The Saxon Clinic

Quality Report

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

Ratings

Overall rating for this location	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

The Saxon Clinic is operated by BMI Healthcare Limited. The hospital has 33 beds. Facilities include two operating theatres, endoscopy services, 12 outpatient consulting rooms and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging for patients, either as outpatient appointments or inpatient admissions. The majority of patients are admitted for day case surgery, however, there is a portion of patients who require longer inpatient stays after more complex surgery. Specialities include orthopaedic surgery, urology, gastroenterology and general surgery. We inspected surgery, medicine, outpatients, diagnostic imaging and services for children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out the short notice announced inspection on the 17 and 18 September 2019.

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

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

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

Services we rate

We last inspected this provider in September 2016 when we rated it as requires improvement.

Our rating of this hospital improved. We rated it as **Good** overall.

We found the following areas of good practice:

Staff were aware of their roles and responsibilities and completed training appropriate to their roles. This included safeguarding training. There was a robust process in place to ensure all staff, including consultants had completed training.

The hospital was visibly clean and tidy and there was evidence of a maintenance programme to ensure facilities were of a good standard.

There were enough numbers of staff to ensure that services ran smoothly. Skill mix was appropriate to clinical need and bank and agency staff were fully inducted to the service. Where possible, the same staff were used to improve consistency of care.

Services used safe processes for the storage, prescribing and administration of medicines and radiation.

Any incidents were reported and taken seriously. Staff investigated incidents and took steps to prevent reoccurrence and promote learning across the hospital.

The hospital used national guidance and policies to inform policies and promote best practice.

Patients were assessed and provided with nutrition and hydration across all services and staff ensured that patients pain was well managed. Fasting guidelines were in place to ensure patients were not starved for long periods whilst waiting for operations.

Summary of findings

There were processes in place to ensure that patient outcomes were measured and staffs ability to complete their roles were continually assessed and monitored by leads. Teams worked collaboratively to ensure that services ran smoothly and ensure that patient pathways were robust.

Services were provided across six or seven days, although urgent services were provided 24 hours per day.

Patients were supported to make decisions about their care and were given advice on making health choices.

Patients, including adults and children were cared for respectfully and with kindness and compassion.

Services were planned to provide care in a way that met patients' needs taking into consideration individuals needs and preferences. People could access services at times to suit them and admit, treat and discharge times were in line with national guidance.

Staff took any concerns or complaints seriously, investigating them and ensuring any learning was shared across the organisation.

Leaders were visible, approachable and had the right skills and abilities to manage the services. There was a clear vision and staff were involved with developing their local strategy and clinical areas.

Staff felt supported, valued and were proud to work at the hospital. Senior managers were engaging and collaborated with external partners.

There were robust processes in place to ensure effective governance and risk management. Staff used performance data to make decisions and improvements.

Staff development was encouraged, and services were continually learning and improving. Leaders promoted innovation.

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

Within Surgery:

- Non-clinical staff appraisal rate was below the hospital target.
- Complaints were not responded to in line with the timeline outlined in the policy.
- Consultants rarely attended governance meetings.
- The hospital did not have a senior nurse at director of clinical services or ward manager position, who had oversight of the hospital activity.

Within Medicine:

- Within endoscopy, the service environment did not always follow national guidance.
- Endoscopy services were not utilising the full WHO five steps to safer surgery checklist.
- Within endoscopy staff did not always address risk in a timely way. There was no standardised system in place to monitor and escalate deteriorating patients.
- Endoscopy services did not always follow best practice guidance when gaining patients' consent.

Within Children and Young People:

- Compliance with national best practice guidance and clinical outcomes for specific procedures were not checked by managers.
- The service did not routinely use audit findings to make improvements and achieved good outcomes for patients.

Summary of findings

Within diagnostic imaging:

- Not all radiation protection equipment was clearly labelled as being checked annually.
- Some staff felt unsupported by the wider BMI corporate team.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirements notice(s) that affected medicine. Details are at the end of the report.

Name of signatory

Heidi Smoult- Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good for effective, caring, responsive and well led. Although we rated safe as requires improvement.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good for safe, effective, caring and responsive. We rated well-led as requires improvement.
Services for children & young people	Good	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well led.
Outpatients	Good	We rated this service as good because it was safe, effective, caring, responsive, and well led.
Diagnostic imaging	Good	We rated this service as good because it was safe, effective, caring, responsive, and well led.

Summary of findings

Contents

Good

The Saxon Clinic

Services we looked at

Medical care (including older people's care); Surgery; Services for children & young people; Outpatients; Diagnostic imaging.

Summary of this inspection

Background to The Saxon Clinic

The Saxon Clinic is operated by BMI Healthcare Limited. The hospital/service opened in 1985. It is a private hospital in Milton Keynes, Buckinghamshire. The hospital primarily serves the communities of Buckinghamshire. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 2013.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors, one assistant inspector and six specialist advisors with expertise in surgery, medicine, paediatrics, radiography and outpatients. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about The Saxon Clinic

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

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

During the inspection, we visited inpatient and outpatient areas, theatres, recovery, endoscopy and diagnostic imaging. We spoke with 62 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 33 patients and relatives. During our inspection, we reviewed 37 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected twice, and the most recent inspection took place in September 2016, when the hospital was rated as requires improvement for safe, effective, responsive and well led, and good for caring.

Activity (April 2018 to March 2019)

- In the reporting period April 2018 to March 2019 there were 874 inpatient and 3,474 day case episodes of care recorded at the hospital; of these 40% were NHS-funded and 60% other funded.
- For the same reporting period, the hospital admitted 120 children and young people for procedures, either as a day case or for an inpatient admission.
- From March 2018 to February 2019, there were 29,196 outpatient total attendances in the reporting period March 2018 to February 2019. Of these, 85% were non-NHS funded and 15% were NHS funded.
- From March 2018 to February 2019, there were 13,228 first and 15,968 follow up outpatient appointments.

At the time of the inspection,118 consultants worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a weekly rota. The hospital employed 113 staff which included 22 registered nurses, 14 care assistants, as well as 62 bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety April 2018 to March 2019

- No never events

Summary of this inspection

- 472 clinical incidents, with 303 no harm, 161 low harm, eight moderate harm and no severe harm or death
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (codify)
- 241 complaints

Services provided at the hospital under service level agreement:

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

The five key questions about services and what we

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe improved. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The services had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- The service had enough medical and radiology staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Summary of this inspection

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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

- Within endoscopy, the service environment did not always follow national guidance.
- Endoscopy services were not utilising the full WHO five steps to safer surgery checklist.
- Within endoscopy staff did not always address risk in a timely way. There was no standardised system in place to monitor and escalate deteriorating patients.
- Not all radiation protection equipment was clearly labelled as being checked annually.

Are services effective?

Good

Are services effective?

Our rating of effective improved. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.
- The imaging team did not provide patients with food and drink; however, they did provide clear guidance on nutrition and hydration in relation to the investigation being completed.
- Imaging staff assessed and monitored patients regularly to see if they were in pain.
- Due to the type of service, imaging staff did not monitor patient outcomes. However, they used patient feedback to improve the patient pathways.
- Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieve good outcomes for patients.

Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Within outpatients' key services were available six days a week to support timely patient care. Inpatient areas were open seven days per week.
- Within surgery and imaging, key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

However:

- Non-clinical staff appraisal rate was below the hospital target.
- Within children and young people's services, compliance with national best practice guidance and clinical outcomes for specific procedures were not checked by managers.
- Within diagnostic imaging, they did not always use audit findings to make improvements and achieved good outcomes for patients.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Are services responsive?

Good

Our rating of responsive improved. We rated it as **Good** because:

Summary of this inspection

- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However:

- Complaints were not responded to in line with the timeline outlined in the policy.

Are services well-led?

Good

Our rating of well-led improved. We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Summary of this inspection

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

- Some staff felt unsupported by the wider BMI corporate team.
- Consultants rarely attended governance meetings.
- The hospital did not have a senior nurse at director of clinical services or ward manager position, who had oversight of the hospital activity.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Requires improvement	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

Are medical care (including older people's care) safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **requires improvement.**

Mandatory Training

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

Nursing staff received and kept up-to-date with their mandatory training. Mandatory training compliance in endoscopy was 91% at the time of inspection, this included a member of staff who had been in the service less than three months. This met the providers mandatory training target of 90% if the service included individuals who were within three months of starting their role.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of patients and staff. Training covered a range of topics including life support, infection prevention and control, waste management, safeguarding and health and safety.

Staff received training in both adult and paediatric life support.

Clinical staff completed training on recognising and responding to patients living with dementia.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff completed mandatory training in both adult and child safeguarding. At the time of inspection theatre staff were 93.3% complaint with safeguarding children level three training and were trained to safeguarding adults' level two. Ward staff were trained to safeguarding children level two training and 100% complaint with safeguarding adults' level two training.

Staff followed safe procedures for children using the service. Patients aged under 18 years, would be accompanied throughout the whole endoscopy pathway by a registered children's nurse.

Cleanliness, infection control and hygiene

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

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Recovery rooms and bays were minimally furnished, reflecting the short stay nature of the patients. All furniture and furnishings had wipe clean services. One sink within the endoscopy area was not fully complaint with regulations however, it was suitable for hand washing. This risk was noted on the services risk register and was due to be replaced as a part of the improvement works planned for October 2019.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that all rooms and toilets used as a part of the endoscopy pathway were clean.

Staff followed infection control principles including the use of Personal Protective Equipment (PPE). Gloves and aprons were available on entrance to the recovery area and within the theatre, we staff using and disposing of these in line with national guidance. All staff were 'bare below the elbows' and we observed good hand hygiene practice during the inspection. Hand sanitiser was available on the entrance to each area and within the recovery bays. We reviewed the hand hygiene audit conducted on endoscopy staff in March 2019, results showed an average of 97% compliance across 19 hand hygiene assessments.

A provider wide infection prevention and control annual work programme was in place. This ensured all infection prevention and control audits and requirements were mapped out across the year to ensure timely completion.

The service had a policy in place for infection prevention. A policy entitled infection prevention and control in the perioperative environment and a further policy for transmission-based infection prevention and precautions were in place for staff to refer to. The service did not perform procedures on those with known infection such as blood-borne viruses (BBV), human immunodeficiency viruses (HIV) and Creutzfeldt-Jakob disease (CJD). Information on the assessment and management of Carbapenamase producing enterobacteriaceae (CPE) was displayed in the admission room. This detailed that if a patient was deemed as at risk of having CPE then extra precaution would be taken during their procedure and swabs taken for patient information and infection prevention and control surveillance.

We reviewed the endoscopy specific infection prevention and control observational audit from April 2019 and saw 100% compliance. No clostridium difficile (c. diff), surgical site infections or CPE infection had been recorded from January to June 2019.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw beds and equipment being cleaned after used and being labelled with an 'I am clean' sticker.

Disposable curtains were in use around the recovery bays, the date these were last changed were displayed on each set.

Decontamination of scopes was not performed on site. The service had a contract with a different provider to decontaminate scopes used in procedures. Staff followed standards for decontamination of endoscopes by performing a bedside clean immediately post procedure.

At the time of inspection, scopes entered and exited the endoscopy theatre through the same door and there was not a one-way flow of clean and dirty items through the theatre. Clean scopes were delivered to the door of theatre and taken on a trolley into the theatre. After use each scope was then packaged and placed into a further trolley in an adjoining room at the end of the list this trolley was taken back through the theatre to the main door to be collected. The new endoscopy refurbishment included plans for a back door from the scope preparation room to allow for one-way flow of equipment.

The theatre was not a dedicated endoscopy theatre. Dermatology procedures were also carried out within the endoscopy suite on the day of our inspection a dermatology list had been completed between two endoscopy lists. The dermatology procedures performed include deep core biopsies and posed a risk of infection from excised tissue and from blood contamination from the patient. Staff we spoke with felt these lists were often close together and a full deep clean was not possible. Although it was an accepted risk by both local and provider level management the fact the theatre was not dedicated to endoscopy was not on the services risk register.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe. However, the design of the environment did not always follow national guidance. Staff managed clinical waste well.

Patients could reach call bells. All recovery bays and discharge rooms had access to call bells for patients to use if they required.

The design of the environment did not always follow national guidance. The entrance to the endoscopy theatre/ recovery area was not secure, there was no buzzer entry or restriction on who could enter the area. A poster was displayed that said restricted entry but there was no

physical deterrent. We noted that the recovery bays and did not allow for enough space for resuscitation and a resuscitation team if required. The service had recognised this risk and it was on the endoscopy risk register. The decision has also been made to reduce the bays from three to two to limit the people and equipment in the area. We were shown refurbishment plans that included widening of the recovery bays, work was due to start in October 2019.

The endoscopy suite was located at the end of a corridor away from other services, this meant that the area was quiet and calm and was not used as a thoroughfare by other patients and staff moving around the hospital. The flooring throughout the endoscopy area was hard laminate to allow cleaning to be performed easily. The theatre was large and had good lighting and contained all the relevant equipment without being cramped. Toilet facilities were available. Each recovery room and the consenting room included a toilet, a further toilet was located by the waiting room.

Staff carried out daily safety checks of specialist equipment. A resuscitation trolley was present in the theatre and a paediatric resuscitation trolley was located in the reception area of endoscopy. The resuscitation trolley was secured and easily accessible.

The service had suitable facilities to meet the needs of patients' families. The endoscopy suite consisted of a waiting area, admission room, consenting room, an endoscopy theatre, two recovery bays and two recovery/ discharge rooms that contained five recovery chairs. This was in line with national guidance from the Royal College of Physicians that patients who are not allocated a private room during their procedure have a confidential area for reassessment to be undertaken.

The service had enough suitable equipment to help them to safely care for patients. Staff told us they had enough equipment to carry out their roles. Scopes were pre-ordered and delivered daily to the hospital. The service also kept a stock of decontaminated scopes to use in case any problems were encountered with the planned delivery. These scopes were kept securely with the decontamination date clearly noted.

A consumables room was located off the endoscopy theatre. This room was well stocked with the appropriate items and all was stored in an orderly way. We checked 10 items, and all were within their expiry dates. We checked three electrical medical devices and saw that each had been serviced in line with manufacturers requirements.

Staff disposed of clinical waste safely. We saw that clinical waste bins were appropriately located and labelled, we observed staff disposing of items in the suitable bin. Clinical waste was collected daily by the portering team.

Assessing and responding to patient risk

Staff completed risk assessments for each patient however, these did not always address risk in a timely way. No standardised system was in place to monitor and escalate deteriorating patients. Endoscopy services were not utilising the full WHO five steps to safer surgery checklist.

The service did not perform procedures on very high-risk patients. The American Society of Anaesthesiologists (ASA) score assesses the physical status of a patient before surgery from one (normal healthy patient) to five (patient is not expected to survive). BMI The Saxon Clinic did not treat patients over level two.

Staff completed most risk assessments for each patient on admission and on arrival and updated them when necessary and used recognised tools. Patients were screened for risk factors during an outpatient appointment and pre-assessment telephone call. We saw that the additional screening on admission, helped to identify anything that was missed at the pre-assessment phase, ensuring safety. For example, during inspection a patient who had been through this process arrived for their appointment and it was found out they were not suitable for treatment at this hospital due to increased risk factors.

The service did not consistently use a nationally recognised tool to identify deteriorating patients. The hospital had a policy related to the management of deteriorating patients which stipulated that staff should be using National Early Warning Scores (NEWS2). NEWS2 is a quick and systematic way of identifying patients who are at risk of deteriorating and recommended in the standardisation of the assessment of acute-illness. Perforation and complications in endoscopy although not common can be life threatening and rapid in their onset. Therefore, it is essential that

patients in this setting are monitored closely and any deterioration is acted on quickly. During our inspection, we saw that staff were not completing NEWS2 assessments in line with guidance or the hospital's policy.

Staff were completing observations of patients on admission within the endoscopy pathway booklet, during the procedure and in recovery. However, these observations were not totalled into an overall score for each patient at each moment in time. This posed a risk that subtle changes in a patient's physiological condition may not be recognised and acted upon at an early stage. The pathways booklet did not facilitate a section for completing NEWS2 scores.

Staff told us that if they thought a patient's condition was deteriorating, they would commence a NEWS2 chart, this was in line with the policy. However, this was contradictory to the BMI's deteriorating patient policy which stated that a NEWS2 score should be calculated for every adult patient observation. This was escalated at the time of inspection. Following inspection, we were told that the BMI endoscopy care pathway documentation was being re-printed to include the NEWS2 chart.

Staff could explain the process to us if they thought a patient was deteriorating which involved the consultant being the first point of call to review the patient and if needed an ambulance would be called to arrange transfer to an emergency department. An emergency patient transfer agreement was in place with the neighbouring NHS trust. This outlined that transfer requests must be made consultant to consultant unless the consultant is unavailable, and the patient has a NEWS score of seven or above.

We reviewed the observations recorded in three sets of patient notes. We saw that although these were frequently recorded for all patients not all the suggested criteria were recorded for each patient each time. For example, patient one had their observations done twice during their procedure with no temperature or respiration rate recorded in either set, they did not have their temperature taken during the two sets of observations taken in recovery either. Patient two had their observations taken twice during their procedure both had no temperature recorded and one had no respirations recorded, observations were taken a further three times in recovery, two of which had no temperature recorded. A further patient had a full set of observations taken on admission but then did not have their procedure performed.

We escalated concerns related to the non-compliance with the deteriorating patient policy and NEWS2 assessments to the senior management team. Immediate actions were taken to ensure patient safety. The hospital commenced daily audits of the NEWS2 scores and provided additional training on correct calculation and escalation of scores. Following inspection, we were told that the NEWS2 process had been changed to ensure that baseline observations were recorded from outpatient's appointment, and the same form kept for the whole admission enabling staff to identify any changes. The endoscopy pathway booklets were being reprinted to ensure that the NEWS2 scores could be recorded.

A two-stage recovery was undertaken for patients who had received sedation, this involved the patient being kept in the recovery bay for a minimum of 30 minutes with a minimum of two sets of observations being performed. They were then asked to self-mobilise in the recovery lounge where a final set of observations and discharge would be performed. Those who had not been sedated or did not need to change were able to go straight to the discharge lounge post procedure. The service was utilising the post anaesthesia recovery score (PARS) for patients in recovery to assess when they could be discharged from the service however, this was not consistently recorded for all patients. After our inspection we were advised the endoscopy pathway audit tool had been changed to ensure this element of the paperwork was being monitored for completion.

The hospital was using an adapted version of the World Health Organisation (WHO) surgical safety checklist. The completion of this checklist pre, during and post procedures keeps patients safe from avoidable harm or errors if followed correctly. The five steps to safer surgery include: Team brief, sign-in, time-out, sign-out and debrief.

The time out step was not being performed immediately prior to starting the procedure on each patient. This is the final part of the pre-check procedure where details of both the patient and procedure to be performed are checked and could expose patients to risk if this isn't performed correctly. The WHO checklist forms in use within endoscopy included an overall document to record team brief prior to

the list starting, each patient then had a WHO checklist as a part of their pathway booklet this provided instruction and an area to confirm and sign that the 'sign-in' and 'sign-out' procedure had been performed but provided no prompt for 'time-out' to be performed. We observed the WHO checklist being performed and saw that no 'time-out' was performed during the procedure. We reviewed the WHO checklist forms for three patients on the day of inspection and saw that the 'sign-in' and 'sign-out' documentation had been completed in full.

We reviewed WHO observational audits completed in endoscopy in May, July and August 2019. We saw that this audit documented whether the 'time-out' phase of the WHO checklist had been recorded and this was documented as being the case in all audits. Compliance rates for the WHO checklists and all five parts being performed were 97% in May 100% in July and 100% in August 2019. Ineffective WHO process and safety checks had previously been on the endoscopy risk register but had been closed in January 2019.

Staff knew about and dealt with any specific risk issues. Staff received annual training in sepsis recognition and management, we spoke to one staff member who was able to describe signs and symptoms of sepsis to us. We saw a sepsis poster was displayed in the recovery area of theatres. Post inspection we reviewed the hospitals care of the deteriorating patient manual in which sepsis training was covered, staff were advised to 'think sepsis' when a patients NEWS score was five or more, we could not be assured that sepsis pathways would be started in a timely manner due to NEWS scoring not being in place.

A major haemorrhage protocol was in place; however, not all staff were aware of it. We saw evidence in two staff files that training in major blood loss had been conducted in April 2019 which covered major blood loss, use of O negative blood, the major haemorrhage policy, managing major blood loss and the survival blood ordering policy. However, two staff members we spoke with had limited knowledge of this policy and the procedure in the event of an emergency. Equipment to use in the event of a major haemorrhage was not clearly labelled or readily accessible to staff, not all staff we spoke with were sure if this could be found. However, the endoscopy lead was able to describe the emergency pathway thoroughly. Staff described how they would immediately manage and then transfer patients to the local acute trust. We reviewed the competency assessment for standard skills for health competencies for management of major haemorrhage, this did not provide detail of individual roles and responsibilities of individuals in the event of an emergency.

Emergency equipment for any immediate procedure related bleeds such as clips were available, however, these were not kept within the theatre room or clearly labelled. Staff told us that they knew the location of emergency equipment and therefore confident that there would not be a delay.

Staff shared key information to keep patients safe when handing over their care to others. We saw the nurse that had accompanied the patient during their procedure handover any relevant details to the nurse stationed in recovery when the procedure had finished. Shift changes and handovers included all necessary key information to keep patients safe. A morning huddle was held prior to the day's procedure list starting here the plan for the day and any potential problems were discussed.

All scopes used during procedure had their serial numbers logged and recorded. All scopes were electronically recorded into the providers endoscopy management system prior to procedures to ensure traceability of the equipment used. Traceability stickers for all equipment used were also placed into each individual's records.

Samples obtained in theatres were labelled immediately in the procedure room, these were then double checked by a second nurse in the recovery area where they were double checked by the recovery nurse and logged onto a dispatch form and sent to laboratories for testing the lab was different depending on an NHS or private patient.

Fire evacuation plans specific to the endoscopy area were displayed. Endoscopy had a dedicated fire escape out from the recovery area.

Nurse staffing

The department planned to have enough nursing staff. At the time of inspection nurse staffing was one of the main risks to the department upon the endoscopy risk register. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction to keep patients safe from avoidable harm.

Good

Medical care (including older people's care)

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants needed for each shift in accordance with national guidance and an internal BMI staff planning tool. The endoscopy lead told us that staffing levels was one of the biggest risks to the service at the time of our inspection. We requested planned verses actual staffing levels for Endoscopy for August and September 2019 however, the service was unable to provide this in a reportable format.

Managers limited their use of bank and agency staff where possible and requested staff familiar with the service. The service used repeat bank and agency where possible, so staff were familiar with the hospital and procedures used. In the 12 months prior to our inspection, bank staff had accounted for 1435 hours (10.5%) of an available 8242 planned hours on wards while agency cover was used for 565 hours (5.8%). Bank staff usage in theatres was used for 400 (4.2%) out of 11434 available hours in theatres with 1954 hours being filled by agency staff (20.6%).

The endoscopy service currently employed three registered nurses and used one regular agency nurse. Staff from the main surgery team would also be moved to support in the recovery area of endoscopy when needed. We were told one list in September had to be cancelled due to lack of staff. Nurses rotated their role in the endoscopy pathway.

Medical staffing

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

The service did not employ any medical staff directly. Consultants worked under practicing privileges when providing care at the hospital. Endoscopy procedures were consultant led.

The hospital had two resident medical officers (RMO) between them providing 24-hour a day seven-days a week medical cover for the hospital. The RMO could review patients that nursing staff had concerns about and prescribe medication.

For our detailed findings on medical staffing please see the Surgery report.

Records

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

Patient notes were comprehensive, and all staff could access them easily.

The service did not audit patient note availability. However, we were told a procedure would not be undertaken if the relevant documentation was unavailable.

Records were stored securely. Notes for the days list were stored in a locked trolley within the recovery area. Upon a patient's arrival they were taken out of the trolley and followed the patient through the pathway. The notes trolley was found to be locked throughout our inspection.

We reviewed three sets of patient records from the day of the inspection. Current medical conditions and allergy information was clearly displayed in each. Each file contained a pre-assessment questionnaire which assessed medical history, mental health, current medical conditions and medication and lifestyle questions.

Each patient had an endoscopy pathway booklet that was completed during their procedure, this booklet provided space for all steps on the admission, procedure, recovery and discharge information to be captured. Each patient we reviewed had one of these for the period of their admission.

We reviewed endoscopy documentation audits from June and August 2019. Each was performed on 10 sets on notes. The audit covered 24 areas including, evidence of referral, completion of consent and pre and post procedure tasks. Compliance with documentation was generally good, however, there appeared to be a trend with missing referral letters from patient files, (six missing in June and seven missing in August). The audit also detailed actions to be taken, for example, the use of a different audit tool for cystoscopy patients as the endoscopy audit tool used was not suitable.

Medicines

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

We saw that allergen information was clearly visible on the front page of each patient's pathway booklet.

Good

Medical care (including older people's care)

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Controlled drugs were stored in line with national guidance. Drugs within the endoscopy unit were stored securely and in their original packaging. We reviewed the controlled drugs log book and saw that drugs quantities balanced, and controlled drugs had been signed for by two registered nurses. We saw documented evidence that the controlled drugs were consistently checked twice a day by two registered nurses.

Pharmacy audited controlled drugs monthly to ensure governance and management requirements were being met. We reviewed the theatres medicine management audit from April 2019 which covered medicines storage, preparation, emergency medications and access to resources, the overall score was 95%.

Fridge temperatures were monitored. The drugs fridge within the endoscopy unit was locked and was monitored daily. Ambient room temperature was also recorded daily. Both were recorded daily and had not gone out of recommended ranges.

Oxygen cylinders were stored in line with national guidance.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The hospital used an online incident reporting and investigation tool which all staff had access to. Once incidents were raised the clinical service manager would be notified and then if necessary the lead endoscopy nurse would be assigned the incident and be responsible for performing all or part of the investigation.

No never events or serious incidents had been reported in relation to endoscopy. From January to March 2019 94 incidents had been raised in relation to surgery and inpatients and 24 to surgery and diagnostic imaging. Thirty-seven of these were classed as low harm with one moderate harm. Five incidents were recorded specific to endoscopy between March and September 2019. These included patient deterioration, cancelled appointments and patients who were ineligible for treatment at BMI The Saxon Clinic. The patient deterioration referred to post procedure complication which was investigated fully, and areas of learning identified. This included the monitoring of patients.

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

Staff met to discuss feedback and look at improvements to patient care. Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning with their staff about incidents that had happened at other BMI sites. We saw that all local incidents had immediate actions taken and learning points identified.

Managers investigated incidents thoroughly and we saw evidence that changes had been made because of feedback. We were told how after two patients had left the endoscopy service with cannulas still in situ that a change in process had been adopted to prevent reoccurrence. The pathway documentation had been changed to include an area for the recovery nurse to document that the cannula had been removed and a section for the discharge nurse to double check completion of this task. This had also been added as a criteria to the documentation audit in endoscopy.

For our detailed findings on incidents please see the Safe section in the Surgery report.

Are medical care (including older people's care) effective?

Good

Our rating of effective improved. We rated it as **good.**

Evidence-based care and treatment

Good

Medical care (including older people's care)

The service did provided care and treatment based on up to date national guidance and best practice. Managers checked to see if staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

The endoscopy unit did not have Joint Advisory Group (JAG) accreditation. The service had registered with JAG and completed an endoscopy global rating scale (GRS) self-assessment. GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. The service was about to start building works to provide a dedicated endoscopy department. Following inspection, we were told that works had commenced and planned to be completed by the end of December 2019 with documentation evidence being submitted to support the application for accreditation.

Sepsis training was delivered in line with national guidance. However, was based on using National Early Warning Scores (NEWS2) as part of the criteria which the service was not using at the time of inspection.

We saw that policies followed national guidance for example, policies reflected best practice and National Institute for Health and Care Excellence guidance. We saw that policies were generally in date, however, we found that one policy was out of date. A comprehensive document was in place detailing the standards of practice for flexible endoscopy including clinical, decontamination and risk management standards was dated 2014, for review in August 2019.

Decontamination of scopes was not performed on site. However, staff did follow standards for decontamination of endoscopes by performing a bedside clean immediately post procedure.

Patients were provided with information on discharge on who to contact if they began to feel unwell or had any questions post procedure.

Nutrition and hydration

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

Staff followed national guidelines to make sure patients were not without food for long periods. Patients who had fasted as part of their procedure were informed of the time they could eat and drink post procedure by the recovery nurse. This ensured that a light snack was available for them as soon as possible before they left the department.

Staff made sure patients had enough to eat and drink. The waiting area had access to a water and coffee machine for patients and those accompanying them to use.

Pain relief

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

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. We observed patients' pain level being assessed before, during and after their procedures, pain scores were recorded in patient records.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had yet to be accredited under the Joint Advisory Group (JAG) on GI endoscopy.

The service was in the process of applying for accreditation under JAG, this accreditation is awarded to high-quality endoscopy services. Accreditation is awarded upon the achievement of a framework of requirements supporting the assessment of endoscopy services and achievement of person-centred care. The service was aiming to gain accreditation within the next year.

Managers carried out a comprehensive audit programme. The hospital had an audit programme in place which included audits within the endoscopy service. Audits were completed, and findings discussed in clinical governance meetings. Audits included infection prevention and control equipment, asepsis, environment and cannula care, hand hygiene, decontamination and WHO checklist. In addition, the service submitted data to JAG twice a year against the GRS quality improvement system framework. We were told that the service was in the position to apply for JAG accreditation, however, needed the refurbishment of the department completed to support the application.

Managers used information from the audits to improve care and treatment. The service performed an endoscopy patient comfort survey, we reviewed the results from April 2019. Twenty-eight patients had their experience audited regarding confidence, anxiety, dignity and pain throughout their procedure. Audit results enabled staff to compare their impressions to the results recorded by patients to gain a deeper insight into patient's experiences.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Managers also made sure all bank and agency staff had a full induction and understood the service.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers supported staff to develop through yearly, constructive appraisals of their work. One hundred percent of staff working within theatres had received an appraisal within the current appraisal year, 100% of staff had also received an appraisal in the previous year.

Managers made sure staff received any specialist training for their role. Endoscopy staff completed the BMI endoscopy competencies for registered nurses/ practitioner's competence assessment log book. We reviewed two staff competency files and saw that competency assessments were performed on clinical and professional competencies. Clinical competencies included an assessment of knowledge and practical application in assisting in a variety of procedures such as colonic endoscopic mucosal resection. Training on specific equipment used to perform procedures was also conducted and documented in staff files. It was company policy that competency assessments were performed every two years unless otherwise indicated and we saw assessments had been conducted within this time frame. A competency matrix was displayed within the recovery area which listed each core member of endoscopy staff and what procedures and tasks they were competent in performing.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw that staff had had some competencies completed at a neighbouring NHS hospital that performed different procedures to those at the BMI Saxon clinic. This enabled staff to keep their skill set high.

The Medical Advisory Committee was responsible for ensuring any new consultants were only granted practising privileges if they were competent and safe to practice.

Endoscopists were provided with specific individual feedback. Feedback for each consultant endoscopist was provided and measured their performance against key performance indicators and standards set by JAG.

Multidisciplinary working

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

We found good multidisciplinary working in endoscopy services. We observed medical, nursing and support staff working well together before, during and post procedure to ensure the effective and co-ordinated delivery of care.

Seven-day services

Not all services were available seven days per week.

The endoscopy service was not a seven-day service. Clinics were run Monday to Friday with a range of morning, afternoon and evening appointments available. Consultants managed their own theatre lists and endoscopies were undertaken at agreed times for each consultant.

Inpatient care, if required was available seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles. Information was available on how to live with and manage a range of conditions including ulcerative colitis, irritable bowel disease and chrons disease.

Good

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation. We reviewed three sets of medical records to assess the consent procedure in endoscopy. We found in all three cases, the consent form was signed on the day of the procedure on the patient's arrival to the unit. However, this process is not in line with current best practice guidance from the Royal College of Surgeons. The Royal College of Surgeons guidance on taking consent states that patients should sign a consent form at the end of the discussion around consenting to the procedure. Patients should then be given a copy of the consent form to allow time to reflect on the decision. On the day of the procedure, the lead clinician should reaffirm consent for the procedure.

Staff made sure patients consented to treatment based on all the information available. Staff explained procedures to patients during the pre-admission process and on the day of their procedure. One patient we spoke with told us they had received good information prior to their procedure being performed. Staff clearly recorded consent in the patients' records.

Staff received mandatory training that covered mental capacity and Deprivation of Liberty Safeguards. This content was delivered as a part of the safeguarding modules which we saw had high compliance for both ward and theatre staff. Training in consent was delivered as a part of mandatory training 100% of theatre staff and 94.4% of eligible ward staff had completed this training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. An up to date policy was available on the providers intranet service.

Are medical care (including older people's care) caring?

Good

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

Compassionate care

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

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

Patients said staff treated them well and with kindness. We spoke with one patient who told us the nurses were kind and caring and they were happy with the treatment provided.

Staff followed policy to keep patient care and treatment confidential. Separate rooms were provided for patients to have discussions with clinicians away from other patients. Patients were also able to get changed in an area away from other patients who were having procedures performed.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Patients were asked to disclose information on their mental health at pre-assessment to ensure any adaptations or considerations could be made throughout the patients' procedure.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. One of the nurses had been appointed as a dignity champion, patients were informed of this nurse and their role upon admission.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We spoke with one patient who told us they had received good information prior to their procedure about what to expect and how to prepare.

Good

Medical care (including older people's care)

Endoscopists and nurses provided support to patients and explained what was happening while procedure were being performed.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients were provided with information before and after their procedures on how to monitor their condition and any side effects that may be experienced.

Staff talked with patients, families and carers in a way they could understand. We saw staff keeping patients and those accompanying them updated throughout their time in the department. The length of appointments allowed time to go through information, provide reassurance and allow flexibility to meet the needs of patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. We saw feedback questionnaires available in the department for patients to leave their feedback on the treatment they had received.

The feedback from the Friends and Family Test was positive for all wards. Results showed that overall in 2018 97.6% of patients who used services at the BMI Saxon clinic were likely or extremely likely to recommend the service, 96.9% rated the care as very good or excellent with 91.6% of patients saying expectations were met or exceeded.

Are medical care (including older people's care) responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The service also relieved pressure on other departments when they could treat patients in a day. Endoscopy services were mainly delivered through an ambulatory pathway allowing patients to attend at a specific time for their procedure and leave the unit shortly after without having to be admitted to one of the hospital wards.

Private patients could choose to have procedures undertaken at The Saxon Clinic. Private patients could book appointments through a centralised BMI healthcare team or the hospitals website, which included a 'live chat' support function.

NHS patients could access the service through the national choose and book portal. This gave patients a choice of appointment times and enabled the hospital to manage its capacity and workloads. This also gave patients a greater choice of appointment time.

Patient views were considered in the improvement of the service. Satisfaction surveys were performed to enable the hospital to continually improve its services.

The hospital provided solely elective procedures. The service worked with consultants to ensure appropriate lists were run to meet demand.

Facilities and premises were mostly appropriate for the services being delivered. A refurbishment programme was due to start in October 2019 to improve and update the endoscopy suite environment.

Post procedure advice and care information was available for all types of procedures performed at the clinic. Information sheets provided details of potential side effects and the contact details for the endoscopy unit both in and out of hours for patients to use if they had any questions or concerns.

Meeting people's individual needs

Good

Medical care (including older people's care)

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

Staff had access to training and information on supporting patients living with dementia and learning disabilities. Dementia awareness was included in mandatory training modules, staff also could access information about supporting patients with learning disabilities throughout their treatment from safeguarding policies.

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. The pre-assessment questionnaire assessed each individuals level of English understanding. If English was not the patients first language or if the patient requested support during their consultation a language line could be used during their procedure. We were told this was accessed by patients three or four times per month.

The service had information leaflets available on post procedure after care. We saw various leaflets on conditions such as ulcerative colitis and diverticular disease were available along with post procedure information for post sedation and all types of procedures that were performed within endoscopy. The service had access to leaflets in languages other than English and displayed multi-lingual posters relating to chaperoning.

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

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

There were three theatres at BMI Saxon Clinic, endoscopy and minor procedures were performed in one dedicated theatre.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Average referral to treatment times for NHS patients were provided. NHS patients should have a maximum wait of 18 weeks for non-urgent treatment referrals. In the 12 months before our inspection the average waiting time was 3.2 weeks, November 2018 had the longest wait of 4.2 weeks. The service did not routinely monitor the referral to treatment time for private endoscopy patients, patients were booked at a time suitable to them and agreed by the consultant, management told us the average wait for private patients was seven to ten days.

Patients received a reminder text message about their appointment 24 hours before.

Managers worked to keep the number of cancelled appointments to a minimum. Between September 2018 and August 2019 eight patients had their appointment cancelled on the day of procedure. Two due to lack of equipment, one due to bowel preparation not being completed, one due to an unrecognised risk factor and four being cancelled on the same day due to staff sickness. Managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers and staff worked to make sure patients did not stay longer than they needed to. We saw nursing staff communicating any delays and the progress of the patients journey to those accompanying them.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas.

A complaints policy was in place at the time of inspection. This clearly outlined roles and responsibilities in relation to complaints handling and the timeframes in which they should be acknowledged. The policy included relevant information about complaints referral to relevant external bodies at stage three of the complaints body such as the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) for private patients and the Health Service Ombudsman for NHS patients.

Good

Medical care (including older people's care)

An electronic complaint monitoring tool was in use across the hospital. Complaints and the actions and investigations taken would be recorded on the system to provide an audit trail. Once a complaint was recorded on the system it would be allocated to the service lead to investigate.

We were told no formal complaints specific to endoscopy had been raised in the last 12 months. Staff told us they aimed to resolve any issues at the time while the patient was present. Management told us that the main themes of informal complaints was communication around waiting for treatment dates and delays within the department.

For our detailed findings on complaints please see the Surgery report.

Are medical care (including older people's care) well-led?

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

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

Endoscopy services were led by a lead nurse. They reported into the clinical service manager for theatres. If the lead nurse was not working clinically their office was within the department so they were accessible to staff.

Staff we spoke with told us they felt supported by their local management. Staff told us managers were visible within the department and they were happy to seek support from them.

Leaders communicated important messages to staff. We saw messages being conveyed from senior leaders to local leaders and consultants within endoscopy user group meetings.

Local leaders were aware of the challenges within the service and were included in planning service developments.

For our detailed findings on leadership please see the surgery report.

Vision and strategy

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

Saxon Clinic is part of the BMI Healthcare Group. BMI has a network of hospitals across the UK all of which share the same vision which was 'Serious about health. Passionate about care'.

The hospitals local strategy and operational plan was in place for 2019-2020 and focussed on both clinical and non-clinical priorities. The strategy was developed in consultation with all departments.

The local strategy for the endoscopy service was to be successful in attaining Joint Advisory Group (JAG) accreditation for their service. Refurbishment works, and improvements had been planned to ensure specific environmental criteria of the accreditation were met.

For our detailed findings on vision and strategy please see the surgery report.

Culture

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

Staff were happy working within the departments. Staff we spoke with were happy in their role and described it as a friendly supportive team to work in.

Staff put the patients care and experience at the heart of what they did.

The service was committed to improving the health and wellbeing of its staff. BMI Saxon Clinic had an action plan to work towards achieving the health and wellbeing

commissioning for quality and innovation (CQUIN). The local Clinical Commissioning Group had confirmed that all associated criteria for this CQUIN had been met for the 2018/2019 period.

For our detailed findings on culture please see the Surgery report.

Governance

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

A hospital wide governance reporting pathway and structure was in place.

Governance and patient safety related issues were discussed at monthly clinical governance meetings. We reviewed meeting minutes and saw that items including risk registers, incidents, audit, NICE guidance updates and infection prevention and control were standing agenda items. Reports and minutes from subcommittees were also reviewed by those in attendance. An action plan with named action owners was produced at the end of each meeting and reviewed at the next.

Clear reporting lines were in place. Issues would be escalated from endoscopy lead, to clinical services manager to director of clinical services and then to executive director.

The service followed the hospital wide audit calendar and completed audits in all areas of practice including national early warning scores (NEWS2) and World Health Organisation (WHO) surgical safety checklist. We were told that NEWS2 had previously flagged as not being completed and the hospital had implemented additional training and support to staff. Since this, they had seen an improvement in completion. We saw that WHO audits were completed regularly and showed good compliance. Following our inspection, the hospital provided us with copies of the NEWS2 and WHO checklist audits and we saw that compliance across all areas had improved.

Incident summaries were sent out weekly. Clinical governance, quality and risk bulletins were circulated which included an overview of updates from across the hospital and lessons learned from any complaints and incidents.

Endoscopy user group meetings occurred quarterly. We saw that these had a good representation of senior management, local management and medical staff. Standing agenda items included. incidents, patient experience and staffing levels. However, apart from the endoscopy lead nurse there was little representation of the other nursing staff within the department at these meetings.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. Some but not all risks were identified.

Risk registers were in place for each service. Each service including endoscopy had their own risk registers which contributed to the hospitals overall risk register. The endoscopy lead described the main risk to the service and these included staffing, the environment of the recovery areas and a non-complaint sink in the recovery. Staffing and the non-complaint sink were noted on the risk register however the environment in the recovery bays was not on the hospitals or service specific risk register. We were told that the details of the environment were outlined in the theatre refurbishment plan, which was in progress at the time of inspection.

Although it was an accepted risk by both local and provider level management the fact the theatre was not dedicated to endoscopy was not on the services risk register.

Performance was reported locally and nationally, and a national report was submitted annually, which compared BMI Saxon Clinic to other BMI locations around England.

For our detailed findings on managing risk please see the well led surgery report.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff had access to a BMI internal intranet system that provided them with up to date policies, procedures and changes to practice.

Medical records were stored securely throughout our inspection.

The service collected, analysed and used data to monitor and improve services. We saw audit results were discussed at governance meetings.

For our detailed findings on managing information please see the well led section in the Surgery report.

Engagement

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

The service gathered feedback from patients through questionnaires given to patients at the end of their treatment or inpatient stay. Patient satisfaction surveys were undertaken for the service to improve their care and highlight areas of good practice. For example, some patients had highlighted they did not receive enough advice on bowel preparation before their procedure and this was passed onto the pharmacy team who administer the bowel preparation medication for patients.

Staff engagement surveys were undertaken. Staff were able to complete the BMI wide staff engagement survey which was reported at both location and provider level. The engagement index for the hospital was 72/100, this was an improvement from 67/100 in 2017 and was better than the provider average of 63/100. All staff that responded to the survey reported being committed to doing their very best for BMI healthcare.

An equality and diversity policy was in place. The policy aimed to ensure any areas of discriminatory practice in respect of protected characteristics were identified, removed or minimised.

For our detailed findings on engagement please see the well led section in the Surgery report.

Learning, continuous improvement and innovation

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

The service was committed to improvement and this was evidenced through services changed to meet JAG requirement.

Information sharing between sites took place. A monthly conference call was in place for endoscopy leads across the BMI sites, aimed at supporting each other through the JAG accreditation and promoting and knowledge sharing across sites.

Good

Surgery

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

Are surgery services safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. There was a robust process for monitoring the compliance with mandatory training across the hospital. Staff were reminded in advance of training dates expiring and were booked onto essential courses, such as basic life support. This process ensured that staff training compliance was maintained. Staff were provided with dates of training in advance and were able to visit any other BMI site to complete training. Compliance for mandatory training was 96.6% across all staff groups and topics at the time of inspection.

Medical staff received and kept up-to-date with their mandatory training. There was a robust process for ensuring training was completed. Training was usually completed at the consultant's host hospital, and evidence of completion required to enable them to practice at the hospital. We were given examples of when consultants were required to complete training before being permitted to work within the hospital. The Medical Advisory Committee chair confirmed that doctors were required to ensure training was completed and liaised directly with the host hospitals if there were any concerns regarding completion. Consultant mandatory training compliance was 100%.

The mandatory training was comprehensive and met the needs of patients and staff. Topics included in mandatory training were, basic life support, infection control and prevention, health and safety and sepsis awareness.

Staff were trained in basic life, immediate life and advanced life support skills depending on their role and responsibility. We saw that 100% of theatre staff were trained in both basic life support and paediatric life support. 71.4% of theatre staff had completed immediate life support (more advanced training to basic life support). 66.7% of ward staff had completed immediate life support and 50% paediatric life support. Five members of staff had completed advanced life support (ALS), including the registered medical officer. All staff who cared for children had completed paediatric intermediate life support. We were told that there were plans to increase the numbers of staff with ALS and two additional staff were booked on courses.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The ward sister provided opportunities for e-learning to be completed and ensure staff had dates booked for face-to-face modules. Managers told us that training programmes were embedded due to the BMI training programmes.

We saw evidence that the doctors employed by an external agency (resident medical officers), completed all required mandatory training.

Mandatory training for practising privileges consultants was completed via their employing NHS trust, checked and updated by BMI The Saxon Clinic.

Good

Surgery

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. Compliance with training across all staff groups was 96.6% at the time of inspection. The hospital target was for 100% compliance. The target for new staff was 90%, to accommodate time taken to complete all relevant training. Staff were able to give examples of when patients had been escalated and referred to the safeguarding team.

All staff completed safeguarding children level 1 and 2 training and updated every three years. Safeguarding children level 3 training was completed by all registered practitioners and clinical managers and updated every three years.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was a safeguarding lead within the hospital and at corporate level who could be contacted for advice. The hospital safeguarding lead was planned to complete safeguarding children level 4 training. This had not been completed at the time of inspection due to their recent promotion to the role. Level 5 training was completed by the director of governance and national head of nursing. This meant that staff had appropriately trained people in place to escalate any concerns.

Safeguarding vulnerable adults training level 1 and 2 were completed by all staff and updated every two years. The director of clinical services and a nominated deputy were trained to level 4 providing clear escalation. There was a plan to roll out level 3 training across all staff in line with guidance, however, at the time of inspection this was limited to managers who worked on call.

Medical staff received training specific for their role on how to recognise and report abuse.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All the clinic rooms, bedrooms and corridors we visited on the wards and the pre-operative assessment unit were compliant with HBN00/10 Part A, flooring was complete and intact, visibly clean, impermeable and ran up the walls.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed the cleaning schedules for the ward area and saw this had been fully completed for the week and month so far.

Staff followed infection control principles including the use of personal protective equipment (PPE). The hospital had two theatres, one of which was laminar flow. Laminar flow theatres work to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments, surgeons and the patient's own skin.

The intraoperative phase of patient care and preparation was in line with the National Institute for Clinical Excellence (NICE) clinical guidance 74. Staff scrubbed aseptically for theatre, wore the correct sterile gowns and gloves and administered the correct antiseptic skin preparation.

Theatre staff wore 'scrubs' (loose clothing of the type worn by theatre staff) to prevent cross-contamination from their clothing. We observed how theatre staff wore disposable gowns over their theatre clothing when leaving their department.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment in the theatres and ward area were cleaned regularly and once cleaned had a green 'I am clean sticker' attached. We reviewed the equipment store in the theatres and ward, which were all clean and had 'I am clean stickers' from the day before our inspection.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital reported low infection control rates. The hospital reported four surgical site infections between April 2018 and March 2019.

There were hand sanitiser gels available for staff to decontaminate their hands in the ward areas. The practice we observed showed all staff on the wards and in the pre-operative assessment clinic decontaminated their hands in line with World Health Organisations (WHO) Five Moments of Hand Hygiene (2009). All the patients we spoke with on the wards told us they saw staff decontaminate their hands before and after patient contact. All clinical areas reported on hand hygiene compliance as directed by BMI provider policy. Hand hygiene audit results we reviewed showed the service met or exceeded expected level of compliance of 95% over the three months prior to our inspection.

The hospital reported no incidences of methicillin-resistant Staphylococcus aureus (MRSA) or methicillin sensitive Staphylococcus aureus (MSSA), no incidences of E-Coli and no cases of Clostridium difficile (C-diff) in the 12 months prior to our inspection.

The hospital held patient forums to review hospital performance against patient expectations. The most recent forum was held in July 2019. Areas of discussion in every forum included 'Your hospital stay'. None of the patients gave negative feedback regarding cleanliness of their rooms or the ward.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. There had been several changes to the hospital following our last inspection. This included the removal of carpets in clinical areas and the instillation of hand washing sinks.

The service had suitable facilities to meet the needs of patients' families. The hospital had undergone several refurbishment projects since opening in 1985. Staff reported that plans were always discussed openly, and updates provided through staff newsletters and forums.

Current plans include the refurbishment of patient rooms, provision of a dedicated children's area and refurbishment of the endoscopy service to meet Joint Advisory Group (JAG) requirements. JAG is an accreditation scheme that is awarded to endoscopy services following a peer review of standards.

The service had enough suitable equipment to help them to safely care for patients. Heads of department were involved in the replacement of aging equipment and those items which were required for service developments. There was an equipment replacement program in place.

There was one laminar flow theatre and one theatre without laminar flow.

Staff carried out daily safety checks of specialist equipment. The wards and theatres had resuscitation trolleys. The trolleys were tamper-evident to reduce the risk of equipment being removed and not available in an emergency. Staff carried out daily and monthly checks of the equipment to ensure it was ready for use in an emergency. We checked four trolleys across the departments and saw all were checked in line with policy and no dates had been missed. We saw information was located with or above the trolleys, providing guidance for staff about the emergency procedures and action to take, such as sepsis.

Staff disposed of clinical waste safely. Sharp instruments were managed safely. We checked sharps containers across all areas we inspected and saw all were stored correctly and safely. Sharps bins were correctly assembled signed and dated in line with Health Technical Memorandum 07/01. Sharps were managed in line with EU Directive 2010/32, prevention of sharps injuries. Sluices on wards had locks to control entry and all were locked. Inside all the sluices were locked cupboards, which contained hazardous cleaning chemicals (COSHH) therefore not accessible by the public.

Consumable equipment, for example, syringes, needles and dressings, were managed effectively across all areas we visited. The consumable items we checked were stored in unbroken packaging and were within their expiry date.

In all areas we inspected staff complied with the Department of Health, Health Technical Memorandum 07/01, safe management of healthcare waste (2013). All waste was segregated in different coloured bags and posters were displayed explaining which item went into which waste stream.

Fire extinguishers on the ward had all been checked within the last two months and we saw clear signage for the fire exits which were easily accessible and free from clutter.

The hospital held patient forums to review hospital performance against patient expectations. The most recent forum was held in July 2019. Areas of discussion in every forum included 'Your hospital stay'. All patients at the forum gave positive feedback on their room and ward environment.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This system was based on a simple scoring system in which a score was allocated to physiological measurements undertaken when patients present to or are being monitored in hospital. We saw variable practice with regards to the calculation of the National Early Warning Scores 2 (NEWS2) for patients. We reviewed 10 sets of records while on inspection where one set was not completed and one set where the NEWS2 calculation was not legible. We saw that the service completed regular record audits in all clinical settings. NEWS completion had not been flagged as an issue on the ward, however, we were told that additional training had been provided to staff within endoscopy following recent record audit results.

Following our inspection, we asked the service to confirm what actions had been taken in response to concerns with NEWS2 scores. We were told that staff were now using the same NEWS2 charts for the duration of the patient pathway (preadmission to discharge) enabling a trend to be measured against a baseline. The hospital had also introduced weekly compliance audits ensuring that baseline observations being completed correctly, scores were calculated and escalated appropriately. The hospital had also introduced an escalation audit to ensure that patients who triggered were escalated to the consultant.

All staff were aware of the sepsis six protocol and had received training as part of their mandatory training. Senior staff had provided the ward with a sepsis box, this contained information and vital equipment to hand during an emergency. All the staff we spoke with knew where this box was kept.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. We reviewed 10 sets of patient records and found that staff used nationally recognised risk assessment tools to measure each patients risk relating to pressure ulcers, moving and handling, nutrition, falls and dementia screening. Risk assessments were completed on admission and when there was a change in the patient's condition.

Staff knew about and dealt with any specific risk issues. Comprehensive risk assessments were carried out for patients who used the services and risk management plans were developed in line with national guidance such as National Institute for Health and Care Excellence (NICE). All patients who were admitted to the hospital received risk assessments such as venous thromboembolism (VTE) risk assessments, malnutrition screening assessment (MUST), pressure area and a falls assessment. Once assessed and if found to be at risk, management plans were put in place such as falls preventions action plans and pressure ulcer care plans. Staff on the ward reviewed their patients daily.

Those patients who required insertion of invasive devices such as , catheters or central venous lines had care pathways. These identified the reasons for and the safe insertion of the tube/line and directed staff to provide ongoing monitoring.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Patient records detailed the necessary information for staff taking over their care between shifts. Staff sent letters to the patients GP on discharge outlining the care they had received and any ongoing medical needs.

There was a daily communication meeting which was attended by all departments and highlighted any challenges facing them that day. This was the team's opportunity to discuss and cascade learnings from incidents and recognise good practice. We saw that the meetings included planned activity, details of any high-risk

patients in attendance, an overview of staffing and review of any recent events or incidents. The meeting lasted approximately 15 minutes and staff were concise in detailing their information for sharing.

The hospital completed a variety of scenarios which included emergency situations. These were completed at regular intervals and staff told us that they were beneficial. We saw that staff were allocated roles for managing emergencies at the morning communication meeting. This meant that in the event of an emergency staff were aware of their roles and responsibilities.

Staff had access to all consultant contact details for when they were not on site. This ensured that staff could access a consultant in the event of an emergency.

There was a formal arrangement for patients to be transferred to the local NHS hospital if the patient deteriorated or required critical care. Over the period September 2018 to August 2019 the service had transferred 12 patients to the local NHS trust.

We attended two full procedures in theatres which enabled us to observe the complete WHO surgical safety checklist pathway. We observed all staff being fully engaged with team/safety briefings, sign in, time out and de brief. Swabs, needles, instruments and sharps were counted to prevent foreign body retention and subsequent injury to the patient by two members of staff.

Nursing and support staffing

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

The service had enough nursing staff of relevant grades to keep patients safe. Staffing numbers were calculated using the BMI Healthcare Nursing Dependency and Skills Mix Planning Tool, which was introduced in 2015. This process enabled staff to make judgements of the right number of staffing depending on patient acuity and skill. This was completed a minimum of five days in advance of the planned activity. A similar tool was used in theatres, which was designed to automatically calculate the number of staff required according to the procedure. Weekly planning meetings were completed which enabled the team to discuss cases and the staffing number required.

We saw that staffing numbers varied according to the daily activity. For example, during inspection, we saw that there were three nurses on duty supported by two healthcare assistants. The number of staff on duty decreased at night, as most patients were day case admissions. We were told that there was always a minimum of two nurses on duty for day and night shifts. Staff told us that staffing levels were always as planned and substantive staff were supported using bank or agency staff when needed. The ward sister supported staff with the coordination of activity and was not always included in numbers.

All leads reported that recruitment was a concern. We saw that there were 11 vacancies across the hospital with seven being within surgery. Some posts had been vacant for several months and to address this, staff had tried to be creative in recruitment, and developed staff internally. The hospital used regular bank and agency staff to supplement staffing levels. We saw that where possible, the same staff were used to ensure continuity of care.

Managers made sure all bank and agency staff had a full induction and understood the service. Any new member of staff was required to complete a local induction which included an overview of the building, fire safety, emergency equipment and key policies. Staff were provided with a buddy, so they had a nominated person to discuss any concerns.

The hospital used an electronic roster tool across all departments in line with BMI policy.

Medical staffing

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

The service had enough medical staff to keep patients safe. There were 118 consultants working at the hospital under practising privileges. Consultants were required to provide evidence that they were competent for the roles which they were proposing to complete at the hospital. Evidence

required by a consultant prior to being accepted at the hospital for practising privileges included a curriculum vitae, certificates of education, annual appraisal, General Medical Council (GMC) details and medical indemnity certificates, immunisation status and Information Commissioner's Office (ICO) certificates. All staff were required to have enhanced Disclosure and Barring Service (DBS) completed.

All applications for practising privileges were reviewed by the medical advisory committee speciality representative ensuring that the application and practice was in line with the hospitals work. All consultants were required to provide evidence on annual training, appraisals and certificates. Biannually, the hospital completed a more in-depth review of consultant's practises which included a review of key indicators, such as number of procedures, readmission rates, infection rates, complaints and a review of scope of practice. Hospital data showed that 100% of consultant had completed an appraisal within the last 12 months.

When patients were admitted for surgery, either as a day case or for overnight stays the consultant responsible for their care was required to be available. Consultants ensured that staff had contact details for the duration of their patient's inpatient stay or arranged cover from peers with practising privileges at the hospital. There was a similar process in place for anaesthetists, who also needed to ensure that hospital staff were aware of any cover arrangements.

There were two resident medical officers (RMO) who provided 24-hour cover. RMOs were responsible for the day to day management of patients under the supervision of the consultants. Their working pattern included one week on/ one week off. Working time and rest time was closely monitored by the director of clinical services. Staff told us that when activity was high and the RMO had not had enough rest, an agency RMO was asked to provide cover to enable enough rest.

Records

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

Patient records demonstrated a multidisciplinary collaborative approach to patient care and were well maintained. We reviewed 10 sets of patients records and found there was a good standard of record keeping. All paper records were legible, contemporaneous, and signed. Management plans and daily ward rounds were clearly documented, and evidence of escalation was clear. Records contained all relevant information regarding patients' care and treatment.

Prior to inspection, patients' records were primarily maintained by the consultant responsible for the patients care. All consultant records for outpatient appointments were held by the consultant. However, the hospital had identified that this was a potential risk and the senior management team (SMT) reported that the hospital was moving towards a single patient record. This was being implemented at the time of inspection and planned to be completed by the end of 2019. This meant that all records would remain on site and therefore available if a patient attending the hospital for an appointment with different consultants. At the time of inspection, the outpatient's department were starting a patient file at the time of appointment, which would become the patients one set of hospital notes.

Clear pathway documents were used throughout patient admissions. Risk assessments were completed from the start of the patient's pathway in pre-operative assessment and throughout the admission. Surgical pathways were carried out in line with NICE guidance. We reviewed a sample of these and found staff completed thoroughly.

Staff completed and recorded intentional care rounding. Intentional care rounding is a structured process where staff performed regular checks with individual patients at set intervals. For example, we observed HCAs visiting patients to check that call bells and drinks were within reach and they asked if the patient was comfortable or in any pain. We saw these were documented in the patients' records we reviewed.

Nursing staff completed a discharge summary letter for the patient's GP. This gave details of the operation performed, any medication required as a continuation of their care and any follow-up requirements. Consultant contact details were provided to GPs, so they could contact them for further advice if required. Discharge letters were sent electronically to the patients GP and a copy provided to the patient.

Records were stored securely. Either in lockable records trolleys or in locked cupboards.

Good

Surgery

When the hospital completed contract work for the local NHS Trust there was an agreement that the relevant NHS medical records were made available prior to and during the treatment pathway. Staff reported that there were no issues or delays in accessing records.

Consultants were not permitted to remove patients notes from the hospital and we were told that if a consultant wished to view the hospital's patient notes, they are asked to do so within the hospital and in accordance with data protection legislation and the Caldicott Principles.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely in locked trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely, and stock levels checked regularly to ensure safe and appropriate use. This was in line with the provider's policy.

Policies and procedures were available and accessible to staff. Policies viewed as part of our inspection were in date and in line with best practice and national guidelines.

Staff followed current national practice to check patients had the correct medicines and gained consent before administering medicines. Staff supported patients to make informed decisions about their care and treatment. We saw that nursing staff explained what medicines they were giving, and observed the patient take them. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We reviewed 10 medicine prescription charts and saw medicines were administered, recorded and prescribed safely. Patient allergies were clearly recorded on all drug charts.

A pharmacist visited the ward daily to review prescriptions, provide advice and support to staff and provide information to patients before discharge.

The service made sure patients received their medicines as intended and completed monthly medical record audits. Compliance was 100% in May, July and August 2019. We reviewed 10 medicine prescription charts and saw medicines were administered in a timely manner, where doses were delayed or missed for any other medicines, there were documented reasons.

Emergency medicines and equipment were readily available and at the time of our visit, all medicines we looked at were in date. All emergency medication boxes that were kept on or near the resuscitation trolleys in sealed boxes. Records showed that daily checks of medicines stock on the resuscitation trolleys had been performed to ensure that they were fit for use in accordance with BMI policy.

We checked a selection of medicines across all the areas we visited, all of which were in date of their manufactured expiry date. Stationery used for prescribing was stored securely and managed appropriately.

Medicine fridges were kept in treatment/clean utility rooms which were temperature monitored to ensure medication stored in these rooms did not exceeded the manufacturers recommendation for storage. The fridge temperatures were monitored daily and recorded on a dedicated sheet, which informed staff of the process to go through should the fridge not work properly. We checked fridges in theatres and the ward where no gaps were noted.

The service had systems to ensure staff knew about safety alerts and incidents. Medicine incidents were reported through the hospital's electronic reporting system and information shared across the team at team meetings, handovers and safety briefings.

Medicine alerts were managed by the pharmacy team, and actions taken in response to alerts were recorded. The hospital pharmacy was predominantly staff by agency staff, whilst recruitment was taking place. However, this was the same person which enabled consistency and prevented repetition of induction.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Good

Surgery

Staff knew what incidents to report and how to report them. The hospital used an electronic system to record any incidents. This system alerted the senior management team and corporate leads of the incident reported which enabled urgent escalation. We saw that incidents were investigated locally when appropriate and actions completed to mitigate or correct the incident.

Managers investigated incidents thoroughly and patients and their families were involved in these investigations when appropriate. We saw that relatives and patients were given the opportunity to comment on investigations when they were completed. The senior management team gave examples of when meetings had been arranged with patients, relatives and clinicians to discuss incidents and investigation findings.

Staff told us that they were happy to report incidents and were encouraged to escalate any concerns. The number of incidents reported were compared to peer hospitals, and the senior management team, were happy that the number of incidents and type were consistent with peers and showed a positive culture towards reporting.

The hospital reported 472 clinical incidents between April 2018 and March 2019, 303 with no harm, 161 with low harm, eight incidents with medium harm, and zero incidents with severe patient harm. There were no serious incidents reported by the hospital from April 2018 to March 2019.

We were told that managers debriefed and supported staff after any incident. We saw that incidents were discussed, and key messages shared with the wider team to prevent reoccurrence. For example, emails were sent reminding staff of policies or local procedures which may support them in their roles.

The hospital reported no never events. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

The hospital reported one unexpected death from April 2018 to March 2019. This incident was reported, fully investigated and shared across the wider BMI group. The incident identified some areas for learning which were being tracked through team and governance meetings.

Staff received feedback from investigation of incidents, both internal and external to the service. Newsletters, emails and memos were used to share information. There was also a process for sharing learning across BMI with corporate news flashes, and cluster meetings. For example, never events that occurred in other BMI hospitals were shared with the team locally though newsletters and corporate training. This process ensured that all staff were aware of incidents and any resulting changes to practice.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. We saw evidence within incident investigations where explanations and apologies were given.

There were no serious incidents reported by the hospital from April 2018 to March 2019.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Hospital data showed that there were five unavoidable hospital acquired venous thrombosis (VTE) and pulmonary embolism (PE) from April 2018 to March 2019. All patients who experienced a VTE or PE were receiving prophylactic therapy to prevent blood clots. There were no reported falls, no catheter acquired infections and no hospital acquired pressure ulcers.

Are surgery services effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national

guidance. The hospital used nationally recognised guidance and standards relating to patient safe care and treatment. Policies and procedures were in place, and easily accessible to staff.

The hospital had a structured audit programme to ensure practise was reviewed. The programme utilised experts where appropriate, for example, infection prevention and control lead completed infection control audits. National guidelines such as National Institute for Health and Care Excellence (NICE), were also reviewed to ensure the service provision was in line with best practice evidence.

Clinical effectiveness was supported through staff training and development. Policies were based on NICE guidance and located on the intranet. Services within BMI were compared at a regional and national level.

Patient's needs were assessed using BMI clinical pathways, which were evidence based and used nationally recognised risk assessments tools. The hospital also used national manuals which were available online for staff as reference guides.

Patients received care in line with the national guidance such as NICE guidance. For example, patient records showed they had been assessed for the risk of venous thromboembolism (VTE) on admission, throughout their stay and on discharge. This was in line with NICE guideline NG 89 Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The hospital followed National guidance by the Royal College of Anaesthetists (RCA) and the Royal College of Nursing (RCN) that patients should receive clear fluids up to two hours and food up to six hours before surgery.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

As part of the nursing inpatient admission documentation, all patients were screened with a validated nutritional screening tool, which identified patients who were malnourished, or at risk of malnutrition.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The hospital provided specialist foods, such as kosher and halal, to meet patients' religious needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. As part of the nursing inpatient admission documentation, all patients were screened with a validated nutritional screening tool (Malnutrition Universal screening Tool - MUST), which identified patients who were malnourished, or at risk of malnutrition. We observed MUST assessments were completed in all the records we reviewed. These were routinely updated as required.

We saw that staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used fluid balance charts to monitor patients' fluid intake.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients waiting to have surgery were kept 'nil by mouth' in accordance with national safety guidance. This was to reduce the risk of aspiration during general anaesthesia.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Patients recovering from surgery had jugs of water within reach. These were regularly refilled. Staff completed hourly care rounds for each patient and checked they had a drink.

The hospital held patient forums to review hospital performance against patient expectations. The most recent forum was held in July 2019. Areas of discussion in every forum included 'Accommodation and catering.' All patients gave positive feedback on the quality and variety of food offered at the hospital.

Pain relief

Good

Surgery

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management to ensure following surgery patients were given effective pain relief. Ward staff assessed patients' pain and the effectiveness of pain management regularly using a nationally recognised numerical scoring system. We observed nurses checked patient's pain levels during routine observations and interventional rounding.

Patients were asked about pain in the pre-assessment consultation. Anticipatory pain relief was prescribed, and we saw this in the patient records we reviewed and being administered in the operating theatre. Information was given to patients pre-operatively to explain what sort of analgesia they could expect to receive during their operation. This included explanations of epidural, spinal, general and patient controlled analgesia.

The surgical care pathways used, prompted staff to assess, record and manage pain effectively. We reviewed 10 patient records which showed pain was assessed with the NEWS2 pain scale and hourly on intentional care rounds, high pain scores were acted on promptly. A monthly medical record audit was completed which looked at assessment of patients' pain and use of the pain score, compliance was 100% in May, July and August 2019.

Staff prescribed, administered and recorded pain relief accurately. We reviewed 10 patient records and saw that pain relief was prescribed appropriately and administered in a timely manner.

Patients received pain relief soon after requesting it. We heard staff asking patients if they had pain and after administering analgesics returned to check if they had been effective.

Patient outcomes

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

Patient outcomes were audited through participation in national and internal audit programmes. Including patient feedback from the patient Satisfaction Survey, NHS Friends and Family Test, NHS Choices and the Private Hospital Information Network (PHIN).

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further.

The hospital participated in clinical audit as part of the BMI Group Audit Programme and reviewed local data and trends at clinical governance and medical advisory committees (MAC). Outcome indicators included surgical site infection rates, falls, transfers, returns to theatres, day case conversion rates, readmission rates and overall quality of care scores. Outcomes were benchmarked against other comparable services both internally through the BMI Dashboards and national audit. This process enabled the team to work collaboratively to make improvements where appropriate.

The hospital participated in the National Joint Registry (NJR) to collect information on orthopaedic joint replacement operations, monitoring the performance of implants and the effectiveness of different types of surgery.

Patient Reportable Outcome Measures (PROMs) measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information was collected before and after a procedure. The hospital currently participated for hip and knee replacement surgery, hernia repair and cataract surgery. PROMs calculate the health gains after surgical treatment using pre and post-operative surveys.

The service had a low expected risk of readmission for elective care. Between September 2018 and August 2019, the service had 11 patients readmitted. All patients were graded either low or no harm as a result of the readmission.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. All PROMs data was discussed at the hospital and cross-site governance meetings. A summary of any key action points was then shared at the MAC and actions for improvement were developed if indicated.

Managers carried out a comprehensive audit programme. Local and national Clinical Quality Improvement Initiatives (CQUIN) were completed and progress was monitored by the Commissioners at Contract Review Meetings. The hospital published all NHS services on the NHS e-Referral service (e-RS) providing patients with improved access to services.

Patient feedback was gathered from the Patient Satisfaction Survey, NHS Friends and Family Test and NHS Choices and patient forums. Patient satisfaction feedback from specific admitted care and outpatient questionnaires, patient forums, incidents/complaints/claims and activity data were used to ensure that learning or change in practice were cascaded to the teams.

A specific feedback form for completion by children was in place and this was followed by a follow up phone call with parents following surgery.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, non-clinical staff appraisal compliance was below the hospital target.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Consultants and anaesthetists worked under a practising privileges agreement, which gave them the authority to undertake private practice within the hospital.

Managers gave all new staff a full induction tailored to their role before they started work. All staff we spoke with on the inspection had received a full induction before starting work in the service. The induction pack gave details of essential hospital policies, contact details and facilitated a standardised induction.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they were given the opportunity to develop and progress within the service.

Managers made sure staff received any specialist training for their role. For example, staff were supported with management training when obtaining senior positions and external courses for clinical specialities development.

Managers supported staff to develop through yearly, constructive appraisals of their work. The hospital reported that most staff had completed annual appraisals, although this was slightly reduced within the administrative teams. Staff training, and development was reported to be discussed during appraisals. Hospital data showed that 100% of clinical staff, and 40% of administration staff had completed an annual appraisal.

Managers identified poor staff performance promptly and supported staff to improve.

There were enough clinical educators to support staff learning and development. BMI employed regional and national trainers to deliver and facilitate learning for staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. All staff we spoke with on inspection told us they were encouraged and supported to attend team meetings. Minutes from previous meetings were shared with staff and copies were available in staff break rooms.

Theatre staff had a dedicated training half day monthly, which has recently been extended to include the wider clinical team across the hospital.

Medical staff competency was assessed by the consultant host site. The chair or clinical lead for each speciality ensured competency and the senior management team liaised with the host hospital for evidence to support competency. If there were any concerns with consultants abilities, there was national leads who supported the medical leads with decision making and reviews.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. In line with the National Clinical Enquiry into Patient Outcome and Death (NCEPOD). Patients received relevant care from multidisciplinary (MDT) and multispecialty healthcare

teams to treat their condition as well as any underlying co-morbidities. We observed how staff of different kinds worked together to assess, plan and deliver care and treatment.

MDT working started when patients visited the pre-operative assessment unit. Staff worked with the local GP surgeries and would contact them should they pick anything up during a pre-assessment appointment. The team in the pre-assessment clinic had a process in place with their local GPs, which they told us worked well.

All staff told us they had good working relationships with consultants and the RMO. We saw good interactions between all members of the team. The RMO, consultants, pharmacist and physiotherapists were present on the ward daily and reviewed patients' together as a team. Staff said they were all approachable and they worked well as a team. Patient records we reviewed confirmed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists and occupational therapists.

The service ensured arrangements for discharge were considered prior to elective surgery. Staff on the pre-operative assessment area started the conversations about discharge. For those patients having day surgery someone to collect them needed to be arranged prior to admission. For those patients who may require help after discharge were encouraged to start arranging this as early as possible.

Seven-day services

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

The hospital only undertook elective surgery, and operations were planned in advance. Normal operating times for theatres was 8.30am to 6pm Monday to Saturday, with additional theatre time to 8pm three times weekly. The exception to this was if a patient was required to return to theatre due to complications. If a patient required a return to theatre out of hours, there was an on call surgical team and theatre dedicated to providing this service.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. There was access to most key diagnostic services 24 hours a day, seven days a week to support clinical decision-making, this included critical imaging and reporting, MRI was available in hours only.

Consultants responsible for patients were always required to be contactable when their patients were at the hospital. RMOs provided 24-hour care seven days a week.

Patients who had been discharged could phone the ward staff for advice at any times, and they could contact the consultant via their secretary if required.

Physiotherapy staff were present on the ward seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on every ward/unit.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

There were health promotion and awareness information leaflets and posters displayed around the hospital. A wide range of leaflets were available for patients regarding their care and health. Patients received leaflets on patient safety which included how to reduce the risk of developing a VTE, falls prevention, pressure ulcer prevention and recognition of sepsis.

The service ran free event evenings on a variety of subjects through the year, including: Men's Health, varicose veins, hips and knees, back pain, and women's health. The events included free consultation and advice for those living with long term conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Good

Surgery

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Patient records we reviewed showed consent was obtained in accordance with hospital policy. We observed consent being obtained for two patients prior to their surgical procedure. The consultant explained all the risks, gave the patient time to ask questions and spoke in non-medical jargon. We saw audits for consent gained in medical records for May, July and August 2019. Staff recorded 100% compliance in all three audits.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Including the Mental Capacity Act (MCA) 2005 and knew who to contact for advice. There was an effective up-to-date consent policy for staff to follow.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff told us they would involve the patients' representatives and other healthcare professionals. Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process, where it was determined whether they could be admitted for treatment at the hospital.

Staff made sure patients consented to treatment based on all the information available. Patients were given information about their proposed treatment both verbally and in writing, to enable them to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required. The pre-assessment clinic used comprehensive leaflets to explain to patients the possibility of post-operative confusion, and that behaviour and memory could be affected.

All theatre and ward clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Are surgery services caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff followed policy to keep patient care and treatment confidential. Patients told us that the staff always knocked on the door before entering their room and we observed this at the time of our inspection. We observed staff spoke with patients discreetly to maintain confidentiality.

Patients said staff treated them well and with kindness. All patients we spoke with told us the staff were kind and caring, they could not fault the service. They said that they had received excellent care and their hospital experience had been positive. Patients said that all staff were pleasant, and they helped to make them feel relaxed, and theatre staff made them feel looked after.

All patient and relatives' responses were positive, and patients told us 'all nursing staff were very friendly and supportive post surgery' and 'staff are friendly and attentive'.

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

The hospital had a patient centred culture where the emphasis was for the team to put patients at the centre of care. We were told that the team strive to meet and exceed patient expectation in all aspects of their interaction with the hospital.

Staff were respectful and responsive to individual patient preferences and need. All patients were treated with dignity and respect and patients regularly commended staff on their kindness and compassion either through the patient satisfaction survey or cards to the hospital. Patients were involved in the planning and decisions about their care and

provided with an interpreter if required. Additional staffing was provided when activity and complexity increased, ensuring the right staff were on duty at the right time and with the right skills to ensure patient care.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. If patients were anxious about the procedure they were admitted for, staff gave extra care and responded compassionately to put the patient at ease. We observed patients on the ward, in the anaesthetic room and in recovery being reassured by staff that were empathetic when patients were nervous or anxious. A patient told us that they had been very nervous about having their operation, but staff in pre-assessment and theatres had helped to reassure them

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. For example, we saw staff supported patients who were anxious or distressed while they were being prepared for surgery. Staff were reassuring and maintained a calm, relaxed environment. Pre-assessment included consideration of patient's emotional well-being. Patient told us that the pre-operative assessment with the nurses was very thorough and everything was explained in detail.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients reported that they had all been provided with clear information about their treatment and care by the consultant and nursing staff, with opportunities available to ask further questions for clarification. Patients felt that they had been fully supported in making decisions regarding their treatment and that they had all that they needed to know for this.

Patients told us nurses explained what they were doing and asked for permission before they did anything. Patients said medical staff explained plans for their treatment and provided opportunities to for them and/or their family members to ask questions when needed. Patients told us they were given choices regarding their treatment options.

Staff supported patients to make informed decisions about their care. Patients felt that they had been fully supported in making decisions regarding their treatment and that they had all that they needed to know for this.

All patients were complimentary about the way they had been treated by staff. We observed staff introduce themselves to patients and explain to them and their relatives, care and treatment options.

Patients who paid for their treatment privately, told us costs and payment methods had been discussed with them before their admission.

Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. The hospital recognised how important relatives were to the rehabilitation and recovery of their patients and allowed flexible visiting.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A high proportion of patients gave positive feedback about the service in the Friends and Family Test (FFT) survey. From November 2018 to April 2019 the hospitals FFT performance ranged from 95% to 100%.

Patient satisfaction was also captured through local patient satisfaction questionnaires. The questionnaire was independently managed, and the results collated monthly. The results report provided to the hospital for view and analysis and cascade to the hospital team and medical advisory committee (MAC).

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

Good

Surgery

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

Managers planned and organised services, so they met the changing needs of the local population. The hospital provided elective surgery to self-funded and NHS patients for a variety of specialities. The hospital worked with the local clinical commission groups (CCGs) and the local acute NHS trust to plan services to meet the needs of the local population. The services provided ensured flexibility, choice and continuity of care. Private patients could book appointments through the centralised team or hospital website, which included a 'live chat' support function. Patients were offered a choice of appointment to suit their needs including evening and Saturday morning clinics.

Facilities and premises were appropriate for the services being delivered. The site was accessible to patients with limited mobility and interpretation services can be provided if necessary. Chaperones were available and offered for all consultant consultations.

Managers monitored and acted to minimise missed appointments. The hospital published the NHS services on the national choose and book portal (eRS), giving patients choice of appointment time. Clinic capacity was managed to ensure short waiting times.

Managers ensured that patients who did not attend appointments were contacted. The pre-assessment clinic would contact patients who did not attend and made another appointment. If there was further nonattendance, then they would be referred back to their GP.

The SMT reported working closely with the local CCG to ensure that the services offered met the needs of the local population. Working with the local NHS Trust to support areas of capacity concern and offer 'step-down' care to relieve bed pressures.

Patients were offered a choice of surgical date based on consultant and clinical skill mix availability, for example the paediatric lists were planned with the children's nurses.

Discharge planning was commenced at pre-assessment to arrange on-going support after discharge where required.

There was access to local religious and spiritual support if required.

Meeting people's individual needs

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

All patients were treated equally whether they were self-funded, privately insured or NHS. The service only received planned admissions. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The pre- operative assessment process identified patient's needs prior to their admission, using specific screening tools. If a patient had specific dietary requirements these would be passed on to the kitchen and the ward.

Wards were designed to meet the needs of patients living with dementia. Patients, relatives or carers were encouraged to stay overnight with patients living with dementia and learning disabilities. Staff told us patients that required support would stay in a room nearest the nurses' station. All rooms had wheelchair access. The corridors and doors were wide, which meant wheelchair users could get through easily.

All patients had their discharge planned. In the pre-operative assessment, patients were asked about their home situation. Staff could arrange extra support for a patient's discharge when needed, such as social care at home.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

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

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. Access to interpreting services could be arranged by telephone or face to face for those patients who did not speak English. Staff were aware of the service and reported no delays with access.

Patients were given a choice of food and drink to meet their cultural and religious preferences. There was a large variety of hot food options available. This encouraged patients to eat and ensured their nutritional needs were met.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The Hospital had a policy and framework for managing NHS-funded elective access to consultant-led care and treatment in BMI hospitals. The Referral to Treatment (RTT) pathway target for NHS-funded patients, stipulates that no patient should wait longer than 18 weeks from referral to the start of their treatment. The service did not have patients waiting longer than 18 weeks for any procedure.

Between April 2018 and March 2019, the service had two unplanned returns to theatre, and 13 unplanned readmissions to the hospital.

Managers worked to keep the number of cancelled operations to a minimum. The service had cancelled 21 operations between April 2018 and March 2019. Of the cancelled operations 19 had been rearranged within 28 days of the cancellation. Most cancellations had occurred at the same time, because of a piece of equipment in theatres requiring replacement. The senior management team apologised to patients for any inconvenience and arranged for additional theatre lists to ensure that the patient who had been cancelled were booked onto slots as soon as possible.

When patients had their procedure cancelled at the last minute, staff made sure they were rearranged as soon as possible. The service monitored the number of cancellations and procedures were only delayed or cancelled when necessary. There had been no recent cancellations at the time of inspection. The pre-assessment clinic staff told us that text reminders were sent to patients in advance of their appointment. Patients would also be telephoned if they did not attend to ascertain the reason and to see if any adjustments could be made to help them attend.

Staff did not move patients at night. All inpatients were admitted to their own, private room.

Managers did not formally monitor theatre delays and overruns. However, the theatre manager said they did not have any concerns with theatre delays or overruns. The hospital had not received any complaints regarding delays in theatres.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff started discharge planning started at pre-assessment and made any necessary plans to support patients' discharge home prior to their admission for surgery.

Managers monitored patient transfers and followed national standards. The service had transferred seven patients to the local NHS hospital in the period April 2018 to March 2019. The service had a service level agreement with the local hospital for them to accept all unplanned transfers.

The Hospital administration team monitored patient wait times and helped facilitate admissions/care to ensure no breaches occurred. Hospital waiting times, DNA rates and cancelled procedures were monitored and reported at contract review meetings with the CCG.

The hospital did not formally audit waiting times for private patients as by choosing to access their care privately they have choice of when they access treatment. If required, the hospital could review internal databases to ascertain waiting times / conversion rates from outpatient to surgical episodes.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, complaints were not responded to in line with the timeline outlined in the policy.

Good

Surgery

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patients we spoke with were aware of how they could raise concerns or make a formal complaint.

Staff understood the policy on complaints and knew how to handle them. Where possible staff told us, complaints were managed locally to prevent escalation into a formal complaint.

The process for complaint management was that the complainant would receive an acknowledgement letter within 48 hours of receipt. This letter detailed the complaint process and details of expected response time. Responsibility for overseeing the management of complaints was with the executive director (ED). The ED and executive assistant reviewed all complaints and then directed the concerns to the most appropriate manager to investigate. Senior managers were all directly involved in initial investigation and collation of relevant information of patient complaints. For clinical issues the director of clinical services coordinated the investigation. All formal responses were reviewed and signed by the ED.

The hospital followed the corporate BMI Healthcare guidelines for managing complaints. Patient complaints follow a three-stage process, with each stage having set timeframes for responses. Stage one involved an investigation and response by the hospital within 20 days. Stage two involved in a regional or corporate review and response within 20 days. Stage three was for an independent, external adjudication. We reviewed 10 complaint files and found that eight had not been responded to within the 20 days described in the policy. On review of the complaint's tracker database, we saw that there were several complaints which remained open after the initial 20 days outlined. We were told, that the longest open complaint dated back to October 2018, although this was a complex case, which had been closed then reopened following further concerns. We asked the ED about the difficulties with complaints management and were told, the biggest influences on timeliness of responses was responses from consultants. We were told that any delays were escalated appropriately with a letter from the ED and discussion with medical advisory committee chair if necessary.

Following our inspection, we were told that all complaints had been reviewed and responded to. The hospital had introduced a more robust tracking system and were confident that they would meet the 20 day response rate for all complaints, unless agreed otherwise with complainants regarding more complex concerns.

The hospital had introduced a stage zero process for complaints, this encouraged and empowered staff to identify and address any patient (or relative) concerns or issues whilst the patient (or relative) was on site. These were escalated to line managers for prompt resolution if necessary. For more serious issues staff were encouraged to escalate complaints and concerns immediately to the ED, director of clinical services, operations manager or the manager on-call.

We saw that complainants were kept informed of the progress of complaints. This included letters detailing delays which also offered an apology for not meeting the expected timescale.

All complaints were managed through an electronic database. This held details of the complaint, who had accessed the files, details of the investigation and any actions resulting from the complaint.

Complaints were reviewed and tracked to ensure learning was cascaded to all staff, and where necessary changes made to practice.

We were told that the senior management team (SMT) encouraged a culture of responsibility and accountability, empowering staff to respond proactively and resolve issues locally and to escalate swiftly if they are unable to provide a resolution to concerns. The director of clinical services was visible to patients and actively sought feedback from patients.

Complaints were discussed in several forums within the hospital including at a weekly senior management complaint review meeting and at the Heads of Departments meetings. This ensured that actions were taken in a timely manner and learning shared throughout the hospital. Complaints were discussed at relevant committee meetings; if a complaint was clinical in nature it would be discussed at the Clinical Governance Committee meetings and medical advisory committee meetings to identify any learning and modifications required to clinical practice.

Heads of departments also cascaded complaints relevant to their departments at departmental meetings. Any complaints attributable to individuals or teams were recorded onto the complaints reporting system and shared with the individuals appropriately.

Comments (positive and negative) were acted upon, shared and recorded within the clinical governance reports to ensure strive for continued improvement.

BMI produced an information leaflet "Please tell us" which was available throughout the Hospital and provided guidance on how to raise concerns. Patients were able to speak with Heads of Departments during their visit/ admission to hospital to discuss any issues they may raise.

All patients were encouraged to complete a patient satisfaction survey during or after their admission or outpatient visit which, alongside 'Friends & Family' feedback, allowed the evaluation of the service being provided. The patient satisfaction survey also included a section asking for the hospital to contact them should the individual completing the survey wish. There were collection boxes for these throughout the hospital and forms could also be returned by pre-paid post or via email. The surveys were analysed by an independent third party and the results communicated back to the BMI Board and hospital monthly for learning and action.

Should the complainant remain unhappy staff signposted the complainant to the Independent Sector Complaints Adjudication Service [ISCAS] which involves an independent adjudication by someone outside of BMI Healthcare. NHS patients treated at the hospital also had the option of writing to the Parliamentary and Health Service Ombudsman (PHSO).

Learnings from complaints is disseminated through the hospital committee meetings including heads of department, departmental, governance and MAC meetings. Themes are identified, and processes reviewed to try reducing the risk of recurrence.

Examples of changes made because of complaints include,

- Discharge medication costs - complaints were received regarding the charging of drugs given to patients on discharge particularly Ibuprofen / Paracetamol which patients stated they had at home. Nurses have been instructed to communicate the cost of these medications to patients giving them the choice as to whether they wanted them.
- Pathology Costs – introduction of charge forms for pathology and histology to provide an instant quote to the patient to make them aware of cost of tests.
- Re-Booking Forms – concerns were raised that patients may not be rebooked in a timely fashion with notes being returned to medical records. A re-booking form introduced which is a different colour allowing a visual reminder that the file should be returned to the admissions unit for re-booking.

Are surgery services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as **requires improvement.**

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, there was a concern that the hospital did not have a senior nurse who had oversight of the hospital activity or a ward manager.

The hospital had a hospital director who had been in post since 2013. The senior management team (SMT) had previously consisted of the executive director, director of clinical services (DCS), quality and risk manager and operations manager. However, due to the resignation of the DCS in April 2019 the position of DCS had been merged with the quality and risk manager role and was now held by the same individual. This role was held by someone with Health and Care Professionals Council (HCPC) registration. We were concerned that this combined with the fact that the ward manager post was also vacant, limited clinical oversight across the hospital. It was felt that this gap, placed the service at risk, particularly as minutes from

governance meetings showed that there was regularly no attendance of a consultant at the monthly governance meetings. This meant that there was limited senior clinical oversight of hospital wide activity.

There had been changes to the hospital plans, and we were told that the hospital was in the process of working in parallel with another BMI hospital site. The changes had meant that the executive director was currently overseeing the delivery of services at both the Saxon Clinic and the other BMI hospital. The DCS is working two days per week at Saxon Clinic to provide senior clinical support, until the recruitment of a ward manager. We were told that the full details of the proposed structure had not been confirmed, however, there were provisional plans to arrange services across the two sites to prevent duplication and improve efficiency. Staff were aware of the changes.

The ward manager post had been vacant for several months and recruitment was in progress. In the interim the ward sister was managing the daily activity of the inpatient area, however, had only been in post a few months prior to inspection. The DCS from another BMI hospital was providing professional support and advice. Following inspection, we were informed that the service had recruited a ward manager who was planned to join the team in January 2020. In the interim, the individual was attending meetings.

Managers took responsibility for their departments staffing and worked together to support each other. Staff told us that this had been demonstrated recently when recruitment challenges resulted in management vacancies.

Staff confirmed that the SMT were visible, and we were told that they completed daily walkabouts within each clinical area and attended team meetings on an adhoc basis. Staff told us that the SMT was supportive and easily accessible.

The hospital was aligned to the BMI Healthcare Ltd corporate team who offered regional and speciality support. We were told that regional meetings occurred monthly and that corporate leads were easily accessible.

Vision and strategy

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

There was a BMI Healthcare Corporate Vision which was refined by the local team to develop a Saxon Clinic vision and strategic goals. We were given examples of how the vision was shared amongst the team and they were given the opportunity to change aspects that they felt reflected their services better. The vision and goals were focussed on quality and safety.

The hospital vision and strategy were discussed at informal staff forums where feedback on progress and staff concerns can be discussed in a supportive manner.

There was a staff quality action group which supported the hospital strategy through implementation of actions to improve the hospital environment for patients and staff.

Culture

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

We were told that every member of the team from housekeeper to nurse played a part in delivering a high-quality care to patients. Staff were recognised for going the extra mile through the hospital quality action committee employee of the month award. We saw that the employee of the month was displayed in the staff canteen, along with details of the nominations and reasons for their acknowledgement.

Staff were positive about their roles and responsibilities. We saw that staff were friendly towards each other as well as to patients and visitors.

Staff reported an open culture. Staff forums were held monthly to disseminate information on corporate and local performance as well as giving staff the opportunity to raise concerns. There was also a monthly staff newsletter which kept staff informed.

Good

Surgery

We were told that the senior management team (SMT) created a culture where staff felt empowered to take responsibility, make decisions in the best interest of the patient and continuously learn. Staff felt that they could raise concerns to line managers and the SMT.

The hospital followed the corporate Workforce Race Equality Standard action plan which focused on ensuring that the hospital was an inclusive environment providing equal opportunities to all staff, regardless of ethnicity. Data was collected by the corporate BMI group and reported nationally as required.

The senior management team reported that where possible, they have endeavoured to retain staff by developing them internally. For example, supporting staff to undertake assistant practitioner training.

Staff we met with, were welcoming, friendly and passionate. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.

Governance

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

The governance framework enabled the monitoring of performance with outcomes being reviewed at the medical advisory committee, health and safety group, integrated governance and head of department meetings. Minutes from these meetings showed that there was a cascade of information between meetings and evidence that learning was shared.

However, minutes from the governance meeting showed that there was rarely attendance by a consultant. We reviewed minutes from November 2018, January, March, April, June, July and August 2019. Of these meetings, there was one occasion when a consultant anaesthetist attended (April 2019). We discussed the attendance of consultants at meetings with the SMT and was told that there had been recent discussions regarding the provision of a fee for attending meetings, as currently consultants attended meetings voluntarily.

There was a robust governance and meeting structure in place with governance and patient safety related issues discussed at the monthly governance meetings. All sub-committees fed into the governance committee. The medical advisory committee met bimonthly and had oversight of the clinical quality and governance.

The hospital held weekly SMT meetings and monthly heads of department meetings and we saw that governance was a standing agenda item at these meetings. Issues were monitored for trends and these were reported at governance meetings. Weekly incident updates and lessons learnt were disseminated to all staff members via email.

We saw that complaints were managed thoroughly, however, responses were not in line with target.

We saw that there was a daily communication meeting which addressed any concerns in real- time.

A comprehensive audit programme supported the hospital to ensure patient safety. The hospital made comparisons to their peer hospitals to confirm performance and reported against these dashboards in terms of trends.

A clinical governance bulletin which was produced corporately, supported the hospital monthly to manage risk. The bulletin identified changes in legislation relating to NICE publications and alerts (drugs, equipment). It also provided details of issues and best practice at other sites so that shared learning could be applied locally.

Managing risks, issues and performance

The hospital had a hospital risk register which was regularly reviewed and updated to ensure risks were monitored and appropriately managed. There were a high number of risks identified in the risk register which included topics such as staffing, the environment and equipment. Risks were allocated a risk score based on the probability and severity of the risk. Risks were managed through an electronic database, which captured all reviews, data entries and any changes to the risk. We were told that risks were reviewed as part of the weekly SMT meetings and at any relevant meeting, and mitigation added at the time of review. Staff reported that staffing was the biggest risk, and this was reflected within the risk register.

Heads of department managed departmental risk registers which fed into the hospital register.

There was a robust audit calendar which supported the identification of areas for improvement. This included audits on patient records, including early warning scores, cleanliness, including environmental and infection rates and patient feedback. Audit results were discussed at all meetings and as part of ward meetings.

Performance was also reviewed regularly, and data was tracked through a performance dashboard. The dashboard was used by the corporate team and local SMT to identify any areas which required additional training, support or development. We were told that performance was in line with other BMI hospitals of a similar size.

Performance locally was reviewed by the commissioners and the hospital reported an effective relationship whereby information was shared and discussed.

Managing information

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

Staff were aware of the need to maintain confidentiality and ensured that information was always secure. Computer screens were not visible to unauthorised people and computers were locked when not in use.

Information regarding performance was predominantly kept electronically, however, key messages and findings were shared with staff in team meetings, newsletters and when appropriate wall displays.

All private patient billed data was sent to Private Healthcare Information Network (PHIN). Minimum data sets were submitted and available to the public via the PHIN website.

Private patient reported outcomes collection had commenced and covered hip, knee and hernia surgeries. This was provided through Quality Health alongside the BMI patient satisfaction survey.

Extensive work had been undertaken on the BMI patient administration system to facilitate patient coding, NHS number look up and allocation of consultant to patient episode. The hospital captured private patient data on clinical coding sheets (as per NHS patients) to help support provision of improving our data collection.

Engagement

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

Staff reported that they were proud to work for the organisation and worked collectively to benefit the patients. There was a positive safety culture and the hospital used safety culture questionnaires to capture themes.

There was a quality action group, which consisted of a number of staff who used this meeting to share ideas of areas of improvement. The hospital reported that this group resulted in changes to the environment, including the refurbishment of patio areas making it easier for patients to access.

The hospital is located adjacent to the acute hospital which promotes working across both services. Staff reported that there was an effective working relationship.

Senior leaders reported a positive relationship with the local commissioning group.

The hospital has an active role in the local community and reported completing fundraising activities and supporting local charities.

The SMT reported that there had been a decrease in the response rates for patient satisfaction surveys. We were told that the team were working with peer providers to understand where improvements could be made.

Patient feedback was used in defining future strategy and is collected through surveys and patient forums and is discussed at hospital meetings. Patient forums enabled staff to gather views on aspects of service not covered by the questionnaire. Staff told us that this feedback was shared with all relevant stakeholders.

Staff told us that the hospital actively engaged with the Patient Led Assessment of the Clinical Environment (PLACE) Audit programme. A selected group of patients

were invited to review and provide feedback on different aspects of the patient journey. An Action Plan was developed to ensure that the team responded to areas requiring improvement. Feedback on the national 'NHS Choices' website and other associated websites was monitored and responded to. Electronic feedback was responded to and shared with the team in the same manner as written feedback.

Staff feedback was from the annual national BMI Say survey, a local survey and staff forums.

Learning, continuous improvement and innovation

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

The service had implemented pictorial menus for all meals the organisation offered to help patients in their choices.

The service had produced new leaflets for suitable exercises for patients to undertake post discharge to aid their recovery from surgery.

Information sharing between sites took place. A monthly conference call was in place for leaders across the BMI sites, which was aimed at sharing learning and best practice across sites.

Good

Services for children & young people

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

Are services for children & young people safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

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

Paediatric nursing staff received and kept up-to-date with their mandatory training. Training data we reviewed during the inspection showed over 90% compliance for all mandatory training subjects in September 2019.

Medical staff received and kept up-to-date with their mandatory training. Managers reported 56 consultants provided care to children and young people. There was over 99% completion of mandatory training, including paediatric resuscitation, infection prevention and control, medicines management, mental capacity and equality and diversity.

The mandatory training was comprehensive and met the needs of patients and staff. Subjects covered in mandatory training included, documentation, fire safety, information governance, infection prevention and control, conflict resolution, the deteriorating patient, health and safety, PREVENT, consent and moving and handling. All clinical staff working with children and young people completed paediatric immediate life support training (PILS). The resident medical officer (RMO) was the paediatric resuscitation lead and was trained to advanced level. The paediatric lead nurse had European paediatric advanced life support (EPALS) training and other members of the team had training planned. One member of the theatre recovery team also had EPALS training.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. However, staff we spoke with had a good understanding of these conditions and explained the steps they took to meet patients' needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Completion of mandatory training was recorded on the provider's database and managers viewed reports for their areas regularly. Staff told us the paediatric lead nurse reminded them when their training was due.

For additional findings on mandatory training please see the safe section in the surgery report.

Safeguarding

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

Nursing staff and allied health professionals received training specific for their role on how to recognise and report abuse. Staff in children's and young people's services told us they had completed level three safeguarding children training and data checked during inspection confirmed this. Nursing staff working in the

general outpatient's department had also completed level three safeguarding children training. All clinical staff who treated children in other departments such as x- ray received level three safeguarding children training.

Medical staff received training specific for their role on how to recognise and report abuse. Consultants were required to complete level 3 safeguarding children training and we were told the management team would withdraw their practising privileges for children and young people, if they did not complete the required training and updates. The paediatric lead nurse checked completion of the training if a consultant, who did not regularly treat children at the service, booked children to treat at the clinic. Following the inspection, we were provided with training data that showed 100% of consulting providing care to children had completed children's safeguarding level 3 training. Staff had access to corporate leads with level 4 training.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing, medical and allied health professional staff we spoke with, showed a good level of awareness of the signs of abuse. They said they would record their concerns on the incident reporting system and discuss them with the paediatric lead nurse who was also the children's safeguarding lead. We saw records kept by the paediatric lead nurse of concerns and referrals made, with detailed information about the action taken.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Several staff described referrals they had made to the local authority safeguarding team and discussions they had had with other agencies to obtain further information and share their concerns appropriately. Contact telephone numbers for the safeguarding team were kept in each department.

Our observations during inspection demonstrated that staff followed safe procedures for children visiting the ward. We saw that staff liaised effectively with local authorities during our inspection to ensure appropriate arrangements were made to protect children at risk of abuse if this was identified prior to admission.

Cleanliness, infection control and hygiene

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

The ward, outpatient areas and other departments were visibly clean and had suitable furnishings which were clean and well-maintained. Nursing staff said the same housekeeping team was allocated to the areas each day and worked collaboratively together. They said that if an area needed attention, they could call the team and they were very responsive.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeeping and nursing staff and allied health professionals-maintained cleaning schedules that demonstrated each area had been cleaned regularly in accordance with the schedule.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was readily available in the clinical areas and we observed staff using it appropriately. We observed staff using good hand hygiene practice during the inspection. Data provided following the inspection showed hand hygiene audits were regularly completed and showed good compliance by staff.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used "I am clean" labels to show equipment was clean and ready to use.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Patients and parents said they had not needed to use their call bell as staff were very attentive to their needs and checked on them regularly.

The design of the environment mostly followed national guidance. When children and young people were admitted to the ward, a section of the ward was allocated for their use, which was separated to the rest of the ward by a set of double doors. There was also a manned nurses' station immediately after the double doors which meant that anyone entering the area would be seen. During

inspection, we saw that patients attending for endoscopy, needed to pass through a central seating area to access theatres, however, patients were always accompanied by staff and they did not pass the children's rooms. Children were not admitted for overnight admissions.

We were told that the hospital was going to refurbish a clinical area which would be converted into a secure children's ward. Building works were due to commence in January 2020. In the interim, parents were asked to accompany their child at all times to ensure safety.

Fire doors leading from a central seating area opposite the nurses' station provided an escape route in the event of an emergency but were not alarmed and could be used by a child or abductor, giving direct access to the outside and car park. A risk assessment had not been completed in relation to this. Managers agreed to review this, complete a risk assessment and had plans to develop and move to a more self-contained and secure area in the near future. The environment was spacious and provided easy access for people with disabilities. Prior to children being admitted to the ward bedrooms and the rooms within the imaging department, safety checklists were used to ensure there were no avoidable environmental risks for children. The rooms used for caring for children attending for day surgery did not have piped oxygen. However, oxygen cylinders were put into the rooms prior to the child's return from theatre and they were secured appropriately.

Staff carried out daily safety checks of specialist equipment. A resuscitation trolley was available on the ward and second trolley had been purchased and was in the process of being stocked for the adjacent outpatient's department. Paediatric airway boxes were taken into each room when a child returned from theatre. Documentation indicated they were checked daily. There were two emergency boxes specifically for children and young people that were kept on the ward. An asthma box and a seizure box. Each box contained the correct drugs and information for administration and dosage in case of emergency.

The service had suitable facilities to meet the needs of patients' families. The ward had a central seating area for families to use and relax in. There was access to facilities for making hot drinks and families were provided with a meal while they stayed with their children.

The service had enough suitable equipment to help them to safely care for patients. Equipment we checked was maintained and appropriately tested for electrical safety.

Staff disposed of clinical waste safely. Clinical waste and sharps were disposed of in the correct receptacles and staff covered waste disposal in their mandatory training.

For additional findings on environment and equipment please see the safe section in the surgery report.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The national paediatric early warning score (PEWS) was used and were mostly completed with every set of vital signs observation. We reviewed ten patient records and found PEWS was completed in all records, however, in two records the PEWS was not calculated while the child was in recovery. Managers said their own audits had identified some omissions in the PEWS scores and awareness was being raised of the importance of calculating a PEWS with every set of observations.

Staff said they contacted the registered medical officer (RMO) and the patient's consultant if a patient's condition deteriorated and they responded promptly. The service also had access to an on-call resuscitation team in an emergency. The service had a programme of unannounced paediatric emergency scenarios facilitated by resuscitation trainers to ensure staff were able to respond appropriately in an emergency.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. Approximately two weeks prior to surgery, children attended the clinic for a pre-operative assessment. Children's nurses completed a systematic assessment of the child to identify any anaesthetic risk and any additional needs the child might have. Where there were any issues that might increase the risk to patients, staff discussed these with an anaesthetist and where necessary children were seen by an anaesthetist for a pre-operative assessment.

Staff conducted a series of risk assessments on admission. This included a skin integrity risk score, safe use of bed rails checklist and a pre-operative checklist. We observed that a child attending for a surgical procedure was identified as having a raised temperature and a cold on the morning of surgery. They were therefore assessed by the nursing staff and the anaesthetist and, following discussion with the consultant, it was decided that the surgery should be postponed until the child had recovered.

Staff knew about and dealt with any specific risk issues. Staff ensured bedrooms were stocked with emergency equipment such as oxygen cylinders and masks required in the event of a deterioration post operatively. The provider had a service level agreement with the Children's Acute Transfer Service (CATS) to ensure the speedy and safe transfer of any child requiring high dependency care.

Staff knew about the action to take if a child was found to be missing or was abducted from the ward, however, there wasn't a policy or protocol in relation to this. The risks were mitigated by the fact that parents/guardians were informed they must remain with their child at all times unless a nurse was present. We raised the absence of a policy or protocol during the inspection and were told this would be rectified as soon as possible.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health) through referrals to the local child and adolescent mental health team (CAMHS).

Staff shared key information to keep patients safe when handing over their care to others. When children and young people were admitted for surgical procedures, nursing staff completed a pre-operative checklist prior to their transfer to the operating theatre, to ensure all risks were systematically checked prior to surgery. We reviewed the checklist for ten surgical patients and found they had been completed fully. We observed theatre staff checked each patient's identity when they collected them for theatre by checking their identity band and asking the patient and parents to confirm the details. Handover between ward and theatre staff was structured and provided key information.

To reduce and potentially eliminate errors occurring in the operating theatre, the service used the World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. However, although the WHO checklist has five stages and staff completed all five of these stages when we observed practice, the documentation only required them to record three checks. The documentation of the checklist was fully completed in all the records we reviewed. We also observed staff strictly adhered to the WHO checklist in practice.

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

Nurse staffing

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

The service had enough nursing staff of relevant grades to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The management team reported they used a nursing dependency and skill mix planning tool to support the assessment of nurse staffing requirements. The number of children and young people attending the ward and outpatient department was small and steps had been taken to ensure children's nurses were available whenever children were in the ward or department. Three registered children's nurses were permanently employed, and an additional two registered children's nurses had bank contracts. This enabled the number of staff to be flexed according to the fluctuating requirements.

The management team also used a theatre utilisation tool to assess staffing requirements in theatres and recovery. An experienced nurse with a children's qualification was available in the recovery area. Weekly planning meetings were held, at which all cases booked in the following two weeks were reviewed, to ensure appropriate staffing and skill mix was in place.

The lead paediatric nurse could adjust staffing levels daily according to the needs of patients. They planned staff according to the activity within the ward and outpatient

department and were able to obtain bank nursing staff when activity was increased or there was sickness/absence. On days when children were admitted for day surgery two registered children's nurses were rostered on duty. Staff told us there were normally two or three children booked on a list, however, if the number exceeded four, an additional nurse would be rostered on duty.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. We reviewed the nursing rotas for six weeks prior to the inspection and saw that the planned numbers of staff were achieved.

The service had low vacancy rates, turnover rates and sickness rates.

The service had low rates of bank and agency nurses used on the wards. We were told that there were regular bank staff who were very experienced at the service who were utilised as required. Agency staff were not normally used.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. The service had two bank nurses who were flexible and were experienced in the service. We were told that on the rare occasion, if a child needed an overnight stay they would ensure a paediatric nurse was obtained.

For our additional findings on nurse staffing please see the Safe section in the Surgery report.

Medical staffing

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

The service had enough medical staff to keep patients safe. Those consultants treating children were clearly identified and this was stated on their profile. Anaesthetists with paediatric experience were available. Most consultants including anaesthetists had contracts at NHS hospitals and therefore the volume of work they undertook with children, was sufficient to maintain their skills. The service was supported by a named consultant paediatrician who sat on the medical advisory committee. There were also two additional consultant paediatricians with practice privileges if additional support was required.

It was a requirement of the practice privileges policy that consultants and anaesthetists were always available to care for their admitted patients. In addition, key staff had access to all the contact details of consultants to enable contact at any time. The anaesthetist for the evening list provided on-call support in the first instance.

A resident medical officer (RMO) was available throughout the 24 hour period and the service operated a one week on duty, one week off duty rota. They told us they received a good handover at the beginning of their week on duty and handed over to their colleague at the end of their shifts.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Patients received care from consultants with support from the RMO. Anaesthetists were present throughout the child's stay in recovery and checked regularly with recovery staff that they were happy with the child's condition. An anaesthetist was available until children were fully recovered from the anaesthetic and they checked with the ward prior to leaving the service.

For our additional findings on medical staffing please see the Safe section in the Surgery report.

Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, patient records were not always detailed and did not always contain information about previous health consultations.

Patient notes were not always comprehensive; however, all staff could access them easily. Patients records were largely maintained by the consultant responsible for the care of the patient. Some records we reviewed during the inspection contained minimal information about patients' consultation history prior to surgery. Staff told us they were moving towards a single patient record. The senior

management team reported that the transfer to a single patient record was the focus of the newly appointed patient administration manager. The hospital strongly discouraged the removal of hospital medical records from the site in all circumstances; consultants we spoke with confirmed this and told us they kept their records on site. Medical staff said records availability was good and they did not experience problems in accessing them quickly if they were required unexpectedly.

Staff completed care pathways to document pre-operative, operative and post operative care. These were mostly completed clearly and consistently and were signed, dated, timed and the person making the entry was clear. However, we found one record that was poorly completed by an anaesthetist and no observations were recorded.

Records were stored securely.

For additional findings on records please see the Safe section in the Surgery report.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines charts we reviewed were completed clearly and consistently. Two registered children's nurses checked medicines prior to administration and made the necessary checks of the identity of the patient to reduce the risk of errors.

Staff reviewed patients' medicines and provided specific advice to patients and carers about their medicines. Parents told us their child's medicines were explained clearly to them and they were given all the information they required.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored securely and safely. The pharmacy provided a service to each department to oversee the storage and management of medicines.

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

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

For additional findings on medicines please see the Safe section in the Surgery report.

Incidents

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

Staff knew what incidents to report and how to report them.

Staff reported incidents that they should report. Staff were clear about their responsibilities for reporting incidents. The completed incident reports on an electronic incident reporting a management system. They all had log in details and were familiar with the process.

Staff reported serious incidents clearly and in line with BMI policy. However, there were no serious incidents in children and young people's services in the year to September 2019.

The service had no never events.

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

Managers debriefed and supported staff after any serious incident. Staff told us they discussed all incidents and how they could be prevented in the future. They said managers were supportive and there wasn't a culture of blame in the service.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. The service provided a weekly incident report with information about incidents and the outcomes, with learning identified. We saw these displayed within the service and staff told us they received them regularly. There was a children and young people's steering group for the provider with representatives from each service. Incidents and learning from incidents were discussed at these meetings.

Good

Services for children & young people

Staff met to discuss the feedback and look at improvements to patient care. Staff said they had opportunities both at meetings and informally to discuss their ideas for improvements to patient care.

There was evidence that changes had been made because of feedback. For example, changes were made to the post operative information provided to parents of children admitted for circumcision to reduce the risk of post operative infections. "Grow taller" steps were provided to improve access to bathroom and toilet facilities for younger children.

Managers shared learning with their staff about never events that happened elsewhere. Staff were aware of never events related to wrong site surgery and the importance of adhering to the safety checklists.

For our additional findings on incidents please see the Safe section in the Surgery report.

Are services for children & young people effective?

Good

Our rating of effective improved. We rated it as **good.**

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a selection of policies and guidelines related to children and young people and found they were within their review date and were based on the latest national guidance on the subjects. They had been approved by the clinical governance committee or other relevant committee. A consultant we spoke with said they met with colleagues in their specialty regularly and discussed their practice in relation to NICE guidance. The trust said they undertook peer audits of adherence to national guidance. However, we did not see evidence of any review of adherence to national and local guidelines within the service.

A care pathway was used for children and young people admitted for day surgery to ensure a systematic approach was used based on best practice guidance. Records audits were undertaken to monitor completion of the documentation and adherence to the pathway.

Staff protected the rights of patients' subject to the Mental Health Act and followed the Code of Practice. Staff were aware of the requirements.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

For our additional findings on evidence-based care and treatment please see the Effective section in the Surgery report.

Nutrition and hydration

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

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Patients waiting to have surgery were not left nil by mouth for long periods. Parents told us staff gave them clear instructions in relation to withholding food and drink prior to surgery. The fasting periods were in line with national guidance. Staff told us that when the patient arrived and was assessed by the anaesthetist, they discussed the order of the list and whether it was appropriate for the patient to be given an additional drink if they were to be waiting for a longer period.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The chef visited patients on admission to identify dietary requirements and any requests in relation to the food provided. A drinks dispenser was available in the wards area and outpatients. Staff provided children with food and drink following surgery and ensured they were able to eat and drink prior to discharge.

Staff weighed and measured the height of children and young people attending the service and checked they were within expected norms.

Specialist support from staff such as dieticians was available for patients who needed it.

For our additional findings on nutrition and hydration please see the effective section in the surgery report.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used a 0 to 10 pain scale and a series of pictures of facial expressions to enable children and young people to describe the severity of their pain. Staff completed a pain assessment hourly throughout the post operative period and recorded the results on the child's observation chart. Pain was discussed, and existing pain issues were documented at pre-assessment. The anaesthetist also discussed pain relief with patients and parents prior to surgery.

Patients received pain relief soon after requesting it. We witnessed staff providing pain relief in a timely manner and parents we spoke with said staff were very attentive to their children, checked on their pain and provided pain relief promptly. Patients and parents were given the opportunity to comment on the management of their pain as part of the telephone feedback following surgery.

Staff prescribed, administered and recorded pain relief accurately. Staff applied anaesthetic cream to a child's hand prior to inserting a cannula for their sedation. Records we checked indicated children were prescribed pain relief and nausea reducing medicines for administration as required after surgery. We saw examples of when this had been administered and recorded.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. However, compliance with national best practice guidance and clinical outcomes for specific procedures were not checked by managers.

There were no relevant national clinical audits for the service to participate in.

Managers carried out an audit programme as part of the provider group audit programme. The provider told us outcome indicators included surgical site infection rates, falls, transfers out, returns to theatres, readmission rates and overall quality of care scores. They said results on patient outcomes were compared with other provider locations both regionally and nationally enabling them to work collaboratively to make improvements where appropriate.

In addition, an individual consultant provided evidence of the review of their clinical outcomes for a specific surgical procedure (myringoplasty). This indicated they achieved good outcomes for patients in comparison to national outcome data. They also attended an NHS clinical improvement group in which improvements to practice were considered. However, we did not find evidence of monitoring of clinical outcomes of specific procedures by the management team.

A systematic approach was taken to the obtaining feedback from parents to continually improve patient experience. Parents were contacted by telephone, four weeks after surgery and feedback sought to obtain information on any complications and outcomes from surgery along with information about their experience. There was also a specific feedback form for children to complete which was followed up as part of the phone call with parents.

Managers used information from the audits to improve care and treatment. Staff contacted parents four weeks after their surgery to obtain feedback on their experience and to identify any issues or adverse outcomes for patients. These were collated to identify themes or trends and actions were taken to improve. For example, staff identified a rise in infections following circumcision and as a result refined the information given to patients and their families about hygiene following the procedure, to give specific advice on daily showering and hygiene.

A range of audits were completed regularly. This included medicines management, surgical safety checklist audits. Patient record audits were completed most months. Results indicated there were some areas for improvement, which had been discussed with staff and had improved. An audit calendar was produced to schedule the audits regularly.

There were engagement meetings and/or follow-up of audit outliers. The senior management team reported their outcomes were benchmarked against other comparable services both internally through the provider's dashboards and national audit. Outcomes were reviewed at medical advisory committees and integrated governance and head of departments meetings, trends were identified, and learning identified.

Managers shared and made sure staff understood information from the audits.

Improvement was checked and monitored. The service participated in local and national Clinical Quality Improvement Initiatives (CQUIN); progress was monitored by commissioners at contract review meetings. Patient feedback was reviewed and collated to identify themes and issues. Action was taken to improve, and this was assessed through the ongoing feedback.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We spoke with the three permanent nursing staff covering the ward and outpatient department, and recovery nurses. They were all very experienced nurses with a children's registration. One of the recovery nurses had recently completed a two-day paediatric, theatre recovery course.

Managers gave all new staff a full induction tailored to their role before they started work. A newly appointed member of staff said they had received a good induction and other staff were supportive. They had been made to feel welcome. They had met with their manager at the end of their induction and a meeting was scheduled at the end of their probationary period. The service had a comprehensive set of competencies that nursing staff completed within the first three months of appointment, to ensure their clinical skills were developed and assessed. Medicines management competencies were reviewed annually.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us appraisals were constructive and helpful and they were able to discuss any training needs. They had a full appraisal annually and a six-monthly review. They said that the director of clinical services regularly held reflective meetings to discuss how care could be improved.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. A formal discussion of training needs was incorporated into staff's annual appraisal. For example, one member of staff said they were completing an electrocardiogram (ECG) course on line and they were exploring availability of wound care courses.

Managers identified poor staff performance promptly and supported staff to improve.

For our additional findings on competence please see the effective section in the surgery report.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. Consultants were able to refer patients to the paediatricians and a psychologist when required. A formal agreement was in place for the transfer of patients to the local NHS hospital when the necessary services were not available at the clinic. There was also a service level agreement with the children's acute transfer team when a child needed urgent transfer to a high dependency unit.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. They told us they were able to refer patients to the local child and adolescent mental health service when necessary.

Patients could see all the health professionals involved in their care in one -stop clinics. During the inspection, we observed an audiologist had a clinic scheduled on the same day as an ear, nose and throat consultant. This enabled patients to be seen by the consultant and have any hearing tests conducted at the same visit. The audiologist explained that whilst some patients were

scheduled to see both the consultant and the audiologist, they were also able to accommodate additional patients, who were referred during their appointment with the consultant, thus preventing an additional visit.

For our additional findings on multi-disciplinary working please see the effective section in the surgery report.

Seven-day services

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

Children and young people were not admitted for surgery which required them to stay overnight to recover. Patients were reviewed by consultants prior to, and following, surgery. Outpatient clinics took place six days a week (Monday to Saturday) and patients were given a choice of the most convenient time to attend.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The RMO was available 24 hours a day and staff could access imaging out of hours when necessary. There was an on-call theatre team 24 hours a day, seven days a week.

For our additional findings on seven day please see the Effective section in the Surgery report.

Health promotion

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

The service had limited relevant information promoting healthy lifestyles and support on the ward/unit. A poster providing advice on staying safe in the sun was displayed in the service and also information on sepsis and the identification of sepsis provided by the Sepsis Trust was displayed.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The pre-assessment documentation identified any long term health conditions and any issues that might affect the child's health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. The consent policy contained within the children's and young person's operational policy included reference to the Gillick competencies and staff we spoke with showed a good awareness of the requirements.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed a consultant obtaining consent for a procedure from the child and their parents. They explained the procedure, the risks and possible complications to the family. The patient was reassured, and all their questions answered. We observed staff checked again when the patient and parent were in the anaesthetic room, that they were happy to go ahead with the procedure.

A consultant explained how they discussed treatment options at the first outpatient visit and re-visited them when the patient returned for their second review. Patients were given written information and/or directed to national websites to obtain information from national bodies such as ENT UK, for example. Patients or parents were then asked to sign their consent form and it was re-visited on the day of surgery.

Staff clearly recorded consent in the patients' records. The service used the national consent forms for children and young people undergoing surgery. Eight records we reviewed for patients who had undergone a surgical procedure contained a copy of a fully completed consent form which contained information about the potential risks and complications of the surgery. In the case of an older child, the child and the parents had both completed the consent form.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care

Good

Services for children & young people

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff were able to describe the best interest decision making process.

Staff made sure patients consented to treatment based on all the information available. Patients and parents were provided with verbal and written information about treatments and surgical procedures. We saw there was some nationally produced age appropriate information for children and young people undergoing MRI scans or having an anaesthetic.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the Trust's target. This was a part of the mandatory training programme.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

For additional findings on consent, mental capacity, and Deprivation of Liberty Safeguards please see the Effective section in the Surgery report

Are services for children & young people caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Children and young people used words such as brilliant, friendly, lovely and excellent to describe the nursing staff they met at outpatients and on the ward. The same nurses frequently saw patients at their outpatient visit, their pre-operative assessment, and on the ward. This enabled them to build a relationship with the children and young people and provide reassurance. Parents were also very positive about reception staff and staff in other departments they met during their visit.

Patients said staff treated them well and with kindness. Parents told us staff had good skills in caring for children and understanding their needs. For example, one parent explained how the audiologist had conducted the tests and gained the child's cooperation by giving the impression it was a game, which the child had been happy to participate in. We also observed a child was anxious and distressed when they entered the outpatient department, so staff gave them time to play in the play area and settle down prior to their tests.

Staff followed policy to keep patient care and treatment confidential. Patient records were stored securely, and children and parents were not asked for confidential information in communal areas where they could be overheard.

Staff understood and respected the individual needs of each patient and showed understanding. Staff took time with the children and young people to gain their cooperation and reassure them. We saw staff treated each child and young person as an individual and took time to get to know them, tailoring their approach accordingly. A child proudly showed us the sticker they had received at the end of their investigation for being brave.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed two children were treated with dignity and respect during the time they spent in the operating theatre and recovery area. Staff were able to describe the adjustments they made to take account of the cultural, social and religious needs of patients and their families.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff showed an understanding of the anxiety's parents faced when bringing their child for surgery and provided support and

reassurance. Parents and children were given the opportunity to visit the ward and theatre suite at their pre-operative assessment to familiarise them with it and reduce their anxiety on admission. They were also shown an oxygen mask and allowed to handle it as staff had previously identified this had sometimes distressed children when they first saw it in the anaesthetic room.

Staff demonstrated empathy when having difficult conversations. We were aware of a sensitive situation with some parents during the inspection and observed that staff handled the situation with care and respect for all those involved. They had previously spoken with the parents about the process and developed a relationship with them; this enabled the child's admission and treatment to proceed smoothly and ensured boundaries were clear.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure patients and those close to them understood their care and treatment. All parents told us they had received good explanations about their care and treatment and any treatment options. One parent told us they had originally been given the option of watchful waiting which they had taken up; however, later they had made the decision that surgery was the best way forward. A parent accompanying their child for a surgical procedure told us the initial consultation was focused on the child and they were put at their ease. They said that this consultation and the pre-assessment visit with the children's nurse were very informative and they felt reassured and prepared for admission. A parent said, "The consultant was clear and quick at making it happen when the decision was made".

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Children said staff spoke with them and explained things, so they understood. A consultant showed us some of the models they used to help children and parents understand the anatomy and what would be done during surgery. There was a welcome booklet designed for younger patients to use while in hospital.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback forms were given to children and parents to identify ways the service could be improved. For example, young children had difficulties in reaching the hand washbasin and toilet. As a result, a "Grow taller" step had been purchased.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. Friends and family test results were not provided by core service, however, overall response rates for BMI Saxon clinic were good and over 95% of patients recommended the service.

Are services for children & young people responsive?

Good

Our rating of responsive improved. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. However, facilities in recovery and imaging were not always optimal for children.

Managers planned and organised services, so they met the changing needs of the local population. Services for children and young people had increased following an increase in the paediatric nursing establishment. Consultants identified they were able to treat more children due to this increase. The service provided access to and support from a paediatric dietitian when required.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Staff told us they tried to combine blood tests with visits for other investigations or imaging. In the same way, if patients needed to return for a wound check, this would be coordinated with other visits such as physiotherapy. Staff said they were flexible according to the wishes of patients

and their families. Parents we spoke with were appreciative that they were able to reduce the number of outpatients visits due to staff being able to accommodate investigations and other treatments such as wound dressings at the same appointment.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All children and young people admitted for day surgery were accommodated in single ensuite rooms.

Facilities and premises were mostly appropriate for the services being delivered. Children and young people were cared for on the same ward as adult patients. However, the ward was comprised of single ensuite rooms and when children were admitted they were allocated rooms at one end of the ward, which was separated from the rest of the ward by double doors. Staff showed us plans that had been approved by the provider, to convert a section of the ward to accommodate three children in an enclosed area with secure access, its own en-suite facilities and play area. This would provide better separation of adults and children. Staff did not have a timescale for the completion of this, however, the funding had been agreed. In the meantime, when the rooms were used for children, child size equipment was taken into the room, age appropriate bedding was provided and the doors to the rooms where children were cared for were identified by pictures of animals on the door which the child was encouraged to choose.

There was no separate operating theatre recovery area for children. A bed space within the main recovery area was allocated for children and separation of adults and children was achieved by use of curtains drawn around the bed space. We were told the recovery area was rarely full and as children had only minor procedures, and were placed first on the list, they were frequently the only patients in recovery and were transferred back to the ward in a timely way. Recovery staff were in constant attendance with the child during their stay in recovery. This mitigated any risk to children through the lack of full separation from adults. The Royal College of Anaesthetists, “Guidelines for the Provision of Paediatric Anaesthesia Services” (2019) state that, “Children should be separated from, and not managed directly alongside adults throughout the patient pathway, including reception and recovery areas. Where complete physical separation is not possible, the use of screens or curtains, whilst not ideal, may provide a solution.” The service was therefore meeting the guidelines, although the circumstances were not ideal.

The outpatient’s department had a small waiting area for younger children that was equipped with a range of toys, games and books. Colouring sheets and books for older children were available. Children attending for x- ray and magnetic resonance imaging (MRI) scanning, waited in the main outpatient’s department until they were ready to be called in for their imaging. Each area was prepared for a child prior to them being called, however, there were no adjustments to the décor to make them more child friendly. We were told the children’s nurses would bring appropriate toys if necessary. Staff showed good interpersonal skills to use with children, however, simple adjustments could have been made to the environment to make it less intimidating for children.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. Children were placed first on the operating list in age order, unless a child had additional needs which required them to be placed before younger children. However, there was no flagging system to alert staff when patients had additional needs and might need adjustments to be made to improve their experience, such as those with a learning disability or autism. Consultants treating children also treated adults therefore transition to adult services was not an issue.

Managers monitored and acted to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted. Staff contacted parents if there was a missed appointment and re-booked at a time convenient for them.

Meeting people’s individual needs

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

Children’s nurses conducted the pre-operative assessment clinics and they told us they were able to spend considerable time with children and their parents to put

them at their ease and provide information tailored to their individual needs. They said they showed them some of the equipment such as the oxygen masks as feedback previously had showed that children were often frightened by this and the opportunity to look at it and hold it reduced their anxiety. They said the nurse completing the pre-assessment was frequently on duty for the patient's admission as they were such a small team. This provided continuity and reassurance for children and families.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. Staff made referrals to mental health services as necessary. When children with additional needs attended the outpatient clinic, staff spoke with them and their family to identify ways in which their needs could be accommodated. For example, waits were minimised, and staff could accommodate them in a vacant consulting room if they found it difficult to wait in the waiting area.

Wards were designed to meet the needs of children, young people and their families. Although children were cared for in rooms also used for adults, staff prepared the rooms for a child's admission, using a safety checklist, providing bedding with age appropriate (decoration), and indicating a child's presence with a picture on the door which the child chose. Rooms were spacious enough to accommodate the child family members during the admission. There was a range of different activities for children and young people of different ages and books in different languages, as staff had identified that when English was a child's second language they often preferred to read books in their first language.

Staff supported children and young people living with complex health care needs by identifying their needs at pre-assessment or prior to their outpatient visit.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had access to some information leaflets available in languages spoken by the patients and local community. They told us the information leaflets they used could be printed in two other languages.

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. All staff we spoke with were aware of the arrangements to obtain telephone or face to face interpreters when required. They said that the patient's referral letter would normally alert staff as to the requirement for an interpreter.

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

Staff had access to communication aids to help patients become partners in their care and treatment. Staff used the national 'Hospital Communication Handbook' for patients who had difficulty with communication and/or the written word. This handbook provided a wide range of symbolic pictures to aid communication and was available in the ward and outpatient department.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The service treated children and young people from birth to 18 years of age as outpatients and admitted children and young people age three years and over for day surgery. Most patients accessed the service through the national enquiry booking centre or through a consultant. There were no specifically allocated clinic appointment slots for children and young people and they were seen in the same clinics as adults in most cases. However, checks were made to ensure paediatric nurses were available whenever children were booked to attend.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Families were offered choices in relation to their outpatient appointments and admission dates for surgery. Managers held a weekly planning meeting to go through theatre lists for the following two weeks and ensure there was no overbooking.

Managers and staff worked to make sure patients did not stay longer than they needed to. Nursing staff said outpatient clinics mostly ran on time and it was unusual for anyone to have an extended wait. On the rare occasion a clinic ran late, staff informed patients and apologised to

them, explaining the reasons for any delay when possible. Parents we spoke with said they were normally seen within about 15 minutes of their appointment time and no one complained of extended waits.

Managers worked to keep the number of cancelled appointments/treatments/operations to a minimum.

When patients had their appointments/treatments/operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. For example, a child's operation was cancelled due to an issue with their health and a new date was agreed with their parents before they left.

Staff planned patients' discharge carefully. All children and young people were treated on a day case basis. Patients who had complex health needs that might result in a prolonged stay and more complex surgery was not undertaken at the clinic. These patients were offered surgery at alternative facilities. Discharge was planned with the parents at the pre-operative assessment visit. Parents told us staff had explained to them what to expect when their child went home.

Staff supported patients when they were referred or transferred between services. If a patient required an urgent transfer to an acute hospital, staff would liaise with the children's acute transfer service and support parents in the transfer.

For our additional findings on access and flow please see the Responsive section in the Surgery report.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. They told us they would speak to the management team if they had an issue.

The service did not display information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints. There were very few complaints about the service. The paediatric lead nurse could only recall one complaint over the previous 12 months, therefore it was not possible to identify themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff said they tried to avoid complaints by communicating well with children and their families and helping to solve any problems that arose. However, they said if someone wished to make a complaint they would advise them of the complaints procedure and provide an information leaflet explaining the process.

Managers shared feedback from complaints with staff and learning was used to improve the service. In relation to the one complaint about children's and young people's services, the lead paediatric nurse identified action that had been taken to reduce the risk of a similar complaint occurring again. Complaints were discussed at clinical governance meetings and actions to prevent similar issues in the future were explored.

Are services for children & young people well-led?

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

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

The service had a lead children's nurse who was also the children's safeguarding lead. They had an overview of the care of children in all areas of the clinic. We found them knowledgeable and experienced; they had a good grasp of the issues and had been instrumental in improving the provision of services for children and young people. Staff throughout the organisation we spoke with, told us the

lead children's nurse was available for advice and was approachable and helpful. They were visible on the floor and had a good knowledge of the activity and individual admissions. There was a lead paediatrician who was a member of the medical advisory committee and who was available for advice when needed.

There was a local children and young people's steering group, that oversaw the development of the service, care pathways, protocols and guidelines. These were chaired by the lead children's nurse and attended by a consultant paediatrician and a consultant anaesthetist. The paediatric lead nurse also attended the provider's national children's and young people's steering group.

For additional findings on leadership please see the Well-led section in the surgery report.

Vision and strategy

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

The vision for children's and young people's services was to deliver high quality care to children and young people in a child and family focused service. This was supported by eight strategic objectives and priorities. Staff were familiar with the vision and expressed their commitment to it.

The vision and objectives were further developed in a five-year plan for children's and young people's services, organised under the headings of information, efficiency, growth, communication, patients, facilities, people and governance. This provided broad goals for the development of the service.

Culture

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

Staff were focused on the children and young people they cared for and they built relationships with them, showing empathy and understanding towards them and their families. Managers and staff actively sought feedback from patients and their families and were proactive in addressing any potential concerns.

Nursing staff felt valued and listened to. They went out of their way to accommodate patients and family's wishes whenever they could. They all told us the organisation supported them in their efforts to further develop services for children and young people and they were able to discuss improvements with the senior management team. They also told us they were given opportunities for professional development.

Governance

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

There were regular clinical governance meetings where incidents, complaints, risks and medical and nursing staff told us they attended clinical governance meetings for children's and young people's services. They told us incidents, complaints, post-operative outcomes, risks, patient and parent feedback were monitored and discussed. Reports from the children's and young people's steering group were also discussed at the meetings.

Results from regular clinical audits were reported to the director of clinical services and they were discussed and action plans for improvement were produced.

Staff were clear about their responsibilities and told us they were able to discuss and reflect on improvements to the service. They received regular updates on quality and safety indicators and were focused on continuing improvement.

Managing risks, issues and performance

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

Good

Services for children & young people

Performance issues were discussed at the clinical governance meetings including safe staffing, mandatory training compliance and attendance statistics including admissions, attendances, re-admissions and complications.

The service had a risk register identifying the key risks to the children's and young people's service and actions taken to control and reduce the risks. An annual health and safety risk assessment was also completed and identified risks from such issues as hot domestic appliances, windows, slip, trip and falls, medical gases, mixer taps etc. However, the service had not recorded a risk associated with the non-alarmed fire doors within the ward area.

Staff were clear about their roles in responding to emergency situations.

For additional findings on managing risks, issues and performance please see the well-led section in the surgery report.

Managing information

For our detailed findings on managing information please see the Well led section in the Surgery report.

Engagement

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

Staff said they were encouraged to put forward their ideas for improvements and they were supported to implement them where appropriate. However, one professional said they were not consulted about changes to the environment or the service, although they said that if they raised an issue, managers would consider it and act upon any concerns.

Although there were no children's and young people's forums as patients normally did not attend the service on an ongoing basis, staff obtained feedback from patients and parents to identify areas for further improvement and development. They also reviewed ideas from other provider hospitals in relation to improvements to patient experience. For example, they told us they had obtained some samples of sports bags for teenagers to store their personal belongings, however, following consultation with their patients, they had determined they wouldn't be popular.

The senior management team said they actively encouraged their patients to complete patient satisfaction questionnaires to enable them to review and improve our patient experience. Patients were encouraged to complete an independently managed detailed questionnaire; the results are collated by the independent provider and a monthly report provided to the hospital for view and analysis and cascade to the hospital team and medical advisory committee.

For additional findings on engagement please see the well-led section in the surgery report.

Learning, continuous improvement and innovation

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

Services for children and young people had increased in volume since the last inspection and the service continually reviewed activity and opportunities for development. They had developed the information about children's and young people's services on their website and had held events to promote the services.

A consultant identified they had increased the number of children undergoing surgery at the clinic as more resources were made available. The appointment of three children's nurses had improved the service and enabled them to be available for outpatient clinics and day surgery. A dedicated paediatric workforce improved the quality and consistency of care for children.

There were plans in place to provide a children's inpatient bay to further improve the environment and facilities for children and young people. The children's waiting area in the outpatient clinics had also been developed. Little cars were available for the younger patients if they wish to 'drive' themselves to theatre.

A process had been introduced to follow up children and young people 'not brought into the clinic' or did not attend appointments to check their safety.

Good

Services for children & young people

Staff told us they were encouraged and supported to make further improvements on an ongoing basis.

For additional findings on learning, continuous improvement and innovation, please see the Well-led section in the Surgery report.

Good

Outpatients

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

Are outpatients services safe?

Good

We previously inspected the outpatients service at BMI The Saxon Clinic jointly with the diagnostic imaging department so, we cannot compare our new ratings directly with the previous ratings.

We rated safe as **good.**

Mandatory training

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

Staff were assigned to mandatory training modules appropriate to their role. The hospital had a mandatory training matrix that specified what training staff needed to complete and how frequently they needed to complete it.

The mandatory training was comprehensive and met the needs of patients and staff.

Mandatory training was provided either face-to-face or through on-line learning. Mandatory training modules included infection control, life support, consent and the Mental Capacity Act. All staff were required to complete training modules such as fire safety, information governance, dementia, consent and life support.

The hospital set a target of 100% for completion of mandatory training for existing staff. The mandatory training target for new staff was 90%.

Staff received and kept up-to-date with their mandatory training. As at August 2019, in outpatients the overall mandatory training compliance rate was 97%.

As at August 2019, qualified nursing staff mandatory training compliance met the target at 100% compliance.

As at August 2019, non-clinical and physiotherapy staff training compliance rates were just below the hospital target at 98% and 94% respectively.

Managers monitored mandatory training and alerted staff when they needed to update their training. We discussed training compliance rates with staff during our inspection. Staff understood where there were gaps in their mandatory training and were booked on courses to complete training.

Staff had access to the mandatory training database which enabled them to monitor their own mandatory training compliance and when training was due.

Staff were released from their duties to attend their mandatory training or completed their training when they were not on shift.

Safeguarding

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Concerns regarding patients were usually flagged at the pre-assessment stage.

Staff gave examples of when they had made a safeguarding referral. Staff knew they could contact the hospital's Director of clinical services for advice as they were the safeguarding lead.

Staff received training specific for their role on how to recognise and report abuse. The hospital set a target of 100% for completion of safeguarding training levels one and two for adults and children. The training target for new staff was 90%. At the time of our inspection, the overall safeguarding training compliance rate for qualified nursing staff in outpatients was 100%. Staff who had direct contact with children were also trained to level 3 safeguarding.

Consultants were required to provide evidence that they were up-to-date with their safeguarding training at their trust as part of their practicing privileges. Failure to comply with training, meant that they would have their practising privileges withdrawn until training was completed.

Staff followed safe procedures for children visiting the outpatient's department. Children visiting the department were accompanied by a children's nurse trained in level 3 safeguarding children.

Staff could give examples of how to protect patients from harassment and discrimination, including patients with protected characteristics under the Equality Act. Staff had access to an up-to-date safeguarding policy for children for guidance. The BMI safeguarding adult's policy was under review however, staff could still access the policy on the shared drive.

Staff could access safeguarding policies to obtain information on female genital mutilation (FGM). The policies stated what actions staff should take if they had FGM concerns. Safeguarding children and adult policies included PREVENT advice. PREVENT aims to protect vulnerable people from becoming radicalised to support terrorism or becoming terrorists themselves.

See the safeguarding section of the surgery report for additional information

Cleanliness, infection control and hygiene

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

This was an improvement from our 2016 inspection where we had identified some of the treatment room surfaces, flooring and furniture in the outpatient's department were not easily cleanable. The service had replaced carpet and furniture to ensure all areas of the treatment rooms were now suitable to be cleaned.

Staff understood current infection prevention and control guidelines and had access to a named microbiologist for expert infection, prevention and control advice. Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff had access to an up-to-date standard infection prevention and control precautions policy.

All areas were visibly clean. Cleaning schedules and checklists were up-to-date in treatment rooms and communal areas. Disposable curtains were used in treatment rooms and were in date. All patients and visitors told us the department was clean and tidy.

Staff cleaned equipment and labelled equipment to show when it was last cleaned. The five pieces of equipment we checked were clean and had labels attached to demonstrate when it was last cleaned.

Staff cleaned hands between each patient contact. All staff arms were bare below the elbow and met the requirements of the BMI uniform policy. Hand gel was available to staff, patients and visitors in each area of the department.

Infection prevention and control audits were carried out for the department.

Hand hygiene audits for the outpatient department excluding the physiotherapy department for July 2019 and August 2019 showed 92% compliance. Areas of non-compliance had been addressed directly with the individuals concerned. Compliance had improved to 100% in September 2019.

Hand hygiene compliance results for the physiotherapy department for July 2019, August 2019 and September 2019 were 100%.

Standard precaution audits were completed which checked staff compliance with infection prevention and control practices. Audit results for June 2019 and September 2019 showed 100% compliance.

Infection prevention and control equipment audits were carried out. This included availability of personal protective equipment and checking if the cleaning schedule was up-to-date.

The service did not report any hospital acquired infections for the previous 12 months.

The hospital held monthly infection, prevention and control (IPC) meetings. We reviewed minutes of these meetings. They showed any staff non-compliance with IPC measures were addressed directly with the staff concerned. Actions were discussed and put in place to improve IPC compliance rates.

The physiotherapy department had a handwashing sink in line with national guidelines. This was an improvement from our previous inspection.

Environment and equipment

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

The main outpatient department had 14 consulting rooms, with two waiting areas and a reception desk. The physiotherapy department had two consulting rooms and three bay areas. The design of the environment followed national guidance.

The service had enough suitable equipment to help them to safely care for patients. Equipment was maintained in line with guidelines and facilities were used appropriately to keep people safe. Staff carried out daily safety checks of specialist equipment.

The cardiac arrest trolley was easily accessible in the outpatients waiting area. Daily checks were up-to-date. Drugs and consumable items we checked were in date.

The service had suitable facilities to meet the needs of patients' families. The outpatient service was easily accessible to patients and visitors as it was located on the ground floor of the hospital.

Staff had access to personal protective equipment (PPE).

Staff managed general and clinical waste appropriately. Sharps disposal bins were correctly labelled and were not overfilled.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration.

Staff knew about and dealt with any specific risk issues. Staff responded promptly to any sudden deterioration in a patient's health. Staff routinely completed risk assessments and patient observations on admission.

Staff shared key information to keep patients safe when handing over their care to others. Patient records were comprehensive and included details of risk assessments conducted.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers included information on incidents and any relevant information from the previous shift to ensure patients were safe.

The service ensured children were safe during their time in the department. A children's nurse trained in paediatric immediate life support accompanied children when treated in the department.

Staff completed sepsis training and had recently attended a sepsis awareness day held at the hospital. Staff could access the BMI sepsis policy for guidance. This was in line with national guidance.

The department completed in house training which included the management of emergency situations. The team had recently carried out a practice resuscitation drill which staff had performed well.

The outpatients team completed a small number of procedures within the department. These were completed in a treatment room and followed a patient pathway for safety.

Nurse staffing

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

The service had enough nursing staff of relevant grades to keep patients safe.

Good

Outpatients

As at 1 April 2019, the outpatient department had 4.8 full time equivalent qualified nursing staff and five healthcare assistants employed in the department.

The outpatient manager could adjust staffing levels daily according to the needs of patients. Managers assessed the needs of each clinic to assess the level of nursing support needed, based on the specialty and patient complexity.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. Managers used the electronic roster tool in accordance with the BMI rostering policy. Managers ensured the skill mix for the department was two level 3 healthcare assistants and a minimum of one qualified nurse per shift. During our inspection, staffing levels met this required level. The number of nurses and healthcare assistants on all shifts in each clinic matched the planned numbers

Weekly planning meetings were held to discuss all cases booked for the following two weeks. Managers reviewed staffing needs to ensure appropriate numbers and skill mix.

There were no unfilled shifts in the outpatient department from February 2019 to April 2019.

The service had low vacancy rates. As at September 2019 the department had a vacancy for one full time qualified nurse in pre-assessment and two bank posts for preassessment. The service had a rolling advertisement to fill the bank posts. The vacancy rate as at April 2019 for healthcare assistants was 11%. The service was in the process of advertising these vacant posts at the time of the inspection. In the interim, regular bank staff were covering any gaps in staffing provision to meet staffing requirements.

The service had low and reducing turnover rates. The turnover rate for qualified nursing staff in outpatients reduced from an average rate of 22% from May 2017 to April 2018 to an average rate of 12% from May 2018 to April 2019. The equivalent rate for healthcare assistants in the same period was 1.8%.

The service had low sickness rates. From May 2017 to April 2018, the hospital reported an average sickness rate of 0.6% for qualified nursing staff in outpatients. From May 2017 to April 2018, the hospital reported an average sickness rate of 1.8% for healthcare assistants in outpatients.

The service had low rates of bank nurses used in the outpatient department. From May 2018 to April 2019, the rate of usage of bank staff remained low at 9% for qualified nursing staff. There were no bank staff used to cover any healthcare assistant shifts during this reporting period.

No agency staff were used between May 2018 to April 2019.

Managers limited their use of bank staff and requested bank staff familiar with the outpatient service. The service used two regular bank nurses known to the service as they had previously been permanently employed in the department.

From February 2019 to April 2019, the number of qualified nursing staff shifts covered by bank staff was 33. No healthcare assistant shifts were covered by bank staff.

Managers made sure all bank staff had a full induction and understood the service.

During our inspection we saw staffing levels for administration staff in the outpatient's reception were below planned levels by one receptionist, due to sickness. We saw this caused an increased workload for administrative staff to cover all of their required duties. The service was in the process of recruiting bank staff to fill shortfalls in administrative staffing. Despite the staffing shortfalls, staff told us reception staff made appointments accurately and administration tasks were completed to a high standard.

Medical staffing

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

The service had enough medical staff to keep patients safe.

Good

Outpatients

The hospital did not employ any consultants directly. Medical staff were employed by other local NHS trusts in substantive posts and they had up-to-date practising privileges with The BMI Saxon Clinic.

Consultants were granted practising privileges to see patients at the hospital at the agreement of the executive director in consultation with the medical advisory committee. Consultants had their practising privileges reviewed each year to ensure they still met the standards expected by the provider.

The service always had a consultant on call during evenings and weekends.

Records

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

All patient records were in paper format. The service was in the process of implementing single sets of patient notes which staff told us had been a challenge for the service. Prior to the single set of records, patients appointment records would be held by the consultant which were made accessible for inpatient episodes.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. The notes trolley was stored in the nurse's office. The notes trolley and the nurse's room were locked when not in use.

The patient notes demonstrated good use of care pathways.

No patients had been seen in outpatients without relevant medical records being available for their appointment during the 12 months before our inspection.

When patients transferred to a new team, there were no delays in staff accessing their records.

There had been no recorded instances of records being removed from the hospital site during the 12 months before our inspection.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All medicines were kept in a locked cabinet. All medicines we checked were within their expiry date. Consultants named prescription pads were locked away.

Daily drugs fridge temperature checks and ambient room temperatures where medicines were stored were up-to-date. Staff made sure that drugs were stored at the right temperature to prevent them becoming ineffective or dangerous.

Patients would be required to bring their own medicines with them if required. Staff followed current national practice to check patients had the correct medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

The hospital's pharmacy team was responsible for stocking up medication in the department each week. The hospital pharmacy was open from 9am to 5pm.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

For our detailed findings on medicines please see the safe section in the surgery report.

Incidents

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

Staff knew what incidents to report and how to report them. This was an improvement from our previous

inspection where we identified not all incidents were reported appropriately. Staff could access the hospital's electronic incident reporting system and had completed training in how to use it.

There had been zero serious incidents in outpatients in the 12 months before our inspection.

The hospital director held a communication meeting each morning. Managers from the outpatient department attended the meeting. Information regarding incidents was discussed at the meeting. Managers would share this information with their team to ensure all staff were up-to-date.

Staff reported incidents clearly and in line with BMI policy. From March 2019 to September 2019, there had been 42 incidents recorded in outpatients, of these 6 were graded as no harm and 36 as low harm. No harm incidents mainly included patients feeling feint following procedures and patient medication concerns.

The outpatient department had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They gave patients and families a full explanation when things went wrong.

Clinical governance meeting minutes showed incidents and incident root cause analyses across all areas of the hospital were discussed.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care.

Managers gave positive feedback to staff when they had completed an incident report well and told staff where improvements were needed. There was evidence that changes had been made because of feedback.

The overall environment of the department had improved in response to feedback. Managers shared learning with their staff about never events that happened elsewhere.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff. However, this information was not displayed in the outpatient department for patients and visitors to see.

The service continually monitored safety performance.

There had been no hospital acquired infections.

Are outpatients services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients. However, we are not currently confident that, overall CQC is able to collect enough evidence to give a rating for effective in the outpatient department.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff knew how to protect the rights of patients' subject to the Mental Health Act 1983.

The outpatient department did not regularly treat patients with mental health concerns, in line with the patient acceptance criteria for outpatients.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff could access policies on the hospital's intranet. Managers ensured staff signed a confirmation of reading BMI policies sheet to state they had read updates to policies. The BMI policies applicable to outpatients were evidence-based and based on the National Institute for Health and Care Excellence (NICE) guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Patients and visitors had access to hot and cold drinks.

Patients had access to hot drinks and water in the outpatient waiting areas.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Outpatient staff did not routinely provide patient pain relief. However, staff assessed patients pain levels before and during procedures.

Patients would bring their own pain relief medicines with them if needed for most outpatient appointments. However, registered nursing staff would prescribe patients the required pain relief for specific procedures.

Staff prescribed, administered and recorded pain relief accurately.

Staff gave patients pain advice booklets at their pre-assessment appointment to prepare them for surgery and to use as a guide following their surgery. Staff discussed and recorded patients pain levels at their pre-assessment appointments.

Patients could feedback on how staff had managed their pain on the patient satisfaction feedback form.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients.

BMI The Saxon Clinic did not have a performance dashboard for the outpatient department. However, the overall hospital dashboard was used to benchmark data for incident reporting against similar size hospitals within the BMI group. The outpatient department was able to monitor its performance against all hospitals in the BMI group.

The service did not participate in national benchmarking clinical audits or audits on patient outcomes. However, outpatient departments do not generally participate in national or patient outcome audits. Managers monitored performance outcome results to improve services further. Managers carried out a comprehensive environmental audit programme.

Managers conducted audits in line with the hospital's annual clinical audit programme. These included example audits of patient pathways and medicines management. The audit performance results were reviewed at heads of department meetings.

The service collected data and monitored unplanned outpatient reviews to ensure they were aware of any themes. This data from April 2019 to September 2019 showed there had been 61 unplanned reviews. The reasons for reviews included for example, pain medication reviews, infection reviews and patient's needing further reassurance regarding their care and treatment.

Outcomes from these reviews were recorded in the patient records.

The physiotherapy department collected Patient Reported Outcome Measures (PROMs) to measure health gains in patients. For the period between January 2017 and August 2019 initial data was collected on 328 procedures with knee injuries being the most common (175/327, 53%), followed by hip (112/327, 34%). The pre, post and change questionnaire scores demonstrated an increase in score from pre to post operation. The neck showed the biggest increase while the most common procedure sites hip and knee, reported increases in score of 22 and 14 respectively.

Managers used information from the audits to improve care and treatment. Managers gave us examples of where they had made improvements to the environment and physiotherapy pathway to recovery booklets in response to audit findings.

Clinical meetings were held to follow-up audit outliers. Managers shared and made sure staff understood information from the audits. Managers discussed audit outcome results with teams and improvements made where necessary during team meetings.

Competent staff

Good

Outpatients

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff competencies were specific to each role. Healthcare assistant competencies included wound care, phlebotomy, electrocardiogram (simple test to check the heart's rhythm), chaperoning and observations.

Managers gave all new staff a full induction specific to their role, before they started work. All new starters had a four-week supernumerary period and completed a 90-day induction programme, in line with the BMI induction policy. Recently recruited staff confirmed they had received a BMI induction.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff confirmed they could discuss their training and development needs during their annual appraisal. From October 2017 to September 2018, 100% of required staff in outpatients had received an appraisal.

Managers supported staff to develop through regular clinical supervision of their work. Staff had enough support to access learning and development.

Monthly team meetings were held in the department. Managers made sure staff attended team meetings when possible. If staff were unable to attend, they could access minutes from the meetings to ensure they were up-to-date.

Consultants held specialist clinics and were competent in those areas of expertise. Consultants who had practising privileges need to show they had the relevant clinical experience in their area of expertise. This was in line with the procedures they performed as part of their NHS practice. Practising privileges were reviewed annually for consultants by the hospital's executive director and the MAC chair.

Consultants provided BMI with their annual appraisal details from their NHS trust and had an annual BMI appraisal.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers gave them the time and opportunity to develop their skills and knowledge.

Managers supported staff to attend external courses and obtain extra qualifications. Staff were encouraged and given opportunities to learn by their manager. Staff had completed BMI funded courses such as a mentorship course and a healthcare assistant apprenticeship.

Managers made sure staff received specialist training for their role. For example, the physiotherapy lead had a sports science qualification.

Managers identified poor staff performance promptly and supported staff to improve. Managers confirmed any concerns regarding the performance of staff were addressed through a programme of performance management.

The service had access to the BMI healthcare practice educators to support staff learning and development such as practice development nurses.

Managers did not recruit volunteers to support patients in the service.

Multidisciplinary working

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

Patient's care and treatment was delivered though multidisciplinary working across a range of staff groups including medical and nursing staff, healthcare assistants and administrative staff. Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, physiotherapists attended ward meetings to ensure they were fully updated regarding the patients they supported.

Patients could see all the health professionals involved in their care in one-stop clinics. The department held several one-stop clinics such as the joint school where patients could be reviewed at different specialist clinics on one day.

Seven-day services

Good

Outpatients

Key services were not available seven days a week to support timely patient care. However, patients were offered a choice of appointment to suit their needs including evenings and Saturday morning clinics.

The outpatient department was open from Monday to Friday from 8am to 9pm and from 8am to 1pm on Saturdays.

Physiotherapists covered an on-call rota to ensure they were available out-of-hours.

The hospital's Resident Medical Officer was available 24 hours a day.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Physiotherapists supported patients to increase their activity levels and improve their mobility following procedures.

Pre-operative health questionnaires were completed by all patients before pre-assessment. They included questions about a patient's smoking habits and alcohol and use of recreational substances.

The service was participating in the Commissioning for Quality and Innovation (CQUIN) for 2019-2020 for 'risky behaviours.' The service planned to use the data collected from the pre-operative assessment clinic and day surgery, orthopaedic, gynaecology and general surgery clinics to inform and signpost patients to appropriate support networks to encourage risk reduction. The signposting of patients and support given was documented in the pre-operative assessment record to confirm the data of actions.

Managers were aiming to meet the Commissioning for Quality and Innovation (CQUIN) target for staff health and wellbeing at the hospital. BMI promoted staff health and wellbeing by offering staff corporate gym membership and supporting the staff cycle to work scheme.

However, the service had limited information available in the waiting areas promoting healthy lifestyles and support for patients and visitors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff did not frequently treat patients who lacked mental capacity and where Deprivation of Liberty Safeguards applied as patients were elective. However, staff were required to complete Mental Capacity Act and Deprivation of Liberty Safeguards training and additional support was provided to staff by the hospital's safeguarding lead, if necessary.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could access the Mental Capacity Act and Deprivation of Liberty Safeguards policy for guidance. This policy was up-to-date.

The service did not frequently treat patients with psychological health concerns. Consultants would see these patients at their NHS trusts where specific mental health support would be available.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Patient consent was recorded in all nine patient records we reviewed. The service had an up-to-date consent policy.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. However, staff did not frequently treat patients who were unable to consent to treatment due to the elective nature of the department.

Good

Outpatients

Staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Are outpatients services caring?

Good

We rated caring as **good.**

Compassionate care

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

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

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff followed policy to keep patient care and treatment confidential. Staff held confidential discussions about patients away from public areas to ensure they could not be overheard. The reception desk was positioned away from the seating area in the reception to ensure patients could speak to the receptionist without being overheard. All patients we spoke with confirmed staff had treated them with dignity and respect.

Consultants took the time to ensure patients did not have any further questions or concerns.

Patients said staff treated them well and with kindness. All patient feedback without exception stated staff had treated them in a kind way. Staff introduced themselves at the beginning of their appointment and explained their role.

Staff pulled curtains around patients when they were undressing for their consultation. All the consulting rooms were single rooms. This ensured patient's privacy and dignity was maintained. Staff ensured they asked patients what their preferences were regarding removing certain parts of clothing to conduct exercises in physiotherapy.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to patient's care needs. There was access to local religious and spiritual support if required. Staff ensured they asked patients what their preferences were regarding removing certain parts of clothing to conduct exercises in physiotherapy.

The provider conducted a patient satisfaction survey. Results for the outpatient department in August 2019 showed 95% of NHS patients and 99% of privately funded patients would recommend the department to their friends and family.

Chaperones were offered to patients in line with the BMI chaperone policy. Staff recorded this in-patient note. However, chaperone notices were small and may not be visible to patients as they were not displayed at eye level.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Patients told us staff alleviated any anxieties and helped them to stay calm. Staff had supported a patient who became uncomfortable and anxious in the waiting area before their appointment.

Staff gave patients and those close to them help, emotional support and advice when they needed it. For example, physiotherapy staff provided an example of when they had given emotional support to a patient when they had become emotional regarding their mobility changes and associated limitations.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult

conversations. Although the outpatient department did not have a dedicated quiet room, staff could access unused consultation rooms to hold private conversations with patients.

The outpatient lead ensured they were present to support patients when consultants needed to give them an upsetting diagnosis.

Staff supported one another following challenging appointments. Staff gave an example of senior leaders supporting them through personal difficulties by adapting their working hours and ensuring they had enough support in place.

Patients could access a range of patient information leaflets in the department available to explain their condition and treatment plan.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff gave enough information to patients and those close to them from the start of their treatment and provided regular updates. Patients felt involved in their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff explained patient's treatment plans in a way which was easily understandable. Staff allowed time for patients and carers to ask any questions.

Staff supported patients to make advanced decisions about their care. Patients told us staff gave them enough information to make well informed decisions about their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. However, patient satisfaction response rates remained low for the department and the results were not displayed prominently in the outpatient department.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

Staff offered patients paper questionnaires to complete in outpatients when returning for further care if they have not completed them on line. This was to try to improve the low participation rate.

The senior management team was liaising with other BMI hospitals to learn how to improve response rates.

Are outpatients services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. Managers co-ordinated with the local commissioning groups to ensure that the outpatient services met the needs of the local population. The service had close links with the local NHS trust and filled gaps in their outpatient service provision where possible.

Appointment time slots depended on the type of outpatient clinic appointment. Managers managed the outpatient clinic capacity to ensure patients had short wait times.

The department was open from Monday to Friday from 8am to 9pm and from 8am to 1pm on Saturdays. Patients told us they could obtain suitable appointments. The service held several one-stop clinics and minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Most staff were phlebotomy trained. This allowed patients to have blood tests in a timely way on the same day as their clinic appointment.

The service had systems to help care for patients in need of additional support or specialist intervention. However, patients who accessed the outpatient service were elective, so staff did not regularly treat patients with additional needs.

Good

Outpatients

Managers monitored and acted to minimise missed appointments. The service sent text messages to remind patients of their appointment details. Appointment letters included information such as contact details, directions, consultant name, and what samples patients needed to bring to their appointment.

The hospital administration team monitored patient wait times and helped organise appointments to ensure no breaches occurred. Waiting times, do not attend rates and cancelled appointments were monitored and reported at contract review meetings with the local clinical commissioning group.

Staff ensured that patients who did not attend appointments were contacted. Reception staff informed the patient's consultants when a patient missed an appointment. Administrative staff recorded this missed appointment on the appointment system and contacted the patient to make another appointment.

We requested overall did not attend (DNA) rates for the department. However, we received DNA rates for physiotherapy, health screening and GP surgery clinics separately. From September 2018 to August 2019, the average DNA rate for physiotherapy was 2%, health screening was 1% and GP surgery clinics was 3%.

Outpatient facilities and premises were appropriate for the services being delivered. The outpatient environment was suitable for patients and visitors. There was enough comfortable seating and a separate children's play area.

The department was clearly signposted form the main entrance. Patients told us they had found the department easily.

However, car parking capacity at the hospital was limited. Patients and relatives had to allow extra time to ensure they could find a car parking space in time, so they were not late for their appointments.

Meeting people's individual needs

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

The outpatient environment was suitable for patients with a physical disability. Corridors were wide enough for wheelchair users.

Patients' needs would be assessed during their referral process and during their pre-assessment appointment.

The service did not regularly provide support for obese patients, patients with severe mental health problems, learning disabilities and dementia in line with the patient acceptance criteria for outpatients. These patients would usually be treated at their local NHS trust where specialist support was available.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, the department had a loop system for people with a hearing impairment.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff provided examples where they had adapted their communication methods to ensure staff understood their care and treatment plans in detail.

Patient communication needs would be assessed during the referral process and at their pre- assessment appointment to ensure translators could be arranged ahead of a patient's procedure. Translators were available over the phone and face-to-face appointments could be made when needed.

Managers made sure staff, and patients, relatives and carers could get help from interpreters. Telephone or face-to-face translation services were available to patient's where English was not their first language. Staff understood translators would be needed for consent purposes as it is not good practice to use relatives to support the consent process. Staff told us they did not regularly see patients whose first language was not English.

However, the service did not have information leaflets available in languages spoken by the patients and local community. Leaflets were all written in English and were not available in easy read formats. We had identified this at our previous inspection. However, staff told us they did not frequently treat patients whose first language was not English.

Access and flow

Good

Outpatients

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients could access care and treatment at a time that suited them. Patients told us they were given a choice of appointments and could easily re-arrange if needed.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The Referral to Treatment (RTT) pathway target for NHS-funded patients outlines that no patient should wait longer than 18 weeks from referral to the start of their treatment.

As at October 2019, the outpatient department had seven patients who had waited over 18 weeks. These related to patient choice where patients had not accepted the date they had been offered and had chosen to postpone their surgery.

Managers and staff worked to make sure patients did not stay longer than they needed to. During our inspection, outpatient appointments ran on time. Where there were short waits of up to ten minutes, reception staff notified patients of the delay on arrival.

The service did not audit waiting times for private patients. Private patients had a choice of when they accessed treatment. However, the hospital could review internal databases to calculate waiting times and conversion rates from outpatient to surgical episodes if required.

The department used technology to support timely access to care and treatment. Patients were sent text message reminders to ensure they were aware of their appointment details.

We requested the number of cancelled appointments in the outpatient department however, the service did not submit these. During the inspection, we saw managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were re-arranged as soon as possible in line with national targets and guidance.

Staff supported patients when they were referred or transferred between services.

The department held different specialist clinics. The main outpatient activity was orthopaedic surgery accounting for 30% of the outpatient department's activity. The remaining activity is outlined below:

- General Surgery: 9%
- Ear Nose and Throat: 8%
- Dermatology: 7%
- Gynaecology: 5%
- Urology: 4%
- Gastroenterology: 4%
- GP Consultation: 4%
- Pain Management: 3%
- Plastic Surgery: 3%
- Rheumatology: 3%
- Ophthalmology: 3%
- Cardiology: 2%
- Neurology: 2%
- Paediatrics: 2%

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients were aware of how to raise a compliant if needed. Patients we spoke with had not needed to raise any concerns or to log any complaints however, they told us it would be easy to do so.

The service provided patient information leaflets about how to raise a concern in patient areas. BMI had a complaints information leaflet available in the outpatient department. This explained how patients could complain about the service and provided clear

guidance on how patients could raise concerns. However, the service did not clearly display how patients could raise a complaint information in any of the outpatient areas.

Staff understood the policy on complaints and knew how to handle them. Staff followed the BMI complaints policy when formal complaints were made. This described staff roles and responsibilities to manage complaints. The department lead, and executive director were responsible for managing individual complaints. The policy stated written acknowledgment of the complaint should be sent within three working days. A full written response should be provided within 20 working days when the outcome of the investigation was known.

Staff told us they would try to resolve complaints as soon as possible to try to prevent them from becoming formal complaints. Senior staff would offer to meet with the complainant. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The outpatient department received a low number of complaints. There had been nine complaints in the outpatient department over the 12 months before our inspection. Complaint subjects included concerns regarding charging and staff attitude. Managers investigated complaints and identified themes. Changes in response to complaints had been made to improve the service. For example, a charging card was given to patients to ensure patients were aware of any additional fees in advance of their treatment

Complaints were shared and recorded in the hospital's clinical governance reports to ensure they were used as an opportunity to learn and improve the outpatient service.

BMI had introduced a stage zero process for complaints. This was to encourage and staff to identify and address any patient or visitor concerns at the time the complaint was raised. Staff could escalate concerns to their manager to resolve quickly. For more serious concerns, staff were advised to escalate complaints and concerns immediately to the executive director, director of clinical services, operations manager or the manager on call.

The hospital was a member of the Independent Sector Complaints Adjudication Service (ISCAS). This service independently reviews private healthcare sector complaints. There had been no outpatient service complaints investigated by ISCAS in the 12 months before our inspection.

NHS patients could complain to the Parliamentary Health Service Ombudsman (PHSO). The Ombudsman is an independent review body for NHS patients in England. There had been no outpatient service complaints investigated by PHSO in the 12 months before our inspection.

Managers shared feedback from complaints with staff and learning was used to improve the service. The outpatient leads discussed complaints relevant to their department at departmental meetings. Managers raised any complaints involving staff directly with the staff member involved.

During the 12 months before our inspection, the outpatient department had three compliments from patients.

Are outpatients services well-led?

Good

We rated well led as **good.**

Leadership

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

The department lead was visible and accessible in the outpatient department. The outpatient lead was currently covering the role in the interim until the hospital had recruited a permanent replacement. The outpatient lead was available in the nurses' office located in the department. We saw managers communicated well with staff and patients during our inspection.

Good

Outpatients

Leaders understood the challenges to quality and sustainability and identified actions needed to address them.

Leaders for each shift were clearly identified. A noticeboard was displayed in the nurses' office recording the nurse in charge for each shift. A notice was clearly displayed next to the reception desk to inform patients who was in charge on that day.

The service had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership.

Leaders communicated important messages to staff during staff huddles. The nurses' office had information displayed including policy updates and audit results. This ensured staff were aware of any relevant issues and updates.

A communications meeting was held each morning. Leaders from each department including outpatients attended. Discussions included sickness, hospital activity and concerns and incidents across the hospital. All service leaders were updated each day and able to provide staff with information about the department and the overall hospital.

Vision and strategy

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

The Saxon Clinic is part of BMI Healthcare Limited. BMI has hospitals across the UK. All hospitals in the BMI group have the overall vision: to deliver the best patient experience, in the most effective way, from our comprehensive UK network of acute care hospitals. BMI had eight strategic objectives included in their five-year vision for 2015 to 2020: people, patients, communications, growth, governance, efficiency, facilities and information.

The service had a clear vision and set of values with quality and sustainability as the main priorities. The outpatient department had a local five-year vision and strategy. This was aligned to the hospital vision and strategy. The main priorities included an ongoing refurbishment programme to streamline patient services and to get it right first time,

The vision, values and strategy for the service had been developed in collaboration with staff and people who use the service. Staff felt involved with the overall hospital and local outpatient vision, values and strategy. Staff understood how they could achieve them.

Staff discussed with their manager how their personal objectives were linked to the hospital priorities and vision, values and strategy for the outpatient department during their appraisal.

The strategy for outpatients was in line with local plans and had been planned with external partners to meet the needs of the local population. Plans for the outpatient department included to support external partners to fill gaps in their service provision. This was to ensure the needs of patients and the local population were met.

The hospital had a quality action group. The information collected from this group was shared with the BMI national staff engagement group. This supported the hospital strategy through implementation of actions to improve the hospital environment for patients and staff.

Culture

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

The culture centred on the needs and experience of people who use the outpatient service. Staff felt positive and proud to work for the department and organisation. Staff had few complaints about working in the department and told us it was a friendly department to work in.

Action was taken to address behaviour and performance inconsistent with the hospital's vision and values.

Managers described how they had experience of managing poor performance through a performance management process in response to negative staff feedback.

The culture encouraged openness and honesty at all levels in the organisation and people who use services.

Staff were aware there was a Freedom to Speak Up Guardian based at the hospital. Staff had not needed to raise any concerns with the Guardian as they felt comfortable raising concerns directly with their manager. The provider had a Guardian at provider level to support staff and represent the organisation as a Guardian.

Staff at every level had access to the development they needed, including high-quality appraisals. Staff had career development opportunities to gain additional specialist skills specific to their role.

There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked together for the benefit of patients. All staff worked well together as a team. We saw numerous examples of positive engagement between staff during our inspection. Staff told us the department was a good environment to work in. All staff in different roles and at all levels had a supportive working relationship and valued each other. Recently recruited staff felt welcomed into the team.

The hospital was focussed on improving the overall health and well-being of staff.

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. This was an improvement from our last inspection where we identified governance arrangements in the department did not always operate effectively.

The governance and management of the outpatient department worked effectively in line with the overall hospital governance system. Governance arrangements we reviewed showed the hospital committee and meeting structures ensured any outpatient performance concerns and current risks could be raised in a timely way. Monthly governance meetings included performance and risk discussions and associated actions put in place as a result.

The department had monthly team meetings. This supported shared learning from across the hospital. Meetings were recorded to ensure even if staff were unable to attend, they would remain updated. Handover meetings were held every afternoon to share updates with staff.

Managing risks, issues and performance

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

There were comprehensive assurance systems and performance issues were escalated appropriately through clear structures and processes. These were regularly reviewed and improved. This was an improvement from our last inspection where we identified infection, prevention and control risks were not fully recognised, assessed and managed.

Consultants were up-to-date with the requirements of their practising privileges at the hospital. Each year, consultants needed to show they had up-to-date competencies to practise at the hospital. Managers reviewed each consultant's practice during their annual appraisal and throughout the year. This review included monitoring consultant performance against clinical indicators and any incidents, complaints and compliments involving the consultant.

The service had processes for identifying, recording and managing risks. The recorded risks for the service were representative of the current risks for the service.

The overall hospital risk register included the main risks to the outpatient service. Managers regularly reviewed outpatient risks at monthly clinical governance meetings and updated and amended them when required. This

was an improvement from our previous inspection where we were not assured all risks relating to the department's environmental and infection prevention and control risks, were not sufficiently mitigated.

Managers monitored service developments and efficiency changes.

Managers reviewed any applications to set up new outpatient clinics and further develop existing clinics to make sure patient care was not affected.

Managing information

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

Staff had access to accurate information and up-to-date policies and procedures. Staff could access policies and procedures on the hospital intranet.

The service had clear and robust performance measures which were reported and regularly monitored.

There had been no data security breaches in the department in the 12 months before our inspection. Paper patient records were securely stored in a locked notes trolley in the nurses office. This office was locked when unattended.

The service had robust arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards.

Staff could access the information they required.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve services.

Patient feedback was collated through the patient satisfaction survey, NHS Friends and Family Test, NHS Choices and patient forums. Managers held patient forums every three months involving 10 patients selected at random after discharge from the hospital. Improvements implemented following feedback from the forums included changing the physiotherapy care plan booklets to include patient exercises.

Staff forums were held each month to share information on corporate and local performance as well as giving staff the opportunity to raise concerns. Staff were actively engaged so that their views were reflected in the planning and development of services.

Staff could complete the staff engagement survey each year.

Hospital newsletters and bulletins were circulated to all staff across the hospital.

The hospital had started a staff recognition scheme to recognise and promote staff contribution.

There was transparency and openness with external partners about the service's performance. Managers shared performance data with stakeholders to ensure partners understood the main challenges and ensure any performance concerns and gaps in provision were addressed.

Managers promoted the outpatient department in the local community. For example, people running the Milton Keynes marathon were offered free sessions on specialist physiotherapy equipment. Runners were offered dedicated foot and ankle consultations with orthopaedic surgeons at the hospital.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, they did not always have a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation however, participation in research was limited.

Staff were not involved in any research projects at the time of our inspection.

We did not see any examples of innovative practice during our inspection.

Good

Outpatients

However, the service encouraged the development of the service to provide specialist one-stop clinics.

Leaders encouraged the development of additional clinics in outpatients. For example, a hand disorder clinic had recently begun.

The physiotherapy department was developing their service. The department had plans to re-locate to a dedicated newly-build physiotherapy clinic. The physiotherapy had some newly developed equipment, such as the anti-gravity treadmill to support patients' rehabilitation. The physiotherapy department had arranged for an external pilates instructor to hold pilates classes for patients at the hospital.

Staff were committed to learning from incidents, complaints and when things went well. Learning was shared across the hospital to improve care and outcomes for patients.

The outpatient service had not been subjected to any external reviews in the year before our inspection.

The physiotherapy lead was the musculoskeletal (MSK) champion for BMI. Musculoskeletal (MSK) Musculoskeletal physiotherapists provide advice and treatment for a wide range of orthopaedic and rheumatological conditions that affect joints, muscles, ligaments and tendons.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

We previously inspected diagnostic imaging with outpatients and cannot therefore compare ratings with the previous inspection.

We rated it as **good.**

Mandatory training

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

Staff were assigned to mandatory training modules appropriate to their role. All staff were required to complete key modules such as infection prevention and control, waste management, safeguarding and health and safety.

Managers monitored mandatory training and alerted staff when they needed to update.

We saw evidence that the overall staff compliance rate for mandatory training, for staff within the imaging department, was 99%. The hospital target was 90%.

For details of mandatory training, please see the Safe section of the surgery report.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse.

Staff in the department received level three children's safeguarding training which included child sexual exploitation training.

Staff told us when children attended the department, they were always supported by a paediatric nurse who was trained in safeguarding level three. Staff told us if they had any safeguarding concerns prior to, during, or after a child's appointment they could discuss them with the paediatric nurse and the safeguarding lead.

We saw that safeguarding procedures for children visiting the department were being audited.

Actions taken in response to the audits were not available at the time of inspection.

Information about safeguarding was visibly displayed across the department to ensure that staff could access timely advice and support from the safeguarding lead.

For details on safeguarding training, please see the safe section of the surgery report.

Cleanliness, infection control and hygiene

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

All areas inspected were visibly clean and clear of clutter. We observed staff cleaning equipment between uses and items not in use were labelled as cleaned.

We saw hand gels were available across the department for staff and visitors. Personal protective equipment such

as aprons and gloves were available and used as necessary. A uniform policy was in place and staff adhered to this. Staff were arms bare below the elbow when within the clinical area.

Staff we spoke with were aware of current infection prevention and control guidelines. These were also accessible on the hospital intranet.

We saw staff clean equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff used and updated cleaning schedules and checklists to ensure tasks for cleaning the environment and equipment were completed in line with recommendations. Checklists were up to date.

Arrangements were in place for the appropriate handling, storage and disposal of clinical waste, including sharps.

Scanning and waiting areas were clean and had suitable furnishings which were clean and well-maintained. The changing areas had disposable curtains that were changed every six months or when they became soiled.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all radiation protection equipment was clearly labelled as being checked annually.

The imaging department was located on the ground floor of the main hospital building and consisted of a general x-ray room, and ultrasound room. Mobile magnetic resonance imaging (MRI) equipment was provided by an external provider.

Rooms where ionising radiation exposures occurred were clearly signposted with warning lights. Redevelopments to the building had meant the environment had improved since the last inspection. Plans were in place to replace the doors in the imaging room in October 2019 at the last stage of refurbishment programme. There were also plans for the MRI to move from the mobile vehicle situated outside the main building to be brought indoors as part of the radiography department.

All staff wore radiation exposure devices to ensure they were not over exposed. Staff radiation exposure was monitored by the radiation protection supervisor and records of dose badges were recorded. Appropriate action would be taken if overexposure was identified.

Staff wore lead aprons to protect themselves from the risk of radiation exposure. The aprons were tested annually to ensure their effectiveness. We saw that these were in good condition and that any deemed to be not fit for purpose were taken out of use. There were three thyroid shields that had not been checked since March 2018. We raised this with staff to arrange for them to be checked and/or replaced.

All equipment was serviced regularly through service line agreements with the manufacturer or an external provider. We saw that the senior management team had a record of all service history and tracked any repairs.

Adult and paediatric resuscitation equipment was available and located close to the department. We saw records of daily checks completed and all equipment was within expiry dates and stored securely.

Assessing and responding to patient risk

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

The department had written and displayed local rules, as required by the Health and Safety Executive, in all areas where medical radiation was used. Staff followed the local rules and adhered to radiation protection procedures.

Emergency resuscitation equipment was available in the department which included a paediatric ‘grab bag’ which contained equipment for use in any emergency affecting children.

The service had access to support from a radiation protection advisor (RPA) who was based offsite but contactable by email and phone. The radiation protection supervisor worked within the department and was easily accessible.

The service used the pause and check system. This is a prompt system to ensure that the right patient received the right investigation.

Good

Diagnostic imaging

There were processes in place to ensure that women of child bearing age were not pregnant. Staff asked women prior to the investigation to confirm whether they may be pregnant and if they were, staff discussed the investigation with the radiologist to confirm whether it was safe to proceed.

Contrast media for investigations was only used when a doctor was on site. This process ensured that if a patient became unwell or reacted to the contrast media, there was enough staff to attend the emergency.

Staff used the emergency call bell to summon medical help in the event of an emergency. Warning lights were lit when radiation was being used to prevent staff accessing rooms in use.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction. No agency staff were used.

Staff at the service comprised of one imaging manager, two senior radiographers, two radiographers and one imaging assistants. All radiographers working within the service had current professional registrations.

Managers accurately calculated and reviewed the number of radiographers and healthcare assistants needed for each shift in accordance with national guidance.

We saw that staffing levels were pre-planned. The manager planned rotas and adjusted the staff numbers and skill mix around the requirements of patients attending.

The service was actively recruiting for a vacancy with an advert at the time of the inspection. Whilst recruitment was taking place, bank staff were used to cover any gaps in the rota. We saw that from June to August 2019, 10% of total hours was covered by bank staff.

Sickness within the service was low. The staff sickness rate in the department was 2% in the 12 months prior to the inspection. This was below the BMI corporate target of 3%.

Radiology staffing

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

Radiologists worked within the hospital under practising privileges and worked against a schedule of activity. This process enabled images to be reviewed by the most appropriate clinician with the appropriate competency.

All consultants carried out procedures that they would normally carry out within their scope of practice. Radiologists were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development, before their practising privileges were renewed.

Consultant radiologists, who were new to the hospital received a formal induction.

All inpatients were under the care of a designated consultant and the referring consultants were accessible in and out of hours. In addition, the service had access to the resident medical officer (RMO) from the main inpatient ward if needed. The RMO was available 24 hours, seven days per week. Imaging was not completed out of hours unless there was a clinical emergency.

Consultants participated in the medical advisory committee (MAC) meetings for the main hospital. There was a radiology lead who attended the meetings and shared information across the team.

Records

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

Patients had a paper record detailing the referral and the investigation to be completed. We saw that these were stored in a folder attached to the wall within the imaging department. The room was locked when not in use. Once the investigation was completed, the investigation details were scanned into the electronic system which detailed the investigation, the image and details of any contrast media/ medicines used.

All computers observed were locked and password protected when not in use. Computers were in rooms out of public areas which reduced the risk of confidential patient information being seen by other patients or visitors. The computers on the mobile MRI scanner had privacy screens that kept patient information confidential.

For details of records, please see the safe section of the surgery report.

Medicines

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

Staff did not routinely administer any medicines other than those necessary for the investigation, for example contrast media.

Patient referrals determined whether a contrast media was required for the investigation. If they were the details of the contrast type was confirmed by the radiologist and staff administered the contrast against patient group directions (PGDs). PGDs allow specific health care professionals to supply and/or administer a type of medicine directly to a patient with an identified clinical condition without the need for a prescription or instruction from a prescriber.

We saw that the PGD arrangements were safe. There were four PGDs in this department to allow trained and assessed radiographers to administer such medicines including contrast medium. We reviewed the PGDs which were in date and contained the appropriate information.

Staff took precaution to ensure the right patient received the right medicine. Patient identity and dose was checked and confirmed prior to administering. Radiographers checked the contrast solution with a colleague after cannulation to ensure the accurate medicine had been given.

All medicines were kept in locked cabinets in the radiology department. We checked the medicines and they were in date. There was an audit to confirm the use of the medicines and we saw that all audit documentation had been completed.

Radiation Dose

Radiation doses were monitored and administered within guidelines.

Dose reference levels were set by an external radiation protection service in line with the national reference levels. Staff reported that there was an effective relationship between the external provider and staff, and they told us that they were responsive to their needs.

Radiation dose audits were completed at regular intervals to ensure that equipment was working effectively and to ensure that patients and staff were not at risk of over exposure to radiation.

Radiation Protection

The service ensured that there were processes in place to ensure radiation protection.

The service had a full set of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures as required under regulations. Radiation protection services were provided by an external company. The company was responsible for the provision of radiation protection advisor (RPA) as required by UK law. There was an RPA audit process in place.

There was a radiation protection audit completed annually which confirmed compliance with regulations.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff were aware of their roles and responsibilities for the escalation of concerns and knew what incidents to report and how to report them. The service used an electronic system for recording any incidents.

There were ten incidents from 1 March to 30 September 2019. Of these incidents, four were categorised as low harm, four as no harm, and two related to equipment issues.

In the twelve months prior to the inspection, there had been one ionising radiation incident reported by the

Good

Diagnostic imaging

hospital. This related to the completion of an unnecessary x-ray due to an issue with the notes. We saw that an investigation was completed and that the patient was notified of the error.

Incidents were reviewed to identify any themes and we saw that themes were discussed in the diagnostic imaging department staff meetings.

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

For details of incidents, please see the safe section in the surgery report.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We currently do not rate effective.

Evidence-based care and treatment

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

The service followed the policies and guidance from the BMI group. We reviewed the standard operating procedures (SOPs) in place across the department and saw they were clear and up to date. We saw the SOPs were based on national guidance and regularly reviewed. The imaging manger had oversight of all the SOPs and ensured that new starters, and all staff knew when there were updates, and reviewed and signed the documents.

Dose reference levels were set by an external radiation protection service in line with the national reference levels. Patient doses were monitored and audited. We saw results of annual audits conducted by the radiation protection advisor and action taken to investigate the cause of higher radiation for certain procedures.

Nutrition and hydration

Staff made sure patients had enough food and drink to meet their needs. The imaging team did not provide patients with food and drink; however, they did provide clear guidance on nutrition and hydration in relation to the investigation being completed.

Patients received information to advise about timescales for when they could eat and drink in advance of any invasive procedures. This was provided in the appointment letter.

Water and hot drinks were available in the waiting room for patients and those attending with them.

Pain relief

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

Radiology staff did not routinely administer pain relief. However, staff assessed patients comfort prior to completing procedures and aided with repositioning if required.

Patient outcomes

Due to the type of service, staff did not monitor patient outcomes. However, they used patient feedback to improve the patient pathways.

Managers completed regular audits to identify any areas where improvement was required. These were used, in conjunction with any patient feedback to improve care and treatment. Audits were completed in line with the hospital agenda and speciality requirements. For example, in house audits included infection prevention audits such as hand washing and environment cleanliness. Speciality audits included, dose reference levels (DRL) which ensured that radiation was in line with guidance and an audit of protective equipment to ensure that it was safe to use.

Competent staff

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

All staff were required to complete an induction when commencing in post. This included a designated period whereby the staff member was supernummary and supervised by a designated person.

Good

Diagnostic imaging

Radiographers in the department completed competency assessments prior to using equipment. We saw records of staff training and competencies which were up to date and clearly documented. The manager of the service reviewed competencies during the annual appraisals and identified any further training needs.

All staff were appropriately trained and signed off as competent to administer radiation which met with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

Data provided showed 80% of applicable staff were up to date with their appraisal.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Bank staff were also inducted into the clinical area, and there was a clear process for ensuring that bank staff were familiar with the environment, escalation of concerns and emergency procedures. Bank staff were part of the BMI team, and therefore familiar with policies and procedures.

Supervision was consistent across the department. Staff were able to access the manager or radiation protection advisor for support or guidance. Additional support could be sought from the corporate team if necessary.

Radiologists were not permitted to complete any investigations or procedures at BMI the Saxon Clinic unless they had been deemed competent at their host hospital. There was a robust process for checking competence through the medical advisory committee, and all consultants were expected to provide evidence of competence for any proposed procedure.

For details of competence, see the surgery report.

Multidisciplinary working

Staff of different disciplines worked together as a team to benefit patients. They supported each other to provide good care.

There was effective team working between all staff groups. We saw that staff across disciplines prioritised the patient experience and communicated well to meet their needs.

There was a daily communications meeting attended by staff from all departments in the hospital. Information was shared and then disseminated across the services.

Radiologists were accessible and there was a good working relationship with staff across the hospital. Staff told us they could contact them at any time for support and guidance despite no formal on call arrangement.

Information was shared between radiologists and referring consultants in a direct and timely manner.

Seven-day services

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

The imaging department was open 8:30am to 8pm Monday to Friday and 9am to 1pm on Saturdays. Outside these hours, radiographers provided an out of hours on call rota for urgent investigations. Staff providing cover were able to claim time back if required to attend the hospital at night or at the weekend.

Radiologists could be contacted out of hours if necessary.

Health promotion

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

There was a range of information displayed in the waiting area on health and health promotion. There were some leaflets available to advise patients about health issues including how to live a healthier lifestyle.

For our detailed findings on health promotion please see the responsive section in the Surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA) and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Good

Diagnostic imaging

The hospital policy for MCA and deprivation of liberty safeguards (DOLS) was up to date and accessible for all staff. The safeguarding adults' policy also included information to guide staff on the MCA.

Staff were aware of the process to follow if they had concerns about a patient's mental health or capacity to consent verbally to investigations. Staff told us if this was the case they would discuss with the imaging manager, radiologists and the patient's GP when appropriate.

Children over the age of 16 who attended for investigations accompanied by a responsible adult were asked by staff to consent to their treatment when deemed competent to do so.

For our detailed findings on consent please see the responsive section on the Surgery report.

Are diagnostic imaging services caring?

Good

We previously inspected diagnostic imaging with outpatients and cannot therefore compare ratings with the previous inspection.

We rated it as **good.**

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

We saw staff treat patients in a respectful and caring manner. Staff spoke about the personal, cultural, social and religious needs of patients in a non-judgmental way. We saw staff introduce themselves and explained their role. All the patients we spoke with told us they had felt the staff were attentive and took the time to treat them with a caring manner.

The reception desk was situated away from the waiting area and so allowed for patients to speak to the receptionist without being overheard.

Emotional support

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

Staff supported patients through procedures by keeping them well informed throughout and provided reassurance.

Staff adapted their approach to provide appropriate additional reassurance for patients who appeared anxious about the processes. Staff provided information and timescales to help patients feel informed and comfortable.

Staff kept patients informed of any waiting times to reassure and minimise distress. The department had a calm and quiet atmosphere at the time of the inspection and patients told us they had not experienced a long wait.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw staff detailing investigations and ensuring that patients understood them before proceeding.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The provider conducted a patient satisfaction survey. Results for the diagnostic imaging department in March 2019, showed 99.4% of patients would recommend it to their friends and family.

Are diagnostic imaging services responsive?

Good

We previously inspected diagnostic imaging with outpatients and cannot therefore compare ratings with the previous inspection.

We rated it as **good.**

Service delivery to meet the needs of local people

Good

Diagnostic imaging

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

The department planned services around the needs of patients with appointments available Monday to Friday 8.30am to 8pm and Saturdays 9am to 1pm.

The hospital and department were clearly signposted and there was car parking available. The facilities and premises were appropriate for the services being delivered. The magnetic resonance imaging (MRI) was in the process of being relocated to the main building and was expected to be completed by mid 2020.

The waiting area was suitable and comfortable for adults. There was enough seating, toilet facilities and drinks available.

Meeting people's individual needs

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

Appointment times allowed for patients to ask questions and take their time prior to and after procedures. Staff went through information, provided reassurance and allowed flexibility to meet the needs of patients.

Staff told us alerts would be placed onto referral forms for patients with disabilities, sensory loss or complex needs including mental health, dementia or learning disabilities. This enabled patients to be easily identified and adjustments made to the planned investigation as necessary. For example, additional time for explanation, or pre-appointment visit. When appropriate staff would encourage carers and/or relatives to attend appointments with patients.

Noticeboards in waiting areas were up to date and had a range of information about the processes conducted in the department and advice.

Telephone or face to face translation services were available where English was not the patient's first language. However, information leaflets were unavailable in other languages or other accessible formats.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients were referred to the department, predominantly by consultants who used the hospital for treatments. Patients investigations were requested using a paper request form to the department, which was reviewed by the team to ensure that the investigation was suitable. The referral was then forwarded to the booking team for a convenient appointment to be allocated. Where possible, the service ensured that patients attending clinic appointments had their investigations completed on the same day to prevent returning to the hospital.

Patients referrals were allocated an appointment within 48 hours of receipt in the department. The service did not have a waiting list as patients chose appointments to suit them. This meant that, for example, the patient could choose an appointment around their home life and plans.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Diagnostic investigations were usually reported on between 24-48 hours of the test being completed and reports were sent to the referring clinician. The reporting time varied according to the type and day of investigation completed. For example, radiologists with a speciality in abdominal images may work on a Wednesday and therefore images taken on a Monday. Tuesday and Wednesday would be reported on within 48 hours. However, the images may not be reviewed until the following week if completed on a Thursday or Friday.

Staff told us that any investigation completed, which highlighted any concerns would be escalated to the relevant radiologist at the time of completion. This process ensured that patients images were reviewed urgently if there was a suspicion of any abnormalities.

Learning from complaints and concerns

Good

Diagnostic imaging

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

Staff were aware of their roles and clear of the protocol to follow if there were concerns raised. There was an up to date policy which outlined the process and staff responsibilities. They told us they would try to resolve this at a local level where possible but would also inform the patient of the formal complaints process.

Leaflets to inform patients of the complaints process were available in the waiting area. We reviewed the information provided which outlined the process for making a formal complaint and what steps to take if complainants were dissatisfied with the outcome.

The service did not have any complaints specific to them, although were aware of complaints that referred to investigation costs or as part of a patient's pathway. We saw that complaints and concerns were taken seriously and investigations completed. When necessary, patients were included in investigations and informed of any outcomes.

For details of complaints, please see the responsive section of the surgery report.

Are diagnostic imaging services well-led?

Good

We previously inspected diagnostic imaging with outpatients and cannot therefore compare ratings with the previous inspection.

We rated it as **good.**

Leadership

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

Since the last inspection, a new imaging manager had been recruited. All staff we spoke with told us there had been much positive development and change in the department. Staff said they felt there was good leadership within the service and organisation.

The imaging manager worked clinically alongside the team as well as completing managerial/ non-clinical tasks.

The manager had been asked to oversee the merging of the imaging departments within BMI the Saxon Clinic and another BMI hospital site. This was in progress during the inspection and although staff were uncertain of the details of plans, it was clear that the imaging manager had a clear action plan to ensure success.

Staff told us the local and hospital managers were visible and approachable. They demonstrated they had most of the skills, knowledge and experience through the support provided to the team. We were given examples of additional training and support either provided by or arranged by the imaging manager to ensure staff development. Staff told us that they were encouraged to develop.

Vision and strategy

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

The hospital vision had been developed in conjunction with staff and was aligned to the wider corporate vision. Staff felt that the vision reflected their views.

The vision for the imaging department was for a merged workforce across two sites. This posed challenges for the imaging manager, and there was a clear plan in place. The team were aware of the planned change; however, details had not been finalised at a corporate level and therefore not shared with the wider team.

The relocation of the magnetic resonance imaging (MRI) was part of a hospital wide reconfiguration. The team were aware of the planned changes and the expected timescales for completion.

Good

Diagnostic imaging

For our detailed findings on vision and strategy, please see the well led section in the Surgery report.

Culture

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

Staff told us that they enjoyed their jobs and felt valued and part of a team. Staff shared a common focus on providing a high standard of patient care and demonstrated this through interactions with patients, staff and their relatives.

Staff were encouraged to develop new skills and competencies. We saw that training was provided internally and staff had access to external training and study days for development. For example, we were told of one staff member who had wished to develop skills within magnetic resonance imaging (MRI) and was being supported to complete more work within the department under supervision.

We saw that patients were encouraged to give feedback at the end of their appointments and this was taken into consideration by the team. All feedback was discussed at team meetings and any learning shared across the wider hospital.

For our detailed findings on culture, please see the well led section in the Surgery report.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and learn from the performance of the service.

The local governance structure reflected the corporate structure, with information shared to the most appropriate committee. Meetings mirrored the corporate structure, which enabled local and senior managers to have clear oversight of performance.

Staff across the department were clear about their roles and what they were accountable for. There were clear guidelines, roles and responsibilities for all staff working within the department. Performance was monitored locally and centrally by the corporate team to track overall performance. Monthly dashboards were produced, and these were discussed with the service leads and senior management team.

The team held regular team meetings and minutes were shared electronically. We saw that meetings followed a set agenda and detailed any actions that should be taken in response to any discussions. The team held daily meetings to discuss the day's activity and any emerging risks or issues. For example, during inspection we saw that a patient was being admitted the following day who had an allergy to perfumes. All staff were reminded of this and asked to ensure they were perfume free the following day. In addition, we saw that the hospital wide team were alerted to the patient.

Daily communications meetings took place at the hospital to share any key information regarding activity or issues. For example, we saw that the presence of workmen and servicing of equipment was highlighted. Key information from these meetings were cascaded to the team.

The service had representation at the medical advisory committee (MAC), with the lead radiologist attending meetings to escalate any concerns, discuss service delivery plans and offer specialist advice.

For our detailed findings on governance please see the well led section in the Surgery report.

Managing risks, issues and performance

The service had effective systems in place for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. There was a consistent approach to overseeing compliance with requirements such as training and equipment maintenance.

There were robust processes in place to ensure the service ran smoothly, Performance was monitored through audits, compliance with targets and ad hoc senior management visits. Risks were regularly assessed and recorded.

Good

Diagnostic imaging

The service used a risk register to record any concerns along with any mitigation taken to reduce risks. Risks were discussed with the senior management team, and any identified as high risk were added to the hospital risk register.

There was an audit calendar which was completed locally and overseen by the senior management team (SMT) and shared with the corporate team. The SMT used the audit results to identify any areas for development and used these for the basis of monthly departmental meetings with the imaging manager.

The Radiation Protection Advisory (RPA) audit was completed annually. We saw that this was discussed at the radiation protection committee, clinical governance committee and heads of department meetings. This ensured that all relevant persons were up to date with the actions being taken to ensure radiation protection.

We saw that equipment was regularly serviced to ensure it was safe to use.

For our detailed findings on managing risks, issues and performance please see the well led section in the surgery report.

Managing information

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

There were systems in place to enable consultants to view images remotely. This ensured that any patients image escalated as a concern, could be reviewed by a suitably trained radiologist at any time.

Staff were able to access any old images for patients attending the department. This meant that staff could check to make sure that patients had not had the image taken previously, preventing unnecessary investigations.

The service completed quality assurance checks of images. Staff worked collaboratively to ensure that the quality of the image was of a high standard. Staff told us that they would discuss techniques used to share best practice.

For our detailed findings on managing information please see the well led section in the Surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. However, some staff felt unsupported by the wider BMI corporate team.

The service did not directly participate in any patient engagement or focus groups; however, the hospital had commenced focus groups with orthopaedic patients who used the service. We were told that patients had not highlighted any areas of concern relating to diagnostic imaging.

Staff felt engaged with the hospital and the organisation. Staff told us they were largely supported to do their jobs well, although some raised concerns regarding recent changes and the merging of services between two BMI hospitals. Staff agreed that the full details were not yet known.

Some staff told us that although locally the senior management team was supportive, they did not feel supported by the corporate team when they escalated concerns. Staff felt that this placed them under unnecessary pressure.

For our detailed findings on engagement please see the well led section in the surgery report.

Learning, continuous improvement and innovation

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

We were told that the potential merging of two BMI hospitals was being completed to improve the utilisation of services across both sites. The details for the plans had not been agreed or finalised, however, the imaging department was leading the way with promoting streamlined services across both sites. The imaging manager was working with the hospital executive director to make any improvements.

Good

Diagnostic imaging

Since taking up role, the imaging manager had identified areas for development within the team locally and there was a clear plan of what needed to be done, in line with priorities and time lines. The plans were reviewed by the senior management team regularly.

For our detailed findings on learning, continuous improvement and innovation please see the well led section in the Surgery report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure that a recognised method of assessing patient's deterioration is used throughout procedures within endoscopy services.
- The provider MUST ensure that the WHO five steps to safer surgery checklist is adopted and performed in its entirety during endoscopy procedures.

Action the provider SHOULD take to improve

Within Surgery:

- The service should ensure that non-clinical staff appraisals are completed in line with the hospital target.
- The service should ensure that complaints are managed in line with the hospital policy timelines.
- The service should ensure that there is consultants' representation at governance meetings.
- The service should ensure that there is senior nurse support for all staff, ensuring oversight of hospital activity.

Within Medicine:

- The service should ensure that the environment is suitable for endoscopy services and in line with national guidance.

Within Children and Young People's Services:

- The service should ensure that national best practice guidance and clinical outcomes for specific procedures are monitored.

Within Outpatients:

- The service should use audit findings to make improvements and achieved good outcomes for patients.

Within diagnostic imaging:

- The service should ensure that all radiation protection equipment is clearly labelled and checked annually.
- The service should ensure that staff are appropriately supported by the wider BMI corporate team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The was not nationally recognised system in place to monitor and detect patient deterioration during procedure in endoscopy. Endoscopy services were not utilising the full WHO five steps to safer surgery checklist.