BMI The Harbour Hospital

Quality Report

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Date of inspection visit: 12 May 2017
Date of publication: 08/09/2017

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

Overall summary

BMI The Harbour Hospital is operated by BMI Healthcare Limited. The hospital has 30 beds. Facilities include three operating theatres, X-ray, outpatient and diagnostic facilities and an onsite pharmacy.

The hospital provides surgery, medical care, and outpatients and diagnostic imaging. We inspected surgery and outpatients and diagnostic imaging.

We inspected this service using our focussed follow up inspection methodology. We carried out the unannounced inspection on 12 May 2017.

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.

Summary of findings

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.

We rated this hospital/service as **good** overall.

We found areas of good practice –

- The hospital had systems and processes in place to protect patients from avoidable harm and abuse.
- In surgery, the surgical safety checklist was adhered to.
- The processes for reporting, investigating and learning from incidents were well established and implemented.
- Infection prevention and control practices were good, and staff followed hospital policies. The environment was clean and fit for purpose.
- Medicines were managed and stored correctly; administration was in line with good practice and relevant legislation.
- Staff assessed risks to patients and responded appropriately when individual patient's risks increased. Staff used the early warning score to ensure early signs of deterioration in a patient's condition were responded to.
- The service participated in national audits where applicable and outcomes were good. The hospital was fully engaged in the Private Healthcare Information Network (PHIN) work to develop outcome measures for private patients.
- The hospital had a comprehensive internal audit programme in place to monitor services and identify areas for improvement.
- Staff treated patients with care, kindness and compassion and feedback about the care provided by staff was consistently positive.
- Complaints and concerns were taken seriously, responded to in a timely way and improvements were made to the quality of care as a result.
- Adjustments were made to meet the differing needs of individuals using services at this hospital.
- Managers were visible, approachable and effective.
- Staff across the hospital enjoyed their work and were proud to work at the hospital. They described an open culture and felt supported and listened to by their managers.

Following this inspection, we told the provider that it should take some actions, even though a regulation had not been breached, to help the service improve.

Action the provider SHOULD take to improve

- The six practitioners working in theatres should complete the surgical first assistant training undertake the programme of study, as required by BMI group policy, and detailed on the risk assessment dated 11 April 2017.
- All local risks should be captured on the ward risk register.
- Documentation pathways should support staff with the documentation of variances during a patient procedure/ treatment.
- The hospital should ensure patients medical and nursing records integrated, and the risk of unauthorised access to nursing records minimised.
- The provider should reassess the radiology service continuity and major plant failure business plans on an annual basis.

Professor Edward Baker, Chief Inspector, Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
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, responsive and well led. • The processes for reporting, investigating and learning from incidents were well established and implemented. • Staff had a good understanding about hospital safeguarding procedures. Surgical safety checks were adhered to. • Staffing was at planned levels. There were no staffing vacancies at the time of our inspection. • Staff routinely assessed and monitored risks to patients. They used the national early warning tool score to alert staff if the patient's condition deteriorated. The tool also gave specific actions to follow if the score changed. • Staff provided care and treatment that took account of nationally recognised evidence based guidance and standards. • The service participated in national audits where applicable and outcomes were good. The hospital was fully engaged in the Private Healthcare Information Network (PHIN) work to develop outcome measures for private patients. • Feedback from patients about their care and treatment was always positive. We observed staff treated patients with kindness, compassion and dignity though out our visit. • Complaints and concerns were taken seriously, responded to in a timely way and improvements were made to the quality of care as a result. • Staff were aware of the mission, vision, values of the hospital and wider organisation, and demonstrated commitment to them in their care practices and personal development plans within their appraisals.

Summary of findings

- The hospital did meet the 92% target for patients being on the incomplete pathway from April 2016 to March 2017. The incomplete measure captures the experience of every patient waiting for treatment.

However,

- In February 2017 and March 2017 the hospital did not meet the 18 week admission target of 18 weeks.
- The theatre manager told us only one member of staff out of seven nominated had undertaken the Surgical First Assistant (SFA) programme of study in line with national guidance and BMI Healthcare policy. A risk assessment had been undertaken, and measures in place to reduce the risk.
- The generic surgical pathway documentation did not allow for recording of unplanned patient returns to theatre. Staff used day surgery documentation to cover this gap.
- Not all the risks staff told us about were on the local ward risk register.

Outpatients and diagnostic imaging

Good

- The hospital had systems and processes in place to protect patients from harm.
- The outpatient and diagnostic imaging services had sufficient numbers of appropriately trained and competent staff to provide a safe service.
- Managers were visible, approachable and effective.
- Infection prevention and control practices were good, and staff followed hospital policies.
- The clinical environment was visibly clean, well-presented and fit for purpose.
- Medicines were managed and stored correctly; administration was in line with good practice and relevant legislation.
- Patient care records were accurate and stored securely in line with the Data Protection Act 1998.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- We observed that staff interactions with patients were kind, caring, and considerate and respected their dignity. Patients told us they were put at ease when having their investigation.

However;

Summary of findings

- The hospital radiology service continuity plan was out of date (2011).

Summary of findings

Contents

Good

Location name here

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

Summary of this inspection

Background to BMI The Harbour Hospital

BMI The Harbour Hospital is operated by BMI Healthcare Limited. The hospital opened in 1996. It is a private hospital in Poole, Dorset. The hospital primarily serves the communities of the Dorset.

CQC have inspected the hospital four times and the last inspection was in September 2015. Following this inspection, two requirement notices were issued relating to regulation 12 (in relation to cleanliness and infection control) and regulation 17 (in relation to good governance). During the previous inspection, we inspected medical care, surgery and outpatient and diagnostic imaging. Medical care and surgery were rated as good and outpatient and diagnostic imaging was rated as requiring improvement.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, three other CQC inspectors, and specialist advisors with expertise in surgery and radiology. Emma Bekefi, CQC inspection manager, oversaw the inspection team.

Why we carried out this inspection

This was an unannounced, responsive inspection. We inspected outpatient and diagnostic imaging as there had been regulatory breaches identified in September 2015 in respect of that service. We inspected surgery at this inspection as, whilst the hospital was rated a good for surgery overall at the previous inspection, there had been concerns about the leadership of surgical services at that time and a never event had occurred in July 2016.

How we carried out this inspection

During the inspection we visited theatres, the ward, and outpatient and diagnostic services. We spoke with 48 staff members including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 19 patients and five sets of relatives. During our inspection, we reviewed 15 sets of patient records.

Information about BMI The Harbour Hospital

The BMI Harbour Hospital is one of 62 hospitals or treatment centres provided by BMI Healthcare Limited. The BMI Harbour hospital has one ward and is registered to provide the following regulated activities:

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

The hospital provided a range of services to patients who were self-funded or used private medical insurance. 33% of patients were NHS funded from October 2016 to July 2017.

The Registered Manager, Mr Dan Stonell, registered on 1 October, 2010.

The on-site facilities include an endoscopy suite, three operating theatres (two with laminar airflow), two

Summary of this inspection

treatment rooms, 9 consulting rooms and 33 beds (29 in-patient and four day case). Physiotherapy treatment is offered as an in-patients and outpatient service and there is an on-site gym. There is no critical care or emergency care department at this hospital.

Services provided at the hospital under service level agreement:

- Catering and kitchen services
- Clinical engineering
- Critical care
- Decontamination of theatre instrumentation
- Maintenance provision
- Medical physic
- Pathology
- Pharmacy
- Radiation protection advice
- Resident Medical Officers
- Resuscitation services

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

We rated safe as good because:

- Incidents were reported and investigated and learning was shared to improve safety practices. Openness about safety was encouraged.
- Infection control procedures protected patients from the risk of infection. There had been no reported cases of hospital acquired infections in the reporting year prior to our inspection.
- Staff had a good understanding of safeguarding processes. Patients were protected from avoidable harm across surgical and outpatient and diagnostic services.
- Medicines and records were stored securely and managed correctly.
- Staffing levels were sufficient to provide safe care and treatment.

Are services effective?

Good

We rated effective in surgery as good because:

- Staff provided care and treatment that took account of nationally recognised evidence based guidance and standards.
- The service participated in national audits where applicable and outcomes were good. The hospital was fully engaged in the Private Healthcare Information Network (PHIN) work to develop outcome measures for private patients.
- Patients had their pain levels assessed and managed effectively.
- Staff monitored patients' fluid intake and output for some operations to ensure patients were adequately hydrated and their kidney function was within expected range. Staff correctly recorded this on fluid balance charts.

We did not rate effective in outpatient and diagnostic imaging as we currently do not collate sufficient evidence to be able to do so.

Are services caring?

Good

We rated caring as good because:

- We observed staff consistently providing kind and compassionate care. Staff cared for patients in a manner that demonstrated courtesy and respect.
- Patients were involved in all aspects of decision making about their care.

Summary of this inspection

- Feedback about care and treatment at this hospital from patients and relatives was consistently positive.
- The hospitals friends and family test score for NHS patients showed 100% would recommend the hospital to friends and family from April 2016 to March 2017.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service. Consultants would organise additional clinics outside of usual working hours to meet the needs of individual patients as required.
- Pre-assessment nurses reviewed patient's needs before admission for treatment ensuring individual needs could be met.
- Person centred adjustments were made to support patients with additional or complex needs.
- Staff could access translation services if needed when providing care to patients whose first language was not English.
- The hospital dealt with complaints and concerns promptly, and there was evidence that the hospital used learning from complaints to improve the quality of care.
- The hospital met the 92% target for patients being on the incomplete pathway from April 2016 to March 2017. The incomplete measure captures the experience of every patient waiting.

Are services well-led?

Good

We rated well-led as good because:

- Staff across the service told us they enjoyed working, and were proud to work at the hospital. They described an open culture and felt supported, and listened to, by their local line managers.
- Staff were aware of the vision and strategy for the hospital. The values of the organisation were well understood by staff.
- There was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff were aware of the risks, and action taken to mitigate these risks for their individual departments.
- Staff and public engagement was good, with high levels of satisfaction. Engagement included patient and staff forums.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

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

We rated safe as good.

Incidents

- The hospital from April 2016 to April 2017 had reported one never event in July 2016. This involved wrong site surgery, when a patient had the wrong tooth removed. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations that provide strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The quality and risk manager undertook a root cause analysis following this never event, recommendations were made and changes in practice were implemented. Recommendations included ensuring the surgical site marking policy and safer surgery policy were followed correctly and there was a review of the consent process. Meeting minutes we reviewed demonstrated that the learning and recommendations had been shared at meeting including department meetings and the medical advisory committee meeting.
- From May 2016 to April 2017 there had been no unexpected deaths at the hospital. The director of clinical services (DOCS) notified the care quality commission (CQC), of two expected deaths. The DOCS explained the two deaths had occurred in the medical service, and were patients at the end of life.
- Staff said there was an open culture to reporting incidents, and they knew how to report them using the hospitals electronic forms. The hospital from May 2016 to April 2017 reported an average of 19 clinical incidents relating to surgery a month. Clinical incidents included an extended stay of one day for clinical reasons, wound infection and communication.
- Staff reported that clinical incidents were discussed at meetings, including the heads of department and team meetings. For example, an incident relating to a medicine error, was due to be discussed at the theatre unit meeting on the day of our unannounced inspection 12 May 2017, so there could be shared learning.
- Staff we spoke with were fully aware of their responsibilities under the duty of candour legislation, they told us that they 'had been already doing this'. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. There had been one incident requiring the duty of candour legislation to be followed from April 2016 to April 2017. We saw evidence from investigations that staff had provided an apology and support to the patient involved.

Clinical Quality Dashboard or equivalent

- The Safety Thermometer is a national tool for measuring, monitoring and analysing common causes of actual harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous

thromboembolism (VTE or blood clots). The hospital recorded and reported results of the NHS Safety thermometer to commissioners for the NHS patients using the service. The hospital showed us data from January 2017 to May 2017, and this showed that no patient harms had occurred.

- The hospital was not currently displaying this data. The hospital was aiming to display the data for NHS patients from July 2017.
- The hospital was not displaying any clinical data for non-NHS funded patients although this was collected.
- The hospital audited VTE assessment across the hospital monthly for all patients, and compliance was 100%.

Cleanliness, infection control and hygiene

- The hospital healthcare acquired infection rates were low. The hospital reported no incidences of clostridium difficile, no incidences of methicilin sensitive staphylococcus aureus (MSSA) and no incidences of methicillin resistant staphylococcus aureus (MRSA) from April 2016 to April 2017.
- Staff routinely screened patients for MRSA prior to surgery. If positive, they received treatment for MRSA and surgery was not performed until they were clear of the infection.
- The theatre suite was visibly clean, and there was safe flow from clean to dirty areas to minimise the risk of cross contamination of equipment. Cleaning records showed there was a schedule of cleaning. There were gaps in the signing of the schedule for the week commencing 24 April 2017. The theatre manager acknowledged this, and asked staff at the theatre meeting held 12 May 2017 to ensure cleaning schedule signed when cleaning had been undertaken.
- Staff followed policies in place to minimise the spread of infection. For example, staff were 'bare below the elbows', and used personal protective equipment, such as aprons and gloves, to minimise the spread of infections. Staff adhered to theatre dress code.
- We observed staff demonstrating good practice with hand washing. Hand hygiene audits showed 100% compliance from April 2016 to April 2017.
- The ward areas were visibly clean and there were hand sanitisers available for patients', visitors' and staff. Since the inspection in September 2015, the hospital had put two hand basins at either end of the ward corridor for hand washing, to minimise risk of infections. We observed cleaning of non-single use equipment between patients.
- The hospital had a clear agreed process, which staff followed, for skin disinfection and management. The protocol included use, labelling and storage of skin disinfectants which met national guidelines.
- The hospital in line with Public Health England requirements reported four surgical site infections (SSI) from April 2016 to April 2017. Two of these involved hip surgery and two knee surgery. The nurse specialist for infection control at the hospital undertook a root cause analysis following these investigations. Department leads shared lessons learned and recommendations from the investigations at team meetings. For example, diabetic training took place in November 2016, to ensure staff knowledge up to date in meeting the needs of a patient with diabetes.
- The hospital held infection prevention meetings monthly. Representatives from theatre and the ward attended, who cascaded information to their respective team.
- The hospital had changed most patient bedroom carpets for easy clean material. The cleaner discussed how much easier the new material was to maintain. We saw minutes of clinical governance meetings, which highlighted the hospital aimed for the patient bedrooms to be carpet free by the end of September 2017.

Environment and equipment

- Staff managed equipment safely and checked to ensure compliance with safety standards. The service level agreement with the local acute hospital covered planned preventative maintenance for the environment. The maintenance manager oversaw safety testing of non-medical equipment. Medical equipment was safety tested as part of annual servicing.
- The hospital had in place external checks of the theatres one and two ventilation systems. The annual checks carried out in January 2017 and February 2017 identified maintenance work that needed to be undertaken. At our inspection in May 2017 the work had been completed.
- Appointed staff champions oversaw maintenance and servicing of equipment in each department.

- An operating department practitioner and anaesthetist checked the anaesthetic machines at the start of a theatre list, as per national guidelines published by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) 2012.
- The theatre manager ensured a difficult airway trolley was available and stocked in line with national guidelines.
- The resuscitation equipment in theatres and on the ward was tamper proof, and records showed equipment items were checked regularly.
- Staff in theatres and the ward classified and, segregated clinical waste appropriately. Sharps boxes were available in theatres and the ward in various sizes, and below the recommended three quarters full.
- Staff checked the temperature of the fridges in theatre containing bloods and fluids daily. We saw the completed logs.
- Staff recorded any implants used in a register, which was fully completed.
- Staff had access to a patient hoist and disposable slings in a range of sizes, if needed to support the transfer of a patient.

Medicines

- The hospital had an onsite pharmacy. A pharmacist and pharmacy technician staffed the hospital pharmacy. The pharmacy was in a room on the ward. Access to the pharmacy was controlled by a keypad with a secure code system.
- The pharmacist checked with nursing staff regarding any requirements for medicines to take home, and then Monday to Friday reviewed all inpatient drug charts, to check medicine prescribing safe and nursing staff had access to all medications patients required.
- On the ward and in theatres medicine related stationary and medicines including controlled drugs were stored securely. Staff from pharmacy undertook audits of CD management in theatres and the ward two monthly. In the main the audits demonstrated compliance with policy. Where any non- compliance with the hospital's medicine management policies were demonstrated, this was followed up by department leads. For example in a controlled drug audit in theatres in November 2016, one non- compliance was found which was balances of controlled drugs not being carried over to a new page and signed by two members of staff. The plan following the audit was for the theatre manager to discuss with staff working in theatres.
- A pharmacist undertook a missed dose audit in December 2016. This demonstrated that for an audit of six patients there was a rate of 18% drug omissions. The omissions were mainly a low risk rating. One omission was a high risk rating, where an anticoagulant had not been signed for as given.
- A ward medicine audit in May 2017, demonstrated some non- compliance with the medicines management policy. For example, staff stored external medicines with internal medicines. In early 2017 medicine management training commenced at the hospital. The medicine management training was planned to be delivered bi-monthly through the whole of 2017.
- Medicines were stored at safe temperatures. Staff monitored and recorded refrigerator and room temperatures daily and appropriate actions were taken when temperatures outside the recommended ranges.

Records

- Patient medical records were stored in a trolley in a secure office. Patient nursing records were stored on the ends of their beds. This meant the nursing records were not integrated, and there was a potential risk of relatives or visitors picking up patients nursing records and reading confidential information.
- Staff used care pathways. These were multidisciplinary and included the complete patient pathway, for example the hip and generic surgical pathway.
- We reviewed a patient's records of a patient that had been cared for using the generic surgical pathway and had needed to return to theatre and found gaps on the records used to document the patient's return to theatre. The nurse in charge explained there was insufficient space on the generic surgical pathway, in the situation when a patient needed to return to theatre for further treatment. Staff had therefore used a day case surgery pathway for the patient's return to theatre in order to access a WHO surgical checklist and document their treatment and ongoing care. The gaps we found on the day case surgical pathway were due to information already detailed on the original generic surgical patient pathway. There was no documentation on the day case pathway documentation, that information including bibliographical and risk assessment information was in

the generic surgical pathway document, used to record the patient's care and treatment. This put the patient at risk of receiving care and treatment not based on their needs, if a staff member did not appreciate there was a separate pathway that also contained a patient's information.

- Compliance with the hospital health records recording policy had improved. The hospital audited patient health records monthly. In April 2016, audit results had been 88% and July 2016 87% of hospital records checked were compliant with policy. Between August 2016 and April 2017 compliance averaged 94%. We reviewed six patient medical records, which staff had fully completed except for all the patient observations in one record.
- We checked the theatre logs, which included patient details, type of surgery, staff present and time patient in and out of theatres, and the logs were all fully completed.
- Theatre staff recorded the relevant surgical implant details into required logs, for example, recording individual identification codes of joint replacement prosthesis or implants. This was for contacting patients in the event of a product recall.

Safeguarding

- The director of clinical services (DOCS) was the hospital lead for safeguarding in adults and children. The lead had undertaken face to face level 3 safeguarding training for both adults and children.
- Staff we spoke with were aware of their responsibilities for safeguarding patients from harm and could describe their local escalation process and the principles of the Deprivation of Liberty Safeguards (DoLS). The lead said a couple of times since October 2015 staff had come with concerns to the DOCS. When the DOCS had talked through concerns with staff and there had been discussion with patients, the concerns were not requiring a safeguarding referral to be made.
- The staff recruitment processes, including for those under practising privileges, included employment reference checks and a current and enhanced disclosure and barring check specific to the hospital.
- The clinical teams overall safeguarding training compliance was over 95% at May 2017. Safeguarding training included female genital mutilation and 'Prevent' training. 'Prevent' training was undertaken by staff to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves.

Mandatory training

- All staff working at the hospital were required to complete mandatory training to ensure that they were able to care for patients safely. New staff had mandatory training as part of a two-week supernumerary induction period.
- Mandatory training included information governance, infection prevention and control, equality and diversity, moving and handling, health and safety and resuscitation. Depending on the training frequency to complete this ranged from once or annually to three yearly.
- Staff working during the day and at night told us they did get time at work to complete their mandatory training. Staff compliance with mandatory training in April 2017 was 88%, against a hospital target of 90%. The executive director had responded to this by requesting the heads of departments (HODS) encourage staff to complete mandatory training during quieter times during their shifts.

Assessing and responding to patient risk

- Staff assessed patients pre-operatively for surgery. All patients self-completed a health questionnaire which guided the nurses in assessing them over the phone or face-to-face. All patients for hip, knee and spine surgery attended a dedicated preoperative clinic that was held on a Wednesday.
- Risk assessments included risk of falling and pressure damage and nutrition and hydration risk (MUST score). The patients' risk of developing venous thromboembolism was assessed on admission for a procedure.
- The assessment included documenting if patient had any allergies, for example, latex allergy. Pre-operative staff recorded the information on the admissions list and the operating theatre list, so theatres and ward staff aware of patients' needs. Preoperative staff also ensured if patients' had a high body mass index (BMI) or needle phobia. They recorded this, so theatre and ward staff aware and prepared to meet patients' needs.

- Staff followed admission criteria which included the need to ensure staff could meet patients' needs, with the support services available at the hospital.
- We observed theatre staff used the five steps to safer surgery (World Health Organisation –WHO) check list correctly. The theatre manager told us an observational audit of the five steps to safer surgery (World Health Organisation –WHO) was undertaken monthly by a non-clinical person. The theatre manager told us the consultants had queried this, but the theatre manager felt because the person non- clinical they were able to be more objective. Compliance with the five steps to safer surgery (World Health Organisation –WHO) from April 2016 to April 2017 averaged 97%.
- Nursing staff carried out observations on patients as regularly as was appropriate to their post-operative recovery. Nurses used a combined document to record patients' vital signs and pain scores, which, depending on the results calculated and provided a national early warning score (NEWS). This score alerted the staff of the patients' deterioration and gave specific actions to follow when the score increased. Patients we spoke to described how they had frequent observations carried out when they were in the recovery area or on the ward.
- Fully completed NEWS charts were located within the notes, with appropriate actions recorded when there was an escalation in score, which could show the patient's condition was deteriorating. This was to escalate their concerns to a senior nurse, the RMO or consultant. Staff we spoke with working at all times said access to medical support was always very prompt.
- The hospital identified an issue with national warning scoring in January with an audit showing 75% compliance. The ward sister discussed an improvement in compliance to 80% at the ward meeting in May 2017.
- The theatre manager told us there was a policy in place in case of major haemorrhage. There was a blood fridge in theatres, managed under a service level agreement with the local NHS trust.
- A consultant surgeon at the hospital said that if a patient requested cosmetic surgery who was under the care of a psychiatrist/ psychologist, they would be informed following a consultation. This was to enable the psychiatrist/ psychologist to review the patient if required for suitability for surgery. If a consultant surgeon consulted with a patient and felt a psychological assessment was required, the consultant referred the patient for a psychological assessment.
- The hospital undertook monthly resuscitation scenarios. The local NHS trust led the scenarios. The practice scenarios run to ensure staff able to deliver best practice in the event of a cardiac arrest.

Nursing and support staffing

- The hospital used a 'labour tool' and professional judgement to assess staffing levels required on the ward. The BMI group were trialling a trend tool that looked at patient needs as well as volume of patients. Staff involved in the trial reported it was easy to use and gave hourly data about number of registered nurses and healthcare support workers required. The DOCS advised us the plan was to roll out across all BMI sites by the end of 2017.
- The DOCS told us there had been vacancy within the ward team from May 2016 to April 2017 and an average sickness rate of five percent. From May 2016 to April 2017, there had been 19% bank usage, one percent agency usage and 11% had been covered by staff working overtime. Staff we spoke with told us they felt there had always been enough staff on duty, including always two registered nurses at night. The DOCs advised at May 2017, the ward had no vacancies.
- Staff told us that when required a one to one member of staff would be provided to ensure patients' needs safely met. When we spoke with a member of staff working mostly night shifts during the inspection process, a one to one member of staff had been provided on their previous shift for a patient who was confused.
- Nursing staff used a 'dictaphone' to record morning and evening handovers. Staff also verbally handed over any additional information as required. Staff said during the day a face- to-face handover took place when staff working on an afternoon shift, rather than working an all day shift, joined the team. Nursing staff we spoke with told us the handover system worked well, and enabled the focus to be on handovers without distractions.
- The DOCS told us there had been vacancy within the theatre team from May 2016 to April 2017 and an average sickness rate of four percent. From May 2016 to April 2017 there had been 7.5 % bank usage, 7% agency usage. Staff working in theatres told us there had always been enough staff on duty to undertake the planned work.

- The hospital followed Association for Perioperative Practice (AfPP) guidelines when determining theatre staffing with appropriate numbers of registered nurses (RNs), operating department practitioners (ODPs) and healthcare assistants (HCAs) for the cases on each list. On the day of our announced inspection the staffing was good, and when we reviewed the following week the staffing also met AfPP guidance. The theatre manager noted in the theatre unit meeting in May 2017 that there were no clinical vacancies in theatres.
- The hospital recognised at times the operating surgeon required the surgical assistance of a member of the theatre team during surgical procedures. The surgical first assistant (SFA) role can be defined as the role undertaken by a registered practitioner who provides continuous competent and dedicated assistance under the direct supervision of the operating surgeon throughout the procedure, whilst not performing any form of surgical intervention. The perioperative care collaborative (PCC) in 2012 recommended that the role of the SFA must be undertaken by someone who had successfully achieved a programme of study that had been benchmarked against nationally recognised competencies underpinning the knowledge and skills required for the role.
- The theatre manager told us at May 2017 there was one theatre practitioner who had completed the necessary program of study recommended by the PCC for the role of SFA. The hospital had completed a risk assessment and provided a work instruction to minimise risk to patient. Current controls included that theatre staff involved in providing surgical assistance had previous training and were experienced in the role. However, the training undertaken was no longer recognised by BMI healthcare policy or the PCC. Furthermore the medical advisory committee (MAC) chair told us the SFA role worked with the direct supervision from experienced knowledgeable consultant surgeons. The risk assessment included an action that staff completed the training recommended by the PCC. The DOCS told us the hospital anticipated they would have a further six competent theatre practitioners with recommended training by October 2017.
- Any externally provided first assistants, for example brought in via the consultants, had their curriculum vitae, general medical council number, current disclosure and barring service document, immunisation status, and individual indemnity insurance checked. The theatre manager did the checks personally and kept records of relevant documents.

Medical staffing

- There were 151 consultants employed at the hospital with practising privileges. The hospital granted practising privileges to consultants who agreed to practice following the hospital's policies and provided evidence of appropriate skills and registration. The MAC oversaw and ratified practising privileges for the consultants. We saw evidence of processes the hospital had in place for ensuring sufficient checks and references were undertaken prior to granting practising privileges, and these were kept updated on an ongoing basis. All the consultants working at the hospital undertook a similar role in the NHS, and so received their appraisal and revalidation with the trust they worked for. The consultants supplied a copy of their appraisal and revalidation to the hospital.
- All surgery was consultant led. This meant that consultants were responsible for their own patients 24 hours a day. It was the responsibility of each consultant, who had been granted practising privileges, to cover their absences and ensure that the person appointed to cover for them had the appropriate skills and a practicing privileges agreement in place.
- The consultants working at the hospital all lived within one hour of the hospital. There was a resident medical officer (RMO) onsite 24 hours per day to manage emergency situations who called the consultant as needed.
- The hospital employed two RMOs from an agency. The RMOs worked in fortnightly blocks to ensure consistent cover. The DOCS and executive director met with the RMOs' at their fortnightly handover to provide an opportunity to discuss any issues or concerns.
- Ward staff described good working relationships between nurses and medical staff, including senior consultants.

Emergency awareness and training

- The hospital had a generator, in case of power failure, that was tested monthly.
- The hospital had fire evacuation plans and fire tests. Staff told us that during a 12 month period, one fire test was held at 9pm, two at the weekends, and the

remaining took place during the day. Staff undertook an e learning module for fire training. The DOCS told us in addition there was a fire walk round on induction, and fire training face to face annually where the principle of fire management and staff responsibilities discussed.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example, the national early warning system (NEWS) was used to assess and respond to any negative change in a patients' condition. This was in line with NICE guidance CG50.
- Theatre staff followed NICE guidance CG74 surgical site infections: prevention and treatment. Staff set up instrumentation immediately prior to an operation and in a designated preparation area as per national guidelines, and skin disinfection followed a clear protocol.
- The hospital used evidence based care pathways. This ensured care was based on best practice models, for example, the sepsis pathway. This was in line with NICE guideline 51. In our review of patients' records, we observed how effective the pathways had been in supporting the management of patients care.
- The hospital had a rapid recovery programme in place based on evidence based care for orthopaedic patients. The programme created fitter patients who recovered faster from surgery.
- There was a local and corporate annual audit programme, which measured the hospital's compliance against policies and national guidance. These included audits checklist, controlled drugs, infection prevention and control (IPC), VTE assessment and resuscitation. Staff discussed audit findings at the clinical governance meeting held bi-monthly.

Pain relief

- During the pre-admission assessment process, staff discussed pain relief after surgery. This ensured patients knew the type of pain relieving medicines available; any previous sensitivity to pain relieving medicine was noted at this point.
- Ward staff assessed patients' pain and the effectiveness of pain management regularly using a nationally recognised numerical scoring system.
- If appropriate, patients received postoperative pain relief via patient controlled analgesia infusion pumps. Nursing staff checked these regularly with the patient and monitored their effect.
- The four surgical patients we spoke to said they had received adequate and timely pain relief following frequent pain assessments.
- The ward sister had undertaken audits of pain management. Audit compliance in August 2016 had been 86% and 79% in February 2017. When we asked about these results the DOCS told us the issue was around documentation by staff rather than patient pain management. The sister has been working closely with all new staff at induction and existing staff where possible on managing pain during supervised medicine rounds. Staff lack of documentation of pain management was also discussed at ward meetings and the ward sister had undertaken further pain management education sessions with ward staff.

Nutrition and hydration

- Staff advised patients about fasting times prior to surgery at pre-assessment and in their booking letter. The hospital aimed to ensure fasting times were as short as possible before surgery to prevent dehydration and for clear fluids to be available as long as possible. Medical staff were prescribing water in quantities for patients preoperatively that would not cause any post-operative complications.
- Staff monitored patients' fluid intake and output for some operations to ensure patients were adequately hydrated and their kidney function was within expected range. We observed that staff correctly recorded this on fluid balance charts.
- The hospital offered light snacks and drinks for day patients before discharge home and were able to access snacks for post-operative patients returning late from theatre.
- Nursing staff assessed patient's risk of malnutrition using the malnutrition universal screen tool (MUST)

scores and recorded them in patient notes. Staff could access a dietitian if indicated, for either malnourished or bariatric patients or patients with any other unmet nutritional needs.

- A patient who had written on the NHS choices website in March 2017 had complained about the quality of the food and staff ordering process. The hospital had responded on NHS choices apologising and advising the hospital would make improvements. During our inspection in May 2017, patients' we spoke with had been happy with the food and menu choices. One patient commented the food was 'fabulous'.

Patient outcomes

- The BMI organisation was fully engaged in the Private Healthcare Information Network (PHIN). PHINis an independent, not-for-profit organisation that publishes trustworthy, comprehensive data to help patients make informed decisions regarding their treatment options, and to help hospitals improve standards.
- The hospital used the National Joint Registry to record patient outcomes following replacement joint surgery and patient reported outcome measures (PROMS) collected from suitable NHS patients following their procedures. The hospital showed health gains above the national average for hip replacement and knee replacement.
- From April 2016 to March 2017 there were two unplanned returns to theatre, this figure is not high compared other independent hospitals the CQC hold data for. The day before our inspection there had been an unplanned transfer to theatre. The theatre manager told us that the ward staff had been good about keeping theatre informed about this patient's condition, and that they may need to return to theatre. The hospital told us they always investigated these cases to ensure any learning was shared.
- The hospital from April 2016 to March 2017 had no readmissions within 28 days of discharge per 100 bed days.

Competent staff

- The hospital undertook recruitment checks to ensure that new staff were appropriately qualified and suitable for the posts. All new staff, including agency and bank staff, had a formal induction process. The components of the induction included core organisational information plus role- specific training. We saw signed records confirming that induction was undertaken.
- Staff reported that they had access to further training, and financial support was available for training relevant to their role. The DOCS explained to us the hospital had chosen to pay for accredited national surgical first assistant training (SFA) rather than the BMI training that was not accredited. This was partly as the national training was provided at weekends so minimised disruption to the hospital business, and to support those staff who in the future may want pursue other opportunities.
- All staff (100%) had completed an annual appraisal, which included an interim appraisal half way through the year. This provided opportunity for any development needs or support needed to be discussed with their line manager.
- Staff working mostly night shifts told us there was opportunity for them to undertake day shifts if they were able. One staff member told us how this had helped them keep their skills and knowledge refreshed. Junior staff told us that they had received good mentorship from senior nursing staff on the ward that had helped them develop their knowledge and skills, for example with medicines management.
- Consultants and anaesthetists worked under a practising privileges agreement. The medical advisory committee (MAC) were responsible for granting and reviewing practising privileges. New consultants provided evidence of qualifications, training, accreditation, scope of practice and indemnity insurance and there was a process at their biennial review.
- There were close links with the local NHS trusts whose medical directors were responsible for the General Medical Council revalidation of the consultants.

Multidisciplinary working

- Our observation of practice, review of records and discussions with staff, confirmed effective multidisciplinary team (MDT) working practices were in place. MDTs included nurses, medical staff, pharmacy support and physiotherapists.
- Staff from the multidisciplinary team including the above along with the DOCS, executive director, a theatre representative, catering and a housekeeper attended a

Monday to Friday ward 'huddle' at 9.30am led by the ward sister. At the meeting staffing discussed and the sister went through the patients' on the wards and their needs. For example, the huddle we attended included a discussion about the planned discharges and the needs of the patients regarding medicines, and advice that two rooms needed to be closed for new flooring.

- Physiotherapy staff supported effective recovery and rehabilitation and followed up patients at outpatient clinics. They visited the wards daily Monday to Friday, and nursing staff could call them at the weekend if required.
- The hospital had service level agreements in place to access the services of local NHS hospitals. These included microbiology and pathology services.
- There was excellent working with the local NHS trust where there were agreements for the transfer of deteriorating patients for care or expertise not provided within the hospital.
- There were links with local GPs to ensure that effective transfer of care took place.

Seven-day services

- The hospital was open seven days a week, although there were no operations performed on Sundays.
- Consultant surgeons provided cover for their inpatients 24 hours a day, seven days a week. They arranged alternative cover by a named consultant if they were not available. Staff confirmed that consultants were always available out of hours for advice and guidance. An RMO was available and on site all day, every day.
- The physiotherapists were available out of hours for emergencies, such as chest physiotherapy for respiratory compromised patients.
- Pharmacy services were available during normal working hours, and outside these, the RMO was authorised to dispense medicines in exceptional circumstances in line with BMI policies. The hospital had a service level agreement with the local NHS hospital to be able to access pharmacy services out of hours if required.
- An on call surgery team that consisted of a surgical consultant, anaesthetist, and three hospital theatre staff were available outside normal working hours. The hospital theatre on call staff included a practitioner to support the anaesthetist, a scrub practitioner and a recovery nurse.
- The hospital operated a senior manager on-call system seven days a week 24 hour cover for staff to access for support if required.

Access to information

- Staff reported timely access to blood test results and diagnostic imaging. Results were available for clinical review of the findings and if necessary to change the patient's treatment plan.
- Paper medical records were in use on the ward, and staff were able to access them in a timely way.
- Staff accessed policies and procedures via the hospitals intranet. The ward manager had printed off some policies on the ward for staff to refer to and these were up to date.
- The hospital sent discharge letters to GPs and district nurses about the patients' treatment and care, which informed them of their patient's medical condition and treatment they had received. This ensured the GPs knew of their patient's discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were completed correctly within patient records we looked at and appropriately detailed the risks and benefits of the procedure. The operating consultant routinely recorded consent on the same day of the operation, with the patient's 'reflection' on information given to them taking place between their initial consultation and admission. Patients we spoke with confirmed that they felt well informed about the procedure they were consenting to.
- The DOCS told us that cosmetic patients were always given a two week 'cooling off period', so they could change their mind before consenting to the surgery.
- The pre-operative assessment nurses asked patients having joint replacements to consent to their details being uploaded into the National Joint Register (NJR), this register collated national data and helped to identify patient outcomes and care 'outliers'. The hospital had a recorded consent rate of 94%, which was better than expected nationally which was 85%.
- We observed nurses on the wards and in theatres sought verbal consent from patients before taking observations and delivering general nursing care.
- Staff undertook training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory safeguarding training. DoLS are to

protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority. Staff we spoke with could explain their responsibilities within MCA and DoLS.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- BMI healthcare gave all inpatients the opportunity to complete a patient satisfaction questionnaire that was administered by a third party. The hospital from April 2016 to March 2017 scored 94% for responsiveness to the personal needs of patients, against a BMI national average of 70%. The hospital displayed comments from the questionnaire on the ward. Comments included 'all staff were exceptional in their care and attention and 'nursing care has been wonderful, hardly any way to improve'.
- The hospital also participated in the Friends and Family test national survey for NHS funded patients'. From April 2016 to March 2017 the average number of patients who would recommend the hospital was 100%.
- We observed compassionate and caring interactions from all staff. Patients we spoke with described the care as 'fantastic' and staff to be 'helpful and attentive'.
- Patients told us that nurses, physiotherapists and head of housekeeping always introduced themselves. We witnessed all staff having a friendly rapport with patients, including for example, porters and administration staff.
- Patients reported that staff respected their privacy and dignity at all times. We observed knocking on patient doors and waiting for a response before entering.

Understanding and involvement of patients and those close to them

- Surgical patients on the ward told us they understood the care and treatment and had enough opportunities to discuss their surgery and risks involved. For example, we observed a preoperative assessment of a patient with clear information given about fasting and pain relief.
- Patients were given written information to help their understanding of a treatment. For example, a patient needed a blood transfusion, and was given a leaflet to support the explanation the RMO had given her.
- Patients' were kept informed and up to date at all times. We spoke with a patient who had a complication following surgery. The patient explained they had been kept aware of what was happening to manage the problem at all times.

Emotional support

- Ward staff showed sensitivity towards the emotional needs of patients and their relatives. On the ward, we observed staff discussing a patient's anxieties and how they could best support them.
- The hospital encouraged and supported patients to maintain contact with friends and family, therefore visiting times on the ward were between 9am to 9pm. The ward sister would shorten visiting hours if the patient was not feeling well enough.
- The hospital was able to access specialist nurse support to meet patients' needs. For example, for patients with breast care needs specialist support provided directly by the hospital. For patients' with diabetes, specialist nursing support for patients' available and under a service level agreement with the local NHS Trust.
- Staff asked patients during preoperative assessment about their beliefs/ spirituality. The hospital had access to chaplaincy, if requested by a patient.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital provided elective surgery to NHS and private patients for a variety of specialities, which included ophthalmology, orthopaedics and general surgery. The hospital worked closely with the local clinical commission group (CCG). From April 2016 to March 2017, 33% of the overall work from October 2016 to July 2017 was NHS.
- The CCG monitored the hospital's performance for NHS patients at quarterly contract meetings. The hospital

pre-planned all admissions to allow staff to assess patients' needs prior to surgery. They accepted patients for treatments whose post-operative needs could be met through ward based nursing care. The hospital routinely planned surgical lists from Monday to Friday. The hospital offered patients a choice of admission dates to best suit their needs.

- The hospital met regularly with the local NHS trust so opportunities to expand range of NHS services delivered could be identified.
- There were single rooms available for patients with en-suite facilities. Staff we spoke with were aware of the need for segregation to preserve single sex accommodation in line with current Department of Health (DoH) guidance.

Access and flow

- The hospital accepted referrals from local NHS trusts. Referral to treatment times were measured for NHS patients. The hospital were asked by CQC to provide 12 months referral to treatment time data. However, they provided data from January 2017 to March 2017. The hospital in January 2017 admitted 90% of patients within 18 weeks, in February 2017 the figures were 82% and March 86%. The DOCS told us this was due to the number of referrals for ophthalmology services at the hospital, being greater than the amount of ophthalmology capacity.
- The hospital did meet the 92% target for patients being on the incomplete pathway from April 2016 to March 2017. The incomplete measure captures the experience of every patient waiting.
- There were 921 inpatient stays and 3,210 day cases. The most common surgical procedure performed was cataract surgery.
- From April 2016 to March 2017 there were three unplanned transfers to the local NHS trust. This figure is not high when compared to other independent hospitals the CQC hold data for.
- From September to November 2016 10 patients were delayed by one day as several had not passed urine post-surgery, so did not meet the discharge criteria. The hospital then took an action to review the discharge criteria. From January 2017 to April 2017 two patients stayed one night over and this was due to post-operative nausea and vomiting. When we spoke with staff they confirmed patients did need to pass urine with the reviewed discharge criteria, but this had not been a caused of a delay to a patients discharge from January 2017 to April 2017. Patients length of stay was important to patients in meeting their expectations, and also the hospital that was paid for a certain length of stay depending on patients treatment and care.
- From September 2016 to April 2017 the hospital cancelled one operation for non-clinical reasons. This was because staff had not ordered the equipment required. The patient was rebooked for surgery.
- The hospital admitted patients on the day of surgery at 8am. Patients having cataract surgery had expressed concerns about their time of arrival, as at times they had experienced a long wait for surgery. Staff now requested patients having cataract surgery to arrive 30 minutes before their procedure, as not having a general anaesthetic.
- Staff began to discuss with patients' their preparations for discharge during their preoperative assessment. For example, checking how a patient was getting home, any support required post operatively and how this was being put in place. At the Monday to Friday ward huddle meetings, patients' progress and discharge plans were highlighted. For example at the huddle we attended, the ward sister highlighted the need for the pharmacist to supply additional medicines for a patient to take home.

Meeting people's individual needs

- Staff knew how to support people with complex or additional needs and made adjustments wherever possible. Pre-assessment identified patient's individual needs in relation to communication, dementia or learning disability so that arrangements for additional support could be made. They had leaflets about how to prepare for their procedure before and after the operation and their discharge. Staff told us there were rarely patients who had complex or additional needs.
- The hospital had a standard operating procedure for chaperoning as part of the 'Privacy and Dignity' policy (2016), outlining arrangements for adults. We saw chaperone notices displayed around the hospital.
- The hospital offered enhanced recovery and rehabilitation for orthopaedic patients, with a team of physiotherapist providing individualised care for patients. Physiotherapy treatments were planned into patients' care and account was taken of patients' particular mobilisation needs.

Good

Surgery

- For patients over 18 years considering cosmetic surgery, the hospital in the months, April, June, September and November in 2017 were offering a free 15 minute consultations with a cosmetic surgeon, for patients to discuss their individual needs.
- The patient led assessment of the care environment (PLACE) in 2016, identified the need to support patients who were deaf and hard of hearing. The hospital has now installed a hearing aid loop availability system.
- Staff told us there were rarely patients whose first language was not English. Staff could organise face to face or telephone translation if needed.

Learning from complaints and concerns

- The hospital had an effective complaints procedure in place that involved three stages. Stage 1 hospital resolution, stage 2 corporate resolution and at stage 3 patients could refer their complaint to independent adjudication if not happy with the outcome at stage 2. A complaints meeting was held weekly with the executive director, director of clinical services and quality and safety lead. All the complaints received by the hospital had been resolved at stage 1. The rate of complaints in 2016 per 100 patients was less than one percent.
- The hospital had received 16 written complaints from October 2016 to March 2017, 10 from private patients and six from NHS patients. The complaints had not shown any themes about clinical care, but around process and administration issues. If appropriate, the hospital made changes as a result of the complaint. For example, a change was made to patient documentation to show when a discussion has taken place with a patient about their medicines.
- The hospital informed us that all patients were actively encouraged to complete a patient satisfaction survey that encouraged feedback. Patient feedback forms were part of the standard room set up for all admitted patients.
- Senior staff at the hospital told us that patients' were invited to meet with senior staff to discuss any concerns they had during or after their admission.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The executive director, director of clinical services (DOCS) and a quality and risk manager led the hospital. The DOCS and quality and risk manager had commenced work at the hospital since the last inspection. Ward staff told us that the senior team were regularly visible on the ward, and a representative attended team meetings. The senior team joined team meetings, to support information cascade though the hospital.
- Staff we spoke with felt there was an 'open door' policy within the hospital. There were staff forums, newsletters and the departmental meetings for dissemination of information. A staff member told of a recent experience where they had needed to speak with the senior team, and this had felt supportive in a difficult situation.
- Staff we spoke with were proud to work at the hospital and proud of the standard of patient care they delivered. In the BMI healthcare staff survey in 2016, 97% of staff would recommend the service to friends and family. Staff meetings provided opportunities for senior nurses to engage with their staff and ensured information passed to staff. This was confirmed by records of staff meetings and discussions with staff. Staff were encouraged to develop and there were examples of learning opportunities on notice boards.
- Some ward staff told us how they were supported to work flexibly, one staff member described the support they had received with a change in their personal circumstances.
- The medical advisory committee (MAC) chair told us that the MAC was a useful link between consultants and the management team. He described a positive reporting culture that worked well and open communication between the MAC, executive director and DOCS. The MAC reported to be committed to its responsibilities and provided constructive challenge.
- Due to the volume of NHS work at the hospital, they were required to meet the workforce race equality standards (WRES). BMI Healthcare corporately have been working with the NHS WRES team and other independent providers, to understand how the standards will be appropriately implemented in the independent sector as a whole.
- CQC had not received any whistleblowing concerns about this hospital from April 2017 to April 2017.

Good

Surgery

Vision and strategy for this core service

- The hospital had a clear statement of vision and values, driven by quality and safety, "serious about health, passionate about care". Clinical staff discussed their awareness and knowledge of the service's four core themes – safety, clinical effectiveness, patient experience and quality assurance. These themes were the basis of clinical governance and risk discussions in clinical team meetings.
- The hospital had a business plan based on eight strategic corporate priorities. Priorities included ensuring an effective governance structure; people, performance, and culture are managed to attract the best staff, and the safe management of information.
- The local vision for surgery was to increase the volume of orthopaedic surgery undertaken which included a focus on post-operative rehabilitation. The hospital also had plans to refurbish and upgrade the minor operations theatre. This was to enable the accommodation of appropriate minor procedures currently undertaken in the two main theatres, further enabling increased capacity in the main theatres, to support an increase in the amount of orthopaedic surgery undertaken.

Governance, risk management and quality measurement

- At the inspection in September 2015 there had been concerns about systems in place to assess monitor and improve the quality of services provided, and the assessment, monitoring and mitigation of risks to health. The hospital had put an action plan in place, which the CQC had been monitoring through regular engagement with the hospital.
- The hospital since the inspection in September 2015 had a clear governance meeting structure. Sub committees such as the resuscitation meeting and infection prevention meeting now fed into the bi monthly clinical governance meeting that was chaired by the executive director and attended by all member of the senior management team. The hospital monthly heads of department for team leads included a quality and risk update and complaints themes. Attendance by team leads at these meetings was more consistent than at the inspection in September 2015.
- Monthly meetings were in place on the ward and in the theatre unit using a standard agenda to ensure the effective transfer of information through the teams. The minutes of the meetings showed detailed discussions including topics such as incidents, audit findings and patient feedback. Learning/ actions to be taken forward were made clear, which we were not assured of at the inspection in September 2015. For example, an orthopaedic patient had a post-operative infection and whilst carrying out a root cause analysis it was noticed that the patients dressing was changed within 24 hours. According to best practise recommendations wounds should not be disturbed for forty eight hours post operation. The chair advised if a dressing needs changing within 24hours to document reason why and the type of dressing used.
- Consultants represented specialties at the bi-monthly medical advisory committee (MAC). The chairperson for the MAC was an orthopaedic consultant. All the consultants received the minutes of each MAC to promote learning and understanding. The MAC minutes showed discussions included key governance issues such as incidents, complaints and practising privileges.
- The hospital, at the inspection in September 2015, did not have a system in place to manage risk effectively. A new risk management system was in place called 'risk man'. This was for recording and managing the risk register and reporting incidents. Staff told us there was a safety net for documentation within the risk man system. This meant staff could not move through the form without completing all the boxes, ensuring all required detail was captured.
- The risk register had not been current, and there had not been local risk registers at the inspection in September 2015. A current hospital risk register was in place covering the whole hospital risks, and there was a local risk register for the ward and theatres. The identified lead for each risk put appropriate actions in place to reduce the risk and regularly reviewed the risks they were responsible for managing. Staff we spoke with were aware of the risks within their departments and they were discussed in team meetings.
- Not all the risks staff told us about were on the ward risk register, for example concern with record keeping with regard to pain management and for variances such as unplanned returns to theatre. The hospital was planning to commence bi-monthly clinical effectiveness meetings for staff within teams to focus on risk management and audit. The hospital did not give us a start date for these meetings.

Good

Surgery

Public and staff engagement

- The hospital used various means of engagement with patients and relatives, including the 'friends and family test' and inpatient satisfaction surveys. The hospital had also tried to arrange for three annual patient forums. This only took place for NHS patients in November 2016 as the hospital were unable to obtain engagement from other service users. Patients and staff found the forum was helpful, and did generate some recommendations. These included increased awareness and flexibility of how much information patient requires/needs at each stage of their patient journey and a list of hints and tips (by patients) for patients requiring different procedures.
- The annual staff survey was due in June 2017. The hospital came 7th out of 57 BMI hospitals in the group in the 2016 staff survey for most engaged staff. The hospital ranked first out of 57 BMI hospitals for four months in 2016.
- The executive director and the DOCS both met with the RMO at the fortnightly hand over to update them and give them an opportunity for feedback.
- A celebration event was held for staff December 2016. This included celebrating the reduction of incidents in relation to documentation and improved quality of discharge letters.

Innovation, improvement and sustainability

- The hospital had developed an extended scope practitioner role for physiotherapists to provide care for patients under the direction of an orthopoedic consultant.The role was supported by training and competencies that enabled physiotherapy staff to safely assess patients referred for an orthopoedic opinion before and after surgery. One member of staff was now in the role who saw patients, with the potential for further development.
- The hospital now has a safer surgery training half day each month. The training started in October 2016 and included a discussion about incidents. The theatre manager told us they invited speakers that would contribute to staff development to the training day.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

Outpatient and diagnostic imaging 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 safe as good.

Incidents

- Staff were aware of their responsibility to report incidents, and were confident to challenge poor practice.
- All staff used an electronic system to report all incidents. In the reporting period Dec 2016 to Apr 2017 there were 113 clinical incidents reported across the hospital, 25 of these being in OPD/diagnostics. Of which 15 were low harm, nine were classed as no harm and one was moderate harm. The rate of clinical incidents that took place within outpatients was below the average of other acute independent hospitals we hold this type of data for.
- All reported clinical incidents had been investigated. We saw evidence of investigations and learning being shared within teams. Route cause analysis had been undertaken and learning shared across other departments, evidenced in ward meeting and clinical governance minutes. An example was a patient seen by the physiotherapy team was given a frame to assist with walking and one of the metal legs of the frame broke. There was no harm to the patient, however staff completed an incident form and checked all walking frames throughout the hospital for possible damage. The Medicines and Healthcare products Regulatory Agency (MHRA) were also informed to alert other health professionals of this risk.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R). There were no incidents involving ionising radiation reported during April 2016 and April 2017.
- The hospital has a corporate BMI Being Open and Duty of Candour policy. The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. There were no reportable duties of candour incidents within the OPD.
- Staff told us they had received information and training on the duty of candour (DoC). Staff we spoke with were able to describe the principles of the DoC. They confirmed that they would contact a patient and provide truthful information if errors had been made, they were aware of the legal process that needed to be followed. The hospital had just started trialling a duty of candour checklist sticker for ease of reference in the patient's clinical records.
- There were no never events within OPD. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, be implemented by all healthcare providers.

Cleanliness, infection control and hygiene

Good

Outpatients and diagnostic imaging

- There were cleaning schedules for the outpatient, diagnostic imaging, physiotherapy and MRI and CT department. These were fully completed by the cleaning team, overseen by the infection control lead.
- The 2015/16 infection prevention and control annual report highlighted compliance strategies and action plans updated.
- The hospital had both on-line and paper copy policies for infection control and prevention and hand hygiene. There was a monthly audit of hand hygiene practice which consistently demonstrated 97-98% during April 2016 to February 2017 and 100% compliance of the staff audited in March 2017.
- An annual audit calendar was in place for the hospital. We saw evidence of improvement from action plans. For March 2017 infection prevention and control environment audits in the OPD was 100%. Hand hygiene for all staff in the OPD was 100%.
- The infection control lead audited outpatient departments in April 2017. There was 92% compliance with the hospital policies and procedures and there were actions plans for staff to follow to ensure improvements were made, including ensuring all furniture is covered in impermeable or washable materials. Another improvement target was to ensure that all patient bedroom were carpet free by the end of September 2017.
- All areas we inspected were visibly clean and well maintained. The 2016 outpatient patient led assessments of the care environment (PLACE) score for cleanliness was 77% against the England average 98%. In response to the outcomes of this audit additional cleaning was implemented. All areas seen on inspection were visibly clean and well maintained.
- The hospital had an infection control lead that chaired the infection prevention and control committee and provided a route for escalation of risks identified. Infection and prevention control policies were current and training was provided as part of the hospital's mandatory training.
- The outpatient and diagnostic imaging departments had link staff for infection control. The link nurses throughout the hospital attended monthly meetings with the infection control nurse to share information and ensure compliance with infection control standards.
- The provider's audit of staff compliance with the management of sharps carried out on 10 May 2017 showed staff were 97% compliant with the hospital policy. The audit included detail of actions staff needed to take to improve their compliance. We saw sharps disposal bins in in all consultation rooms, clearly labelled and none of these bins were more than half full. This reduced the risk of needle-stick injury. All sharps bins had stickers to say when the bin was opened ready for use.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff to use in all clinical areas. We observed staff using them appropriately.
- We checked the PPE equipment including x-ray protection lead coats during the inspection, and they were clean and in good condition.

Environment and equipment

- The outpatient clinic had eight consulting rooms, a refurbished general treatment room, a room for urodynamic procedures and a phlebotomy room. The outpatient clinic had access to the minor operation room located in the theatre complex for specific procedures and treatments. Consultation rooms were used for any speciality. Clinics were mainly consultant led, with the addition of specific nurse led clinics, such as breast specialist clinics. All rooms were clean, uncluttered and fit for purpose. The reception desk in the booking in area was situated to maintain patient privacy.
- The hospital physiotherapy suite had three individual outpatient treatment rooms; a gym and a hand therapy room. All equipment was clean and fit for purpose.
- In the diagnostic imaging department, specialised personal protective equipment was available and used in radiation areas. Staff wore personal radiation dose monitors. All diagnostic and imaging equipment was maintained effectively with equipment tags, asset number tracking, maintenance reviews and repair schedules.
- The diagnostic imaging department had been audited annually against IR (ME) R standards, and completed a Radiology Protection audit (RPA).There were no outstanding actions that required an action plan. We saw service and maintenance contracts and the service level agreement for radiation safety.
- Signs in the diagnostic imaging and MRI department identified when X-rays were being taken and not to enter that room.

Good

Outpatients and diagnostic imaging

- The hospital obtained the services of a resuscitation officer from a local NHS hospital to ensure resuscitation equipment had been sufficiently audited with 97% results. The service level agreement ensured the equipment was audited twice a year.
- The management team and the resuscitation officer from a local NHS hospital had risk assessed resuscitation equipment and removed paediatric emergency airway equipment as children were not seen in the outpatient department. We saw adult resuscitation equipment was sealed with tags. Daily checks ensured tags had not been breached. Once a week, tags were broken, all equipment was checked for integrity and use by date and a full clean was completed of the emergency trolley. Records confirmed this occurred.
- Emergency call bells were in all clinical areas and consulting rooms. The functioning of the call bells checks was recorded in the unit diary. We checked the emergency call bell in one of the consulting rooms and evidenced it was working and staff responded promptly to provide assistance.
- The magnetic resonance imaging (MRI) and computerised tomography (CT) scanning services are housed in a separate building alongside the main hospital. There were service level agreements for servicing this equipment.
- An item of clinical equipment called a hyfrecator had been identified as a risk in the 2015 inspection had been replaced. Clear written guidelines were attached to the equipment and staff told us they had received training and competencies to safely use this equipment when the new equipment arrived.
- Electrical safety testing was undertaken every year, and we saw records confirming this. Staff we spoke with were clear on the procedure to follow if items if equipment were faulty or broken. Contractors completed all repair and servicing work for the x-ray equipment.
- The hospital had purchased a new ultrasound scanner.

Medicines

- Medicines were stored and monitored safely in outpatients. Medicines were kept locked in cupboards and access to them was key-controlled. Staff we spoke to were aware of who held the medicine keys.
- We checked six medicines and found they were in date and stock levels matched those on the stock control sheet. The department worked with pharmacy to ensure that stock was rotated.
- BMI prescription pads used by consultants were stored securely and appropriately. Prescription tracking systems were in place and followed by staff in accordance with national guidance.
- There were no controlled medicines kept within OPD and radiology. We found that contrast media was stored securely; this was also in date and ready for use.
- Locked refrigerators ensured medicines were stored at the correct temperature Staff checked and recorded maximum and minimum fridge temperatures daily, this included the blood fridge. There was a procedure for staff to follow if the fridge temperature was out of range.
- Anaphylaxis kits were in all clinical departments. The pharmacist team sealed kits securely with tags and the kits were readily available if needed. Oxygen cylinders were available in suitable holders for staff to access quickly if needed.
- The hospital had an onsite pharmacy open five days per week. A service level agreement between local pharmacists was in place to ensure provision of medicines outside of the normal BMI Harbour hospital pharmacy opening hours. The senior pharmacist attended the controlled drug local intelligence network meetings (CDLIN) to share updates from the Home Office and practical management of medicine management.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Records

- There was a policy for the creation, storage, security and destruction of patient records. All OPD records were paper based and stored correctly. All images and reports were stored electronically, accessible only to authorised staff.
- The hospital had made all the required changes to ensure the safe management of patient records following the 2015 report. To prevent unauthorised access to patient information, records were now stored in double locked cupboards/trolleys with a tracker to locate when patient records were moved to other clinical departments within the hospital. Senior staff

had access to these during evenings and weekends should they be required for on-going patient care. The hospital secretaries told us patient records were rarely taken off site.
- Staff placed risk assessments in the main patient record to ensure colleagues accessing the clinical patient records understood risks.
- All the staff we spoke with were aware of their responsibilities around the safekeeping of records and the confidentiality of patient information. Patient identifiable information such as patient records were stored securely in locked cabinets.
- Medical secretaries collated records 48 hours prior to a booked clinic appointment. This minimised the risk of records not being available. Staff told us that if a patient attended a clinic with no records available, it would be at the consultant's discretion as to whether they would see the patient safely without the records. Staff told us this was a rare occurrence and that it would be reported to senior staff and an incident form completed.
- We reviewed nine sets of patient records. The OPD care records contained patient assessments, observations, medical and nursing records plus ongoing risk assessments. We saw that all relevant timely assessments were completed entries were signed, dated and legible
- The April 2017 OPD patient health record audit scored 94%.with an action plan to improve.
- The imaging service provider hold records to confirm they have registered their work with ionising radiations with the Health and Safety Executive.
- Image transfers, such an x-rays to other hospitals were managed electronically via a secure system. There was a cross checking system in diagnostic imaging that ensured the correct patient identity for the procedure. Reception staff checked patient details on arrival. The radiographer rechecked the patient details and asked any safety questions, such as possible pregnancy, before taking them through for x-ray or scan.

Safeguarding

- There were systems in place for reporting risk and safeguarding patients from abuse. We reviewed the BMI hospital corporate 2016 safeguarding policies for adults and children: these were up-to-date and offered guidance to staff on what constituted abuse and actions to take. Staff we spoke with were aware of the process of raising and escalating a concern.
- The director of clinical services (DOCS) was the hospital lead for safeguarding in adults and children. The lead had undertaken face to face level 3 safeguarding training for both adults and children.
- Safeguarding training included female genital mutilation and 'Prevent' training. 'Prevent' training was undertaken by staff to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. In March 2017, the rate for outpatient staff completing Level 1 safeguarding children and young adults training was 96% and for safeguarding vulnerable adults was 96%, against the hospital's target of 100%. Level 2 children safeguarding training was part of the hospital's mandatory training. The compliance rate with this was 98% in March 2017. In the same period, 25 staff of 100 had undergone Level 3 children's safeguarding within the hospital.
- During the period March 2016 to March 2017, there had been no safeguarding adult or children alerts or concerns reported to the CQC. One safeguarding concern raised by a physiotherapy staff member demonstrated that the hospital safeguarding process had been followed.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction and updated them in line with the current training policy. Training included infection control, fire safety, conflict resolution, equality and diversity, information governance, children and adult safeguarding (levels 1 and 2), manual handling and dementia awareness. OPD staff records we reviewed demonstrated staff were 99% compliant in mandatory training.
- Training was delivered through an online learning package or by face-to-face teaching and practical sessions. Staff reported they completed online learning and booked dates for the practical/face-to-face teaching sessions.
- Staff we spoke with said there were monthly reminders to complete mandatory training and these were seen by management as a priority. Staff were given time to complete mandatory training.

Nursing staffing

- OPD nursing staff considered safe staffing levels one of the department's main risks in the 2015 inspection. During this inspection we saw the risk had been

addressed and sufficient additional staff for OPD had been recruited. The hospital used a 'labour tool' and professional judgement to assess staffing levels required for the OPD. Clinical staff told us they no longer felt the staffing levels posed a risk for the OPD service. We saw staffing levels to show safe staffing levels within OPD, physiotherapy, CT and MRI and imaging.

- The hospital employed eight full time equivalent nursing staff and six part time health care assistants for the outpatient department. There was a bank of nurses that the outpatient staff called on to cover vacant shifts. These nurses had worked in the hospital for many years. Staff in the OPD told us that agency nurses were rarely used.
- There was guidance for safe staffing levels in the outpatient department. All activity was planned to ensure there was staffing to safely cover the clinics running on each day. Staff worked flexibly when there were clinics running on a Saturday.
- Nurses were suitably trained to work within diagnostic specialty. There were no vacancies within the outpatient, physiotherapy, MRI, CT or diagnostic imaging department.
- Staff teams had daily meetings to share important updates, such as staffing for the day. Staff told us they were willing to be flexible when needed, and told us patient safety was their priority.
- The resident medical officer and two consultants we spoke to were highly complementary about the nursing staff. One consultant said "we are very fortunate to have highly experienced and reliable nursing staff here" another doctor said "the nurses are just brilliant, they go out of their way to ensure patient safety and comfort"

Medical staffing

- There was a registered medical officer (RMO) employed by an external agency. The RMO was on duty and onsite 24 hours a day, seven days a weeks on a two-week rotation system. This provided medical cover for all specialities including the outpatient and imaging departments. An established and sufficient patient handover ensured safe management of care between medical officers. The RMOs worked at the hospital regularly and knew the hospital and its routine well. RMOs were advised of cover arrangements for any consultant on leave.
- Consultants were required to live within one hour travelling distance of the hospital to provide on call cover. The RMO reported that the consultant was always available on the phone and attended patients promptly when called. The RMO told us some outpatients just turn up out of hours requesting advice and occasionally the consultant is called to give a clinical opinion or further treatment.
- Patients who became medically unwell could be transferred to the inpatient ward or to the local acute NHS Trust in line with the treatment centre emergency transfer policy.
- 149 consultants with practising privileges worked at the hospital. Consultants held substantive jobs at the local NHS trusts and were granted practising privileges after meeting strict criteria reviewed by the medical advisory committee. This included being on the specialist register, providing a CV, references, undergoing a disclosure and barring service check (DBS) and an annual NHS appraisal.
- There were sufficient consultant staffs to cover outpatient clinics, including Saturday clinics.
- Nursing staff told us that the medical staff were suppo
- rtive and advice could be sought when needed.

Emergency awareness and training

- Staff were aware of their roles and responsibilities during a major incident. Staff told us there was three fire evacuation drills a year.
- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as fire, flood and electrical failure. The business continuity plans were also available electronically.
- The hospital radiology service continuity plan was out of date (2011).The plan included moving services to the NHS as a contingency plan in an emergency. The emergency plan for major plant failure had been reassessed three times, the last being 2015. The senior management team at the hospital were informed the plan was out of date at time of inspection and told us they would update it promptly.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate 'effective', as we do not currently collate sufficient evidence to rate this.

Evidence-based care and treatment

- Care and treatment was delivered in line with the appropriate guidance and evidence based practice.
- All relevant National Institute for Clinical Excellence (NICE) guidelines were sent by the deputy manager to all consultants and head of department four times per year. Documents such as clinical care pathways were based on NICE Guidance as appropriate. An example being, venous thromboembolism: reducing the risk for patients in hospital: NICE June 2015. Assessment and treatment of venous thromboembolism (VTE) at the hospital had improved to 100%. All care pathways used were evidenced based and related to the most current national guidance.
- Staff in in all outpatient areas reported and we saw they followed national or local guidelines and standards to ensure patients received effective and safe care.
- There was role-specific training for staff in diagnostic imaging, CT and MRI. They had a comprehensive induction checklist, and we saw evidence that competencies were checked for individual staff.
- Clinical audits were undertaken in diagnostic imaging by the radiography team and infection control lead. An audit plan and the results of these were observed during inspection. These included audits in areas such as; clinical records, pre-assessment care, physiotherapy records, Ionising radiation, optical radiation, hand hygiene and infection control & prevention.
- Radiation Exposure/diagnostic reference levels (DRL) were audited regularly by a medical contractor provider. The contract and audits were seen during inspection, with no action requirements required.
- Ionising Radiation Medical Exposures Regulations IR (ME) R 2000 and IR (ME) Amendment Regulations 2006. Audits were undertaken in line with regulatory responsibility, copies of these audits, outcomes, actions and results were seen during our inspection.IR(ME)R incidents were all within normal ranges. The hospital was not an outlier for under or over reporting of IR (ME) R incidents.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure with no actions required.
- All radiology reports were checked and verified by a radiologist, before the report was sent to the referrer in line with Ionising Radiation Medical Exposures Regulations IR (ME) R 2000 and IR (ME) Amendment Regulations 2006.

Pain relief

- Please see core service report for surgery for main details.
- In OPD, staff discussed options for pain relief with the patient, during their consultation prior to any procedure being performed. Many procedures could be performed in the hospital theatre department, with the use of local anaesthetic, enabling the patient to go home the same day. Patient records evidenced pain relief was discussed and local anaesthesia was used for minor procedures.
- Patients were given written advice on any pain relief medicines they may need to use at home, during their recovery from their procedure.
- A member of staff in the inpatient ward acted as a pain relief specialist nurse whom the departments could access if further advice and support regarding pain relief was required.
- In the outpatient department, consultants were able to provide private prescriptions to patients who required pain relief. Patients could collect medications from the on-site pharmacy.
- We saw clinical staff explaining pain medicines to patients and the times to take them for effect. For example, before exercising and before sleeping.

Nutrition and hydration

- There was a water cooler for patients and visitors to access water whilst waiting for OPD appointments.
- Nursing staff assessed patient's risk of malnutrition using the malnutrition universal screen tool (MUST) scores and recorded them in patient notes.

Patient outcomes

Good

Outpatients and diagnostic imaging

- Please see core service report for surgery for main details.
- The diagnostic imaging department collected information on images that had been rejected, as the image quality meant they could not be used. We were told that this information was made available to the radiation protection adviser, who could review trends in the number of rejected images and, if deemed appropriate, put in place actions to reduce the number.
- All radiology reports were audited for compliance with the reporting times. Reports were all completed within 48 hours. A designated staff member oversaw this process, and discussed the audit results with the radiologists. This ensured that a robust system was in place to prevent unverified reports causing delay to patient care.
- A comprehensive physiotherapy audit tool (September 2016) checking treatment records, consent and the environment scored 92%: an action plan to improve was included.

Competent staff

- All new staff had an induction package, which included core competencies, and knowledge requirements that were signed off by their line manager. We saw examples of this in the staff files we reviewed.
- Staff administering radiation were appropriately trained. Staffs not formally trained in radiation administration were adequately supervised in accordance with legislation set out under Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R).
- One healthcare assistant positively discussed the opportunities to develop such as phlebotomy and electrocardiogram (ECG) training, The healthcare assistant discussed her role actively assisted the smooth running of the outpatient service, reducing long waits and avoiding additional patient stress.
- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed. Staff confirmed they were well supported to maintain and further develop their professional skills and experience.
- The resident medical officer had annual training and competence assessments.
- There an annual appraisal of competences in nursing staff. Staff we spoke with said they were up to date with their appraisals and had found them useful. Data showed the annual appraisal uptake was 100% for all staff within the outpatient's facilities, diagnostic and imaging, MRI, CT and physiotherapy departments.
- There were processes for confirmation of practising privileges. Consultants were recommended practising privileges by the medical advisory committee (MAC) only after the Executive Director had received the necessary assurance documentation. Practising privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. Evidence of this process, and that of the granting of practising privileges, was seen in the minutes of the medical advisory committee.
- There was support for nursing staff requiring revalidation.

Multidisciplinary working

- We observed there was effective team working, between all staff groups. This was facilitated by a daily morning communication meeting (huddle), where a representative of each department was present. This enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.
- To support cascade of information, the clinical services or quality and safety leads attended all staff monthly departmental meetings.
- If there were unexpected findings following a radiology imaging, the radiologists contacted the referring clinician and the radiographers followed up on the results to ensure if any further action was needed was completed.
- The OPD nurses worked closely with the tissue viability and infection control nurse, and there were referral protocols for referring patients to the breast care nurse.
- We saw service level agreements in place at the NHS hospital for checking equipment, histology, microbiology, pathology and radiotherapy.

Access to information

- All policies and procedures were accessible via the intranet.
- The medical secretaries discussed the importance of the maximum 48 hour turnaround for GP letters following OPD appointments. Bank staff covered medical secretaries when they were on leave, so the process remains consistent. We saw examples of patients

discharge letter sent to the GP for information. The information contained details about the patient's diagnoses, medicines; treatment and plans for follow up.

- Nursing staff told us when they transferred patients between teams, staff received a handover of the patient's medical condition and on-going care information was shared. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk.
- Staff we spoke with reported timely access to test results and diagnostic imaging, which enabled prompt discussion with the patient on the findings and treatment plan.
- X-rays were available electronically for consultants to view in the clinic. The diagnostic imaging department had access to an image exchange portal, which enabled the service to securely access and share images with NHS or other independent hospitals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a deprivation of liberty safeguards (2016) policy. This covered all aspects of the legislation that staff were required to know what constituted a deprivation of liberty.
- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in the staff mandatory safeguarding training. We saw that 100% of outpatient department staff had completed this training (April 2017). Staff demonstrated good understanding about their role with regard to the Mental Capacity Act.
- All clinical staff we spoke with in OPD, MRI, CT physiotherapy and diagnostic and imaging departments understood the importance of seeking both verbal and written consent for clinical procedures. The consent process for patients in outpatients was robust with potential risk of procedures explained. Written patient information, verbal explanation and diagrams were provided before consent for a procedure was sought. Staff told us if there was a concern that a patient lacked capacity to make a treatment decision the consultant would undertake a capacity assessment.
- We observed three patients undergoing cosmetic surgery assessments. Patients were provided with a two week cooling off/ reflection period to allow them time to ask any further questions or to change their mind.
- Verbal consent was given for general x-ray procedures and OPD procedures. Consultants sought written consent from patients for some procedures.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- All staff we spoke with valued and respected the needs of the patients and their families. Patients' emotional, social and religious needs were considered and were reflected in how their care was delivered. We observed medical and nursing staff showed an awareness of treating patients and their families in a sensitive and compassionate manner.
- Patients in the outpatients, diagnostic imaging, MRI and CT and physiotherapy departments told us they were treated with privacy, dignity and respect and they felt staff cared for by them. Patients told us staff were welcoming and explained everything in an unhurried manner. The reception desk was located within the waiting room and staff lowered their voices, so conversations were unlikely to be overheard.
- Patients in all outpatient diagnostic imaging, MRI and CT and physiotherapy departments expressed that staff were pleasant and gave them the information they required and explained treatment options in a way they understood.
- We saw staff ask patients if they would like a chaperone in the OPD, MRI, CT, physiotherapy, diagnostic and imaging departments. Staff worked within the hospital Privacy and Dignity policy (2016) and ensured the use of a chaperone was clearly documented in patient's files.
- Different treatment options were discussed and explained in detail with patients and their relatives. Patients were helped and supported by staff to make their own decisions regarding their treatment

Understanding and involvement of patients and those close to them

- The hospital undertook an OPD quarterly survey that asked patients if they were given explanations that they could understand from clinical staff. Patients were also

Good

Outpatients and diagnostic imaging

asked if they were given sufficient information about their condition, care and treatment given, their overall experience and likelihood to recommend. The results were patients and families were given sufficient written and verbal information by most clinical staff.

- Patients told us they had been provided with the relevant information, both verbal and written, to make informed decisions about their care and treatment. There was a team of administrative staff that helped patients with enquires about the cost of treatment and payment options. There was sufficient time at their appointment to discuss any concerns they had.
- We saw patients' families, or carers were welcome with the patient's permission to accompany them into their consultation providing the opportunity for a second person to hear what the doctor or nurses told the patient and clarify issues later if needed.

Emotional support

- Staff were passionate about caring for patients and put the patient's needs first, including their emotional needs. Patients and relatives told us they had been well-supported by staff when they had been told difficult diagnoses.
- Staff clearly demonstrated their understanding of the impact a person's care, treatment or condition might have on their wellbeing.
- Staff told us they always offered to chaperone patients undergoing examinations and we saw records that showed patients were supported in this way.

Are outpatients and diagnostic imaging services responsive?

Good

Responsive services are organised so that they meet your needs.

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs and demands of patients. OPD clinics were arranged in line with the demand for each speciality, to meet patient needs.
- Clinics were held Monday to Friday, 8am to 8pm, as requested with patients expressed wishes. If consulting space was available, consultants could arrange unscheduled appointments with occasional outpatient clinics held at weekends to meet patient's needs.
- The hospital was a provider of the NHS e-Referral Service which is a booking system for the NHS in England. This allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and book a convenient date and time for their appointment.
- On-site car parking at the hospital was available and was free of charge. Two patients we spoke with commented that they had found difficulties finding space to park. We saw two patients in a heated argument about parking. Staff were quick to resolve and find a suitable alternative close to the main hospital site.
- Patients we spoke with reported they did not have any problems in finding departments in the hospital, as they were clearly signposted. The consultant of the clinic came out to greet the patient from the waiting area and escorted them to their appointment.
- Patients requiring an ultrasound scan, computerised tomography (CT) scan or magnetic resonance imaging (MRI) were escorted to these by a member of staff who also accompanied them back to the department.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by the hospital. This included information leaflets on topics such as, information on fees, pain management, cosmetic surgery, women's health and breast health.

Access and flow

- Patients were registered at the main outpatient reception desk. Staff used an electronic system which tracked patients from the time they arrived at reception and indicated how long they had been waiting. Clinics ran on time. Patients we spoke with said they did not experience long waits from clinics running late and many reported being taken straight through to their appointment on arrival at the hospital.
- Patient's appointments were arranged through the consultant's individual secretaries and with the outpatient reception team. If clinics ran late staff ensured that patients were told how long they would be expected to wait and given refreshments.

Good

Outpatients and diagnostic imaging

- Patients had timely access to initial assessment, diagnosis or treatment. All referral to treatment (RTT) waiting times for every month were above or met the hospitals target of 92% for 18 weeks for the reporting period between the periods of April 2016 to March 2017. RTT measured the total period waited by each patient from referral to treatment and helped managed each patient's journey in a timely and efficient manner.
- The hospital had no patients waiting six weeks or longer from referral for magnetic resonance imaging, non-obstetric ultrasound and dexa scans (bone density) diagnostic tests.
- Radiologists reported on images and scans within 48 hours of the patients' investigation.
- The hospital had a low 1.9% 'Did not attend' rate. All patients who missed their appointment were followed up and audited. Subsequently, the referrer was notified of the non-attendance of their patient.

Meeting people's individual needs

- Patients entered the hospital via the main entrance, which was on one level making this easier for patients with mobility problems and wheelchair access friendly. Staff worked hard to ensure individual needs were met and patient privacy was maintained at all times.
- Patients were encouraged to bring a relative or carer with them to appointments. The consulting rooms in the outpatient department were large enough to accommodate extra people.
- Staff knew how to support people with complex or additional needs and made adjustments wherever possible. For example, patients with dementia or learning disabilities were able to attend the diagnostic department with family members prior to attending for investigations, so they could become familiar with equipment and procedures. However, staff told us there were rarely patients who had complex or additional needs.
- Provision for larger or heavier patients was available within radiology and physiotherapy including suitable equipment and gowns.
- The hospital had a standard operating procedure for chaperoning as part of the 'Privacy and Dignity' policy (2016), outlining arrangements for adults. We saw chaperone notices displayed around the hospital.
- Staff we spoke with said they could access translation services for patients whose first language was not English. This meant that these patients were able to hold detailed discussions about their care and treatment. There were policies for accessing translation services and staff knew how to access these should the need arise.
- Patients and families received an information leaflet explaining different endoscopy, cardiology and surgical procedures. This leaflet was available in other languages if required. Staff told us they could easily print off the leaflet in the right language for the patient or family.
- Patients reported they received information in a timely manner following their appointment. They were informed when and how they would receive results, when their next appointment was and knew whom to contact if they had any concerns. They also received a copy of any letters sent to their GP.
- There was a wide range of health promotion literature in waiting areas. This included leaflets on; orthopaedics, breast surgery, general surgery, physiotherapy. The diagnostic imaging department provided patients with written information on MRI and d X-ray procedures. We saw patients were provided with written, 'before and after' care information leaflets, by both nurses and consultants.

Learning from complaints and concerns

- Patients' comments and complaints were listened to and acted upon. The hospital had a corporate 'comments, compliments and complaints 'policy (2016), which provided staff with a clear process to investigate report and learn from complaints.
- Staff recognised that early resolution of patients' concerns prevented the concern from escalating into a formal complaint. When a concern was first raised, it was highlighted to a senior nurse. If the senior nurse was unable to deal with the concern directly, it was escalated to the deputy manager.
- The hospital dealt with the majority of complaints within the agreed response time. There was evidence the division leads and frontline staff discussed complaints and used these to improve the quality of care.
- The 2016 outpatient patient led assessment of the care environment (PLACE) score for privacy, dignity and well-being was 75%. This reflected the September 2015 inspection findings of the service. During this inspection we saw the hospital had worked within an agreed action plan and significantly improved the environment in the OPD. An example was the OPD built a new treatment

room and separate store room with a soft closing door to ensure patients receiving clinical treatment were given dignity and privacy. Staff said patients were no longer disturbed by staff accessing clinical equipment and the atmosphere was "professional and calm". The next OPD PLACE audit was planned for September 2017.

- We saw evidence that departments acted upon patient feedback. For example, changing the time a patient has to arrive at the hospital for cataract surgery so as not to wait unnecessarily in the hospital for long periods of time. Staff said they were proud of patient's feedback and we saw examples of positive feedback letters and thank-you cards displayed on notice boards.
- Information for patients on how to leave feedback or make a compliant was provided throughout the hospital, in visible and easy to read format. We saw a feedback boxes in use on the wards. Patients told us they would speak to a member of staff if they had any concerns. All of the patients we spoke with said they had no reason to complain, as their care had been good
- The hospital had received 16 written complaints from October 2016 to March 2017, 10 from private patients and six from NHS patients. Four of these related to the outpatient department, which included car parking, cost of treatment and two about staff attitude. All of these complaints were resolved quickly by hospital staff.
- A complaints meeting was held weekly with the registered manager, director of clinical services and quality and safety lead. If appropriate, changes were made as a result of a complaint. For example, a complaint about attitude of reception staff was resolved with an increase in staffing and staff training which focussed on the importance of attitude in interactions with patients. No complaints went to stage 2, which involves the Chief Operating Officer of BMI Healthcare investigating further, as all the hospital complaints were resolved locally.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The hospital had changed the leadership structure following the 2015 inspection report. There was now a deputy manager and/ or a lead in place for all outpatient, diagnostic and physiotherapy departments. The physiotherapy department also had an inpatient lead. Staff in the OPD told us the deputy manager was visible and supportive. However, staff reported similar findings to the 2015 inspection report, that the service manager had limited input in the service provided within the OPD.
- Clinical staff we spoke with told us they worked well as a team and "pulled together" to prioritise patient care.
- Staff felt valued by the senior executive team and described this team as "visible and supportive." Staff felt able to raise safety concerns and described the positive change in the culture in the last 18 months, with openness and honesty encouraged. To support cascade of information the clinical services or quality and safety lead attended all staff monthly departmental meetings.

Vision and strategy for this core service

- The hospital had a clear statement of vision and values, driven by quality and safety, "serious about health, passionate about care". Clinical staff discussed their awareness and knowledge of the service's four core themes – safety, clinical effectiveness, patient experience and quality assurance. These themes were the basis of clinical governance and risk discussions in clinical team meetings.
- Staff in all the outpatients departments demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner. Vision, strategy and values were discussed and reviewed regularly during hospital leadership, senior management and departmental team meetings. The hospital was not currently undertaking any new specialities, but orthopaedics was a growing area of work.

Governance, risk management and quality measurement

- The hospital was informed by NHS England that based on the Friends and Family scores it ranked in the top 80 independent providers of NHS Services. In September 2016 the hospital was in 42nd place overall with consistent monthly scores of 100%.
- A new electronic risk management system was in place, for recording and managing the risk register and

reporting incidents. Staff told us there was a safety net for documentation within the risk management system. This meant staff could not move through the form without completing all the boxes, ensuring all required detail was captured.

- Risk was discussed at clinical governance meetings held two monthly. The deputy manager attended monthly regional clinical care and risk meeting and received corporate quality and risk updates. The Quality and Risk Manager held the Institution of Occupational Safety and Health (IOSH) certificate and received regular corporate updates via meetings and conference calls regionally.
- Consultants were monitored on a practising privileges database to ensure 100% compliance. The hospital granted practising privileges to consultants who agreed to practice following the hospital's policies and provided evidence of appropriate skills and registration. The medical advisory committee (MAC) oversaw and ratified practising privileges for the consultants.
- A member of the pharmacy team attended the clinical governance meeting and gave advice on reducing harm from medicine incidents.
- The hospital completed audits of the OPD, physiotherapy and diagnostic and imaging departments to identify the outcomes for patients and identify areas for improvement. These included treatment records, consent and environment. All departments scored over 90% with action plans to improve.
- We saw a comprehensive risk register for all departments in the hospital. The risks were rated red, amber, green and an action plan documented to improve, with named leads and time frames for completion. We saw clinical governance, heads of department, quality and risk and medical advisory committee meeting minutes highlighting risks and action plans to improve.
- There was robust documentation to ensure the safety of patients undergoing x-rays. For example the IR (ME) R lead completed the justification criteria for radiological examination referral April 2017 to ensure compliance with the ionising radiation medical exposures regulations IR (ME) R 2000 and IR (ME) Amendment Regulations 2006. An IR (ME) R training matrix demonstrated compliance.
- The September 2016 imaging audit demonstrated 96% compliance and action plan to re-audit autumn 2017 were planned. We saw meeting minutes to demonstrate these were documented.

Public and staff engagement

- Patients and relatives were encouraged to leave feedback about their experience. Patient satisfaction surveys were collected throughout the hospital on a continuous basis. Results were not on an individual clinical department, but as the hospital overall. Monthly scores for December 2016 to March 2017 highlight "overall impression of nursing care" 80% to 87% "Individual attention given", 85% to 92% and "Did you feel you were treated with respect and dignity 98% to 100%.
- The hospital had set up patient forums for cosmetic patients, private patients and NHS patients. However, there was only sufficient engagement for the private and NHS patient forum to take place. The 12 attendees took part and raised concerns such as choice of food. The hospital employed a new catering manager as part of the solution. The hospital planned to continue to run patient forums annually.
- All the staff we spoke with enjoyed coming to work and team working was a particular strength. The clinical staff said they "loved working at the hospital", "everyone knows each other, and it's a really lovely place to work" and that they felt valued and respected and listen to by most members of the senior management team. Staff we spoke with said there were staff forums and team meetings to be able to discuss information, raise concerns and offer solutions.
- The annual staff survey was due in June 2017. The hospital came seventh out of 57 BMI hospitals in the group in the 2016 staff survey for most engaged staff. The hospital ranked first out of 57 BMI hospitals for four months 2017. This included a range of measures such as quality and financial measures. The hospital was also ranked in top10 in BMI in 2016 for patient satisfaction.
- A celebration event was held for staff in December 2016. This included celebrating the reduction of incidents in relation to documentation and improved quality of discharge letters
- Attendance at the daily multidisciplinary team huddle at 9.30am has improved staff engagement, as all staff are aware of concerns such as staffing. This meant they could offer staff assistance from one department to another to ensure all hospital departments are safe.

Innovation, improvement and sustainability

Good

Outpatients and diagnostic imaging

- The hospital has developed an extended scope practitioner role for nursing staff to provide physiotherapy under the direction of a physiotherapist. This role is supported by training and competencies. One member of staff is now in the role of an extended scope practitioner with two more staff to undergo the development programme.
- The management team had introduced the NHS 15 steps challenge; which is a toolkit for clinical staff to look at the quality of care from a patient's perspective. The clinical services manager said one staff member had undertaken this assessment to date, and two further members of staff are to undertake this assessment within their departments before evaluating the initial findings.
- The duty of candour checklist sticker for ease of reference in the patient's clinical records was to be rolled out to other BMI hospitals.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The six practitioners working in theatres should complete the surgical first assistant training undertake the programme of study, as required by BMI group policy, and detailed on the risk assessment dated 11 April 2017.All local risks should be captured on the ward risk register.
- All local risks should be captured on the ward risk register.
- Documentation pathways should support staff with the documentation of variances during a patient procedure/ treatment.
- The hospital should ensure patients medical and nursing records integrated, and the risk of unauthorised access to all records minimised.
- The provider should reassess the radiology service continuity and major plant failure business plans on an annual basis.