BMI Goring Hall Hospital

Quality Report

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Date of inspection visit: 16/08/2016 and 17/08/2016
Date of publication: 10/03/2017

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI Goring Hall Hospital is operated by BMI Healthcare Limited. The hospital is registered for 52 beds (but only 39 were in use at the time of the inspection). Facilities include four operating theatres, a three-bed level two care unit, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care including chemotherapy, and outpatients and diagnostic imaging services. The main service provided by this hospital was elective surgery.

Surgery is the main service provided and accounts for the majority of in patient work with very small numbers of medical inpatients being cared for. Emergency care is not provided at the hospital. The hospital does not admit children or see them as outpatients.

We inspected this service using our comprehensive inspection methodology. We carried out the comprehensive announced inspection on 17 and 18 August 2016.

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

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

Services we rate

We rated this hospital as good overall.

The senior management team, supported by the Heads of Departments, had a very sound knowledge of how services were being provided and were quick to address any shortcomings that were identified. They accepted full responsibility and ownership of the quality of care and treatment within their hospital and encouraged their staff to have a similar sense of pride in the hospital. Both the hospital director and the matron were able to talk to us in detail about all aspects of the services provided, all incidents and complaints, staffing levels and key performance indicators without reference to any documents. They knew their hospital exceptionally well.

The care delivered was planned and delivered in a way that promoted safety and ensured that peoples' individual care needs were met. We saw patients had their individual risks identified, monitored and managed and that the quality of service provided was regularly monitored.

The Executive Director was in overall charge of the hospital and all employed staff were line managed through her direct reports. She had six heads of departments reporting directly to her including the Director of Clinical Services (matron), the operations manager, the pharmacy manager, physiotherapy manager, hospital services manager and materials manager. The matron managed the theatre manager, consulting suite and cancer services manager, ward and day services manager and the quality and risk manager.

The Medical Advisory Committee (MAC) met four times a year and included representation from all specialities offered at the hospital. It was attended by the Executive Director and the matron. A wide range of topics were discussed and action taken in response to any concerns raised. The minutes of the MAC meetings were distributed to all consultants.

There were generally robust governance systems that were known and understood by staff and which were used to monitor the provision and to drive service improvements. We did not identify any concerns that the senior management team or local managers were not already aware of and already addressing outside of the oncology service

Summary of findings

We saw a strong safety culture with policies and systems in place to allow staff to challenge practice they felt posed a risk. This was particularly noticeable in the theatres where strong local leadership ensured policies were followed and that measures put in place to protect patients' safety were not circumvented. The explicit admission criteria, pre-assessment processes and refusal to allow consultants to carry out procedures that they were not undertaking frequently in the NHS all ensured that the hospital was able to meet the patients' needs.

There was a positive staff culture with many staff having worked at the hospital for a very long time. Some had worked for the previous provider and transferred across when BMI Healthcare Limited took over ownership. These core staff offered stability and continuity which was balanced by newer appointed staff who brought a fresh perspective and allowed for the introduction of new ways of working. The consultants, in the main, held substantive jobs at the local NHS trust and were used to working collaboratively. The hospital was rated outstanding following an inspection in December 2015 which meant that high clinical and behavioural expectations were seen as the norm by the consultant body.

A clinical governance bulletin was produced across the BMI Healthcare organisation which supported the hospital monthly to manage risk. The bulletin identified changes in legislation relating to NICE publications and alerts regarding medicines and equipment. It also provided details of issues of best practice at other hospitals so that shared learning could be applied locally.

We found good practice in relation to outpatient care:

- The service managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- Staff ensured patients had sufficient information and understood what they were being told. They were involved as partners in care and their decisions were respected.
- There was a good understanding amongst staff of all grades about the safeguarding arrangements and the impact of the Mental Capacity Act 2005.
- Patients were seen in a timely manner. Appointments were offered at times that suited patients. Consultations and treatment were provided within the target referral to treatment times. On site, patients were seen promptly with few delays.

However

- A copy of the consultants individual notes for private patients in the outpatient department were not kept by the hospital, these were kept by the individual consultants. The hospital had a record of the original referral and copies of diagnostic treatments performed only.

We found areas of good practice in surgery:

- In surgery, staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital.
- The theatre team provided a safe surgical environment by insisting that all theatre users adhered to national and local theatre best practice guidance. The WHO Five Steps to Safer Surgery checks were used routinely with all staff present participating fully.
- Incident reporting was encouraged and staff were supported to raise concerns. There was an embedded culture of learning from incidents that spread across the whole service.
- There were robust governance arrangements for surgical services at the hospital. Any anomalies in practice, trends in incidents or complaints were picked up and addressed swiftly. Lessons learned were disseminated across the organisation.

Summary of findings

- There were appropriate transfer arrangements in the event of a sudden and unexpected deterioration of a patient. Deteriorating patients were identified and transferred to a local NHS hospital in a timely manner with good communication with the receiving hospital.
- Patients were overwhelmingly positive about the level of care they received from all staff from the beginning of their contact with the hospital to the end.

We found areas of good practice in medicine:

- Patients were very positive about their experiences at BMI Goring Hall hospital. They felt supported and involved in their treatment planning.
- The arrangements for medicines management were sound with proper controls and oversight by a pharmacist.
- Areas we visited were clean, tidy and fit for purpose. The environment was light, airy and comfortable. Audit results showed infection prevention and control measures such as hand hygiene and cleaning were implemented to a high level.
- Patients receiving chemotherapy were cared for in a designated suite, away from other patients. This created a calmer and more pleasant environment and reduced the risk of cross infection.
- The use of the NEWS system for identifying patients at risk of sudden deterioration was embedded and used correctly. Staff followed the escalation processes, according to the local protocol.

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

- Some patient rooms were carpeted. There was a replacement plan being followed and the carpets should be removed by December 2016 but they are a breach of regulation.
- Private patient consultation records from the outpatient department were not kept on site.
- There was a corporate BMI cancer services strategy in place however the local cancer strategy was in draft. There were no Standard Operating Procedures for the cancer services. This resulted in a lack of clarity for staff and posed a risk of inconsistent practice.
- The provision of out of hours and emergency support to the cancer service was inadequately staffed.
- Breast cancer diagnosis was not consistently made through a 'one-stop' clinic in line with NICE guidance.
- There was ineffective leadership of cancer services. The lead nurse had a very wide remit and the lead consultant did not meet with the team.
- There was a risk that cancer patients who were unwell may have been admitted to the ward when it was not safe to do so. Ward staff were not trained to care for neutropenic patients, however the UKONS triage tool was used by the on-call oncology nurses to identify patients at risk of neutropenic sepsis to direct their ongoing care. The admissions policy allowed for patients to be admitted with support from the critical care team. At the time of the inspection there was no critical care team.
- Support such as wig fitting and payment, employment and financial advice and emotional support systems for patients undergoing chemotherapy or being treated for cancer were not provided onsite. Patients could access the Macmillan centre at the local NHS trust but this was not arranged through Goring Hall.

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

Professor Edward baker

Deputy Chief Inspector of Hospitals (South East)

Summary of findings

Overall summary

BMI Goring Hall Hospital is operated by BMI Healthcare Limited. It is a private hospital in Goring by Sea, near Worthing, West Sussex. Ownership transferred to BMI Healthcare Limited in 1994. The hospital primarily serves the communities of West Sussex. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 2010.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. Assisted conception services are also offered with the hospital operating as a satellite to BMI Esperance Hospital, where the main unit is based. We did not inspect these services.

Our comprehensive announced inspection took place on the 16th and 17th August 2016.

The team that inspected the service comprised three CQC inspectors, and specialist advisors with expertise in theatre management, nursing, chemotherapy nursing, a consultant surgeon and consultant physician and a radiographer.

The hospital had four theatres (two of which are laminar flow, one general theatre and an endoscopy theatre). At the time of the inspection, the hospital was using 39 of its 52 registered beds. The 39 beds were spread over two main wards; Ilex (22 beds and 4 extended recovery beds) and a day surgery unit (DSU) which offered 12 beds and 4 outpatient procedure chairs. The Mulberry Oncology Suite had 4 chairs for day case chemotherapy and a single patient room for longer day care treatments. The hospital also had comprehensive outpatient facilities with 14 Consulting rooms (11 in Consulting Suite and 3 additional rooms in Main Hall), two treatment rooms (one ophthalmic and one general). The diagnostic service consists of X-ray, Ultrasound, Digital Mammography, Echocardiogram, Mobile CT and MRI on alternate days.

During the inspection, we visited all areas of the hospital. We did not visit the onsite MRI Scanner as these are provided by a third party. We spoke with 22 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 19 patients and one relative. We also received 43 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 32 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected four times, and the most recent inspection took place in September 2013, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (April 2014 to March 2015)

- In the reporting period April 2015 to March 2016 there were 5,073 inpatient and day case episodes of care recorded at The Hospital; of these, 14% were NHS-funded and 86% other funded.
- During the same reporting period, 47% of all NHS-funded patients and 22% of all other funded patients stayed overnight at the hospital.
- There were 12,016 outpatient total attendances in the reporting period; of these 80% were other funded and 20% were NHS-funded.

  140 consultants worked at the hospital under practising privileges. Nineteen regular resident medical officers (RMO) worked on a rota. BMI Goring Hall employed 38.9 registered nurses, 28.5 care assistants and a total of 86 other administrative and ancillary staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

  Track record on safety

- One Never Event was reported during the reporting period April 2015 to March 2016. This was a near miss when an incorrect implant was handed to a surgeon but which did not came into contact with the patient. The incident was a significant risk of harm but no harm occurred.
- Clinical incidents 274 no harm, 207 low harm, 64 moderate harm, 2 severe harm, 0 death

Summary of findings

- 1 serious injury but where the patient had attended several healthcare providers and the cause was not attributable to BMI Goring Hall Hospital.

0 incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

0 incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

0 incidences of hospital acquired Clostridium difficile (c.diff)

0 incidences of hospital acquired E-Coli

55 complaints, of which 3 were referred to the Ombudsman.

Services provided at the hospital under service level agreement:

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

The inspection team was overseen by Terri Salt, Inspection manager

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement 	Medical care services were a very small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. There were few medical patients admitted to BMI Goring Hall Hospital but oncology care was provided with a small stand-alone chemotherapy unit. We have also reported endoscopy services under medicine. We rated this service as 'Requires Improvement'. This was because; • There was no local cancer services strategy for the hospital. • There was no standard operating procedure for the admission of acute oncology patients which meant a lack of clarity for staff when patients needed additional support. • When admitting to the Mulberry Suite out of hours, only one chemotherapy competent nurse specialist would be on the suite with the patient. Although emergency call bells were available in all clinical areas, this presented a risk associated with a potentially very ill patient and a single nurse needing to care for them and not being able to summon help quickly. • Ward staff were not trained to manage neutropenic or very sick oncology patients. They relied on advice from the chemotherapy nurses who were on call at night and weekends for advice and support. • The hospital admission policy allowed the admission of patients at risk of their condition deteriorating, whose needs can be met on an acute ward with additional advice and support from the critical care team. At the time of the inspection there was no critical care facility at Goring Hall hospital. • The out of hours provision for managing the care of patients who were ery unwell was

Summary of findings

limited because emergency care fell to the Resident Medical Officer (RMO) who had not completed specialist training in managing the care of cancer patients.

- There was a lack of multi-disciplinary review for cancer patients attending the hospital. We were told discussions took place at the trust where the consultant worked but this did not involve the team caring for the patient at Goring Hall.
- The BMI cancer cluster group had been inactive for over a year whilst a cluster lead was appointed. This left the chemotherapy nurses without effective specialist advice and leadership. There was no forum for the chemotherapy nurses to share ideas, learn from others or raise concerns.
- The oncology lead had a very wide remit that included managing the outpatients and temporarily supporting a cancer service at another hospital.
- There were no meetings between the lead oncologist and the wider oncology team at Goring Hall.

However,

- Areas we visited were clean, tidy and fit for purpose. The environment was light, airy and comfortable. The Mulberry suite had been awarded the Macmillan Quality Environment Award.
- There was an embedded culture of reporting incidents. Investigations were robust and there was evidence of learning being spread across the organisation.
- The endoscopy suite was working towards Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation incorporating the endoscopy global rating scale, which is a quality improvement and assessment tool for the endoscopy service.
- Medical services had an appropriate level of competent staff. The RMO was well supported by consultant physicians.
- Patient feedback about the quality of care was consistently good.

Summary of findings

- Managers were visible, approachable and effective.
- Referral to treatment targets were consistently met with patients being given appointments and receiving treatment in a timely way.

Surgery

Good

Surgery was the main activity of the hospital. We rated surgery as good because;

- Patients who used the service experienced safe, effective and appropriate care and treatment and support that met their individual needs and protected their rights.
- The care delivered was planned and delivered in a way that promoted safety and ensured that peoples individual care needs were met. We saw patients had their individual risks identified, monitored and managed and that the quality of service provided was regularly monitored.
- We found the clinical environments we visited and other communal areas in the hospital meticulously cleaned. Hospital-acquired infections were monitored and rates of infection were of a statistically acceptable range for the size of the hospital.
- Outcomes for patients were good and the department followed national guidelines.
- Complaints were investigated and handled in line with standard policy. We saw the hospital use patient's complaints and comments used as a service improvement tool and the hospital actively encourage feedback from its patients and their relatives or loved ones
- We saw theatre staff were fully compliant with the World Health Organisation (WHO) five steps to safer surgery surgical checklist.
- Surgical theatres equipment was available and working correctly.
- The surgical theatres were well managed and managers had gained the trust and support of their staff and also had good working relationships with senior staff at the hospital

Summary of findings

- The morning Huddle was an effective way to plan for the day ahead and learn from the previous day's events. A record of what was covered in these meetings was also kept.
- Staffing levels in surgical theatres were very close to full time equivalent (FTE) complement. This had been achieved by converting bank and agency staff into permanent staff.
- We saw that there was an open culture among staff for reporting incidents and a commitment to learn from them.
- The hospital had clear and robust policies and protocols for cleaning and infection prevention and control
- Patients were overwhelmingly positive about the level of care they received from all staff from the beginning of their contact with the hospital to the end.

However:

- There was Insufficient storage space in theatres.
- During working hours the drug cupboards in the recovery unit were left unlocked and intravenous fluids were not locked away.

Outpatients and diagnostic imaging

Good

- The hospital had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines.
- Areas we visited were visibly clean, tidy and fit for purpose. The environment was light, airy and comfortable.
- Medicines were stored in locked cupboards and administration was in line with relevant legislation.
- Staff kept medical records accurately and 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.
- The outpatient and diagnostic imaging services had sufficient numbers of appropriately trained competent staff to provide their services.

Summary of findings

- Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- Staff interacted with patients in a kind, caring and considerate manner and respected their dignity. Patients told us they felt relaxed when having their treatment.
- The hospital was responsive to the needs of the local populations. Appointments could be accessed in a timely manner and at a variety of times throughout the day.

- Managers were visible, approachable and effective.

However:

- The hospital did not keep a record of consultations for private patients attending the outpatient departments.

Summary of findings

Contents

Good

BMI Goring Hall Hospital

Services we looked at;
Medical care; Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI Goring Hall Hospital

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Our inspection team

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The inspection team was overseen by Terri Salt, Inspection manager

Why we carried out this inspection

The inspection was carried out as part of our planned programme of comprehensive inspections of all acute independent hospitals.

How we carried out this inspection

During the inspection, we visited all areas of the hospital. We did not visit the onsite MRI Scanner as these are provided by a third party. We spoke with 22 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 19 patients and one relative. We also received 43 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 32 sets of patient records.

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Summary of this inspection

What people who use the service say

People that we spoke with were almost entirely positive about their experiences at BMI Goring Hall Hospital. They talked to us about familiar staff who recognised them when they arrived for appointments, staff having time to talk and explain things properly and about a positive culture where staff smiled and seemed genuinely interested in them.

The few negative comments we heard were about the limited parking facilities and a private patient feeling they should not have to wait in the same area as NHS patients.

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?

Requires improvement

We rated safe as requires improvement because:

Records made by the consultant for private patients were not retained on site with hospital records but were kept by the consultant This is a breach of regulation. You can read more about it at the end of this report.

Oncology patients seeking advice out of hours were seen on the mulberry suite by an on call chemotherapy nurse. Although emergency call bells were available in all clinical areas, this posed a risk that a lone nurse would need to care for a potentially seriously unwell patient and would not be able to seek assistance in a timely way.

There was no Standard Operating Procedure for oncology.

The staff including ward nurses and the RMO were not trained to care for acutely unwell people with cancer.

Ilex ward had twenty three side rooms of which, eight were carpeted. Carpet in a clinical environment presents a risk for infection control. The infection control risk associated with carpets had been identified, risk assessed and being appropriately managed by the provider with a planned programme for replacing the carpets and frequent steam cleaning until all carpets had been replaced.

However, we also found

- The admission policy included patients who could be cared for on the ward with support from the critical care team (such as neutropenic patients). At the time of the inspection there was no critical care facility. This posed a risk that patients who were potentially unsuitable for care at Goring Hall were being admitted instead of being immediately referred to the local NHS trust cancer services.
- People were protected from avoidable harm and abuse. Openness and transparency was encouraged with staff being supported to report any incidents. There were robust investigations with senior clinicians having oversight of any clinical incidents. Where mistakes occurred, these were acknowledged and apologies were given to the patient or relative.
- There were well embedded processes and protocols used throughout the hospital to keep people safe. The theatre team provided care in line with best practice guidance, including the

Summary of this inspection

routine and full use of the 'Five Steps to Safer Surgery' Checklist. There was 'buy in' from the entire theatre team including anaesthetists and surgeons. The pre-assessment process and explicit admission criteria resulted in patients who could not safely be cared for at the hospital being referred to other hospitals.

- Staff in all departments had a sound understanding of the provider child and adult safeguarding arrangements. Training completion rates were high and staff recognised when they needed to seek advice.
- Medicines were managed safely and in accordance with national guidance. There was good oversight of medicines management and adequate pharmacist involvement to meet the needs of the patients.
- In general, staffing levels were adequate. Although there was high agency and bank use these staff had been given a comprehensive induction and were well supervised. The senior management team used staffing planning tools to ensure that they had adequate numbers of staff, with an appropriate skills mix to provide safe care to patients.
- There were clear arrangements in place and known to staff in the event of a major incident such as power failure or fire

Are services effective?

Good

We rated effective as good because:

In the main, peoples' care and treatment was planned and delivered in line with current evidence based guidelines, standards and best practice. The quality of service delivery was monitored to ensure consistency of practice.

Patients had comprehensive assessments of their needs which included their clinical needs and wider preferences and support needs. The hospital was clear which patient's needs they were able to meet and which patients would benefit from a referral to a hospital better suited to their individual circumstances.

The hospital participated in national and local audits. Some data was collected and submitted to national programmes but for some audits there was insufficient numbers to allow comparative outcomes. Local audits were used to drive service improvements, to reduce risks such as from cross infection and to improve patient outcomes.

The provider supported the professional development and learning of staff and had used this as a recruitment tool as well as to improve patient care. The appraisal rate was high across all staff groups.

Summary of this inspection

Consultants with practicing privileges were required to provide evidence that they had a valid NHS appraisal annually. Where this was not provided, a reminder was sent and if necessary, practicing privileges were suspended until the documents were supplied.

Pain was well managed, with patients reporting adequate analgesia during endoscopic procedures and post-surgery.

Consent was obtained in line with national and GMC guidance. Staff always obtained verbal or implied consent before providing care or treatment. Written consent was obtained from the patient by the consultant undertaking the procedure. A discussion took place about potential complications, risk and expected outcomes with each patient and this was recorded on the consent form. Consent was checked again as part of the patient's preparation for surgery. Staff had completed training and could demonstrate an understanding to their responsibilities in respect of the Mental Capacity Act 2005.

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

- Multidisciplinary review of patients with cancer was not taking place in accordance with NICE Guidelines.
- The RMOs who provided on site medical care for admitted cancer patients had no specialist training in oncology and ward staff were not trained to care for severely neutropenic patients. The patient's oncology consultant was available to give advice by telephone to discuss the treatment options but emergency care was led by the RMO.

Are services caring?

Good

We rated caring as good because:

Patients were treated with dignity and respect and were supported to be partners in their care. If patients wished, relatives were also included in discussions about care and treatment.

Feedback from patients across the hospital was very positive. All the patients that we spoke with were pleased with the quality of care they received and the attitude of staff.

Staff took time to make sure people understood what they were being told and that they had the opportunity to ask questions, where they wanted something clarifying.

Are services responsive?

Good

We rated responsive as good because:

Services were planned and delivered in a way that met people's needs and preferences. The needs of different people were taken

Summary of this inspection

into consideration when planning and delivering services. There were well developed relationships with the local clinical commissioning group who purchased a significant amount of treatments from BMI Goring Hall Hospital.

The provider was very aware of which patients it could safely provide care for and whose needs they were able to meet. There were specific criteria that prevented inappropriate admissions being accepted. Breaches of the criteria were not tolerated.

Services were delivered in a timely way, with no delays in patients accessing diagnostic tests or treatment. The provider met the referral to treatment times for all specialities it provided.

The hospital staff were very kind in the way they responded to individual needs, fears, wishes and preferences. They served a predominantly ageing patient base and understood that this group were often reluctant to show they needed or wanted assistance. Staff provided support without patronising and appeared genuinely responsive to individual needs.

The response to complaints was a strength of the service, with senior oversight of all complaints. The investigations were robust and responses showed compassion and a pragmatism that allowed local resolution in most cases. The hospital director offered to meet with complainants to discuss their concerns.

However

- Support services for patients having chemotherapy were not available on site. Patients wanting wigs or advice on coping during cancer treatment were signposted to the Macmillan centre at the local NHS trust.

Are services well-led?

Good

We rated well-led as good because:

From senior management team to local leadership, managers were held in high regard by the staff. The senior management team had a real grip and understanding of how services were being provided, what their strengths were and where they needed to bring about improvements.

There was a clear vision for the service with the corporate vision providing an overarching perspective that was used to build a local strategy that was known and understood by the staff. The staff at all levels talked to us about the quality of the patient experience being central to how they wanted to develop. They talked about planned projects and timescales for these.

Summary of this inspection

The Hospital Director and Director of Nursing both had a wide and deep knowledge of their hospital and their sense of ownership was clear. There was little we asked that they could not immediately answer. The Director of Nursing in particular knew every complaint, every incident, every staff member, every audit result for the preceding year and was able to talk to us about these in detail.

The senior team's knowledge was supported by strong formal governance arrangements. The reporting process was clear and lines of accountability were known to all. There was a good relationship with the MAC chair who worked closely with the senior management team and provided oversight of the consultants working at the hospital.

Theatre management was strong with evidence of good planning and oversight of the procedures being undertaken. The theatre staff were an effective gatekeeping service that ensured only patients whose needs could be met at the hospital were added to theatre lists.

However,

There was no strategy for cancer services at the hospital. There was no Standard Operating Procedures for cancer services at the hospital.

The leadership of the oncology service was not clear and the lead consultant was not providing leadership to the wider oncology staff team.

The MAC had not considered or identified risks around the cancer provision at the hospital.

The lead oncology nurse had a very wide remit and insufficient clarity about their role.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Requires improvement

Medical care

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

Are medical care services safe?

Requires improvement

We rated safe as Requires Improvement

Incidents

- Staff reported incidents via a form onto an electronic web based reporting and staff we spoke with had a good understanding of how the process worked. 170 clinical incidents (31% of incidents reported hospital wide) were reported between April 2015 and March 2016 in the inpatient and theatre departments. The rate of clinical incidents hospital wide was similar to the average of 31 independent hospitals that the CQC holds data for. It was not possible from these to identify how many incidents occurred in the oncology and endoscopy settings as these were included with the hospital wide numbers.
- The medicine department reported no never events between April 2015 and March 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- The hospital did not report any unexpected deaths between April 2015 and March 2016.
- Two serious incidents were reported by the hospital in the period April 2015 to March 2016. Serious incidents are defined by the NHS England Serious Incident Framework 2015 as events in healthcare where the potential for learning is so great, or the consequence to patients, families, carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. This number of serious incidents is not high when compared to a group of independent hospitals that submitted performance data to the CQC.
- One of the serious incidents reported followed an endoscopic procedure. The patient suffered an injury because of accidental leakage of intravenous fluid into skin. A root cause analysis (RCA) investigation was carried out and we saw that there were lessons learned from this incident. A letter was sent to the patient in line with the duty of candour process. We spoke to the endoscopy lead nurse about this incident. They were able to describe how the process had changed following this incident, including an improved recording process and reviewing the IV site during recovery. This meant that any leakage would be recognised and acted upon in a timelier manner.
- We saw email correspondence in a patient's notes between the Mulberry Suite nursing staff and a consultant oncologist regarding a 'near miss' incident which involved a potential error in the chemotherapy dose give following a drop in the patient's blood count. No harm came to the patient. All oncology patients have their specific chemotherapy protocol filed in the front of their medical records as a result of this incident. The consultant responsible confirms and signs the dosage the patient should receive in the event of blood levels varying. We saw this in three sets of notes that we reviewed. We noted that this incident had not been reported via the hospital incident reporting processes.
- The duty of candour is a legal duty on hospitals, community and mental health trusts to inform and

apologise to patients if there have been mistakes in their care that have led to significant harm. Staff we spoke to were able to articulate what duty of candour was and incidents it had been applied to.

Safety thermometer or equivalent

- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE). However, day case patients (such as those having an endoscopic procedure) are excluded from the NHS Safety Thermometer and staff told us that none of the patients undergoing an endoscopic procedure since the endoscopy suite opened in October 2015 had required an overnight stay.
- The hospital reported 100% venous thromboembolism (VTE) screening rates and there were no incidents of hospital acquired VTE or pulmonary embolism (PE) during the reporting period.

Cleanliness, infection control and hygiene

- The hospital's Patient-led Assessment of the Care Environment (PLACE) audits, were worse than the England average for cleanliness, scoring 93% compared to 98% nationally. The hospital had commenced a PLACE action plan following this result and we saw that the cleaning schedule frequency was being reviewed by the hospital services manager.
- During the reporting period April 2015 to March 2016 there had been no reported cases of healthcare-associated infections such as Meticillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.diff).
- Staff were bare below the elbow in clinical areas and demonstrated an appropriate hand washing technique in line with the 'Five moments for hand hygiene, from the World Health Organisation (WHO) guidelines on hand hygiene in health care. Information was displayed demonstrating the 'five moments for hand hygiene' near handwashing sinks and there was hand wash and hand lotion available.
- Adequate personal protective equipment was available for staff use. We observed it being used whilst care was provided.
- A clear decontamination pathway for endoscopes was demonstrated. There was a cyclical process for the cleaning of these which prevented contamination once the endoscope had been used. There was a drying cupboard and a storage cupboard for the endoscopes and staff kept full scope-tracking and traceability records. They indicated each stage of the decontamination process was occurring. The service audited these records and we saw results of these audits, which indicated all stages of the process were completed. The audit followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).
- We saw results of hand hygiene audits of which the majority scored 100% compliance. The January 2016 audit scored 90% and this was due to a consultant not removing their gloves and not washing their hands following patient contact. The consultant was spoken to at the time and was observed subsequently to be compliant with all areas of hand hygiene. Staff told us they felt confident to challenge members of staff who were non-compliant and we saw that non-compliance was discussed at Clinical Governance Committee meetings.
- We spoke with housekeeping staff who were responsible for the cleaning of the departments. We saw comprehensive cleaning schedules that were completed daily, and we saw that staff used green 'I am clean' stickers to indicate when an area or piece of equipment had been cleaned.
- We saw purple lidded sharps disposal bins in the Mulberry suite that complied with national guidance. However, we saw one sharps bin situated on a trolley unsecured. This was not in line with guidance. We escalated this to staff who remedied this and advised that they are normally secured

Environment and equipment

- The hospital's Patient-led Assessment of the Care Environment (PLACE) audits, were worse than the England average for condition, appearance and maintenance, scoring 74% compared to the national

average of 92%. The hospital had commenced a PLACE action plan following this result including plans for a refurbishment plan for toilets and improved signage within the hospital.

- The Mulberry suite had been awarded the Macmillan Quality Environment Mark(MQEM) which is a detailed quality framework used for assessing whether cancer care environments meet their standards required by people living with cancer.
- There was a sluice available on the Mulberry Suite. This room met required standards and was fit for purpose.
- A spillage kit was available in the Mulberry suite in the event of a cytotoxic drug spillage. This was in line with Hazardous Waste Regulations, 2005.
- Flooring in two of the rooms in the Mulberry suite were non-compliant with the national guidance. These rooms had wooden coving on the walls that was separate from the floor. This meant the surfaces could not be effectively cleaned.
- The hand washing sink in one of the patient rooms in the Mulberry suite had an overflow and did not have mixer taps which was non-compliant with national guidance.
- The chairs in the patient and consulting rooms in the Mulberry suite were upholstered in a patterned fabric which made identification of stains difficult and the fabric was not wipeable. This meant that they could not be effectively cleaned. Staff told us that in the event of spillage or contamination, the chairs would be steam cleaned and that there was a re-upholstery plan for the fabric covered chairs that was working through the hospital.
- We saw resuscitation equipment was located close to the Mulberry Suite and easily accessible. There was evidence of daily checks on this equipment.
- Resuscitation equipment was available in the day case area, next to the endoscopy suite. There was evidence of daily checks on this equipment.
- Water was tested and reported to the water committee as required by the water safety management regime HTM 04-01. The required full annual check and appropriate monthly tests were completed.

Medicines

- The oncology department prescribed chemotherapy using an electronic prescribing system, except for haematology chemotherapy which was prescribed on paper charts. The electronic prescribing linked with an NHS trust's chemotherapy protocols.
- The electronic system needed a strong wireless internet signal to perform effectively on the electronic tablets. We observed staff members having problems with slow processing on this system. Staff told us that they often had problems with slow processing which they felt were a result of poor wireless signal in the Mulberry suite. The MAC had discussed this with the hospital senior management and steps were being taken to address this.
- Pharmacists screened chemotherapy prescriptions to check that they were in line with protocols and were suitable doses for individual patients. Exception reports were checked and verified if prescribing was outside of the guidelines.
- Chemotherapy was manufactured off site and supplied through a corporate contract. We spoke to the pharmacist manager who told us they did not recall any supply problems. The pharmacy team communicated with the consultants if the chosen chemotherapy day could not be facilitated because of shelf life or restricted delivery of the medicine.
- Chemotherapy arrived at the hospital pre-labelled for the patient and pharmacists checked the chemotherapy against the prescription when it arrived. They also checked the patient's blood results before it was released for administration. The pharmacy manager designed a clinical check list so that the same process was followed for each prescription and supply which provided good assurance around cytotoxic medicine management.
- Cytotoxic medicines were stored in a separate fridge in the pharmacy in line with safe storage recommendations; this ensured no inadvertent contamination of other medicines.
- Chemotherapy was administered directly into a patient's vein either via a cannula or a venous access device. A complication of this is a leakage of the medicine from the vein into the surrounding tissue which is called extravasation. We saw extravasation kits were in date and available for use on the Mulberry suite.

- Keys for the medicine cupboard on the Mulberry suite were kept securely in a security coded box.
- Medicines management audits of the oncology service by the pharmacy team showed compliance rates of 92% in March 2016 and 95% in June 2016. Both scores were above the target of 90%.
- Fridge audits completed by the pharmacists showed compliance rates of between 90% and 96% between January 2016 and April 2016.

Records

- We reviewed the records of patients who attended the endoscopy unit on the day of inspection. The records were comprehensive, well-ordered and contained all of the relevant information including details of consent. Following their procedure, notes were moved to a locked cabinet in a key coded room in the day case area.
- Patient records in the oncology unit were kept in a locked cabinet within the Mulberry suite and the electronic prescribing system could be accessed from two tablet computers.
- Records for patients receiving chemotherapy were complete with details of contact with other providers regarding their cancer and with information from their GP. Entries were legible, signed and dated. Discussions with patients about treatment and prognosis were recorded.

Safeguarding

- Corporate and local safeguarding policies were available that reflected current national guidance. Staff had access to these via the hospital intranet. The policies had been updated and contained advice on Female Genital Mutilation and sexual exploitation.
- Staff spoke to were aware of the safeguarding policy and knew how to recognise and report safeguarding concerns.
- No safeguarding concerns were reported to the CQC in the reporting period April 2015 to March 2016.
- The hospital had a named safeguarding lead who was the Director of Clinical Services. They were trained to a Safeguarding competency level of 3 which is in line with national guidance.
- According to the BMI training matrix, all staff should complete level 1 safeguarding for children and adults. The safeguarding lead for the hospital told us that Level 1 compliance was at 80% which was lower than the hospital target of 90% compliance for mandatory courses. Level 2 safeguarding training was mandatory for all clinical and non-clinical managers or supervisors and this was at 92% compliance hospital wide, which was better than the compliance target of 90%.

Mandatory training

- All mandatory training was completed online and some modules were followed up by face-to-face sessions. Mandatory training included basic life support, infection control, fire safety and safeguarding. The progress of individual staff training was available on the internal system, BMI learn.
- The corporate target for mandatory training compliance was 90%. Hospital wide, training compliance averaged at 84% over the reporting period which fell below the target**.**
- The endoscopy team were part of the theatre department and as such the figures for mandatory training were encompassed in the overall theatre compliance figure which was 88.6% and below the target of 90%. Staff told us that they were responsible for booking their own training and were supported with time off the rota to complete this. We observed a paper copy of upcoming training bookings next to the rota. New staff were given three weeks to complete their mandatory training and we spoke to two new members of staff who told they were supported in completing this.
- The oncology team had 100% compliance with their mandatory training.

Assessing and responding to patient risk

- The hospital had an admissions policy which detailed the admission and exclusion criteria for patients seeking care at Goring Hall hospital. The hospital admission policy allowed the admission of patients at risk of their condition deteriorating, whose needs can be met on an acute ward with additional advice and support from the critical care team. At the time of the inspection there was no critical care facility at Goring Hall hospital.
- There was a service level agreement (SLA) in place for the transfer of patients to the local NHS trust and staff told us that this had recently been used when an oncology patient became acutely unwell.

- We looked at the notes of a patient who had rapidly become unwell. The notes were well documented and the procedures put in place kept the patient safe from harm.
- We saw that the National Early Warning Scores (NEWS) system was correctly used and the appropriate action taken if needed. NEWS is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital.
- No endoscopy patients had required an overnight stay following their procedure. However, staff told us that if a patient were to require admission, that there is a procedure in place for this and that there were good working relationships between the endoscopy staff and the ward to facilitate admissions smoothly.
- There was a corporate policy on the management of acute oncology patients that had been published during the week that we inspected. However, there was no local standard operating procedure (SOP) on the out of hours management of adverse side effects. This was not in line with the Acute Oncology National Institute for Health and Care Excellence (NICE) guideline; Acutely ill Patients in hospital guidelines (CG50).
- Staff explained that some acutely unwell oncology patients would be admitted to the Mulberry suite out of hours and some would be admitted to the ward. It was unclear to staff how this decision making process was completed as there was no SOP.
- Patients admitted to the Mulberry Suite out of hours would have one chemotherapy competent nurse assisting them and staff told us they could contact the RMO in event of any deterioration. However, there were concerns over the safety of both the patient and staff member being isolated on the suite out of hours. In the event of a sudden collapse, the nurse would need to care for the patient and there could be difficulty contacting the RMO or to the senior nurse on duty for support.
- The nationally recognised United Kingdom Oncology Nursing Society (UKONS) triage tool had been adapted by the oncology team. Staff told us this was because the staff at BMI Goring Hall were not able to access the original tool We did not ascertain the reason for this. Whilst this practice was not unsafe, the use of adapted documentation meant that the tool was not on carbonised paper and therefore could not be used for audit purposes.
- It was also noted that on the adapted document, it was not clear at what time the patient's temperature was taken. We raised this with the BMI Oncology Group Director who was unaware of this issue and told us that they would ensure the correct documentation was ordered and available in the future.
- There had been a national BMI audit of the UKONS tool but staff told us that the audit had not been useful and no action plans were developed as a result of this.
- We reviewed four sets of patient's notes from the Mulberry suite. The UKONS triage tool document was not fully completed on three out of the four notes. Examples of incomplete fields on these notes included the chemotherapy regime, the diagnosis, and the risk rating. Despite these fields not being fully completed, we found that the patients had been managed appropriately when we reviewed the care and treatment they had received using patient records.
- We were provided with the BMI Goring Hall WHO Five Steps to Safer Surgery checklist audit. This showed how they completed the audit to ensure the five steps to safer surgery were completed. This also showed that between January 2016 and May 2016 compliance with the WHO checklist was between 99% and 100%
- The endoscopy department also completed World Health Organisation (WHO) Five Steps to Safer Surgery checklist completion audits monthly which demonstrated good compliance. We also reviewed the WHO checklist completion in three patient records and found these to be completed correctly.

Nursing staffing

- The hospital used a staff planning tool to establish required ward nursing hours for the actual patient dependency on the main ward. This tool is used as a guide to assist trained professionals to exercise and review their clinical judgement to ensure the skill mix was available to ensure safe patient care. The staffing

tool is used to plan the skill mix five days in advance, with reviews and updates done on a daily basis. An on call nurse was available out of hours to support unplanned increases in patient dependency.

- The endoscopy department consisted of a lead endoscopy nurse, an operating department practitioner (ODP), a healthcare support worker and a decontamination technician. The lead endoscopy nurse reported to the theatre manager. The endoscopy staffing requirement was predictable as the department ran endoscopy lists on set days and times throughout the week and rotas were planned four weeks in advance. Any gaps in endoscopy staffing could be covered by those members of theatre staff who had the skills required for endoscopy
- The oncology department consisted of two chemotherapy competent nurses, two nurses and one health care assistant. There were always two members of staff competent in chemotherapy administration on duty Monday to Friday and a chemotherapy competent nurse was available on call outside of normal working hours The on call rota that enabled 24/7 management of adverse side effects from chemotherapy that was covered on a one week on, one week off basis by the two oncology nurse specialists. However there was no provision if one of the nurses was off sick, and it was expected that the remaining nurse specialist would cover in this circumstance. There had been no instances where this situation had had a negative impact on patient safety.
- Ward staff were not trained to care for neutropenic patients and the staffing level was for elective surgery not patients who were unwell as a result of chemotherapy.
- The oncology department occasionally used a bank nurse who was chemotherapy competent. No agency staff were used.

Medical staffing

- Medical staff worked under a practising privileges arrangement as defined in the corporate practicing privileges policy. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector. There were 140 doctors employed under practicing privileges hospital wide and it is a requirement of this policy that consultants arrange appropriate, alternative named cover if they will be unavailable at any time they have patients in the hospital.
- Endoscopy procedures were carried out by six consultants who were employed under practicing privileges and all had NHS contracts. Five of these were surgeons, and one a gastroenterologist.
- We spoke to staff on the Mulberry Suite regarding consultant cover and they told us that the oncologists cover each other on an informal basis and that there have been no issues with this. All oncologists working at Goring Hall held substantive NHS contracts.
- Nineteen resident medical officers (RMOs) worked at the hospital on a rotational basis. The hospital has a contract with a third party company that provided RMO cover 24 hours a day, 365 days a year. RMO duty lasts from 1 to 2 weeks and whilst on duty they are required to stay on the hospital premises. All RMOs had completed appropriate training including Advanced Life Support training.

Major incident awareness and training

- The hospital had a response team who would respond to an emergency situation. The team all held bleeps and would respond immediately when required. We saw the quick response to an emergency during our inspection.
- The provider had Business Continuity Plans that were readily available at the hospital.

Are medical care services effective?

Requires improvement

We rated effective as Requires Improvement

Evidence-based care and treatment

- The hospital participated in the BMI wide collection of data that showed their performance in a number of areas compared with the average scores across BMI. Comparisons were shown in a number of different categories, including patient safety, patient satisfaction, cleanliness and incidents.

- We viewed a number of policies in the Mulberry Suite including a current cytotoxic waste policy and a corporate systemic anti-cancer therapy policy. However the storage of these policies was chaotic and some folders containing policies were not labelled. We asked staff to show us the extravasation policy, and this was found, after searching, in the emergency folder. This was a corporate policy, and had passed the review date as of July 2016.
- The neutropenic sepsis policy had also passed the review date in July 2016.
- Patients with suspected breast cancer were not offered a 'one stop' service in line with NICE Quality Statement 12 standard 1 which recommends that " People with suspected breast cancer referred to specialist services are offered the triple diagnostic assessment in a single hospital visit"
- The services for patients with breast cancer were not provided in line with NICE clinical guidelines (CG80). The guidance states that "All patients with breast cancer should be assigned to a named breast care nurse specialist who will support them throughout diagnosis, treatment and follow-up". There were no breast care nurse specialists at BMI Goring Hall hospital.
- Audit of recurrence rates after treatment for ductal carcinoma in situ were not completed at BMI Goring Hall hospital as recommended in NICE guidance CG80. Neither were there audits of their axillary recurrence rates.
- The endoscopy unit used the British Society of Gastroenterology (BSG) guidelines for their procedures.
- The endoscopy unit took part in ten traceability audits last year, but realised that they needed to increase audits numbers to 30 per year to fall in line with national guidance and were implementing this increase.
- The endoscopy department also completed peripheral cannula audits. We saw results from the July 2016 audit which showed 86% compliance. Staff explained that this is due to some consultants not wearing gloves when inserting the cannula. Whilst staff felt able to challenge this, some told us they did not always feel supported by their managers.
- We spoke with the matron about staff challenging consultants and were shown examples of where individual staff members had been supported to provide feedback to consultants. We were told that the culture was changing but that this took time to embed and for all staff to feel comfortable with the changes.
- The endoscopy unit did not have Joint Advisory Group (JAG) accreditation at the time of inspection. The service had registered with JAG and had completed an endoscopy global rating scale (GRS) self-assessment which we saw. GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation.

Pain relief

- In the March 2016 patient satisfaction hospital report March 2016 showed that the satisfaction response for questions relating to assessing levels of pain and helping to control level of pain had deteriorated a little since March 2016.
- The hospital staff used pain scoring tools to assess patient pain regularly. We reviewed eight sets of notes and saw that pain scoring tools were used routinely when discussing pain with patients on the ward. As there were no medical patients admitted at the time of our inspection visit these were the records of surgical patients for whom the care pathway included regular pain assessment.
- A pain audit carried out in February 2016 showed a score of 92% for inpatients. Scores included the correct use of the pain assessment tool, correct recording of pain and recorded discussions between staff and patient regarding pain.
- We spoke to one patient who was recovering from an endoscopic procedure, they told us they had been sedated during their procedure and had not experienced any pain. None of the patients in oncology we spoke to whilst on inspection were experiencing pain so we were unable to discuss their pain management with them. However, we noted that part of the Clinical Psychologists role was to discuss pain management with patients.
- Staff in endoscopy told us that any special patient requirements including anxiety and discomfort or pain would be discussed between the team prior to the list.

- Sedation requirements would be discussed on an individual needs basis and an anaesthetic throat spray and a gas mixture that provides effective pain relief was available for use before or during the procedure.
- We reviewed three sets of patient notes and saw that pain scores were recorded every five minutes during the endoscopic procedure and we saw that two of the patients were given Entonox following an increased pain score.
- Staff described various methods of helping patients who experienced abdominal discomfort following endoscopic procedures including infusing the water used during the procedure with infacol (a wind reducing medicine) and offering peppermint water following the procedure. Staff also encouraged patients to pass flatus following the procedure and aimed to relieve anxiety or embarrassment around this.

Nutrition and hydration

- The Patient Led Assessment of the Care Environment (PLACE) undertook an audit. During the period April 2015 to March 2016, the food at the hospital was rated at 93%, which was better than the national average 92%. The food on the ward was rated at 98%, which was better than the national average of 94%.
- We observed a patient in the recovery bay having a small meal following their endoscopic procedure. The patient had informed the staff that they were a slow eater and we observed that the patient was given adequate time to finish their meal at their own pace and not to feel rushed.
- Nutritional risk assessments were undertaken on all admitted patients using the Malnutrition Universal Screening Tool. Where a risk of malnutrition was identified, steps were taken to mitigate against the risk.
- Patients having chemotherapy were prescribed antiemetic drugs to use when they developed nausea at home, so that they could eat properly.
- A dietician was available to support patients with complex nutritional needs.

Patient outcomes

- The hospital told us they audited patient outcomes by participating in national and local audit programmes. Locally, a quality dashboard was produced making local data available to the hospital on a monthly basis. This allowed the hospital to compare performance across departments and for departments to compare their own performance over a period of time.
- The oncology department participated in the UKONs triage system audit every 6 months. We were not provided with the audit results.
- We reviewed two sets of notes from patients who were re-admitted within 28 days of their chemotherapy as acute oncology patients. These were found to demonstrate comprehensive management of their conditions.
- There were no unexpected deaths during the reporting period, but any unexpected deaths would be discussed at Heads of Department and the Clinical Governance Committee.
- The hospital inputted patient data onto the Somerset Cancer Register, which is an electronic register used nationally to support National Clinical Audits, Surgeon Level Reporting and the Cancer Waiting Times figures. This had been a recent introduction and there were not, as yet, any local outcomes available.

Competent staff

- All theatre staff, including endoscopy staff, had received an appraisal during the reporting period.
- The compliance figure for oncology staff receiving an appraisal was 94%.
- All endoscopy staff had sedation training which was in line with the British Society of Gastroenterologists (BSG) guidelines.
- Theatre staff had undertaken additional training to ensure they are endoscopy competent in the event of covering endoscopy staff.
- Staff in oncology told us that there had been an increase in complex chemotherapy patients attending, in particular haematology patients. A nurse had recently been recruited that had haematological cancer experience which was felt to be valuable to the team.
- We observed training files for the oncology staff, and noted that chemotherapy competencies, compression awareness, and advanced communication were up to date.

- The oncology team told us they were due to have six monthly training sessions on the administration of the specialist equipment used in the event of an extravasation. This training had not been taking place as the cluster lead post had been vacant for some time and had only recently been appointed to.
- Oncology patients were seen in the Mulberry Suite, however, if a patient receiving chemotherapy deteriorated, or had to be admitted following chemotherapy, they would occasionally be admitted onto the Ilex ward. Staff in oncology told us that none of the ward staff had oncology training and that this was not a suitable environment for acute oncology patients
- Staff on the ward felt they did not have the relevant training to be able to look after acutely unwell oncology patients but that there was an expectation from oncology staff that these are skills they should know. Ward staff told us that they lacked confidence when oncology patients were admitted onto the ward. They were unfamiliar with the specialist paperwork such as the UKONS triage tool and lacked competence in some of the specialist skills required to nurse acutely unwell oncology patients. They did not have access to education on oncology issues. This was identified as an action point following a provider peer review in 2015 and was due for completion in March 2016. This action point was overdue with no planned education or training in place.
- NICE Guidelines for the management of haematological cancers states that, "Cover in haematology units that care for adults and young people who are receiving high intensity chemotherapy should be provided by specialty trainees and specialty doctors who are: haematologists or oncologists; involved in providing care to the patients being looked after by the centre and familiar with and formally instructed in the unit protocols. The RMOs at BMI Goring Hall were not speciality doctors with this level of training and were not usually involved in the management of patients on the Mulberry Suite. They were required to provide support in the event of an emergency and to provide care if the patient were unwell and admitted to the ward or seen out of hours.

Multidisciplinary working

- We reviewed three sets of patient's notes, and found that none had documentation demonstrating that they had been discussed at a cancer multi-disciplinary team (MDT) meeting. We spoke to staff who told us that not all patients that they saw had been discussed at an MDT meeting. This was not in line national frameworks. For example, with the NICE Quality Standard 12 statement 5 for the management of breast cancer and NICE Guideline 47 for Blood Cancers which states 3.3 Every patient with any form of haematological cancer (as defined by current World Health Organization criteria) should be cared for by a haemato-oncology MDT.
- The nursing staff told us they had good working relationships with the oncologists.
- Ward staff could contact the Mulberry Suite nurses for advice about the care of any admitted patient, during the times the Mulberry Suite was open.
- Oncology staff told us that they knew who to contact at the acute trust if they needed to speak with the cancer nurse specialist (CNS), however they rarely felt the need to do this.
- Staff in oncology told us that there were good relationships between the hospital and the local hospice. They gave an example where one of the nurses attended the hospice to administer a pain relieving drug to one of their oncology patients who was not well enough to attend the Mulberry Suite.

Seven-day services

- The hospital had cover from a resident medical officer (RMO) 24 hours a day, seven days a week. When on duty, the RMO was required to remain in the hospital at all times. RMOs worked a one week on then one week off rota.
- Patients did not have access to a 24 hour help and advice line staffed by specifically trained haematology practitioners as recommended in NICE guideline (NG47). Overnight patients with concerns were advised by ward staff.

Access to information

- The hospital used electronic prescribing for chemotherapy. This meant the ward and pharmacy had access to the patients information without removing the prescription charts from the wards.
- Letters were sent to the patient's GP following admission or treatment at the hospital.

Requires improvement

Medical care

- Patient notes were readily available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Dementia awareness and consent training was mandatory for anyone in a clinical role according to the BMI mandatory training matrix. The completion rate for MCA and dementia training was 81% against a target of 90%.
- We reviewed two sets of notes that contained "Do not attempt cardiopulmonary resuscitation" (DNACPR) forms. These were both photocopies and it was unclear from the documentation what had been discussed with the patients. Patient records did not record details of the discussion with the patient or their relatives but the form showed a discussion had taken place. There was no record of the assessment completed to assess whether the patient had capacity to understand the implication of the form. One of the forms was from 2014 and had not been reviewed at the subsequent admission, nor did it have a review date. This meant that staff were not working with a current decision around whether it was appropriate to resuscitate a patient in the event of a cardio-pulmonary arrest.
- We observed an endoscopy procedure where the patient gave appropriate consent and this was documented. The procedure was fully explained to the patient and any questions they had were answered. We also reviewed three sets of notes where appropriate consent was documented.
- Chemotherapy consent forms were in use which detailed the risks and intended benefits of chemotherapy treatment.
- We observed that staff asked for verbal consent before providing care or treatment.

Are medical care services caring?

Good

We rated caring as Good

Compassionate care

- The hospital Friends and Family test (FFT) score for NHS patients were similar to the England average of NHS patients across the period October 2015 to March 2016. The hospitals FFT scores for insured and self-pay patients were similar to the England average of NHS patients over the same period.
- The majority of day case patient's response on FFT cards was positive, with comments such as: "Friendly, professional staff and excellent patient care. Attentive and caring" and "Delightful staff who really care and make you feel at home".
- We received 43 hospital feedback cards which had been completed by patients. Although it was not possible to narrow down the feedback to oncology or endoscopy services, all of these were positive including comments such as "Staff always caring and attentive".
- We saw results from an oncology patient environment questionnaire in 2016 and all comments were positive. One patient wrote: "At a time where you feel a bit isolated, the relaxed atmosphere enables you not to feel alone".
- We spoke with a patient at the time they were having their chemotherapy administered. They were very happy with the care received,
- We also spoke with a patient that was in the recovery bay following an endoscopic procedure. They told us this was the third time they had visited the hospital and had this type of procedure and felt very well cared for.
- We observed a good rapport between oncology staff and their patients.
- The hospital's scored 68% in the Patient-led Assessment of the Care Environment (PLACE) audit for privacy, dignity and wellbeing which was worse than the England average of all hospitals which was 87%. There was a review of why this score was so low and an action plan was in place to address some of the potential reasons.
- We saw that staff knocked on patient's doors and waited for a response before entering.

Understanding and involvement of patients and those close to them

- In the March 2016 Hospital Patient Satisfaction Survey Report, satisfaction rates for the question 'Were you involved in decisions around your care and treatment?' had shown an improvement of 0.9% since March 2015.

- We spoke to a patient following an endoscopic procedure who told us they felt they were involved in their care pathway. They were made fully aware of the procedure and process prior to it taking place.
- Out of normal working hours, oncology patients were given contact details for one of two oncology nurse specialists. The information given to patients explained some possible side effects following their chemotherapy and symptoms to be aware of.

Emotional support

- There were two clinical psychologists who worked as part of the oncology team and the nursing staff could refer their patients to them for support if indicated.

Are medical care services responsive?

Good

We rated responsive as Good

Service planning and delivery to meet the needs of local people

- The endoscopy service ran on set days and times throughout the week. These were Tuesday afternoon, Thursday afternoon and Friday morning, and additionally every second Monday in the afternoon. Staff told us there was no demand for additional lists throughout the week or at the weekend.
- Patients referred for an endoscopic procedure could expect to wait no longer than two weeks and were offered the next available appointment.
- The Mulberry Suite was open Monday to Friday, and staff told us that they typically had three -12 patients attend per week. This meant that there were often days where there was only one or no patients attending for their chemotherapy. Staff told us there were no delays in patients accessing the service.

Access and flow

- NHS England publishes Referral to Treatment (RTT) waiting times, of which diagnostic waiting times is a key part. RTT waiting times measure the patient's full waiting time from GP referral to treatment, which may include a diagnostic test. Therefore, ensuring patients receive their diagnostic test within six weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks.
- The hospital had no patients waiting six weeks or longer from referral for endoscopy procedures.
- There were no waiting lists for patients waiting for chemotherapy.

Meeting people's individual needs

- We saw comment cards from patients which described the "Very good choice of food". We spoke to the catering manager who gave us examples of where patients had requested meals that were not on the menu and how they went out their way to provide for these patient's needs.
- The endoscopy lead explained that the need for an interpreter would be identified and actioned at the pre-operative assessment, but could not recall a time when an interpreter was required. Hospital staff had access to interpreters via language line which is a telephone interpreting service.
- The hospital has a dementia champion who together with e-learning modules promoted dementia awareness.
- Patients with additional needs were assessed to determine whether the service was able to meet their specific needs. Where possible additional support was put in place but for patients with more complex needs, the hospital staff would suggest moving to another provider more able to meet their needs fully. Staff were able to describe an incident where a patient with a learning disability required an endoscopic procedure and was extremely anxious about this. The patient was invited in to view the endoscopy suite prior to their procedure, and was shown some of the pieces of equipment that would be used. The patient was later able to undergo the procedure without any issues or complications.
- The oncology department had a scalp cooler ,this is a piece of equipment used to cool the scalp during the administration of chemotherapy and can reduce hair loss which is a known side effect of some chemotherapy routes.

Requires improvement

Medical care

- Oncology staff would signpost patients who needed to apply for a blue disabled parking badge to Macmillan services, but would support them in the process for this.
- There were no complimentary therapies available in the oncology department, but there were plans for these to begin later this year.
- There were no Macmillan nurses working at BMI Goring Hall to provide specialist support to patients with cancer.
- Patients could get additional support and access additional services (such as wig fitting and confidence workshops) through the Macmillan centre at the local NHS hospital. Wigs were not supplied and fitted for free through the cancer services at Goring Hall.
- Lymphedema is a swelling of a body part (usually the legs) that is a side effect of certain regimes of chemotherapy. The Mulberry Suite was visited by a lymphedema nurse specialist weekly to assess patients who may be at risk or had already developed lymphedema.
- The hospital did not provide end of life care but had links with the local hospice and Macmillan Cancer support.
- The endoscopy lists were mixed sex lists, but staff told us that these can be adapted and grouped into same sex lists if this was the patient's preference to maintain privacy and dignity.
- There was a disposable curtain available inside the patient room on the Mulberry Suite which meant that staff could enter the room with the patient present without affecting privacy and dignity.

Learning from complaints and concerns

- The CQC did not receive any complaints in the reporting period of April 2015 to March 2016**.**
- The hospital received 55 complaints in the reporting period April 2015 to March 2016, of which three were referred to the ombudsman. The assessed rate of complaints is similar to the average of the 36 independent hospitals we hold this type of data for. We could not break the data down to gauge how many related solely or partially to medical care but this appeared very low.
- Patients that we spoke with were all aware of how to make a complaint. Most said they would raise and issues with nursing staff initially but also knew where to address a formal written complaint.
- The responsibility for all complaints rested with the executive director. If the complaint was clinical in nature, the Director of Clinical Services would co-ordinate a response and would decide which head of department and/or consultants needed to be involved in the investigation.
- The BMI Healthcare complaints policy set out the relevant timeframes associated with the various parts of the complaint response process. An initial acknowledgement was required within two working days and a full response within 20 working days. If a complaint was escalated to a further stage the complainant would be given the information of who to take the complaint to if they remained unhappy with the outcome. For private patients they would be signposted to an independent adjudicator and NHS patients treated at the hospital, to the NHS Ombudsman.
- During the complaint investigation the process was monitored to ensure timescales were adhered to and responses provided within 20 working days. If a response was not able to be provided within this timeframe a holding letter was sent so they were kept fully informed of the progress of their complaint.
- We saw that negative feedback from complaints was discussed at the Medical Advisory Committee meeting, although this was at a very generic level and not related specifically to medical services. However in addition, the Clinical Governance Committee provides a more detailed report to the MAC detailing all complaints.

Are medical care services well-led?

Requires improvement

We rated well-led as Requires improvement

Vision and strategy for this this core service

- There was a vision for the hospital which was to build on their reputation as a leading provider of healthcare in West Sussex.

- The Mulberry Suite had a vision and mission statement in place and this was displayed for patients and staff, alongside the Macmillan Quality Environment Mark accreditation.
- The provider peer review that took place in 2015 recommended that a cancer strategy for Goring Hall Hospital was developed. This action point was marked as complete, however the strategy was incomplete and had minimal work carried out on it. We spoke to the Lead oncology nurse who was working on this with the group oncology director.
- The hospital was working towards JAG accreditation of the endoscopy service but was at a very early stage in the process.

Governance, risk management and quality measurement for this core service

- We saw a hospital risk register which was partly driven from corporate level risks for 2016. This included patient safety, financial and reputational risks. However, there were no departmental risks, and some staff spoke of risks that they thought were on the risk register that were not. For example, the Mulberry Suite became very warm in the summer and we were told that the lack of air conditioning was on the risk register, which it was not. There was no evidence that risks relating to the care of oncology patients were identified or escalated.
- There was a generally robust governance committee structure. The clinical governance committee fed into the MAC and the Hospital Director, and to the Quality and Risk Committee. This fed into the regional quality committee, which ultimately fed into the Clinical Governance Board. This was also collated at regional level and ultimately fed into the National Clinical Governance Committee.
- Themes from complaints are shared at departmental meetings, clinical governance meetings, relevant sub-committee meetings and as appropriate with the Medical Advisory Committee (MAC) meetings. We saw minutes from these meetings demonstrating this.
- The MAC meetings were held quarterly, although on one occasion in the reporting period the meeting was not quorate. The MAC was generally well attended and representative of the speciality groups working at BMI Goring Hall Hospital.
- The MAC had not identified concerns about the oncology service. We saw three sets of minutes from the MAC and could not see that the risks relating to not having the recommended staffing arrangements in place for haematology patients had been considered.
- The oncology nursing staff did not regularly meet with the oncologists and relied on any issues being addressed through the Clinical Governance Committee (CGC) and Medical Advisory Committee (MAC). The minutes of the MAC and Governance committee did not indicate an awareness that the service was not meeting the national guidance in relation to staffing arrangements.
- Clinical Governance Committee meetings occurred bi-monthly, and we saw minutes that demonstrated incidents, complaints and patient safety alerts were discussed. The oncology lead nurse and the theatre manager attended these meetings. A clinical governance report was routinely produced by the hospital and this detailed adverse incidents, training compliance and policies due for review and there was a clinical governance committee action plan from March 2016.
- The endoscopy lead nurse attended Quality and Risk meetings and reported back to the team. All incidents for the previous week are reviewed and closed at these meetings
- The endoscopy team had a daily huddle and regular team meetings where any issues are reviewed, including incidents, audits and equipment.
- The oncology service is part of the BMI Cancer Cluster Group which is a forum for discussion of best practice innovation and peer review. Cluster meetings were due to be held monthly but there had been no meetings in the last six months due to a vacancy for the cluster lead post, which had been appointed to in the month we inspected.
- A corporate six monthly oncology audit was completed, however staff felt this tool was not useful and without the monthly cluster meetings taking place, did not feel they had a forum to feed this back to.
- We saw minutes from oncology team meetings which occurred weekly.

- There were three information governance incidents reported hospital wide during the reporting period. This wasn't broken down by department but we spoke to staff who knew how, and felt confident in reporting information governance incidents.

Leadership and culture of service

- There was a lead consultant for oncology but the team did not have regular meetings with them.Staff confirmed a good relationship and said that they were always contactable, if needed.
- Staff in oncology reported to the oncology lead nurse, who was also the safe administration of chemotherapy treatment (SACT) lead. The oncology lead nurse reported to the Director of Nursing.
- The oncology lead nurse was also the lead for outpatients, and was temporarily supporting the cancer service at a nearby BMI hospital. Outpatients' attendances at Goring Hall hospital made up for 83% of the hospital activity, which meant combined with the oncology lead nurse role, this presented an extremely wide remit. The provider peer review that took place in 2015 identified that the role profile for Cancer Manager was unclear and the action point for this was for the role to be reviewed. A restructure proposal had been submitted to the regional team in February 2016 but there had been no further feedback on this at the time of our inspection.
- No whistleblowing concerns have been reported to the CQC in the last 12 months. Staff spoken to were aware of how to raise concerns and reported feeling confident that their concerns would be listened to.
- There was a clear management structure in endoscopy. Staff reported to the endoscopy lead nurse, who reported to the theatre manager, who ultimately reported to the director of clinical nursing. This meant that leadership and management responsibilities and accountabilities were explicit and clearly understood.

Public and staff engagement

- A staff survey was carried out in 2016 which there was a 78% response rate. This equated to 128 completed surveys. The positive results from this was the response regarding job fulfilment and objectives. Staff we spoke to were happy in their roles and proud of the work that they did.
- The negative results from this included staff indicating they did not receive fair pay for their roles, and that the morale in the hospital was not good. There had been a period of change to roles with a review of grading just prior to the staff survey being sent out, which was felt by the hospital management team to have impacted on the results for this question.
- There was a cancer support group held at the hospital every three months for patients.
- Staff could access clinical supervision sessions, but not all staff chose to access these.

Innovation, improvement and sustainability

- The endoscopy unit was, at the time of inspection going through the process of applying for Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation incorporating the endoscopy global rating scale.
- There was a standing agenda item on the MAC for clinical innovations. However, there were no clinical innovations discussed for the medical services.

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as Good

Incidents

- Incidents were reported, investigated and learned from. There were 170 incidents reported in surgery and inpatients. This represented 31% of all incidents reported at the hospital. The rate of clinical incidents was similar to the average of the 31 independent acute hospitals that the CQC holds this type of data for. Incidents that were reported included medicines errors and extended stay due to pain or vomiting.
- Between April 2015 and March 2016 the department reported one Near Miss where an incorrect knee implant was ordered and opened in theatre but noticed at this stage. A Near Miss is defined as an unplanned event that did not result in injury. This event was reported and a satisfactory RCA (Root Cause Analysis) was undertaken. A new Standard Operating Procedure (SOP) was implemented as a result. Staff were able to tell inspectors about the changes to practice when asked.
- Staff were able to provide examples of incidents that led to cross organisation learning. An example was given of a patient who suffered excessive blood loss during a routine procedure. The staff then initiated the massive haemorrhage protocol and transferred the patient out of the hospital. The incident was then used as a training scenario and had been presented across the BMI group.
- The staff we spoke with during the inspection were able to clearly explain their duty of candour responsibilities.
- Staff gave us details of incidents where the hospital had discharged their duty of candour by firstly offering the patient concerned a chance for a face to face meeting. This was declined by the patient but the hospital wrote to them to explain what had happened and apologised. Complaint files showed that the provider had a low threshold for triggering a duty of candour response.
- As part of the duty of candour, the hospital make sure that if mistakes are made, the affected person was given an opportunity to discuss what went wrong, what could done to deal with any harm caused and what was done to prevent it happening again.
- We reviewed incident investigation reports and saw that, where necessary, a written letter of apology was sent to patients who were involved in incidents. The hospital ED and matron chose to write and respond formally to incidents were the degree of harm was low.
- BMI Healthcare has a clear policy - BMI Being Open and Duty of Candour policy.

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

- The National Safety Thermometer data collection tool was used in the department. This tool is used to measure harm and the proportion of patients experiencing harm free care during a hospital admission.
- The number of falls was low with only six recorded falls in the year April 2015 to march 2016.
- Every month the hospital the hospital monitored the patient population to identify any hospital acquired catheter related urinary infections. Throughout 2015 no infections were found to be related to urinary catheters.

- Venous Thromboembolism risk assessments were recorded in all the patient records that we saw. We noted that the use of anti-thrombotic stockings and other prophylactic measures such as anticoagulant injections were used according to the risk assessment and local protocols.
- Venous Thromboembolism (VTE) performance was reported through the corporate clinical incident system. The most recent audit showed 100% of surgical patients had been risk assessed for VTE. There had been no incidence of hospital acquired VTE. It was acknowledged by BMI Goring Hall Hospital that the challenge is receiving information for patients who may return to their GPs or other hospitals for diagnosis and/or treatment of VTE post discharge from the Hospital. As such they may not be made aware of them. The hospital continued to work with their consultants and referrers in order to ensure that they collected as much data as possible.

Cleanliness, infection control and hygiene

- Infection control policies, including policies around hand hygiene and MRSA screening and management were available to all staff and in date.
- There was a start-up and shut down cleaning process in theatres which was done at the start and end of each day. The theatre staff completed a 'damp dust' clean and inspection of the theatres. The staff we talked with and records we viewed demonstrated that the cleaning of the theatre department was carried out in line with national and best practice guidance.
- The theatre was cleaned in line with the provider infection control policy between surgical cases.
- A copy of the cleaning schedule was provided during our inspection. This demonstrated that staff kept satisfactory records of all cleaning activity.
- The department had a regular deep cleaning protocol and records showed that the timescales were adhered to.
- Housekeeping staff that we spoke with told us that they had had all of the training necessary including refresher training. We were told that the items the housekeepers, porters and nurses were responsible for cleaning was clearly defined, documented and kept at ward level.
- The department was undergoing refurbishment which was on track for completion by December 2016.
- There were dry mixed recycling, general waste and clinical waste bins on Ilex ward. All were clearly marked.
- We observed that the sluice was clean and everything was off the floor. Bed pans were stored in racking and looked clean. However, they did not have labelling to indicate they were clean.
- Sharps boxes were all labelled appropriately and disposed of in line with best practice guidelines.
- Curtains on the ward were changed every six months unless damaged or soiled at which point they would be changed immediately.
- We saw that there were adequate supplies of Personal Protective Equipment and that it was used correctly when staff treated patients.
- Surgical instruments were sent to two sites for decontamination and the service was described by staff as good. Items could be fast tracked for delivery when required.
- We were provided with a copy of the hospital's hand hygiene policy. This was issued in May 2016 and was due for review in February 2019. Hand hygiene training and assessment was carried out as part of new staff induction training.
- We were provided with the hospital's World Health Organisation (WHO) hand hygiene audit for May 2016. This showed that all staff were always bare below the elbow and complied with the five moments of hand hygiene.
- Infection and prevention Control (IPC) training and updates were provided for all staff through e-learning and face to face teaching. Completion rates were good and exceeded the hospital target.
- Aseptic Non Touch Technique (ANTT) competency training was provided for all staff that had direct clinical contact that required following principles of ANTT. A practical assessment was also carried out following the training. Aseptic technique that reflected national and best practice guidelines was observed during the inspection.

- In 2016 the hospital commenced the Surgical Site Infection Surveillance Programme for Hip and Knee Replacements (Public Health England). This meant that the hospital continued to monitor patients following discharge for signs of infection up to 30 days post operation.
- Data we reviewed suggested five surgical site infections were identified between April 2015 and March 2016.
- The rate of infections resulting from primary knee arthroplasty procedures from April 2015 and March 2016 was above the NHS average although the absolute number (three, from 425 procedures) was low. SSI data submitted between April 2015 to March 2016, to Public Health England for Orthopaedic surgical procedures showed infection rates for hips as 0.3% and for knees as 1.7%. The rate for hips was lower than the England average of 0.7% but the rate for knees was higher than the England average of 0.6%.
- There were no surgical site infections recorded for other orthopaedic and trauma, spinal, breast, upper GI and colorectal, urological or vascular procedures.
- There had been no reports of Meticillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C.diff) or Escherichia coli (E-Coli) in the period from April 2015 to March 2016.Urinary Tract Infections (UTI's) are monitored by the service regularly. The data we reviewed suggested no infections were identified.
- The kitchen had been audited by the Food Standards Agency in 2016 and had achieved a Food Hygiene Rating of five, which was the top rating and indicated 'very good' food hygiene.
- A Mattress audit was carried out in December 2015. A total of 39 mattresses were audited 100% were found to be of good or satisfactory condition.
- Ilex ward had twenty three side rooms of which, eight were carpeted. Carpet in a clinical environment presents a risk for infection control. The infection control risk associated with carpets had been identified, risk assessed and being appropriately managed by the provider. An example of this was the purchase of a steam cleaner to use in the event of a spillage or during any incident that would present a risk of cross contamination. The provider gave assurances that the room would be closed until the risk had been appropriately dealt with. A steam cleaner had been purchased specifically for this purpose.

Environment and equipment

- The hospital engineers monitored theatre ventilation systems and water quality. Adverse findings were reported to the infection control consultant.
- There was a water safety group who continuously monitored and mitigated the risks associated with water including Legionella and Pseudomonas aeruginosa via ongoing flushing schedules and quarterly water testing.
- The conversations with staff and the records we viewed suggested that the medical equipment in the department was fit for purpose. Staff also told us they had ample access to the resources they needed to undertake their roles.
- A resuscitation trolley was available on the on the day-case unit. Records demonstrated it was checked in line with local policy. However, we found examples of missing tamper evident seal checks.
- Electronic equipment in the department displayed a sticker indicating that electrical safety had been carried out.
- The hospital had its own onsite blood bank. There was also a service level agreement in place with the local NHS hospital to provide blood, if required. This meant that people had access to blood and blood products in the event of an unforeseen emergency..
- During our inspection we did not see any equipment stored inappropriately although store rooms were very crowded. We were told by theatre staff about how the introduction of the endoscopy unit had impacted on the storage availability in theatres. We heard how on occasions this had led to items being stored near the fire exit and potentially creating a hazard should an evacuation be required.

Medicines

- While medicines were stored securely and safely in the department, concerns were identified in the recovery and theatre areas.

- We saw cupboards that were not locked during working hours and intravenous fluids were not stored securely. In theatres, the storage area for intravenous fluids had open access and in the enhanced recovery unit, intravenous fluids were stored in unlocked treatment trollies. Good practice guidance states that storage of intravenous fluids should be secure and access controlled to prevent tampering with the products.
- The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Departments visited had suitable cupboards to store controlled drugs.
- The pharmacy team audited controlled drug storage and processes once every three months and the departments conducted daily stock checks. We saw actions identified and implemented from the audits, which helped to keep processes safe.
- Patients had the medicine reconciliation completed by the doctors and pharmacy team during their hospital stay. Medicines reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines.
- The pharmacy department supplied discharge medication within two hours and frequently much quicker. There were processes in place to supply medicines to patients directly from the ward and DSU, which provided a timely service to patients.
- We saw staff advising patients about their medicines and answering questions. Patients we spoke with confirmed this as usual practice.
- The hospital had an organisational structure to manage medicine safety. Staff reported medicine incidents and the hospital conducted investigations try to prevent recurrence of errors. The pharmacy team discussed the lessons learned from medicine incidents at the weekly meetings with staff across the hospital.
- There was a programme of medicine related audits in place, for example, missed dose audit and medicines management audit (safe storage and processes). Results showed Medicines management audits of theatres at 81% in June 2016, DCU at 88% in March 2016 and Ilex ward at 92% in February 2016.
- Medication errors were reported though the hospital incident reporting system, and were reviewed by both the pharmacist and the matron.

Records

- We looked at a total of 20 sets of individual patient records. They were well kept and recorded whether there had been a venous thromboembolism (VTE) assessment, that the 'Five Steps to Safer Surgery' (which is based on World Health Organisation guidance) had been completed, whether the patient was at risk of falls, consent to proceed with surgery, Malnutrition Universal Screening Tool (MUST), Pressure damage risk assessment, a National Early Warning Scores (NEWS) chart and fluid balance charts, when needed. All notes were intact and on the file.
- BMI Goring Hall Hospital did not allow the removal of hospital medical records from the site in any circumstances. If a Consultant wished to view the hospital's patient notes, they were encouraged to do so within the hospital and in accordance with data protection legislation and the Caldicott Principles.
- The hospital reviewed and audited medical records on a monthly basis to ensure that they could be located and were available for clinics and admissions. Audit results showed missing patient records was a rare occurrence.
- Risk controls in place included a range of BMI Information Security/Management Policies and an Incident Reporting Policy. All staff were required to read and sign acknowledgement of the BMI policy – IT and Information acceptable use policy (BMI IM pol 04) held in the Governance Department office.
- There was an electronic system in place that meant peoples records were tracked and readily available for follow up appointments.
- Consultants who had Practising Privileges at BMI Goring Hall hospital were required to register with the Information Commissioner's Office as independent data controllers and were required to work to the standard set by the Information Commissioner. This included how patients' medical records were stored and transported. Consultants were responsible for their private patient medical records.
- The hospital held a breast implant register which details every breast implant used on every patient. The records

went back approximately 10 years. The detail within the register contained: patient details, implants used, surgeon details, scrub nurse details, and procedure details. This meant that where patients had concerns or problems with their breast implants, the details were available to inform any future consultation.

- We saw two sets of records that did not have a patient weight recorded on the anaesthetic chart. One of these cases was identified as having major surgery.

Safeguarding

- The Director of Clinical Services (matron) was the safeguarding lead and was supported by the Quality Assurance Advisor. The safeguarding lead was trained to level three in both adult and child safeguarding.
- We found a robust system for reporting safeguarding concerns. Staff were encouraged and supported to raise issues or concerns they identified. Heads of department were responsible for escalating concerns through the matron and subsequently, the matron was responsible for escalating concerns through both the internal safeguarding structures and the local safeguarding board. This did not preclude staff making referrals themselves, where they identified concerns or risks, if they felt it was necessary.
- Mandatory safeguarding training was managed according to BMI's mandatory training matrix. A copy of this matrix was provided to the CQC and showed the number of staff having received the training required for their role. All staff received level one safeguarding training for adults and children. All clinicians and non-clinicians in management or supervisory roles had level two safeguarding training for both adults and children. All lead nurses and directors of nursing had safeguarding level three training for both adults and children.
- This training was provided online except for the level three adults safeguarding training which was delivered at a workshop.
- The training matrix showed 100% compliance with safeguarding training.
- The hospital had a safeguarding adult's policy. This also incorporated the Mental Capacity Act and Deprivation of Liberty policies. This was issued in May 2015 and was scheduled for a review in November 2018.
- The hospital had a safeguarding children policy that was aligned to the local safeguarding children board policies and followed national guidance.
- PREVENT (radicalisation awareness and prevention training) had been added to the mandatory training in 2015, in line with national requirements.
- The provider policy advised staff on Female Genital Mutilation (FGM) in line with national policy.

Mandatory training

- Mandatory training was predominantly done as e-learning except level three safeguarding training which was provided face to face. Intermediate life support training was also provided face to face by an external provider.
- Additional courses were added to the mandatory training programme in 2015-16, these included: dementia awareness, conflict resolution, anti- bribery and corruption and consent.
- The theatres team had an information board in the corridor where mandatory training records were clearly visible.
- The records we viewed showed 100% of the staff were up to date with their training. The BMI organisation target for completing mandatory training was 90%.
- The department also had an electronic record of all staff training. This included training completed, training due and overdue.
- The hospital had an e-learning module for all clinical staff to complete on dementia awareness.
- Completion of mandatory training by consultants formed part of the appraisal process and was required for renewal of practicing privileges.Bank staff who worked more than 80 hours a month at the hospital were also required to complete mandatory training. The hospital maintained records of this. Sub-contracted staff,such as catering staff, are also required to submit evidence of completion of mandatory training.

Assessing and responding to patient risk

- The hospital has clear admission criteria for all surgical patients. These were; elective surgical admissions or

surgical re-admissions for those aged 18 or over. Patients with a maximum weight of 160kg (due to bed capacity), NHS patients with a body mass index (BMI) under 40, Non NHS patients with a BMI under 50.

- Patients with a BMI of between 40 and 50 were required to have an anaesthetic review prior to surgery.
- We were provided with the BMI Goring Hall 'Five Steps to Safer Surgery' checklist audit. This showed how they completed the audit to ensure the five steps to safer surgery were completed. This also showed that between January 2016 and May 2016 compliance with the WHO checklist was between 99% and 100%.
- We observed five surgical procedures during our inspection. For each procedure the Five Steps to Safer Surgery checklist (based on the WHO guidance) was completed properly. The WHO Five Steps to Safer Surgery checklist asks a series of questions to ensure that the correct procedure is carried out before the induction of anaesthesia, before skin incision and before the patient leaves the operating room.
- A modified Five Steps to Safer Surgery checklist was used during interventional radiology, such as spinal injections in the day case unit.
- The records we viewed showed that a wide range of risk assessments were undertaken (either at pre assessment or on admission). This meant that patients had their individual care risks identified and addressed in an appropriate way. These included venous thromboembolism (VTE) assessments, falls assessments, nutritional risk assessment using the Malnutrition Universal Screening Tool (MUST) and a pressure damage risk assessment.
- There were suitable arrangements in place for the safe transfer of patients to local NHS hospitals, in an emergency. There was a dedicated transfer portable bag with the relevant disposables as well as a monitor capable of capnography (capnography is the monitoring of the concentration of carbon dioxide in the respiratory gases) and a portable ventilator.
- Capnography monitoring was also available on the theatre resuscitation trolley.
- The transfer bag and emergency drug bag was kept separately on the ward which posed a slight risk that, in an emergency, staff might be delayed whilst fetching both items. Staff told us that as the majority of transfers were made from theatres the operating department practitioners (ODP) would have the relevant drugs at hand if there was ever the need for them. The number of transfers out was minimal and those we saw the records for had been managed and transferred in a timely way.
- We discussed this with senior staff during the inspection, who told us that the current processes would be reviewed by the resuscitation committee to ensure safety.

Nursing staffing

- We were told by a range of staff that there was adequate staffing to run the theatres but problems could occur if there were staff on annual leave or off sick. This was usually covered by bank or agency staff. Any bank or agency staff must complete a competency checklist to ensure that they are safe to practice. If the situation became so serious it would compromise safety, the surgical list would be cancelled.
- The rate of use of bank and agency for theatre nurses was similar to the average of other independent acute hospitals we hold this type of data for in the reporting period (April 2015 to March 2016).
- Agency staff were given a 90 day induction workbook to go through with their line manager. This was a workbook specifically designed for agency staff. When this had been completed, it was signed off by the line manager and the agency staff member could work with reduced supervision.
- The rate of use of bank and agency for theatre Operating Department Practitioners (ODP) and healthcare assistants (HCA) was similar to the average of other independent acute hospitals between April 2015 and November 2015. The use of bank and agency for this staff group decreased from 18% in September 2015 to 7% in March 2016.
- The surgery department did not have any full time equivalent vacancies in theatres. We were given examples of how they had attracted bank staff to join the team on a permanent basis. This included putting together a learning and development package that would allow them to develop in their position through the provision of training that was relevant for the role.

- The hospital used a nursing planning tool to establish required ward nursing hours for the actual patient dependency. This tool was used as a guide to ensure the skill mix was available to ensure safe patient care. This staffing tool was used to plan the skill mix five days in advance, with review and updates on a daily basis. Actual hours worked were also entered retrospectively to understand variances from the planned hours and the reasons for these. The tool was reviewed at least three times a day, and any 'red flags' were escalated. An additional on-call Nurse was available out of hours to support for unplanned increases in patient dependency.
- The theatre team were allocated according to Association for Perioperative Practice staffing standards. Rotas were planned in advance to ensure the required skill level and staff were then allocated to appropriate theatre lists one week in advance.
- Any predicted staffing shortfalls were addressed at both the daily communications meetings when theatre lists were amended to ensure a safe balance.
- The hospital had been pro-active and had some success in trying to resolve their difficulties with recruitment by developing a package to encourage high quality staff to work there.

Surgical staffing

- All anaesthetists and most surgeons in theatres had NHS contracts and their performance was managed through these. The hospital management team and MAC had copies of all consultants NHS appraisals and where these were not provided the consultants' practicing privileges were suspended.
- We found suitable arrangements in place to monitor the performance of the three surgeons who did not have a substantive NHS contract. This was done via the medical advisory group (MAC) chair and hospital director who collated information and provided appraisals. There was documentary evidence that these surgeons were performing sufficient operations to retain their skills and their outcomes were monitored as part of the appraisal process.
- The resident medical officer (RMO) provided medical cover to the wards and surgical areas. The RMO visited clinical areas at regular intervals throughout the day. The RMO's we spoke with told us that they felt confident to escalate any concerns to the relevant staff. The hospital had staff trained in cannulation and phlebotomy to support the RMO.
- The RMO would hand over to the next RMO on a Thursday morning. A full handover of the patients was completed which took around one hour. The RMO on duty at the time told us that the contact details of all the consultants were contained in a folder, so they can be contacted at evenings and weekends. They said that there had never been a problem with getting in touch with a consultant and that even if they had to leave a message, the consultant would always call straight back. The RMO said that they referred to policies and used their clinical judgment to inform their decision as to whether to contact the consultant.
- The RMO participated in the 8:30am handover meeting with all nursing staff. This meeting discussed the cases where they may foresee problems.
- This handover meeting was observed during the course of our inspection. This meeting was short and concise but gave enough detail for it to be fit for purpose.
- Consultant surgeons, anaesthetists and physicians are managed through BMI Healthcare's Practising Privileges Policy. This policy detailed the level of cover required: that consultants/doctors remain available (both by phone and, if required, in person) when they have inpatients in the hospital. It was also a requirement that consultants arranged appropriate, alternative, named cover if they will be unavailable at any time when they had inpatients in the hospital.
- Some consultants worked in consortiums or speciality groups to provide cover, on a rota basis, to all patients under the care of that speciality admitted at any given time.
- There was an explicit expectation that surgeons and/or the anaesthetist remained in theatre whilst patients were recovering. We saw that this happened in practice when observing in theatres. Staff confirmed this was usual practice.

Major incident awareness and training

- The hospital had a Business Continuity Policy which incorporated a series of protocols to respond to a range of incidents. These were supported by a set of action cards. Action cards are plans that are suitable and

proportionate and clearly describe actions to be taken to ensure prioritised activities are maintained when faced with disruption. This policy was issued in February 2016 and was due for review in August 2018.

Are surgery services effective?

Good

We rated effective as Good

Evidence-based care and treatment

- BMI Goring Hall hospital had patient reported outcome measures data (PROMS) available for all patients who had hip, knee and hernia repair.
- Staff had access to BMI Corporate Polices on the BMI Intranet that were based on National Institute of Health and Care Excellence (NICE), national and Royal College guidelines. These included policies for the management of specific conditions and to advise staff on safe practice in areas such as resuscitation, infection prevention and control, thrombolytic event prevention and the recognition and management of sepsis.
- The hospital management team were clear that only procedures that the consultant and staff were competent to provide safely could be offered at Goring Hall. The MAC made explicit that only procedures that were regularly done within the consultants NHS practice or where they could evidence they had the surgical skills to perform were permitted.
- The hospital provided interventional radiology. They undertook spinal injections in theatre under sedation and all patients had access to the recovery ward and the day ward. Other Interventional Radiology procedures were very minor and did not require sedation but could have required local anaesthetic. These patients were walk in, walk out patients and did not need to use the recovery ward.

Pain relief

- Patients we spoke with all commented that their pain was well managed and that regular checks were carried out by the nursing staff to ensure the patients were comfortable. One patient told us how their pain had worsened after surgery and that as soon as they called a nurse they were provided with appropriate and effective pain relief.
- Staff recorded the patient's history of pain at the pre-assessment clinic and recorded discussions about the expected pain for the specific procedure they were having.
- A pain assessment tool was used to help in the assessment of pain and whether the prescribed analgesia was being effective. Pain scores were recorded regularly in the patient records that we reviewed. Where the patient said they felt pain, analgesia was given. Patient records that we reviewed showed that there was appropriate analgesia prescribed and that this was administered regularly.
- A range of analgesia was prescribed dependent on expected and actual pain levels. Alternative routes of administration were available to patients who were unable to take oral analgesia or where another route might be more effective.
- Analgesia was encouraged before interventions that might increase pain levels, such as prior to physiotherapy or before dressing changes.
- The patient satisfaction dashboard showed the responses to several questions relating to pain management. In the period to June 2016, the score for "Did you feel everything possible was done to alleviate your pain" was 92%. A similar percentage reported that they remained pain free.
- A pain audit carried out in February 2016 showed scores of 97% for the day care unit and 92% for inpatients. Scores included the correct use of the pain assessment tool, correct recording of pain and recorded discussions between staff and patient regarding pain.

Nutrition and hydration.

- Fasting times met the Royal College of Nursing standards of perioperative fasting in adults and are staggered where possible. Patients we spoke with clearly understood the instructions they had been given regarding the last time they should eat or drink prior to their procedure
- Nutritional state was assessed for each patient on admission using the Malnutrition Screening Tool (MUST). This assessment was repeated post operatively and daily until the patient was ready for discharge. When necessary, patients were referred to a dietician for specialist nutritional support.

- Most nutritional preferences could be accommodated by the hospital's catering team. Additional dietary advice/special requirements were discussed with the patient on arrival to the ward and daily throughout their stay.
- Ward rounds during meal times were avoided. Pantry staff reported any unfinished meals to the nurse in charge.
- The staff identified patients that needed assistance with meals through the admission processes. Patients who were unable to feed themselves were assisted by the nursing team. The hospital encouraged relatives eating with the patient when this encouraged a patient to eat.
- Food and fluid intake was monitored using food charts and fluid balance charts. We reviewed fluid charts for patients on Ilex ward and saw they were completed and had been totalled each day, when required.

Patient outcomes

- The hospital provided data for the NHS Patient Reported Outcome Measures (PROMs).
- The England average for PROMs – primary knee replacement, was within the estimated range of the hospital's adjusted average health gain. Out of 97 records 81.3% were reported as improved and 10.3% as worsened. Records for the Oxford Knee Score showed that out of 106 records 92.5% were reported as improved and 5.7% as worsened.
- The England average for PROMs – Primary hip replacement, was within the estimated range of the hospital's adjusted average health gain for the following measures. Out of 153 records 91.5% were reported as improved and 3.3% as worsened. The Oxford Hip Score – showed that out of 164 records 95.1% were reported as improved and 4.3% as worsened.
- The hospital's adjusted average health gain for PROMs - groin hernia, could not be calculated as there were fewer than 30 records.
- In the period April 2015 and March 2016, there were 18 cases of unplanned readmission within 28 days of discharge from a total of 6,797 day case and inpatient attendances. This number of unplanned re-admissions was low when compared to a group of independent acute hospitals which submitted performance data to the CQC.
- In the period April 2015 to March 2016 there were 11 cases of unplanned transfer of inpatients to another hospital. This number of unplanned transfers was not high when compared to a group of independent acute hospitals which submitted performance data to the CQC.
- There were eight cases of unplanned return to the operating theatre in the reporting period April 2015 and March 2016. This number of unplanned returns was low when compared to a group of independent acute hospitals which submitted performance data to the CQC.
- In addition to their own audits, results on patient outcomes were compared with other locations within the region and regions across BMI Healthcare Limited through the corporate Clinical Dashboard which uses data from their incident and risk reporting database. This enabled the hospital to review both their own data and compare this with hospitals of a similar size within BMI Healthcare Limited group.
- The hospital had a good working relationship with the NHS clinical commissioning group (CCG). The hospital was fully committed to driving improvement in the Standard Acute Contract and Commissioning for Quality and Innovation (CQUINs) on an annual basis.
- BMI Healthcare Limited continued to work with Private Healthcare Information Network as there was a move towards improved reporting of patient outcomes across the independent healthcare sector. This will enable effective comparison with data available from NHS providers to assist with information transparency and, in turn, patient choice
- A local audit of urethral catheters post spinal anaesthetic showed a higher incidence when compared to the local NHS trust. This was identified at the MAC and was shown to relate to a particular surgeon who was made aware of the findings.
- The hospital used an enhanced recovery programme that focussed on ensuring patients were properly prepared and in optimal health before surgery and that their care followed best practice by the use of set care pathways. For example, prior to admission some cohorts of patients are supported through optimised nutrition involving carbohydrate loading. This increased glucose reserves during pre-operative fasting and promoted fast recovery

- BMI Goring Hall Hospital participated in The National Joint Register (NJR) - The purpose of the NJR is to collect high quality and relevant data about joint replacement surgery in order to provide an early warning of issues relating to patient safety.
- For Hip replacement Goring Hall Hospital risk adjusted 90-day mortality follow hip replacement surgery Data for 1st April 2003 to 31st July 2015 was in line with expected mortality but at the control limit. Knee replacement mortality was also in line with the expected.
- NJR data showed the hospital was broadly in line the England average for health gain post-surgery for hip replacements and performed slightly better than the average for knee replacements.

Competent staff

- Consultants applying for practicing privileges at the hospital needed to complete an application and meet specific criteria. The applicant would have had to be licensed and on the specialist GMC register and have held a substantive consultant post within the NHS or the defence medical services within the last 5 years. The applicant would be asked to demonstrate relevant clinical experience relating to practice. An interview would then take place where the consultant's practising intentions were discussed.
- Staff files and discussion with the matron showed that a record of the consultants most recent appraisal and all necessary documentation, such as DBS checks and GMC registration were required before a consultant could work at the hospital.
- The Medical Advisory Group (MAG) reviewed the application with respect to the credentials, qualifications, experience, competence, judgement, professional capabilities, knowledge, current fitness to practice, character of and confidence held on the applicant. Recommendations were passed to the Hospital Director prior to the application being granted. The Hospital Director was clear they had the final say about whether the privileges were granted.
- Practising privileges were reviewed every two years by the Hospital Director and MAG to ensure that the defined criteria as set out in the policy remain in place. Between these reviews the Hospital Director had the authority to suspend or withdraw practising privileges following identification of any practice concern. In practice, this was carried out in liaison with the MAG Chair.
- The surgery team used surgical first assistants in theatres. Surgical first assistants are registered nurses or operating department practitioners with higher level training to enable them to assist the surgeon with the operation. The practitioners they used had completed the Association for Perioperative Practice (AfPP) Surgical First Assistant (SFA) Competency Toolkit..
- Over 90% of ward staff in the current reporting year had had an appraisal. The records we showed that 92% of nursing staff had had an appraisal, 92% of Healthcare Assistants had had an appraisal and 94% of other staff had had an appraisal. In the most recent reporting period, 100% of theatre staff had participated in an appraisal.
- Nursing staff were given training to assist with their continuous personal development and NMC revalidation. Nursing staff reported that they felt they were given appropriate support through this process. The BMI learn system could also be utilised to assist with the revalidation process.
- Surgeons performing cosmetic procedures were required to be listed on the GMC specialist register and to be undertaking the procedures regularly. All cosmetic surgeons with practicing privileges held substantive NHS contract.

Multidisciplinary working

- The surgery team completed a morning brief which lasted about 15 minutes at 8:15am. This was a chance for the team to look at the day's work and reflect on what went well and what didn't from the day before. We saw that this was documented and a record of the discussion was kept.
- There were suitable arrangements with external organisations (for example) to ensure the safe transfer of patients to an NHS site. This included a South East Coast Critical Care Network checklist, and a critical care transfer agreement with a local NHS trust.
- Ward nurse worked closely with allied professionals such as physiotherapists to ensure the best outcomes for patients.
- The patient records we saw showed involvement of the wider multi-disciplinary team in planning and providing patient care. Physiotherapists, for example, were very much involved in leading the post-operative care of patients who had undergone orthopaedic hi[p or knee surgery.

Good

Surgery

Seven-day services

- The Hospital's patients were supported 24/7 by an onsite RMO who contacted the patient's consultant to discuss or review any concerns.
- The consultant anaesthetists provided an on call rota to support the RMO with any post anaesthetic concerns and were available at all times.
- Consultants who had patients admitted to the hospital were required to be available at all times to attend or advise the RMO, if the patient's condition gave cause for concern.
- Radiologists provided the hospital with 24/7 emergency cover through an on-call rota.
- Pharmacy cover was provided between Monday to Friday between 8:30am and 5:00pm and from 9:00am to 3:00pm on Saturday. There was no pharmacy cover on Sundays.
- If there were any specific drugs that were not held at Goring Hall. The local NHS trust was usually able to supply them.

Access to information

- The provider kept records of all patient contacts by consultants at BMI Goring Hall hospital. This meant that any consultant or other staff member treating the patient could access the full patient record, whenever necessary.
- Letters were sent to patients' GPs after treatment or surgery to ensure they were aware of any changes in the patient condition or follow up that might be necessary.
- Staff had access to all of their training records online. All policies and protocols were also available on line.
- In addition to the resources held online, we saw that there was an accessible folder with the local policies in the theatre manager's office.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 20 sets of individual patient records during the inspection and noted that written consent was obtained by the consultant. This was properly signed and dated in each case and details of possible complications and risks were recorded.
- Consent was obtained during consultation appointments but was checked again on the day of surgery. The hospital had a policy of patients not being put on the theatre lists less than six days ahead of the operation. This allowed for time to think and absorb information about the procedure as well as allowing for better theatre planning.
- Patients undergoing cosmetic surgery (such as breast implants) were given a two week 'cooling off' period between the consultation and the operation date.
- Patients were given sufficient information for them to make an informed decision about the procedure they were scheduled to undergo and there was opportunity during the pre-assessment to ask questions, which staff were happy to answer.
- We were told and shown by staff how the surgery department had a different consent form for those patients living with early dementia and how reasonable adjustments were in place to obtain consents in these circumstances and took into consideration whether consent was valid.
- Staff had received Mental Capacity Act (2005) training and were aware of their roles in respect of this patient group. In June 2016 38% of nursing staff had completed training with a year-end target of 100%.
- The hospital had not had to apply for any Deprivation of Liberty Safeguards and we were told by the hospital managers that they would have to consider carefully whether they would admit any patients for whom this was necessary. The managers told us the ability of the hospital to meet the needs of the patient would be the determining factor.
- We saw that staff asked for verbal consent prior to initiating any care of treatment with patients.

Are surgery services caring?

Good

We rated caring as Good

Compassionate care

- We spoke with five patients on the wards who all reported that they had been treated exceptionally well. They had been given the right level of information. All of the four day case patients we spoke with explained that they had been seen on time.
- A patient on the ward commented that they had been well cared for. They told us that they had a positive and excellent experience.

Good

Surgery

- We observed examples of good communication between the surgeon and the patient and patients being treated with dignity and respect. There was an understanding across the surgical team of the patients' needs and how to meet them.
- We were also told by patients that the staff had been very responsive when the call bells were used. One patient we spoke with had used the hospital a number of years prior to this inspection and had not a good experience. However, on this occasion they felt well looked after and didn't anticipate feeling as positive as they did.
- The hospital's Friends and Family Test scores for NHS patients were similar to the England average of NHS patients across the period October 2015 and March 2016. In this period, between 95% and 100% of patients said that they would recommend the hospital. In the same period, between 97% and 100% of insured and self- pay patients said that they would recommend the hospital.
- The hospital maintained a comprehensive patient satisfaction dashboard that showed a response rate of between 32% and 52%. Of those completing either the long survey of the postcard survey, 96.5% would recommend the hospital.
- Prior to the inspection the CQC gave patients, friends and family the opportunity to make comments on cards. Of the 12 we looked at that had been completed about surgery, 11 were overwhelmingly positive. Some of the positive quotes included; "Wonderful care and attention, amazing experience". "I was treated with dignity and respect and kept well informed". Prior to, and post operation, outstanding".
- The one negative piece of feedback related to a patient who was taken to surgery later than they were expecting and therefore had not eaten or drunk anything for longer than they were expecting.
- While we were speaking with patients we observed good interaction between nursing staff and the patients. Patients spoke of and we witnessed personalised care where the staff would refer to people on first name terms. We were told that patients had been asked how they preferred to be addressed.
- There were patient satisfaction leaflets and a box by reception for patients to place them. We also saw that there were CQC comment cards and a box for them to be dropped in.

Understanding and involvement of patients and those close to them

- We observed a physiotherapist performing a stair assessment on a patient in the presence of one of their children. We observed excellent communication with both the patient and the family member, with the patient being given very clear explanations and advice.
- Patients told us of how the staff has contacted their family post day case surgery and give information such as when they would be ready to be collected.
- Patients stayed in the hospital after surgery until they were ready or the person collecting them was ready.
- Relatives that we spoke with said they felt they were included and involved in decisions about their relatives care and treatment. Consultants had spoken to the patient and their relative together to ensure the relative understood what had been said and could remind the patient.
- The RMO visited patients at least every day and provided clear updates on any changes to the treatment or care plan.

Emotional support

- We observed theatre staff holding the hands of patients who were nervous prior to being anesthetised for surgery. Theatre staff would explain everything clearly and were sensitive to the needs of each individual patient.
- Patients with a specific need could be referred to the counselling service that was provided at BMI Goring Hall hospital.

Are surgery services responsive?

Good

We rated responsive as Good

Service planning and delivery to meet the needs of local people

- The hospital worked closely with the local CCG and provided a large amount of diagnostic and treatments for local NHS patients, relieving pressure on the local NHS services.
- The hospital management team understood their main patient groups and planned services to meet their

needs. For example, the hospital was developing the ophthalmology services as this was identified as an increasing need for the local population. Children's services were not offered as there was limited demand and the service could not meet the required standard of paediatric care without significant additional resources.
- Where a need was identified but the hospital could not resource a local consultant who wanted practicing privileges, they actively recruited from further afield to allow the specific service to be provided.
- The hospital had made changes to improve patient care and there was a planned refurbishment programme. Examples of these changes have been the turnaround of patient bedrooms on Ilex Ward and the floor changes within the Day Care Unit. In recovery and ERU there had been an upgrade to the hand washing sinks to meet with infection prevention guidelines.
- In response to patient feedback and PLACE assessment results the hospital had improved access and parking by resurfacing the car park, repairing potholes and improving external signage. There was improved disability access and the hospital had replaced their wheelchairs. A designated safe pedestrian walkway had been created.

Access and flow

- The hospital met the target of 90% of admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period before the targets were abolished (April 2015 to May 2015). Above 90% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 2015 to March 2016).
- Staff in the reservations department, which arranged bookings for surgical procedures, demonstrated what happened when patients were booked for surgery. We were shown how they tracked the NHS patients to ensure that they met their 18 week referral to treatment time. Every procedure undertaken had its own code to ensure that the correct surgery was performed. The computerised system was straightforward to use and contained the right amount of information to be effective.
- Action was taken to avoid delays. This included changing list allocations, directing to other providers and informing referrers.
- The theatre utilisation tool was calendar based and had separate pages for each theatre. This showed what was booked, when and with which consultant. This way the correct staffing resources were planned in advance and delays or cancellations due to staffing shortages were minimised.
- Some difficulties with theatre utilisation occurred when consultants asked for spaces on a particular list to be reserved for their private patients. If there were subsequently no private patients to fill the lists, it could be difficult to find enough patients to maximise the theatre utilisation. This did cause some frustration as the team could have filled the list if the decision to accept all patients was made sooner.
- In response to this the senior management team had introduced a new rule that patients all had to be booked at least six days in advance of their operation. The policy was strictly enforced and allowed for optimal staffing, bed management and theatre utilisation with a longer time to offer any spaces on the list to other patients – including NHS patients.
- The hospital reported that they had cancelled 25 procedures for non-clinical reasons in the period April 2015 to March 2016. Patients were offered another appointment within 28 days of the cancelled appointments unless they chose to go to another hospital. Cancellations had taken place because of staff shortages in the theatres but the staffing had been increased and this rarely happened now.

Meeting people's individual needs

- The hospital provided telephone interpreters through a contract with a third party provider.. Demographically, the hospitals main patient population was elderly, white British people who were English speakers, so the staff did not need to use interpreting services very often.
- The staff group was more diverse than the patient population and had a number of people who could speak several different languages. Staff who could speak additional languages were happy to use these to support patient care but this was not used to replace professional interpreting, when necessary.
- Some of the services had been adapted to meet the needs of patients with low vision. The hospital had a sight care advisor on site who could direct patients to support services in the community. Two of the hospital's staff had been trained as Eye Clinic Co-ordinators (RNIB), they too could support the needs of low vision patients.

Good

Surgery

- The hospital had identified that a gap in the provision of British Sign Language (BSL) interpreters. The team identified the requirement prior to these patients' attendances and a BSL interpreter was then made available for the patients.
- The chef did regular ward rounds to gather feedback or adapt menus to meet patients' specific needs. All feedback was taken seriously and actioned where necessary.
- We saw comment cards from patients which described the "very good choice of food". We spoke to the catering manager who gave us examples of where patients had requested meals that were not on the menu and how they went out of their way to provide for these patient's needs.
- The hospital's Patient Led Assessment of the Care Environment (PLACE) scores are higher than the England Average for food.
- The hospital participated in the PLACE audit programme and welcomed the opportunity to seek and respond to feedback from their services users.
- The hospitals had an identified dementia champion, who together with e-learning modules, promoted dementia awareness. The pre-assessment teams risk-assessed all patients for early signs of dementia and handled conversations sensitively when concerns about the patients capacity were identified.
- The hospital put curtains into all patient bedrooms on Ilex Ward in order to provide more privacy and dignity when the doors to the bedrooms were open. This had been done in response to a patient comment where they felt vulnerable when being examined, in case someone opened the door to their single room.

Learning from complaints and concerns

- BMI Healthcare followed a 3 stage process in dealing with complaints, with clear timeframes as set out in BMI Healthcare Limited Complaints Policy.
- In the hospital response to a stage 1 complaint, patients were signposted to stage 2 in the event they were dissatisfied with the outcome of their complaint.
- Stage 2 involved a review of the complaint by an appropriate member of the BMI Healthcare Limited regional (or sometimes corporate) team, to ensure that a thorough investigation had been conducted. The Stage 2 outcome letter signposted the patient to Stage 3 should the complainant remain unhappy with the stage 2 outcome. Private patients were signposted to the Independent Sector Complaints Adjudication Service (ISCAS).
- NHS patients treated at the hospital also had the option of writing to the Parliamentary and Health Service Ombudsman. Where appropriate and with the patients consent, the hospital could obtain second opinions and case reports to aid the investigation.
- We saw a response to a complaint where all four theatres had been provided with a 'Ranger' fluid warmer. These had been introduced following a complaint where a patient received blood that was cold and consequently the patient felt cold as a result.
- If a complaint was clinical in nature the Director of Clinical Services coordinated a response involving the relevant head of department. The department head was then responsible for sharing lessons learned from the outcome of a complaint.
- The hospital received 51 complaints in the period April 2015 to Mar 2016. Of these complaints, three were referred to the Ombudsman. The rate of complaints is similar to the average of independent acute hospitals the CQC hold this type of data for.
- As a result of two complaints from separate patients, the hospital invited the complainants to attend their PLACE audit and patient forum. Comments from the complainants at both of the events led to further improvements in services.

Are surgery services well-led?

Good

We rated well led as good.

Vision and strategy for this this core service

- The hospital strived to deliver high quality healthcare in innovative ways that benefit the health economy with particular developments in ambulatory care, orthopaedics, ophthalmology. They partnered with other organisations to work towards seamless patient pathways that improved patient outcomes and kept treatment tailored to an individual's needs.
- The hospital was aiming to be in a position where it could use the latest technology to give the patients that

choose their services the best diagnostics possible, using expert clinical knowledge and skills followed by a treatment and management plan that the patient has bought into.
- There were plans to adapt the existing building to accommodate more patients. Minutes of the MAC showed that the BMI corporate team had planned to use the South Wing for private patients and the North Wing for NHS. The minutes said that BMI would be dividing some of the patient rooms on North Wing to provide shared accommodation for NHS patients and to increase capacity in this wing.

Governance, risk management and quality measurement for this core service

- · The hospital adhered to BMI Healthcare Hospital Risk Management Plan. Local governance and risk management fed upwards into the corporate governance framework by the ED and matron attending regional committee meetings.
- They were informed by the MAC, the Heads of Departments meetings, clinical governance meetings and health and safety meetings. Each committee was chaired by a member of the hospital's senior management team who was responsible for ensuring that the committee has clear terms of reference that align with the corporate committees and that the committee focused on identified key areas of responsibility. Each committee was responsible for identification, monitoring and prevention of risks relevant to the Committee's areas of responsibility and for escalating serious risks to the Hospital Executive Team.
- The Goring Hall Risk Plan detailed the likelihood and impact of the most serious clinical and non-clinical risks and had comprehensive mitigation in place to reduce the risks.
- The hospital had a clinical governance system in place that included a quality and risk team. The team was responsible for co-ordination of and response to patient satisfaction surveys, complaints, incident investigations, audits and action plans, clinical governance bulletins, document control, supporting assurances of compliance with regulatory work including quality and patient safety.
- Heads of Department met monthly with the hospital senior manages to review the preceding month's performance and plan for the month ahead.
- Each meeting had a standard agenda template that involved discussions about risks, quality, compliance and assurances.
- Bi-monthly clinical governance reports were produced by the quality and risk team and presented for review and discussion at relevant governance meetings and the hospital Medical Advisory Committee. The reports contained details of incidents, complaints, patient satisfaction and mandatory training completion rates.
- The Medical Advisory Committee (MAC) met four times a year and included representation from all specialities offered at the hospital. It was attended by the Executive Director and the matron. A wide range of topics were discussed and action taken in response to any concerns raised. The minutes of the MAC meetings were distributed to all consultants. We saw from minutes that issues such as improved Wi-Fi access and restricting access to the theatres were discussed along with a letter which advised the ED that the hospital had been identified as a potential outlier for revision rates for knee procedures for all NJR data reviewed during 2003 – 2015. The committee discussed possible reasons for this and the ED reported their review to the Corporate Quality and Risk Team. The minutes of MAC meetings showed who was responsible for any action created as a result of the meeting.
- Minutes from consecutive meetings showed that concerns had been raised about supplier's representatives in the operating theatre suite. A change to practice had been made, the theatre administrative office was moved outside of the theatre door and any 'reps' now needed to demonstrate their need to be in theatre.
- The hospital worked within the BMI Hospital Committee terms of reference. This structure allowed for a cascade of information from the senior team to individual staff members through departmental team meetings. The approach was supplemented by frequent one to ones with the Heads of Department (HODS) team, monthly group meetings to agree operational priorities, and annual management team building days that enable the management team to review how they worked together and identify each member's strengths and challenges.
- Clinical quality and governance matters were reviewed by the MAC, through the Clinical Governance Committee, which met bi-monthly and enjoyed a high level of engagement from the consultants. The minutes

and actions from these meetings, the Clinical Governance Meeting and the various sub-committees (Health and Safety, Infection Prevention) were reported to the MAC, and to the management team through the HODS team meeting. Information would then be cascaded to other staff from the HODS meeting
- The quality and risk processes at the hospital were supported by a corporate team. They had access to shared information and corporate benchmarking.
- The hospital had a staff member in the role of Designated Information Security Coordinator.

Leadership / culture of service related to this core service

- The senior management team held regular forums where a brief presentation was given on relevant topics, corporate and local news. Feedback and comments were communicated directly to the hospital director.
- The theatre managers explained how they felt that they were supported by senior staff at the hospital. This in turn gave them autonomy and confidence to make decisions.
- We were told how the senior managers were supportive of the surgical team when dealing with a dispute with a consultant who had spoken inappropriately to another member of staff. It was explained that they felt supported and that appropriate action was taken to resolve the dispute. We saw a letter from the hospital director to the consultant which confirmed an approach that demonstrated poor behaviour by any member of staff would not be tolerated.
- Theatre staff told us that senior members of staff at the hospital were accessible and would regularly visit theatres.
- The whole theatres team met formally with the senior staff quarterly.
- Senior hospital staff attended the induction of any new staff for one day.
- The hospital were undertaking a targeted training programme for identified members of staff to ensure understanding of and implementation in relation to the duty of candour.
- There was also a belief among staff we spoke with that a strong team culture assisted with duty of candour and they were encouraged to say if things had gone wrong, apologise and learn from it. We saw a folder which contained reports into incidents and how they had been used to learn and change practice where necessary.
- BMI had an action plan in place to ensure they were ready and would be compliant with the Workplace Race Equality Standards when they came into force from April 2017. The organisation had calculated the percentage of BME staff in senior roles and looked at access to non-mandatory training for non-white staff.

Public and staff engagement

- To address recruitment challenges, the hospital extended the reach of their advertising outside the local area. With dedicated support from an HR recruitment specialist they were able to resolve many of their recruiting difficulties. By giving more support to candidates with a substantive relocation package, they were able to attract high quality staff.
- We found evidence that staff felt listened to and actively engaged with management. Opportunities for training, career and personal development were mentioned by a range of staff as being a key strength of the hospital. One member of staff told us about a mentorship course they were attending. When this was completed it would enable the mentor to assist new members of staff to fully integrate into the team. We heard from staff from different professions and roles across the team about the efforts being made to develop staff from within the hospital. This was referred to as 'growing our own'.
- There were regular social events which included the whole hospital staff. These included fundraising events for local and national charities and celebration of major festivities.

Innovation, improvement and sustainability

- In December 2015 BMI Healthcare Limited applied to Sign up for Safety (Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible).
- Over the last 12 months they had established a four podded ambulatory care space for patients within the Day Care Unit. They upgraded and relocated the treatment room and moved that closer to the theatre environment which improved the patient journey.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as Requires Improvement

Incidents

- The rate of the clinical and non-clinical incidents was similar to the average of other independent acute hospitals the Care Quality Commission (CQC) holds data for.
- Within the outpatient department there were 40 clinical incidents reported from April 2015 to March 2016. Twenty incidents were no harm, 13 low, six moderate and one incident was classified as severe. The type of incidents occurring in the OPD included falls and the wrong appointment booked.
- We asked managers and saw the report about the severe incident. A root cause analysis was completed and the relevant statutory departments were notified. Changes to practice had been introduced. We saw the incident was discussed at the clinical governance meeting in March 2016.
- However, in June 2016 the hospital reported another severe incident regarding an outpatient who required treatment when they developed a similar condition. The incident was classed as avoidable and closed. We did not see a root cause analysis or evidence of discussion of this incident by the clinical governance committee.
- Five incidents were reported in the diagnostic imaging department in the period April 2015 to March 2016. One incident was no harm, two incidents low harm and two incidents were moderate. All incidents outlined the remedial or other action that had been taken immediately following the incident.
- There were eight non-clinical incidents reported during the same period. The rate of incidents was comparable to other independent acute hospitals CQC holds data for.
- The hospital had an incident report writing policy and staff used a paper based incident reporting system. Staff had a good understanding of how to use the system. Staff told us feedback from incidents was discussed at departmental meetings. We saw minutes of meetings which confirmed this. Staff told us the hospital encouraged them to report incidents to help the whole organisation learn.
- We saw in the diagnostic imaging department that learning outcomes were provided for any incidents reported. Staff were required to sign to confirm they have read the information and understood the outcome. This meant learning from incidents was taking place.
- The hospital did not report any Ionising Radiation (Medical Exposure) Regulations (IRMER) incidents to CQC in the last 12 months. Staff had a clear understanding of what was a reportable incident. A Radiation Protection Advisor (RPA) was available for advice, by telephone, when required.
- Staff were able to describe the basis and process of Duty of Candour; Regulation 20 of the Health and Social Care Act 2008. This 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.

- Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised and informed people of the actions they had taken. When necessary, formal letters of apology were sent.

Cleanliness, infection control and hygiene

- The most recent patient led assessment of the care environment (PLACE) score, completed from February to June 2015, was 93% for cleanliness which was slightly worse than the national average of all hospitals (including NHS Hospitals) which was 98%.
- The hospital had audited the infection prevention and control management of the outpatients department in March 2016. The overall score of the audit was 93% against a target of 100%. The hospital scored 100% for general management; staff health; staff training and policies, procedures and guidelines. Areas in the department audited which scored 100% were consultation room three, the store, management of equipment, monitoring and physical equipment, sharps handling and waste management.
- Areas that did not achieve the audit target were consultation room two (91%), waiting area (66.7%), consultation room six (92.9%), disabled toilet (95.7%) the sluice (88.7%) and personal protective equipment (81.8%). This was due to some fittings needing repair, surfaces not easy for cleaning, chewing gum on carpets, floor and chair coverings, dirty computer screens, waste not segregated as per policy and gloves not used by staff when in contact or anticipated contact with body fluids. Most of these had actions and dates for completion of the actions.
- The hospital management team saw infection prevention and control was the role of all staff and it was their responsibility to ensure policies and procedures were followed. The infection prevention and control lead (IPCL) was the director of clinical services who produced an annual report for 2014/15.
- The hospital had suitable and sufficient assessment of risks to patients receiving healthcare with respect of healthcare associated infection. Risk assessments were carried out at pre-assessment, admission and throughout the patient pathway. The IPCL monitored risks of infection through data collection, audit and review of clinical incident reporting. These findings were reported to the infection prevention and control committee and informed future actions.
- Annual mandatory training for infection prevention control (IPC) awareness for all staff in the hospital was 89% and the enhanced training rate was 64% in healthcare up to March 2016. This fell short of the hospital target.
- The hospital had an IPC annual work programme 2015/16.The objectives were monitored by the IPC committee who met twice a year. Areas covered included systems to manage and monitor IPC, provide and maintain an appropriate environment and providing suitable accurate information for service users. All action from this were completed, where appropriate. The IPC lead provided a report to the Clinical Governance meetings.
- The IPC annual report for 2014/15 stated the radiology department was 93% compliant and the physiotherapy department was 97% compliant for maintaining a clean and appropriate environment. Actions required stated new cleaning schedules were to be displayed for the public in the toilets and the physiotherapy department had a window replacement program.
- All the areas we visited in the outpatients and diagnostic imaging departments were visibly clean and tidy and there were good infection control practices being used.
- Staff that we saw were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'Five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care.
- There were sufficient numbers of hand washing sinks available. Soap and hand towels were available next to sinks. Information was displayed demonstrating the 'Five moments for hand hygiene' near handwashing sinks. Sanitising hand gel was readily available throughout the hospital.
- Personal protective equipment was available for all staff and staff used it in an appropriate manner.

Good

Outpatients and diagnostic imaging

- There were cleaning schedules in individual treatment rooms and toilets, which were fully completed. Housekeeping staff showed us their cleaning schedules which clearly set out the tasks to be performed and their frequency. They were required to sign when each task was completed and their supervisor checked their work.
- We saw disposable curtains used in the treatment and consultation rooms. The dates on them indicated they had been changed within six months.
- The outpatients and diagnostic imaging departments did not have carpets in clinical rooms. The flooring was seamless and smooth, slip resistant, easily cleaned and appropriately wear-resistant.
- All seating used within the patient areas was covered in a material that was impermeable, easy to clean and compatible with detergents and disinfectants.
- We saw the hospital had a deep cleaning programme for the outpatients and diagnostic imaging departments. These were completed on a monthly basis and we saw the records for January to July 2016. This included the cleaning of medicine fridges, furniture, computer equipment, air conditioners, and the examination and observation equipment.
- The radiographers had daily task sheets to complete for the cleaning and checking of equipment. These were completed on a daily basis and recorded when the department was closed. They included temperature record, resuscitation equipment, linen availability and daily variance report (incidents, near misses and items recognised outside of the key performance indicators).
- The x-ray department had an infection control daily cleaning sheet. This included the clinical equipment for the x-ray and ultrasound machines. This record was completed on a daily basis and recorded when the department was closed.
- Waste in the clinic rooms was separated into different coloured bags to identify the different categories of waste.
- Sharps bins were available in treatment and clinical areas where sharps may be used. Staff were required to place secure containers and instructions for safe disposal of medical sharps close to the work area. Labels on sharps bins had been fully completed which ensured traceability of each container.
- Water was tested and reported to the water committee as required by the water safety management regime HTM 04-01. The required full annual check and appropriate monthly tests were completed.

Environment and equipment

- The outpatient department had 14 consultation rooms, two treatment rooms and a waiting area. The diagnostic imaging department had a separate waiting area. Adequate seating was available at a variety of heights and space was available for patients to wait in wheelchairs. The hospital had several wheelchairs available for patients to use if required.
- The waiting area of the diagnostic imaging department had glass windows and doors. We saw appropriate risk assessments had been completed and warning signs were in place to ensure patients and staff were safe.
- Each consultation room was equipped with a treatment couch and trolley for carrying the clinical equipment required. It had equipment in to provide physical measurements. This was in line with HBN 12 (4.18) which recommends a space for physical measures be provided so this can be done in privacy.
- We saw equipment service records which indicated 100% of equipment had been serviced recently. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use. We saw stickers on electrical equipment, which indicated electrical equipment had undergone safety checks and was safe to use.
- We saw certificates to indicate staff were competent to use equipment, which was in line with the hospital's medical devices policy.
- The diagnostics imaging department had the appropriate moving and handling equipment to enable them to transfer patients from a bed to an examination couch.
- Staff reported no problems with equipment and felt they had enough equipment to run the service.
- When necessary, rooms and cupboards had numerical key pads and self-closing doors. Staff told us the numbers were changed every month in accordance with BMI Healthcare policy.

Good

Outpatients and diagnostic imaging

- Emergency equipment was located in the outpatients and diagnostic imaging departments. A resuscitation trolley, with defibrillator, was in the outpatients department and was in a secure position. The senior nurse checked all the equipment weekly on a Monday. We saw the records of checks. All equipment needed was available, as indicated by an equipment list. All consumables were in date. The seals of the trolley were checked daily when the department was open and we saw the records of this. The records stated clearly 'not in use' on the days the unit was not open.
- We saw the emergency resuscitation equipment for the diagnostic imaging department was visible and kept underneath the reception desk in the waiting area. We saw this had been risk assessed by the director of clinical services and it was decided this was an appropriate position for the equipment as it needed to be visible and accessible to all staff. The equipment was not left unsupervised and was locked away when the department was closed.
- We saw records of regular quality assurance tests of diagnostic imaging equipment. In addition to this a Radiation Protection Committee reported annually on the quality of radiology equipment, which we saw. These mandatory checks were based in the ionising regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) (2000).
- The diagnostic imaging department had a mobile x-ray unit which was kept in the department and only used by a trained radiographer. The key to the unit was kept in a locked cupboard in the department for authorised access only. This machine was subject to the same quality assurance tests as the static equipment.
- Lead aprons were available in all areas of radiology. Regular checks occurred of the effectiveness of their protection. We saw evidence which showed checks occurred regularly and equipment provided adequate protection.

Medicines

- Staff monitored and recorded the minimum and maximum temperatures of medicines refrigerators and the room temperatures where pregnancy testing kits were stored. We saw records which indicated this was done regularly.
- In the diagnostic imaging department, medicines used to perform scans were stored in a locked cupboard with key pad access in a locked room with key pad access. Only authorised, registered professionals had access to the medicine cupboard.
- The hospital audited dispensing turnaround times of medicines in February 2016. The aim of the audit was to measure the time a prescription was in the dispensary to ensure that suitable processes and resources were available to facilitate timely discharges and provision of medicines. Out of 20 patients the prescription was dispensed for nine outpatients. Seven patients received their medicine in an average of 10 minutes. Two patients waited an average of 31 minutes. This demonstrated the pharmacy service supplied medicines to patients within reasonable timeframes and auditing was used to aid continual improvement. The audit had an action plan and results were presented at the medicine management and clinical governance meetings.
- Staff stored prescription pads in locked cupboards and a registered nurse held the key. We saw registers in place for every clinic room which had prescription pads; this indicated when a prescription had been issued, to whom and what for. This was in line with guidance from NHS Protect, Security of prescription forms (2013).
- We asked staff how the hospital monitored consultant's private prescriptions. We were told the hospital did not monitor this. We saw in the minutes of the clinical governance committee meeting in May 2016 this was discussed and an audit was to be performed.

Records

- The hospital used a variety of information technology systems that held patient data. All staff, clinical and non-clinical were required to comply with information security and data protection policies. Between April 2015 and February 2016, 92% of staff had completed e-learning modules for information security and data protection. When necessary, medical staff were provided with an NHS email address for confidential transfer of patient data relating to all NHS contracts.
- In the three months before the inspection 1% of patients were seen in outpatients without all relevant medical records being available.

- The hospital managers told us they did not allow the removal of hospital medical records from the site in any circumstances. Patient's medical notes could only be viewed within the hospital in accordance with data protection legislation and the Caldicott Principles (the six information management principles which patient information can be used in the NHS).
- We saw the hospital audited medical records on a monthly basis. Risk controls were in place including a range of BMI Healthcare policies around information security and management, IT and information acceptable use and incident reporting.
- Records were stored in the medical records department where staff were responsible for filing, storing and maintaining records. Outpatient treatment records were stored separately within the department. The records department could only be accessed by authorised personnel. A register was completed to indicate if a record had been removed and where it had gone to.
- We looked at eight sets of patients records. Records were complete, legible and signed. They contained letters, results of diagnostic tests and discharge letters.
- The records of patients being seen by the physiotherapists were kept and stored appropriately in the physiotherapy department. These were sent to the medical records department when no longer required.
- At the time of inspection electronic patient records were not held on site. An external provider archived medical records and these were retrievable by an online system. A manual system was used to track medical records and staff were encouraged to use the tracking system. This was to ensure the whereabouts of records were known.
- Consultants who held practising privileges at the hospital were required to register with the Information Commissioners Office as independent data controllers and were required to work to the standards set by the commission. This included how patient's records were stored and transported. The hospital staff knew if a consultant had taken a record off site.
- Consultants were responsible for their private patient medical records. A copy of the consultants individual notes for private patients in the outpatient department were not kept by the hospital, these were kept by the individual consultants. The hospital had a record of the original referral and copies of diagnostic treatments performed only. However, a copy of consultation notes for NHS patients was kept by the hospital. This does not meet the requirements of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This states providers must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Safeguarding

- There had been no safeguarding concerns reported to CQC from April 2015 to March 2016.
- BMI Healthcare had policies for safeguarding adults and children and these were accessible to staff. The polices reflected current national guidance and included advice on the recognition and response to Female Genital Mutilation.
- Safeguarding training was mandatory for all staff and achieved via e-learning. Training for staff in both adult and child safeguarding was provided at induction and then at two yearly intervals.
- The director of clinical services was the lead for safeguarding with level 3 training for safeguarding adults and children and was supported by the quality assurance advisor. The director of clinical services was responsible for escalating concerns through both the internal safeguarding structures and the local safeguarding board. There were flowcharts in all clinical areas with clear instructions for staff if they had concerns or were worried about a child, young person or adult's welfare.
- Staff had a good understanding of what a safeguarding concern might be. They told us they would escalate any concerns to their manager. They knew who the safeguarding lead was. We saw there was safeguarding flow charts displayed in clinical areas to provide advice and prompt staff.
- Safeguarding training was part of mandatory training. Before February 2016 the hospital provided courses for

safeguarding children and adults as two separate courses and these were not separated into levels of training. Compliance was 92% for adults and 92% for children.

- Since February 2016 all staff were to complete level 1 safeguarding adults and children and clinical staff were to complete level 2.
- The training target for safeguarding was 95%. The hospital data showed that 93.4% had completed training by March 2016 but this was a cumulative figure and all staff were expected to have completed the training by the year end. Data showed us 91% were trained to level 1 and 95.5% to level 2 for safeguarding vulnerable adults.
- Safeguarding children level 1 was 91.5%, and 95.5% level 2. These figures were for staff in all departments up to March 2016.
- The safeguarding children training was provided to the levels recommended in the national guidance document, "Safeguarding children: Roles and responsibilities for healthcare staff (2014).

Mandatory training

- The target for mandatory training set by BMI Healthcare was 90%. Goring Hall Hospital had a total of 84.7% in all departments of the hospital up to March 2016. In the outpatient and diagnostics imaging departments 94% of staff (excluding consultants) had completed mandatory training.
- The training programme was comprehensive and contained all the training subjects that would be expected within defined time limits. For example, safeguarding adults and children, dementia awareness, informed consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- BMI Healthcare had a training matrix for any contractor or bank staff who worked 80 hours or more per month. This included staff working in catering or on the MRI scanner unit.
- Consultants were required to submit evidence that they had completed mandatory training through their annual appraisal process.
- There was an electronic monitoring system which flagged when staff's mandatory training was due to expire. Managers described how they used the system to ensure staff remained up to date.
- The mandatory training programme was tailored to each staff job role. Most training was electronic based and included a knowledge check and required updating annually. Staff told us they had no problems completing on-line training. The training programme was comprehensive and contained all the training subjects that would be expected.

Assessing and responding to patient risk

- Medical cover was provided by the resident medical officer (RMO) 24 hours a day seven days a week. The RMO was selected on their experience to enable them to manage and respond to risks relating to the wide mix of patients at the hospital.
- The RMO was suitably qualified and held current advanced life support qualifications.
- A senior nurse was available 24 hours a day, seven days a week as a contact point for both staff and patients.
- We saw there was adequate resuscitation equipment and it was easily accessible. Staff knew where they were located.
- The hospital completed a resuscitation audit every three months. The last two audits completed in January and April 2016 were 97% compliant.
- Up until March 2016, 83% of non-clinical staff had completed basic life support training and 76% of clinical staff. This was below the hospital target of 85%.
- We observed good radiation regulation compliance during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. There was key pad entry to examination rooms and only authorised staff had access.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection advisor was contactable if required. This was in line with Ionising Regulations 1999 (IR (ME) R 2000).
- Departmental staff carried our regular quality assurance checks. This indicated equipment was working as it

should. These mandatory checks are in line with Ionising Regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R 2000). We saw that records of these checks was completed each day.

- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available. Diagnostic imaging staff had a clear understanding of protocols and policies. Protocols and policies were available in printed format and stored on a shared computer file which staff had access to. Staff demonstrated their knowledge of how to access policies.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging department, in line with best practice. Additionally, staff completed forms to indicate whether patients might be pregnant. We saw four forms and these were completed on each.
- Staff used metal markers instead of digital to indicate whether an examination was of the left or right sided limb. This ensured if an image was turned around electronically, the correct side could still be identified.
- The WHO Five steps to safer surgery is a core set of safety checks, identified for improving performance at safety critical time points within the patients intraoperative care pathway. It is for use in any operating theatre environment, including interventional radiology. We saw staff used the 'Five steps to safer surgery' checklist when necessary.
- We saw 'stop and check' signs in all rooms of the diagnostic imaging department to remind staff to carry out patient identification checks.
- To ensure nothing was missed, two members of staff read the results of mammograms. This was in line with best practice.
- The hospital had a risk register which departments could add to. Managers told us each department carried out their own risk assessments.
- We saw the occupational risk assessments for staff in the outpatients and diagnostic imaging departments. The risk assessments consisted of 19 activities and showed the severity, likelihood and risk matrix. Activities included patient resuscitation, risk of infection, disposal of body fluids, collection of specimens and the photocopying of documents. We saw the assessments had been completed for all staff.
- In the outpatient department we saw risk assessments had been completed for the control of substance hazardous to health (COSSH).
- Staff participated in emergency scenarios so that they were familiar with how to respond in the event of patient becoming unexpectedly unwell.

Staffing

- A registered nurse was available for each area of outpatients. The hospital employed 5.2 whole time equivalent (WTE) registered nurses and four WTE health care assistants (HCA's). The ratio of nurse to HCA was 1.3 to 1.
- We saw the staffing rotas which indicated there was always registered staff available in each department. The outpatients and diagnostic imaging department did not use agency staff normally as the hospitals own staff worked as bank staff, when required.
- The use of bank nurses was above the average of the 33 independent acute providers CQC hold data for. Bank nurses were used every month April 2015 to March 2016 with an average of 16.6% shifts being covered by bank staff per month.
- The use of bank HCA's was above the average of the 29 independent acute providers CQC hold data for. Bank HCA's were used every month April 2015 to March 2016 with an average of 52.3% shifts being covered per month.
- From April 2015 to March 2016 the rate of sickness for nurses and HCA's working in the outpatient departments was better than the average of the independent acute providers CQC hold data for.
- The hospital faced recruitment challenges in common with many hospitals on the south coast. They had some vacancies but these were being managed and staffing was adequate to meet patient's needs. The unfilled shifts for the department were 2% in January 2016, 1% in February 2016 and 1% in March 2016. The department

had one full time nurse vacancy. There were no vacancies for HCA's in the department. There was a low staff turnover (below 1%) for outpatient nurses and HCA's in the reporting period April 2015 to March 2016.

- The diagnostics imaging department had 4.5 WTE administration staff (the imaging department undertook invoicing for their patients and therefore required sufficient clerical staff) and 3.2 WTE radiographers. The department had access to two regular agency radiographers who covered for annual leave and sickness.
- Clinical staff were supported by an on-site resident medical officer (RMO) who provided a 24 hour medical presence.
- The RMO was on duty 24 hours a day and was based on site for one or two weeks at a time The RMO was provided to the hospital by an agency and the hospital received assurances that all appropriate training had been undertaken. All RMOs who worked at the hospital were registered with the General Medical Council (GMC) and held a current ALS (advance life support) certificate and EPALS (European paediatric advance life support) certificate.
- A radiologist was present at the hospital every day the department was open. The lead radiologist represented the service at the medical advisory committee (MAC). All applications for practising privileges in the diagnostic imaging department were assessed and monitored by the lead radiologist.
- The hospital told us they had 140 consultants working with agreed practising privileges. This related to consultants in post at 01 April 2016 with more than 12 months service.
- The hospital showed us their Practising Privileges Policy for Consultant Medical and Dental Practitioners, 2015, a corporate policy by BMI Healthcare. The hospital confirmed that all medical staff were restricted to undertaking procedures which they had been fully trained to perform and which they regularly performed within their NHS practice.
- The granting of practising privileges is a well-established process within independent hospital healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. Where practising privileges are being granted, there should be evidence of a formal agreement in place. We saw that these agreements were in place for all medical staff with practising privileges.
- It was the responsibility of the consultant to be contactable at all times when they had patients in the hospital. They were required to be available to attend within an appropriate timescale according to the risk of medical emergency of the patients' diagnoses or procedures they had undergone. The practicing privileges agreement made it clear that consultants needed to be within 30 minutes driving time of the hospital or to have alternative cover arrangements. Some specialities arranged a cover rota where a consultant on call provided emergency cover for colleagues from their speciality.
- At times of annual leave cover was provided by a designated consultant colleague. Staff told us that out of hours contact with consultants was not a problem and they were amenable to being called.

Major incident awareness and training

- Staff told us each department did scenario training for major incidents. Staff in the physiotherapy department told us they had recently practiced the evacuation of a patient in the event of a fire.
- Staff gave us examples of managing a patient in an emergency and they felt the response from the rest of the hospital was immediate.
- The hospital had a response team who would respond to an emergency situation. The team all held bleeps and would respond immediately when required. We saw the quick response to an emergency during our inspection.

Are outpatients and diagnostic imaging services effective?

We rated effective as Not rated.

Evidence-based care and treatment

Good

Outpatients and diagnostic imaging

- In the outpatient and diagnostic imaging departments, staff showed us how they accessed policies on the hospital's computer system. Paper copies were also available in folders and staff signed to indicate they had read them, which we saw.
- The hospital had an audit programme throughout all clinical departments. Regular audits included patient health records, medicine management, hand hygiene and infection, prevention and control. We saw copies of these audits. Findings were reported to the departments and through to the clinical governance committee meetings. Trends were identified and action plans created to improve the service to patients which was communicated back to the clinical departments for their action.
- Local audits for the OPD related to medicines management, records and infection prevention and control showed the department was working in line with the local and corporate policies.
- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example, National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Radiologists guidance.
- We saw all referrals to the radiology department followed the 'iRefer', the radiological investigation guideline tool from the Royal College of Radiologists.
- The imaging department had policies and procedures in place. They were in line with regulations under IR (ME) R 2000 and in accordance with the Royal College of Radiologist's standards.
- The RPA undertook regular radiation audits and an annual review of dose reference levels. We saw the minutes of the meetings for the last three years and results of audits.
- We saw copies of the local rules available in each imaging room. Staff had signed them to indicate they had read them.
- The physiotherapy department offered a knee exercise class and had equipment to enable patients to exercise in a variety of ways. This was in line with NICE guidance CG 177, 1.41 Osteoarthritis: care and management.
- The physiotherapy department provided a continence service for women in the outpatients department. This meant the hospital had recognised NICE guidelines which recommend physiotherapy as the first treatment option, for most women who experienced incontinence or bladder problems.

Pain relief

- In the outpatient department doctors could prescribe pain relieving medicines, if required.
- In the diagnostic imaging department, there were a variety of pads and supports available to enable patients, having examinations, to be in a pain free position.

Patient outcomes

- The hospital managers told us they audited patient outcomes by participating in national and local audit programmes. Locally, a quality dashboard was produced in addition to making local data available to the hospital on a monthly basis. The majority of the dashboard performance indicators did not relate to outpatient department.
- Any downwards trends or unexpected deviations would be reviewed by the governance committee and MAG. Further advice could be sought from BMI Healthcare's group medical director and national director of clinical services.
- Externally the provider held Standard Acute Contract (SAC) meetings with the Clinical Commissioning Group to consider patient outcomes and performance through the SAC quality indicators and CQUIN monitoring processes. Any variance was reviewed and actions fed back to the CCG Team.

Competent staff

- Staff including nurses, radiographers and physiotherapists had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when staff professional registrations were due and to ensure they were renewed. These were shown to us.
- We saw staff were provided with certificates for a variety of areas such as mandatory training. We saw skills assessment for chaperoning, venepuncture and completed induction packs.

- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC).
- Allied healthcare professional staff could access a variety of training within the BMI Healthcare network to develop skills further. They also attended regular training sessions within the department. We saw attendance sheets, signed by staff, which indicated that they attended training regularly. This contributed to maintaining their Health care Professions Council (HCPC) registration.
- We saw completed cannulation competency records, which was in line with the hospital's cannulation policy. Cannulation is a technique in which a cannula is placed inside a vein to provide venous access which is sometimes required to give medicines.
- In compliance with IR (ME) R regulations, we saw certificates were held for staff who were able to refer patients for diagnostic imaging tests. This gave assurance that only those qualified to request a diagnostic examination were able to do so.
- The hospital had an appraisal policy to ensure that all staff understood their objectives and how they fitted with the departmental and hospital objectives and vision. All the staff we spoke with had received an annual appraisal. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with their regulatory bodies.
- The hospital appraisal year ran from October to September. In the current year, the outpatient and diagnostic imaging department appraisal rate was 100% at the time of inspection.
- The MAG was responsible for recommending and reviewing practising privileges for medical staff. The hospital undertook robust procedures which ensured consultants who worked under practising privileges had the necessary skills and competencies. The consultants received supervision and appraisals, usually through their main NHS employing trust.Senior managers ensured the relevant checks against professional registers and information from the Disclosure and Barring Service (DBS) were completed. The status of medical staff consultants practising privileges was recorded in the minutes of the MAC notes.
- In 2016 the hospital launched clinical supervision for staff. These sessions were optional and open to any clinical staff member. The sessions were confidential and led by a psychologist who was a trained clinical supervisor. We asked staff if they had attended the sessions. The staff we spoke with told us they were aware of the sessions but had not attended yet.
- New starters were provided with a corporate induction pack at the start of their employment. This included information relevant to BMI Goring Hall Hospital. Staff told us that new starters were allocated a mentor to support them.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) approach across all of the areas we visited. We observed good collaborative working and communication amongst all staff in and outside the department. Staff reported they worked well as a team.
- We were told the medical staff liaised with colleagues in the NHS when further medical support might be required.
- Whenever necessary, patients were referred to allied health professionals for specialist input from physiotherapists, occupational therapists, dieticians and speech and language therapists.
- Morning 'huddles' had recently been developed for heads of departments, sub teams and all clinical staff. This enabled staff to come together, share information and keep the care of the patient as the focus.
- The RPA service for the diagnostic imaging department was provided by the local NHS acute trust. The hospital had annual radiation protection meetings at the hospital.
- The physiotherapy department attended training sessions with other physiotherapists in the BMI Healthcare network.

Seven-day services

Good

Outpatients and diagnostic imaging

- The diagnostic imaging department provided an on call radiographer service out of hours from 8pm on weekdays and 24 hours a day at weekends. The service had a system in place that if a radiographer was called after midnight then they did not work the following morning. Staff told us the calls for the emergency service were minimal.

Access to information

- We saw in the diagnostic imaging department staff were provided with the protocols for examinations undertaken at the hospital. A folder was kept in the x-ray room to guide radiographers explaining how to perform a procedure, the reason for the procedure and what level the exposure to be set.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). This is medical imaging technology which provides economical storage and convenient access to images from multiple machine types. Theatres, operating rooms and wards could access PACS via a computer. The images could be viewed at the full size in the x-ray workstation only.
- Staff from both departments could access a shared drive on the computer where policies and hospital wide information was stored. Staff demonstrated this to us.
- Letters were sent to patients GPs following consultation at Goring Hall.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a Safeguarding Adults Policy which incorporated the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance that reflected the Mental Capacity Act (2005) legislation and set out procedures that staff should follow if a person was thought to lack the capacity to make a decision. The policy included the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits.
- We spoke with a range of clinical staff who could all clearly describe their responsibilities in ensuring patients gave informed consent to all care, investigations and treatment. We saw consultants providing explanations and detailing the risks of suggested treatment.
- We saw correctly completed and signed consent forms in medical records. This meant patient's had consented to treatment in accordance with the hospital policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- MCA and DoLS were part of the mandatory training programme staff attended. Data provided by the hospital showed up to February 2016, 81% of clinical staff had completed this training. Staff we spoke to had an understanding of how the MCA impacted on their work and when they would need to seek further advice about a patient who appeared to have limited understanding because of confusion.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as Good

Compassionate care

- We saw staff treating patients in a kind and considerate manner. Patients and their relatives told us staff always treated them with dignity and respect.
- We saw that staff introduced themselves to patients and explained their role.
- The PLACE scores for privacy, dignity and wellbeing were 68% which were worse than the England average. The hospital management team had reviewed why the results were l ow and minutes of the MAC showed that discussions took place about Goring Hall not feeling like a private hospital due to outpatients being “overrun” with NHS patients. The committee agreed that there are too many clinics running at the same time.
- However we saw all treatment and consultation rooms had curtains to ensure patients dignity was respected if the door was opened inadvertently.

Good

Outpatients and diagnostic imaging

- We saw signs in the patient waiting areas informing patients they could have a chaperone, if they wished. We saw certificates which indicated staff had chaperone training. Staff would record if a chaperone had been offered and document if a patient agreed or declined. In a separate register it was recorded who had been a chaperone, the patient concerned and the day it occurred. We saw the chaperone register which indicated this was occurring. This was in line with the hospital's chaperone policy.
- We saw there were individual changing cubicles in the diagnostic imaging department.
- In the diagnostic imaging department there was a separate area for viewing scan results. This area could not be overlooked and maintained patient's privacy and confidentiality.
- The hospital asked all patients to complete a patient satisfaction questionnaire that incorporated questions of all aspects of their care and experience.
- The hospital measured national survey information, for example the Friends and Family Test (FTT), and used all patient feedback to guide investment plans, treatments offered and the overall patient experience. The results from the national survey published in September 2016 showed that BMI Goring Hall was recommended by 100% of the patients that responded, although the response was limited with just 10 patients completing the survey.
- The hospital completed its own Friends and Family Test which it reported on each month. The most recent report in March 2016 indicated out of 84 patients, who completed the survey, 94% were extremely likely or likely to recommend the outpatient department at the hospital. The national summary results published in September 2016 showed that for independent healthcare providers the percentage of patients that would recommend the service was 97% and for all providers (including NHS providers) was 93%.
- Ninety five per cent would recommend the diagnostic imaging department. There was no national comparator for radiology services.
- Comments on the survey about the outpatients department included "Charming staff they put me at ease", "Staff were friendly, caring and informative", "More personal service than a big hospital" and "I always feel relaxed at Goring Hall and I know I am going to receive good treatment".
- Comments on the survey about the diagnostic imaging department included "Appointment was on time, staff explained what was happening and they made me feel relaxed. I was shown the results and told what they meant, could not fault it", "Well looked after by all concerned" and "Really helpful, friendly and reassuring nurses and consultant".
- We spoke with 10 patients during our visit. All were positive about the service that they received. One patient told us "I couldn't ask for better" and another told us "the staff make me feel very relaxed".
- During the inspection we asked patients to complete feedback forms to describe their experience at the hospital. We collected 43 completed cards, of which 10 were specific to the OPD. The remaining cards were all positive and included comments "The staff go above and beyond what is required", "Excellent service and caring" and "The reception staff were helpful and friendly".

Understanding and involvement of patients and those close to them

- Staff discussed treatments with patients in a kind and considerate manner.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need.
- We observed staff offering explanations and providing clear guidance to patients.

Emotional support

- Staff could access counselling services and other psychological support for a patient if it was needed.
- We saw staff interacting with patients in a supportive manner and provide sympathy and reassurance.
- Nurses would attend clinic appointments with patients to provide emotional support if required. They told us they were able to provide patients and their families extra time if needed and necessary.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as Good

Service planning and delivery to meet the needs of local people

- The outpatient department was open from 8am until 8pm Monday to Friday. The department could be opened on Saturday mornings if required. Patients told us they had been offered a choice of times and dates for their appointments.
- The outpatient department provided a health screening service which provided an appropriate range of tests and examinations based on clinical need. We reviewed eight sets of patient's records which indicated this was being completed. Reports went to patients and their GP if further investigations were required.
- The diagnostic and imaging department was open 8am to 8pm Monday to Friday for radiology. Occasionally clinics were held on Saturdays, if required.
- The department had a mobile x-ray unit for use in other areas of the hospital.
- Other services provided in the diagnostics imaging department included the mammography unit one day a week, dual-energy x-ray absorptiometry two days a week and CT scanner one day a week. Appointments for the MRI were available 8am to 8pm for four days during the week and 8am to 6pm on Saturdays.
- The hospital had begun work to provide accommodation for a permanent MRI scanner which would be able to provide scans for more patients.
- The physiotherapy department was open from 8am to 8pm Monday to Friday. The department provided a wide range of exercise classes to suit the needs of the patients referred to them. They had a range of equipment to help staff deliver high quality care for patients.
- The hospital provided a pharmacy service Monday to Friday 8.30am to 5pm Saturday 9am to 3pm. The hospital did not have a formal on call service for the pharmacy. However, the hospital had an agreement with the local trust that provided medicines advice 24 hours a day, if required.

Access and flow

- The outpatient department provided several specialities. Clinics available included orthopaedics, ophthalmology, dermatology, general surgery, gynaecology, urology and pain medicine.
- There were 34,129 outpatient attendances between April 2015 and March 2016. Of this figure13,654 were first attendance and 23,547 were follow up appointments. Forty per cent of total attendance was NHS funded and 60% had another funding source.
- From September 2015 to February 2016 the hospital performed 6,547 diagnostic imaging procedures. The highest usage was ultrasound and radiography which accounted for 22.9% each of this figure. Other services were MRI, dual-energy x-ray absorptiometry, fluoroscopy CT and mammography.
- The Referral to Treatment (RTT) waiting times for non-admitted patients beginning treatment within 18 weeks of referral were abolished in June 2015. However the hospital met the target of 95% before the targets were abolished. Above 95% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 2015 to March 2016).
- Patients told us they were happy with the speed at which they had received their appointments.
- Physiotherapy patients received their appointment within two weeks or sooner, which indicated they received their treatment in a timely manner.
- Radiologists attended the hospital to provide a report. An MRI took 48 hours, a CT scan took two days and all other examinations were reported within a day.
- We were told the outpatient department did not routinely monitor clinic delays or cancellations. We were told this rarely happened and would mainly be due to a consultant having to reschedule. Additionally staff told us if the same consultant cancelled clinics regularly this would be investigated by hospital management.
- The clinics we observed ran to schedule, we did not see any patients wait more than five minutes.

Meeting people's individual needs

- Staff could tell us how they would access professional translation services for people who needed them. However, we were told these were rarely needed.

Good

Outpatients and diagnostic imaging

- Information leaflets were available to patients regarding their treatment. Staff either sent the leaflets in appointment letters or gave them to patients to take away and we saw staff including these leaflets in the letter envelopes to be sent out.
- We did not see any leaflets in any other languages apart from English. Staff told us these were rarely needed and they could access leaflets in other languages if required, from a central database.
- Access was suitable for patients who used a wheelchair and the hospital provided wheelchairs for use in the department, if required.
- Staff received training on respecting equality and diversity in their mandatory training. This course was to be completed every two years and 90% of staff had completed the course by March 2016.
- There was sight care advisor on site who could sign-post patients to support services in the community. Two of the staff have been trained as Eye Clinic Co-ordinators (RNIB), they too could support the needs of low vision patients.
- Recently the staff had identified a gap in the provision of British Sign Language (BSL) interpreters. The team identified the requirement prior to these patients' attendances and a BSL interpreter was then made available for the patients.
- We asked staff about any arrangements to support people living with dementia. Staff identified the needs of these patients at the pre assessment appointment and if it was considered that the hospital was able to meet the patients' needs then the appropriate individualised care and support would be provided.
- There was a dementia champion in post whose job description included providing staff training and supporting staff in caring for patients with dementia.
- All patients over 75 years of age were screened for dementia using a standardised assessment tool. Where there were concerns a patient lacked capacity advice was sought as to whether to proceed with offering care at Goring Hall Hospital or to suggest a referral to a setting better able to meet the needs of people living with dementia. The decision was dependent on the degree of understanding the patient had and whether the hospital could meet their needs.
- There were arrangements to ensure self-funding patients were aware of fees payable. We saw information leaflets which gave an explanation to the pricing structure for self-funding patients and gave advice for who to contact if patients had any queries. The website also detailed different payment options for self-funding patients such as finance and pay as you go options and both were described clearly.
- The waiting areas for the outpatients and diagnostic imaging departments had seating areas with refreshments and magazines available for waiting patients and their supporters.
- The waiting area of the outpatients department had limited space and could get very busy. A patient told us they would find it difficult to answer any personal questions if asked due the risk of another patient overhearing. We saw the reception staff asked limited questions to ensure they maintained confidentiality.
- There was a variety of health-education literature and leaflets produced by BMI Healthcare available. Some of this information was general in nature and some was specific to certain conditions. This literature was available in the waiting areas of both the outpatients and diagnostic imaging departments.
- Staff sent detailed information about the examination patients were booked in for with the appointment letter. We saw examples of this information and noted it was in a clear and simple style and language.

Learning from complaints and concerns

- The hospital recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure.
- We saw copies of the BMI leaflet 'Please tell us' were located throughout the hospital to make patients and their relatives aware of how they can highlight any concerns.
- The hospital received 55 complaints between April 2015 and March 2016. The assessed rate of complaints was similar to the average of the independent acute hospitals CQC hold data for.
- Sixteen of these complaints related to the outpatient department. Four complaints were about finance and cost, four about communication, three about staff attitude, three about delays in treatment and two about the procedure or treatment received.

Good

Outpatients and diagnostic imaging

- Complaints and compliments were formally discussed at the monthly senior management team meetings, clinical governance meetings, and department meetings as appropriate.
- The hospital held further separate dedicated patient satisfaction meetings on a periodic basis which was chaired by the executive director. This reviewed patient satisfaction data and where the hospital sat in comparison to it BMI Healthcare peers, complaint trends, onwards action as appropriate and areas for continuous improvements for the patient experience.
- All staff were encouraged and empowered to identify and address any concerns or issues while the patient was still on site. If needed, complaints were escalated to heads of department, director of clinical services or the executive director while the patient or their relative was still at the hospital to prevent issues developing into a formal complaint.
- The responsibility for all complaints rested with the executive director who would decide which head of department and/or consultants needed to be involved in the investigation. Based on the nature of the complaint the investigation may be led by either the executive director, director of clinical services or the quality and risk manager. An acknowledgement would be sent immediately upon receipt of the complaint explaining the investigation process and timescales.
- The BMI Healthcare complaints policy set out the relevant timeframes associated with the various parts of the complaint response process. An initial acknowledgement was required within two working days and a full response within 20 working days. If a complaint was escalated to a further stage the complainant would be given the information of who to complaint to if they remained unhappy with the outcome. For private patients they would be signposted to an independent adjudicator and NHS patients treated at the hospital, to the NHS Ombudsman.
- During the complaint investigation the process was monitored to ensure timescales were adhered to and responses provided within 20 working days. If a response was not able to be provided within this timeframe a holding letter was sent so they were kept fully informed of the progress of their complaint. All complaints information was retained within a paper file, with copies retained electronically and also stored in the hospital information management system.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as Good

Vision and strategy

- BMI Healthcare had a corporate strategy in place. This governance framework ensured an effective organisational structure that supported the delivery of services and minimised the risks across all areas of business.
- Minutes of the MAC showed they were involved in hospital redesign for the future development of the services provided. The hospital had identified a difficulty in providing for patients needing ambulatory care because of the building. The BMI Major Works Team had visited and drawn up a 5 year plan using the existing footprint of the building. In the meantime, the hospital were planning to share X-ray reception with OPD for patients waiting to go into the 'Pod' area in DCU and make other refurbishments to the OPD area.
- One aspect of the vision for growth of the hospital was to change the mobile scanning unit into a static MRI in a dedicated unit and the hospital would relocate some non-essential services off site to accommodate this. We saw the work was in progress and the dedicated unit due to be open in December 2016.

Governance, risk management and quality measurement

- There was a robust system of governance. Heads of departments met monthly and discussed incidents, complaints and the risk register. They reported to the hospital leadership team. The monthly senior management team and heads of department meeting covered a variety of key areas. These were then informed by departmental meetings, health and safety meetings and clinical governance meetings and which all reported to the senior management team. The senior management team attended BMI regional meetings where escalated concerns were discussed.

Good

Outpatients and diagnostic imaging

- There was a corporate risk management policy which was in date and outlined expectations for all staff to work in a manner which reduces risks and to escalate potential risks through the management structure.
- The hospital had a clinical governance committee which met bi-monthly. This committee was responsible for ensuring that the appropriate structure, systems and processes were in place in the hospital to ensure the safe delivery of high quality clinical services. The committee discussed incidents, complaints, infection control issues and reviewed the risk register.
- Clinical quality and governance issues were reviewed at the quarterly MAC meetings. This involved a high level of engagement from the consultants. The MAC was responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.
- The minutes and actions from the clinical governance, MAC, health and safety, infection prevention meetings were reported to the management team through the service leads meeting. The information was cascaded to the wider team through departmental meetings and staff briefings. These were conducted by the executive director and other members of the executive team. They were designed to be informal to encourage a high level of engagement with the staff.
- The hospital utilised a daily informal communication meeting as an effective way to share information and drive continuous improvement. Representatives from all departments met on a daily basis at 9am to discuss the previous day and plan daily hospital activity. This meeting presented the opportunity to discuss daily key performance indicators, incidents, raise concerns and share successes.
- A structured audit programme supported the hospital to ensure patient safety was at the forefront of service provision. Actions were monitored locally and within sub-committees and clinical governance meetings. These ensured lessons could be learnt and actions had been completed.
- The BMI Healthcare business unit plan for the hospital, 2016 identified three risks related to the outpatients and diagnostics imaging department. All three were rated as high impact. The x-ray equipment in the imaging department was obsolete and the plan was to buy a new machine
- The ward and theatre teams were able to escalate concerns to the hospital risk register via the head of department. The corporate and local guidance about risk scoring was used to determine whether the degree of risk was sufficient to place it on the risk register.
- Staff described key risks to us that included staffing for theatres. We saw that this was included on the risk register and that action had been taken to recruit and train additional theatre staff.

Leadership / culture of service

- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of the outpatient and diagnostic imaging services. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- We saw strong leadership at the location with an open and transparent culture. The registered manager used governance and performance management to maintain and improve the quality of the service.
- The manager of the outpatient department was also the manager of the consulting suite and cancer services and reported to the director of clinical services, who reported to the executive director.
- The diagnostic imaging manager and the physiotherapy manager reported directly to the executive director.
- Staff saw their managers every day and told us the executive team were visible and listened to them. Any changes made were communicated through sub team huddles, newsletters and emails. We saw examples of newsletters on notice boards.
- Staff told us the hospital was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did.
- Staff told us if they had been present when bad news had been given to a patient their line managers and other members of the team would provide support.
- Staff told us they worked well together and had good communication with other health care professionals and administrative staff across the hospital and wider BMI region. We saw staff engage in a professional and courteous manner.

Public and staff engagement

- The hospital monitored patient satisfaction in all areas of its service delivery. This was achieved through

obtaining patient feedback and views through the forms they placed in each patients room and outpatient areas. The analysis of this information was provided by an external provider and this was arranged through the corporate teams. The hospital received a corporate monthly report which showed response rates, rating within categories and ranking against all BMI Healthcare hospitals. It also included all the freehand patient comments.

- The recently introduced morning huddles for staff encouraged teams to come together and share information about patient care and safety.
- Staff told us managers shared information via email and newsletters. We saw noticeboards displaying information about infection prevention and control, health and safety, deprivation of liberties safeguards and lessons learned.
- The hospital encouraged social interaction for staff through a range of events organised specific to the hospital. For example, charitable initiatives to encourage staff engagement in a social context.
- Staff told us that they would feel happy speaking to senior management or the corporate Human Resources (HR) department if they were unable to speak to their direct line manager.
- Results of the hospitals employee survey 2016 showed out of 128 completed surveys there was a 78% positive response to working at Goring Hall. Key strengths highlighted by the staff were the people, roles and quality of care. The survey highlighted areas of improvement which were: staffing and facilities, a better work environment, more computers and managing workload. The results of the survey had prompted an action plan to be out in place to address the areas of improvement.
- There were regular staff forums which helped ensure good communication across the hospital.
- The hospital had a patient satisfaction group that met monthly to review trends and particular comments so lessons could be learnt and improvements made

Innovation, improvement and sustainability

- The hospital senior management team were working with staff and the corporate provider to look to the future of the hospital and the changes necessary to allow continuation and growth of the service. The hospital already had substantial contracts with the local CCG to offer a large amount of NHS work and was tendering for more. The senior management team were aware that they needed to balance this against the expectations of private patients. Work was already in progress to make some changes to the premises to accommodate more outpatients and a permanent MRI scanner but there were planning restrictions on the building that limited further development outside the current footprint.
- The local senior management team knew their markets well. They had developed services and were actively recruiting consultants who offered specialities (such as ophthalmology) that were in demand locally.

Outstanding practice and areas for improvement

Outstanding practice

Start here...

Areas for improvement

Action the provider MUST take to improve

- The hospital must keep a record of consultations for private patients attending the outpatient departments as required by regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Ensure that the arrangements for chemotherapy patients who become unwell are safe.

Action the provider SHOULD take to improve

- Carry out planned works without delay to ensure clinical areas comply with Health Building Note (HBN) 00/10 Part A Flooring (DH 2013).
- Develop support services for patients undergoing chemotherapy in line with the range of service offered to NHS patients, such as wig supply and advice about managing symptoms associated with hair loss, ongoing social and psychological support and advice about employment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2) (a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks; The provider must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. · There were no Standard Operating procedures for the oncology services at the hospital. · There was no local strategy for cancer services at the hospital. · The ward staff were not trained to manage the needs of patients with complications of chemotherapy. The ward was not staffed for these patients in line with the national guidance.

This section is primarily information for the provider

Requirement notices

· The advice helpline for patients was not staffed by appropriately qualified staff, in line with national guidance.

· There was a specialist breast care nurse employed at the hospital to support the care or patients with breast cancer. The person who undertook this role had other roles and responsibilities which limited the time available for breast care support and updating of their skills.

· The admissions policy allowed the admission of acutely unwell patients based on support from a critical care team that was not available. Following the inspection this policy had been updated and there was a standard operating procedure in place.

· The risks associated with the oncology service had not been identified and there was no oversight by the MAC. This included the risk of the chemotherapy nurses seeing patients out of hours on their own in the Mulberry suite.

· The leadership of cancer services was ineffective.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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