hospital.
- The strategy of the service was displayed on hospital walls in all areas we visited.
- The mission statement for the service was 'passionate about care'. Staff were aware of this.

Governance, risk management and quality measurement for this core service

- There was a clear and robust governance and risk management structure with accountabilities for

assurance being well defined. The executive team used various methods to gain assurances from the ward to the board. There were committees in place which fed into the clinical governance committee and the Medical Advisory Committee (MAC). Committees included health and safety, heads of department and infection prevention and control.

- The MAC met quarterly and the minutes for the last three MAC meetings demonstrated that key governance areas were discussed including incidents, complaints and practising privileges.
- There were terms of reference to role in supporting the hospital. This document however was not dated. This meant there was a risk that staff accessing the document could not be sure they were referring to the correct or most up-to-date version.
- Information was shared in a top-down, down-up and sideways process throughout the management structure. This ensured all staff were aware of the issues raised and discussed.
- Risks were identified and well managed locally with a risk register in place. We saw evidence of risk assessments undertaken in areas of concern with controls in place and actions taken to mitigate risks. For example the purchase of a new blood fridge had been required and this was in place during our inspection.
- The Director of Clinical Services was also the Director of Infection Prevention and Control (DIPC), and was responsible for coordinating audits and reviewing serious incidents. Activity and outcomes were monitored through monthly clinical governance meetings.
- There was a hospital wide risk register which highlighted key risks to the service. Risks were discussed at monthly senior management team meetings and we saw risks were weighted depending on severity and actions were taken to mitigate them. The risk register was monitored through the clinical governance committee.
- Performance activity and quality measurement was recorded and reported centrally to allow comparison with other BMI hospitals.
- There was a positive working relationship with the local clinical commissioning group (CCG). Senior managers met with the commissioners quarterly to review the hospital's performance via their results of specific measured outcomes for quality and innovation (CQUIN). Four CQUIN's were in place for the year 2015/16.
- The Director of Clinical Services had taken the lead on environmental changes to ensure people with dementia were fully supported. In 2015 a patient-led assessment of the care environment (PLACE) audit highlighted carpets as being a risk for patients living with dementia. This was identified as a risk on the hospital's risk register and this was addressed as part of a refurbishment programme where carpets were replaced with laminate floors. There were also plans to discuss appropriate dementia friendly signage throughout the hospital.

Leadership / culture of service related to this core service

- Although a relatively new senior leadership team, they all displayed the skills, knowledge and experience required to lead. This was demonstrated through their attitude, values and commitment to ensure staff felt valued and involved in decision making throughout the hospital.
- There were clearly defined and visible local leadership roles at hospital wide and local levels. Senior staff provided clear leadership and motivation to their teams. The leadership team were known to staff and were visible throughout the hospital on a daily basis talking with patients and observing clinical practice including attendance during theatre lists.
- The Executive Director for the hospital was aware of their responsibility under the duty of candour.
- The senior management team demonstrated a proactive approach to improving the services. This was observed in the hospital business plan.
- Pharmacy staff were well supported and staff informed us the group pharmacist was very accessible.
- Staff we met were all welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service.
- There was a flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed between the multidisciplinary teams and other agencies.
- Staff felt valued and felt that the managers were supportive and approachable. Staff were encouraged to develop to enable career progression within the service.
- A team leader was available in the surgical ward; they had been in post for a number of years and told us they

enjoyed their work and felt able to approach all the senior managers if a problem arose. They had confidence in the leadership team and felt that issues would be addressed promptly.

- We were informed by theatre staff the newly appointed theatre manager had been encouraged to make improvements. Theatre managers across the group's hospitals met to share audits, standards and good practice.
- Members of ward staff and theatre staff told us of their commitment in providing a safe and caring service for all patients. We saw and heard there was a good morale amongst staff and the caring we observed confirmed this. Staff acknowledged they could be busy at times but always felt they had the time to care on an individual basis which benefited staff and patients alike.
- There was an open culture in the hospital with non-medical staff feeling able to speak with medical staff on an equal basis.
- There had been low rates of sickness (less than 10%) in the reporting period October 2014 to September 2015 for all inpatient staff groups. There was an exception for Healthcare Support Workers (HCSW) working in inpatient departments who experienced moderate levels of sickness (between 10% and 19%) in February 2014.
- The hospital had experienced high levels of staff stability, equal to or greater than 80%, for all inpatient staff groups in the reporting period October 2014 to September 2015 except HCSWs which had been 67%. In the same reporting period there had been high levels of staff stability, equal to or greater than 80%, in the same reporting period for nurses and operating department practitioners working in the theatre department.
- There had been low levels of staff stability, (less than 60%), for health Care Support Workers working in the theatre department in the same reporting period.

Public and staff engagement

- Local patient questionnaires were available and themes were collated and used for patient experience planning. Patients received follow up calls within 48 hours following discharge which provided patients with an opportunity to feed back on their experience. The provider informed us they responded to feedback from both patients and staff.
- Changes had been made to service delivery following feedback from staff, patients and consultants. Examples of these included service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years. A 'bring and share' meal to celebrate the diversity of the workforce had been part of the service of recognition.
- A 'stay and go' exercise had been completed by the Executive Director with staff being asked what they would like to see both stay and go. Refurbishment of the surgical ward had been undertaken as a result.
- A 'you said, we did' feature had been introduced. This had resulted in intravenous drip stands being replaced and the purchase of two electrocardiograph (ECG) machines.
- Amendment of appointment letters to provide additional information on fees for patients, posters in outpatients informing patients of charges and a rolling programme of decoration had been undertaken following feedback from patient-led assessments of the care environment audit.
- The hospital participated in the BMI Healthcare staff survey. However, the survey had not taken place in 2014 due a period of consultation with staff regarding the terms and conditions of their contracts. A further survey had been undertaken for 2015 but the results were not available at the time of our inspection.
- Until the end of 2015, a questionnaire and on-line survey was used to undertake staff exit interviews. The organisation had recognised the process was not effective as the data was not reviewed locally at site level to make any improvements or changes. The corporate human resources (HR) team therefore rolled out a new process for exit interviews using different software which measured staff experience. The results could be downloaded by the hospital each month. As this was a new process, the hospital had not collated any data at the time of our inspection.
- The hospital had very positive relationships within the local health economy including commissioners, local acute hospital trust, local university and community-based assessment and treatment services.
- At our inspection the Executive Director told us they were looking to set up a patient experience focus group. Following our inspection we saw that a patient experience focus group had taken place in March 2016. There were terms of reference and a further meeting had been set to take place a month later. The focus group consisted of front line staff that could effect changes in patient experience at various points of

contact throughout the hospital. We saw evidence that once the focus group was established, service users would be invited to join the group. This group gave staff a chance to share information that concerned patients with the aim of improving the patient experience.

Innovation, improvement and sustainability

- Patients over the age of 65 were screened for dementia at the pre-assessment stage using a screening tool to identify any risks prior to admission. Where appropriate actions were taken to ensure patients were given every opportunity to have their treatment at the hospital. We saw an example where a patient with a diagnosis of advanced dementia had been given the opportunity to stay at the hospital overnight before their surgery. This was to assess how the patient would cope within the hospital environment. This also enabled a full multi-disciplinary team (MDT) assessment to plan the patient's care needs. Following the patient's overnight stay, the MDT met with the patient and their family to discuss how the patient had managed overnight and ultimately, this enabled the team to assess whether they could provide the support and care the patient required. The patient went on to receive successful joint replacement surgery.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatients and diagnostic imaging services at BMI The Lincoln Hospital covered a wide range of specialties including neurology, gynaecology, dermatology, cardiology, orthopaedics, ear nose and throat (ENT), physiotherapy, urology, gastroenterology cosmetic surgery and general surgery. The diagnostic and imaging department carried out x-rays and ultrasound scans. More complex tests such as magnetic resonance imaging (MRI) and computerised tomography (CT) scans were provided by an external provider on certain days of the week at BMI The Lincoln Hospital.

BMI The Lincoln Hospital provided outpatient services for adults over the age of 18. Appointments were offered from 8am to 9pm Monday to Friday with some additional clinics on Saturdays.

The Outpatients Department (OPD) was situated on the first floor near the theatres and consisted of seven consulting rooms, a pre-assessment room, an ambulatory care room, two treatment rooms for minor procedures, cardiology and an eye clinic. The imaging and diagnostics department was based on the ground floor. The physiotherapy department and gym was situated in a separate building very close to the main hospital. Patients were referred by their General Practitioner (GP), through consultants' private practice or as self-referrals. NHS services were commissioned by local clinical commissioning groups (CCGs).

As part of our inspection we spoke with eight patients and 16 members of staff including consultants across the different specialities, healthcare assistants, physiotherapists, radiographers, administrative staff, and team leaders. We observed care and looked at 13 sets of patient medical records. Five sets in the OPD, five sets in the physiotherapy department and three sets in radiology.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated the Outpatients and Diagnostic Imaging service at BMI The Lincoln hospital as good overall.

Systems were in place for keeping patients safe. Staff were aware how to report incidents, safeguarding issues and were aware of the Mental Capacity Act 2005 and the Duty of Candour processes.

Sufficient equipment was available and well maintained, and appropriately checked. Records were securely stored, legible, signed, dated and up to date. Staff completed mandatory training courses with good compliance rates. Staffing levels were sufficient to meet the needs of patients.

Patients received care and treatment in line clinical care pathways and local and national guidance. Patients were assessed for pain relief and provided with medication or treatment where appropriate. Staff confirmed they had received yearly appraisals. We observed effective multi-disciplinary working and staff sought consent from patients in accordance with policy.

Staff were enthusiastic and caring. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received regardless of how they were referred or funded.

Waiting times for outpatient appointments were within the national guidelines. Staff were flexible in their working day to accommodate patients for scans and x-rays at short notice. Interpreters could be booked for patients whose first language was not English, if required. Wheelchair access was available throughout the hospital.

BMI The Lincoln Hospital's strategy and vision was embedded in the departments and staff embraced the values in the work they undertook. There were clearly defined and visible local leadership roles in each speciality within the outpatients and diagnostic imaging areas. Team leaders provided visible leadership and motivation to their teams. The services were represented at executive level and there was appropriate management of quality, governance and risks at a local level.

Are outpatients and diagnostic imaging services safe?

Good

We have judged the safety of outpatients and diagnostic imaging services as good. Patients were protected from avoidable harm and abuse.

We found:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses, and learning from incidents was shared widely in practice.
- There was an effective process for the investigation of serious incidents and a good understanding and use of the Duty of Candour (meaning staff should act in an open and transparent way in relation to care and treatment provided). Staff told us they would apologise and inform the patients or their carers if incidents occurred.
- Medicines were managed and stored safely.
- All areas we inspected were visibly clean and uncluttered.
- Records were stored safely, documentation was clear, dated and signed.
- Staffing levels were sufficient to meet the needs of patients.
- Staff had received up-to-date relevant mandatory training which was relevant to their role.
- Staff checked emergency equipment daily.

However we also found:

- Seating within the waiting areas of the outpatient department did not comply with Health Building Note (HBN) 00-09. The seating was not covered with a washable fabric. This meant if the fabric became soiled it could not be adequately cleaned.
- Hospital data showed that 74% of staff had received Mental Capacity Act and Deprivation of Liberty Safeguards training.

Incidents

Good

Outpatients and diagnostic imaging

- All staff we spoke with knew how to report incidents through the hospital's paper based reporting system. They were aware of the types of incidents they needed to escalate to the senior team and report. Staff told us they were encouraged to report incidents.
- All incidents were reviewed and investigated by the Director of Clinical Services and discussed at the by-monthly clinical governance meetings. The head of department would share findings from relevant incidents with their staff but because there were not many incidents it was difficult to identify themes. There were very few incidents reported for OPD.
- We saw minutes of meetings in outpatient, radiology and physiotherapy departments which demonstrated that outcomes and learning from incidents had been shared at meetings and changes in practice had been made where required.
- The service had not reported any Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or magnet related events incidents in the last 12 months.
- Staff were familiar with the term 'duty of candour' (meaning they should act in an open and transparent way in relation to care and treatment provided) although they had not had reason to use it. Staff told us they would apologise and inform the patients or their carers if an incident of avoidable harm occurred.

Cleanliness, infection control and hygiene

- The outpatient and diagnostic imaging department was visibly clean, tidy and free from clutter. A corporate-wide cleaning schedule was introduced in December 2015 for a consistent approach to cleaning regimes.
- All clinic rooms had working facilities for handwashing, with enough paper towels and protective clothing available to use when necessary.
- Personal protective equipment, such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety and reduce risks of cross infection when performing procedures.
- Domestic and clinical waste was disposed of correctly. We saw appropriate facilities for disposal of clinical waste and sharps such as needles located in the outpatient and diagnostic imaging department. All sharps bins were assembled correctly, signed on assembly and had their temporary closure mechanism in place.
- Staff adhered to 'bare below the elbow' guidance and used appropriate protective personal equipment (PPE), where required whilst delivering care. The last hand hygiene audit showed a 100% level of compliance in December 2015.
- Equipment was well maintained, and appropriately checked, it was visibly clean and the hospital used 'I am clean' stickers to identify that the item had been cleaned.
- The Director of Clinical Services was also the Director of Infection Prevention and Control (DIPC), and was responsible for coordinating audits.
- In addition to the director of infection prevention and control, the hospital employed an infection control nurse to provide training and to liaise with staff so patients who acquired infections could be identified and treated promptly.
- Over the last 12 months there had been no reported cases of healthcare-associated infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.diff) or, Methicillin Sensitive Staphylococcus Aureus (MSSA)for the outpatients and diagnostic imaging department. MRSA, MSSA and C.Diff are all infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection that is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C.Diff is a form of bacteria that affects the digestive system and commonly associated with people who have been taking antibiotics.
- Seating within the waiting areas of the outpatient department did not comply with Health Building Note (HBN) 00-09. The seating was not covered with a washable fabric. This meant if the fabric became soiled it could not be adequately cleaned.

Environment and equipment

- The main hospital building was old, but was generally well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment was well maintained, appropriately checked and signed daily.
- Single-use, sterile instruments were used where possible. The single use instruments we saw were all within their expiry dates.

Good

Outpatients and diagnostic imaging

- Staff told us they always had access to equipment and instruments they needed to meet patients' needs and confirmed any faulty equipment was either repaired or replaced promptly.
- The organisation maintained an electronic asset register which was updated when equipment was removed or added. New equipment was added to the register and tested annually.
- The diagnostics department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were available for staff to refer to.
- The imaging department had assessed exposure to radiation and staff wore radiation detection badges that were sent externally to be analysed routinely to ensure safe levels were maintained.
- All diagnostics and imaging equipment had routine quality assurance and calibration checks in place to ensure the equipment was working effectively.
- Emergency resuscitation equipment was available in all the areas we inspected and was checked on a daily basis by staff. This meant the equipment was ready for use in an emergency situation.

Medicines

- Up-to-date medicines management policies and procedures were available for staff to access.
- There was a pharmacy risk register that contained two risks. Both of which had been actioned and were optimally controlled.
- Medicines in the outpatient department (OPD) were stored, managed, administered and recorded securely and safely.
- Medicines that required refrigeration were stored in a locked fridge, keys were held by the senior member of staff and temperatures were checked and recorded routinely.
- There was part time on-site pharmacist available for eight hours a week. Out of hours staff told us that a 'virtual pharmacy' was used (medicines were dispensed form another BMI hospital in the region). Staff rarely needed to use this system.
- Prescription pads were kept secure and we observed them being signed out by two members of staff and recorded when a consultant requested one.

Records

- Medical records in the OPD were paper based. We reviewed five sets of patient's records. All records were legible, signed and dated. Records contained all the relevant information including letters to the patient's General Practitioner (GP). Records showed that risks and benefits to care and treatment had been explained.
- Radiology information was available to clinicians who needed it. All radiology images were stored on a picture archiving communication system (PACS) for easy access throughout the hospital.
- Patient records were stored securely, and access was limited to those who needed to access them.
- Patient records were requested by the administration and clerical staff a week before a clinic to allow sufficient time to identify any gaps or issues. Records were taken back to the medical records storage area after the clinics.
- Staff did not consider there were any problems with accessing patients' notes for their clinics, they could not remember a time when patient records were not available.
- Patient records were stored electronically in the radiology department. We reviewed three records and found them to be comprehensive and well managed. Staff had risk assessed women's pregnancy status and completed the records accordingly.
- We reviewed five patient records in the physiotherapy department. They were legible, signed, dated and fully completed with clear plans of treatment documented.

Safeguarding

- Safeguarding policies and procedures were accessible to staff. Staff could explain the process if a concern was identified.
- The Director of Clinical Services was the lead for safeguarding and took responsibility for following up any safeguarding concerns.
- Staff completed an on-line electronic learning training module as part of their mandatory training for safeguarding adults and children. At the time of our inspection, 100% of consulting room and physiotherapy staff had completed mandatory training, 96% of diagnostic imaging staff had completed mandatory training.
- Staff that supported the gynaecology clinics had a good understanding of female genital mutilation (FGM). All staff we spoke with knew how to raise FGM as a safeguarding concern.

Good

Outpatients and diagnostic imaging

Mandatory training

- Mandatory training was completed using an on-line electronic learning package. The training included basic life support, infection prevention and control, manual handling, fire safety and information governance.
- Staff compliance with mandatory training reported in February 2016 was 90%. This was lower than the hospital's target of 100%.
- A process was in place to ensure staff not employed directly by BMI had received the appropriate mandatory training. For clinicians that had practising privileges mandatory training was undertaken through their primary employer. BMI The Lincoln Hospital monitored this at the clinician's bi-ennial review. The term 'practising privileges' refers to medical practitioners being granted the right to practice in an independent hospital after being approved by the medical advisory committee (MAC)
- All new nursing staff to the hospital underwent an induction, completing competency paperwork. Induction periods were tailored to the needs of the individual and area of work.
- In-service training was decided at team meetings, generally one to two hours of in-service training was provided each month.

Assessing and responding to patient risk

- There were emergency procedures in place in the outpatient department including call bells to alert other staff in the case of a deteriorating patient or in an emergency. The hospital allocated staff to respond to an emergency with the resident medical officer.
- Emergency resuscitation equipment was available and all nursing staff had undertaken intermediate life support training.
- The physiotherapy department conducted risk assessments on patients before they authorised the use of equipment.
- The provider had an appointed radiation protection supervisor and a radiation protection adviser (RPA) in accordance with IR(ME)R regulations. This meant that the hospital had an independent annual audit of the imaging services.
- An IR(ME)R review of radiology equipment was undertaken every 12 months. The radiation protection supervisor conducted audits and produced risk assessments in accordance with IR(ME)R requirements. We observed a completed action plan, where it was identified that bank radiologists had two radiation badges, this was not necessary. The improved practice implemented was that the bank staff emailed their monthly radiation statistics to the RPA at BMI Lincoln.
- The diagnostic and imaging service had patient safety questionnaires for patients to complete before any scans. There were notices about being pregnant and the dangers of radiation in all waiting areas and changing rooms. We looked at three sets of patient records which identified patient safety questionnaires had been completed by women who disclosed they were not pregnant.

Nursing staffing

- All staff confirmed there were sufficient nursing staff to deliver care safely within the OPD and we observed this to be the case.
- There were no nursing vacancies in the OPD.
- Nurses generally worked from Monday to Friday with Saturday timings dependant on the clinics running. Staffing was planned according to the number of patients attending the clinics.
- Cover for staff leave or sickness was provided by bank staff that were part of the existing nursing team.
- There was no staff sickness reported for the reporting period of October 2014 to September 2015 for staff working in the OPD.

Medical staffing

- There were 99 consultants who had been granted practising privileges at BMI The Lincoln Hospital. 87 of whom had been undertaking work at the hospital for over 12 months. [Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital].
- If a consultant was unable to attend the hospital, it was their responsibility to make suitable cover arrangements with another practitioner in the same speciality with practising privileges at the hospital. They also had a responsibility to document the arrangement in the patient's hospital record and make hospital staff aware of the cover arrangements in advance of the change.
- There was an up to date electronic list of people approved to request x-rays. There was available guidance on appropriate requesting of radiation diagnostic tests and staff were confident to challenge inappropriate requests.

Good

Outpatients and diagnostic imaging

- Consultants had planned clinics that they attended every week.
- There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant if required. Under the conditions of their practising privileges, consultants working at the hospital had to be accessible 24 hours a day, seven days a week. Staff confirmed they were able to contact consultants when required and had not experienced any problems.

Allied Health Professional Staffing

- The physiotherapy department consisted of three physiotherapists and two administrative members of staff who provided inpatient and outpatient care
- There were no staff vacancies at the time of inspection.

Major incident awareness and training

- BMI The Lincoln Hospital was part of a large group of independently owned hospitals. A business continuity plan identified actions to manage any risks in the event of a disaster or a major event where the hospital's ability to provide essential services was severely compromised.
- Staff were aware of the major incident policy and emergency procedures for a major incident such as a fire or adverse weather conditions.
- Radiology staff gave an example of a cardiac arrest live drill which involved team work of all of the departments within the hospital.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We found:

- Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.
- Staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards legislation.
- The outcomes of care and treatment were monitored and actions were taken to make improvements.
- There was a good multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of patients using the service.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- Consent to care and treatment was obtained in line with legislation and guidance.
- Appraisal rates were 100%, staff we spoke with said they found them useful and enjoyed discussing their future objectives with their manager.

However we also found:

- There was no evidence of outpatients and diagnostic imaging taking part in national audits. Imaging services did not audit the report turnaround times.

Evidence-based care and treatment

- The service had local policies and guidelines in place, written in line with national guidance. Locally the guidance folders were updated and we saw signature evidence of staff who had signed to confirm acknowledging and reading the guidelines.
- Staff worked to local policies and care and treatment was delivered in line with the hospital's care pathways and guidance from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges.
- Staff involved in diagnostic imaging demonstrated an understanding of their role with regards to Ionising Radiation (Medical Exposure) regulations 2000 (IR(ME)R) and protecting patients from the risks of unnecessary exposure to radiation.
- Guidance, and the impact it would have on staff practice was regularly discussed and shared at governance meetings. For example, updated resuscitation guidelines relating to additional equipment being added to emergency resuscitation trolleys was discussed and standard operating procedures updated as a result.

Pain relief

- Patients were assessed for pain relief during assessments and supported in managing pain through prescriptions with the appropriate medication. None of the patients we spoke with required pain relief at the time of our inspection.

Good

Outpatients and diagnostic imaging

- The physiotherapists were qualified to administer complimentary pain relief therapies such as acupuncture and Pilates.

Patient outcomes

- There was no evidence of outpatients and diagnostic imaging taking part in national audits.
- Imaging services did not audit the report turnaround times. Senior staff told us they did not have a problem with reporting times; however there was no evidence to support this.
- Staff monitored patients following their outpatient treatments. Patients were contacted following outpatient treatments to check if patients had experienced any difficulties or complications following their treatment.
- The physiotherapy department audited outcome measures on the Knee injury and Osteoarthritis Outcome Score (KOOS) which enabled them to review and improve services.

Competent staff

- All staff completed competency assessments and an induction to the department when they first started, and all staff received a departmental induction before they began to work unsupervised.
- New staff worked in addition to the required staffing numbers until their competency had been assessed and approved by senior members of staff. This helped to ensure that only qualified members of staff worked at the hospital.
- Staff directly employed by the hospital all received annual appraisals. Staff told us they received an annual appraisal and we saw that 100% of staff had received their annual appraisal, which supported their clinical development.
- The hospital had a system in place to ensure qualified nursing staff continued to maintain their registration.
- Data provided by the hospital showed that 100% of nursing and medical staff were appropriately registered with their professional body.
- Practising privileges refer to a medical practitioner being granted the right to practice in an independent hospital. The Executive Director worked collaboratively with the Medical Advisory Committee (MAC) Chair to review practising privileges. In order to assess a consultant's suitability to practice at the hospital, the provider undertook bi-ennial reviews on qualifications, reviewed references and disclosure and barring with the Disclosure and Barring Service (DBS).
- Practising privileges were reviewed by the chairperson of the medical advisory committee (MAC). This included a review of appraisals, General Medical Council (GMC) registrations and medical indemnity insurance. We spoke to three consultants who confirmed they had received appraisals and revalidation of their practice with their substantive NHS employers.
- The hospital had processes in place to address any issues with consultant competence whether the consultant was employed by the hospital directly or worked under practising privileges.
- Medical staff were mainly employed by other organisations (usually in the NHS) in substantive posts with practising privileges with BMI Lincoln Hospital. This included consultants who specialised in areas such as ophthalmology, gynaecology, cardiology and orthopaedics.

Nutrition and hydration

- There was a drinks machine available in the department for patients to access, and food could be acquired on request.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) approach across all of the areas we visited. We observed good collaborative working and communication amongst all members of the MDT. Staff reported they worked well as a team.
- The MDT worked well to support the planning and delivery of care in the outpatients and diagnostic imaging departments. We observed the imaging department responding to a request from a clinic the night before, an urgent appointment was needed and the department ensured the patient was seen.
- Staff told us that they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive to one another. The radiology department allocated staff to complex theatre cases to ensure prompt imaging for the patient and were flexible to provide imaging if a doctor requested an x-ray at short notice.

Good

Outpatients and diagnostic imaging

- Staff in the outpatient department (OPD) worked as a seamless team which benefited the patient's experience. Senior staff attended the weekly senior team meetings and discussed patients of specific needs or requirements.
- Nursing staff reported they had good access to medical staff and could discuss patient related concerns with them.
- There were a number of service level agreements in place with other organisations, for example external providers for magnetic resonance imaging (MRI) and computerised tomography (CT) scanning which involved teamwork to ensure continuity of care for patients. Monthly meetings were held to share good practice and concerns to enable learning across the teams.

Seven-day services

- Various clinics were operating between 8am and 9pm Monday to Friday with clinics scheduled on Saturdays when the demand was high. Staff gave examples of being flexible to provide extra clinics or appointments to meet the consultant's requests or patient needs.
- Radiology services were available 8am to 6pm Monday to Friday, with evening clinics during the week when required. On call radiology staff provided an out of hours service seven days a week. Staff told us that they could always access a consultant radiologist to report on imaging out of hours.
- The physiotherapy department provided services five days a week, with times to suit patients.

Access to information

- Hospital staff received medical information regarding NHS patients from their GP as part of their referral process via the 'choose and book' system. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
- Imaging results were available electronically which made them easily available to staff in outpatient clinics.
- Medical records were requested a week before patient appointments. Appointment lists were printed off daily, which enabled staff to know which patients were attending.
- Relevant patient information was exchanged via letters between GPs and hospital staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a policy in place covering the seeking of consent.
- Five patient records showed verbal and written consent had been obtained from patients. Consent forms were completed where appropriate prior to providing care and treatment. Staff explained that they would request a medical assessment if they were concerned a patient lacked capacity.
- Hospital data showed that 74% of staff had received Mental Capacity Act and Deprivation of Liberty Safeguards training. This was lower than the hospital target of 90% due to a number of new staff completing the training.
- All staff we spoke to could describe the Mental Capacity Act (MCA) 2005 and were familiar with Deprivation of Liberty Safeguards (DoLS). The Safeguards aim is to ensure that those who lack capacity and are in hospital are not subjected to excessive restrictions.
- Staff were able to give examples of where the MCA had been used. For example, a member of staff told us that a patient with a learning disability had attended an outpatient clinic with their carers. Staff assessed the patient who had capacity and a care plan was made incorporating the patient's choices.
- We looked at the last audit which was undertaken in July 2015 to determine whether consent was taken appropriately in the physiotherapy department. The audit concluded all appropriate procedures were followed.

Are outpatients and diagnostic imaging services caring?

Good

We have judged this service as good for caring. We found:

- Patients received supportive care and treatment in an environment that maintained their privacy, dignity and confidentiality.
- A person centred approach was used to ensure patients were involved as partners of their care.

Good

Outpatients and diagnostic imaging

- Interactions between staff and patients were positive.
- The patients we spoke with told us staff were very caring and respectful, and patients felt they were supported emotionally.
- Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.

Compassionate care

- Patients felt that they were treated with dignity and respect by all staff members. All patients we spoke with said they found the staff polite, friendly and approachable. One patient said 'All staff are great, explanations are good and clear.'
- We observed staff greeting patients and introducing themselves.
- The service offered patients the support of a chaperone. This person acted as a safeguard and a witness for patients or healthcare professionals during intimate medical examinations or procedures. For clinics that involved examinations that were more intimate, a nurse was assigned to support patients throughout.
- In situations where there was a need for privacy or if a patient became distressed, there were rooms that could be used for greater privacy.
- The hospital took part in the Friends and Family Test (FFT) (a survey which asks NHS patients whether they would recommend the service they have received to friends and family who need similar treatment or care) showed a high response rate above 85% between April 2015 and September 2015. The FFT results showed the outpatients department received a score of 100% frequently. This meant people would recommend the service.
- Staff respected patient confidentiality and ensured discussion took place in treatment rooms. At reception voices were lowered to ensure patients in the waiting area did not hear conversations.
- The senior team told us that they did not have a multi-cultural prayer room but could accommodate religious beliefs on an individual basis if required.

Understanding and involvement of patients and those close to them

- All patients and relatives we spoke with told us that care and treatments were explained to them and their relatives. Patients told us they felt involved in their care and their appointments were not rushed.
- Patients were given enough time throughout their appointment to discuss their condition in a relaxed and unhurried manner.
- Patients were given information about who to contact if they had any concerns about their care, treatments and condition.
- We observed staff reassuring patients and giving them time to understand the treatment they were due to have.
- Staff told us they had the time to care for patients in the hospital and spend extra time with the patients.

Emotional support

- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive.
- Consultations rooms were private and could be used to deliver any bad news.
- Women with breast lumps were prioritised due to the increased emotional anxiety this condition can cause and extra appointments made to ensure they received a mammogram (scan of the breast) promptly. We observed an appointment made within 24 hours of the request for a mammogram.

Are outpatients and diagnostic imaging services responsive?

Good

We have judged this service as good for responsive. Patients' needs were met through the way services were organised and delivered.

We found:

- Services were planned and delivered to meet the needs of the local population. Patients could be referred in a number of ways.
- Patients could choose appointments which suited them.
- Services coordinated appointments to enable patients to see a number of health care professionals in one day.

Good

Outpatients and diagnostic imaging

- The individual needs of patients were taken into consideration when planning care.
- Waiting times for outpatient appointments were within the national referral to treatment time of 18 weeks.

However we also found:

- A common theme of complaint was the clarity regarding the prices quoted for procedures.

Service planning and delivery to meet the needs of local people

- The waiting areas within the outpatient department (OPD) were spacious and had comfortable seating for patients and visitors. There were drinks available in all of the areas and patients could buy snacks at the main reception. Magazines and newspapers were also available.
- Patients accessed services via a GP referral through the NHS Electronic -Referral Service (previously known as Choose and Book), via self-referral and self-funding or via their health care insurer. Patients were offered appointment times after work and at weekends to fit around their personal and work lives. Patients were treated equally regardless of whether they were NHS patients or self funded patients.
- On arrival patients reported to the main reception area where receptionists booked them in via an electronic booking system and directed them towards the appropriate clinics and waiting areas.
- The hospital had sufficient space and flexibility for the number of patients being treated.
- There was sufficient free parking to meet patients' needs. Signage throughout the hospital was clear and easy to follow.
- Magnetic resonance imaging (MRI) and computerised tomography (CT) scans were provided by an external provider on-site via mobile equipment on certain days.
- The diagnostic and imaging department saw patients on the same day as they had attended clinics. This reduced waiting times in the long term and meant patients did not have to return another day.
- The physiotherapy department had a gymnasium area with fitness equipment and provided exercise classes including Pilates.

Access and flow

- The hospital had scheduled clinics with set specialities on a weekly basis. Between October 2013 and September 2015 the OPD saw 2,106 NHS funded patients for their first appointment and 2,104 follow up patients. During the same reporting period, the OPD saw 4,643 self funded patients for their first appointment and 6,164 follow up patients who were self funded.
- The national standard for referral to treatment (RTT) time states that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral. Data provided by the hospital showed that between October 2014 and September 2015, 100% of patients were seen within this 18-week target for nine months of that year and 99% for the other three.
- Patients told us they did not wait long for appointments. If there was a problem staff came to them to tell them how long the wait would be. We observed staff apologising to patients, when a clinic was running late. Patients we spoke with told us that they were seen on time the majority of the time.
- Patients who did not attend their appointment were contacted and sent another appointment.

Meeting people's individual needs

- Information leaflets were available to patients regarding their treatment. Staff either sent the leaflets in appointment letters or gave them to patients to take away. If patients required leaflets in different languages they would arrange with an external company for the leaflet to be translated.
- Staff used both telephone and face to face interpreting services for patients whose first language was not English.
- The hospital could easily be accessed by patients who had a physical disability. The outpatient department was easily accessible and there was access to disabled toilet facilities.
- Staff told us that equipment could be ordered to meet the needs of patients with a high body mass index (BMI). [BMI is a measurement used to see if adults are a healthy weight for their height].
- Vulnerable adults, such as patients with a learning disability and those living with dementia were identified at the referral stage; steps were taken to ensure they were appropriately cared for. This included an appointment time during less busy periods, continuity

of staff and informing carers or representatives of the plan of care. Staff told us this did not happen often because vulnerable patients were usually treated at National Health Service (NHS) establishments.
- Staff we spoke with described how same gender couples were welcomed within the service.
- The physiotherapy department offered group post-operative exercise sessions or one to one, according to patients' preferences.
- Posters were displayed throughout the department, encouraging patients to ask if they would like a chaperone.

Learning from complaints and concerns

- Information about how to raise a complaint was displayed throughout the hospital.
- BMI The Lincoln Hospital followed their corporate complaints policy for managing complaints.
- Patients were asked to comment on their experiences before leaving the department. All the staff we spoke with could explain how they would attempt to manage the complaint a t a local level but also knew how to escalate a complaint.
- Complaints were discussed at team meetings and opportunities were taken to learn lessons from complaints. We reviewed meeting minutes where we saw examples of discussions.
- The physiotherapy department had an electronic door fitted as a result of patients complaining that it was difficult to access the department when they used walking aids.
- The Executive Director undertook responsibility for responding to all written complaints. The hospital's aim was to provide written acknowledgement within two working days of receipt of a complaint and provide a full written response within 20 working days when the outcome of the investigation was known.
- The hospital received 26 written complaints between January 2015 and February 2016. This included complaints for outpatients and surgical services. The main reason for complaints related to the clarity regarding the prices quoted for procedures, delays in General Practitioners (GPs) receiving letters and patients being asked for their credit card details by reception staff. As a result of this a fixed price was applied to procedures within BMI throughout the organisation. This meant patients would pay the same price regardless of their geographical location. There had been a backlog of discharge letters, however the service had reviewed its internal processes to ensure service continuity and to improve the turnaround time.

Are outpatients and diagnostic imaging services well-led?

Good

We have judged this service as good for well-led. The leadership, governance and culture promoted the delivery of high quality person-centred care.

We found:

- The leadership, governance and culture promoted the delivery of high quality person centred care.
- The hospital had a clear vision and values, driven particularly by quality. Staff were focused on providing the best service they could for all patients whether they were self or NHS funded.
- The senior team were knowledgeable about their service issues and continually made plans to improve the service.
- The senior management team provided clear leadership and motivation to their teams.
- The service proactively engaged staff and the public to comment and be involved with the development of the service.
- There was a culture of openness and flexibility within the service.
- Staff told us that senior managers and team leaders were visible and approachable.

Vision and strategy for this this core service

- The BMI corporate strategy and vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. This was the basis of the hospital wide strategy and vision.
- Outpatient department staff embraced the corporate strategy. All staff we spoke with had an understanding of the strategy and could give at least one example.
- The hospital wide strategy was displayed on hospital walls in all areas.

Governance, risk management and quality measurement for this core service

Good

Outpatients and diagnostic imaging

- There was a clear governance and risk management structure with accountabilities for assurance being well defined. The executive team used various methods to gain assurances from the ward to the board. There were various committees in place which communicated into the clinical governance committee and the Medical Advisory Committee (MAC).
- The MAC met quarterly and the minutes for the last three MAC meetings demonstrated that key governance areas were discussed including incidents, complaints and practising privileges.
- There were terms of reference to role in supporting the hospital. However, this document was not dated. This meant there was a risk that staff accessing the document could not be sure they were referring to the correct or most up-to-date version.
- The hospital held meetings through which governance issues were addressed. The meetings included the MAC meeting, weekly heads of department meeting. Other specialty service meetings took place in their areas and the team leads were responsible to feed back to staff and escalate concerns to the senior management team.
- We looked at a number of clinical governance and MAC meeting minutes and saw that incidents and learning from incidents near misses were discussed.
- The Director of Clinical Services was also the Director of Infection Prevention and Control (DIPC), and was responsible for coordinating audits and reviewing serious incidents. Activity and outcomes were monitored through monthly clinical governance meetings.
- Team leaders were aware of the hospital risk register and could describe risks that were placed on it. We saw evidence of managers and clinicians discussing risks at clinical governance and MAC meetings. We were shown future plans to resolve a number of risks on the register. For example replacing the lift and repairing a number of windows.
- The weekly hospital wide safety planning meeting was held to discuss the week ahead to ensure staffing was safe and patients would be reviewed to identify individual needs that may need further planning. For example religious needs language translation services or specialist equipment.
- There was a positive working relationship with the local clinical commissioning group (CCG). Senior managers met with commissioners quarterly to review the hospital's performance via their results of specific measured outcomes for quality and innovation (CQUIN). Four CQUIN's were in place for the year 2015/16.
- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on intranet and signed a declaration to confirm they had read and understood the policy relevant to their area of work.
- Policies for radiological examination were written up as standard operating procedures. Local rules were on display in every x-ray room

Leadership and culture of the service

- Although a relatively new senior leadership team, they all displayed the skills, knowledge and experience required to lead. This was demonstrated through their attitude, values and commitment to ensure staff felt valued and involved in decisions throughout the hospital.
- There were clearly defined and visible local leadership roles on a hospital wide level and at a local level. Senior staff provided clear leadership and motivation to their teams.
- All staff we spoke with told us they were supported and they had good working relationships. Staff said that team leaders and senior managers were regularly visible and performed daily walks of their areas.
- The senior management team demonstrated a proactive approach to improving the services. This was observed in the hospital business plan.
- Staff we met was all welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service.
- There was a flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed between the multidisciplinary teams and other agencies.
- The majority of staff felt valued and felt that the managers were supportive and approachable. Staff were encouraged to develop to enable career progression within the service.
- Staff reported an open and transparent culture which was apparent during our inspection.
- Unit leads were able to identify constraints to their services and suggest changes which could be made to maintain the standard of care provided to patients.

Good

Outpatients and diagnostic imaging

- Staff felt the senior management team were very focussed on patient care as their main priority and could be relied upon to action, where possible, issues that improved the patient experience.

Public engagement

- The hospital carried out a patient satisfaction survey; patients were encouraged to complete them to improve services.
- Patients received follow up calls within 48 hours which provided patients an opportunity to feed back on their experience. However two out of eight patients we spoke with told us they had not received a follow up call.
- The hospital displayed "You said – We did" information to show patients what action had been taken in response to patient feedback. An example of this was patients found the old physiotherapy department very small. Following these concerns the service was move to a separate building which enabled three consulting rooms to run, group exercises and the use of more gym equipment.

Staff engagement

- The hospital participated in the BMI Healthcare staff survey. However, the survey had not taken place in 2015 but was being undertaken for 2016. The results were not available at the time of our inspection.
- The executive director had engaged with staff through a project called 'stay/go'. This enabled staff to work together to look at aspects of their work at the hospital and to say what they would like to stay and what they would like to go. All staff we spoke with were positive about this exercise and said it made them feel listened to.
- Pin award ceremonies took place at the hospital where pin awards were presented to long serving nursing staff members. In November 2015, 34 staff members received pin awards, 14 of these were for staff who had been in service for five years or more, six were for staff who had been in service for ten years or more, six were for staff who had been in service for 15 years or more, six were for staff who had been in service for 20 years or more and two were presented to staff who had been in service for over 25 years. Staff members were encouraged to bring and share food relevant to their culture to celebrate the diversity of the workforce at the ceremony.

Innovation, improvement and sustainability

- The executive team were very responsive to requests and suggestions for improvement.
- All staff focused on continually improving the quality of care. They were all familiar and were involved in the refurbishment of the unit.
- There were service plans to discuss the implementation of appropriate dementia friendly signage throughout the hospital.

Outstanding practice and areas for improvement

Outstanding practice

- The Director of Clinical Services had taken the lead on environmental changes to ensure people with dementia were fully supported. In 2015 a patient-led assessment of the care environment (PLACE) audit highlighted carpets as being a risk for patients living with dementia. This was identified as a risk on the hospital's risk register and this was addressed as part of a refurbishment programme where carpets were replaced with laminate floors. There were also plans to discuss appropriate dementia friendly signage throughout the hospital.
- The Executive Director had engaged with staff through a project called 'stay/go'. This enabled staff to work together to look at aspects of their work at the hospital and to say what they would like to stay and what they would like to go. All staff we spoke with were positive about this exercise and said it made them feel listened to.
- Changes had been made to service delivery following feedback from staff, patients and consultants. Examples of these included service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years. A 'bring and share' meal to celebrate the diversity of the workforce had been part of the service of recognition.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure seating is washable in patient areas.
- The hospital should audit the imaging reporting turnaround times.
- The hospital should continue to prioritise the recruitment of staff to theatres.
- The hospital should ensure references are obtained for all doctors working at the hospital under practising privileges.
- The hospital should ensure training for all staff in relation to caring for patients living with dementia is completed as soon as possible.
- The hospital should consider purchasing a ventilator to mitigate risks to staff when using paracetic acid for endoscopic processes.