BMI Sarum Road Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Sarum Road Hospital is one of 59 hospitals and treatment centres provided by BMI Healthcare Limited.

The hospital provides a range of medical, surgical and diagnostic services. The onsite facilities include an endoscopy suite, two operating theatres (both with laminar airflow), 48 registered beds (36 in use), one minor operations room, one treatment room and 10 consulting rooms. The hospital offers physiotherapy treatment as an inpatient and outpatient service in its own dedicated and fully equipped physiotherapy suite. In-health, a separate organisation, provides MRI scanning facilities. These services were not included in this inspection.

Services offered included general surgery, orthopaedics, cosmetic surgery, ophthalmology, general medicine, oncology, endoscopy, and diagnostic imaging. Most patients are self-paying or use private medical insurance. Some services are available to NHS patients through the NHS e-referral service.

The announced inspection took place between 25 and 26 February 2016, followed by a routine unannounced visit on 3 March 2016.

This was a comprehensive planned inspection of all core services provided at the hospital: medicine, surgery, outpatient and diagnostic imaging and services for children and young people.

The Sarum Road Hospital was selected for a comprehensive inspection as part of our routine inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology.

The overall rating for this service was 'good'.

Our key findings were as follows:

Are services safe at this hospital?

- Patients were protected from the risk of abuse and avoidable harm across medical, surgical services, outpatient and diagnostic imaging services for children and young people. However, the five steps to safer surgical checklist used in endoscopy was not always fully completed. Two out of ten safer surgical checklists we reviewed in endoscopy patient records were not signed by a clinician and one was incomplete.
- Staff reported incidents and openness about safety was encouraged. Incidents were monitored and reviewed. We saw examples of changes in practice that occurred as a result of learning from incidents.
- Staff were aware of Duty of Candour legislation and how it should be applied.
- Staffing (nursing and medical) was sufficient to provide good care and treatment across all areas.
- All areas inspected were visibly clean and tidy and staff mostly adhered to Bare Below the Elbows (BBE) guidance. However, we observed theatre recovery staff were not always BBE. Equipment was maintained and tested in line with manufacturer's guidance.
- There were suitable arrangements for handovers between shifts and there was a hospital wide 'huddle' that took place daily which gave all departments oversight of the hospital's safety concerns and actions for that day. Clinical staff identified and responded to patient's risks.
- Staff received regular simulation training to ensure they could respond appropriately if a patient became unwell. When needed, arrangements were in place to ensure patients could be safely transferred to a local NHS hospital. Bank staff compliance with mandatory training ranged from 55% to 80%, against a target of 85%.

Are services effective at this hospital?

- Care and treatment followed best practice and evidence based guidance across services.
- The hospital routinely collected and monitored information about patients' surgical outcomes for comparative analysis against the BMI corporate dashboard and national performance audits. Patient outcomes were not routinely

measured following endoscopy procedures. Endoscopy staff followed National Institute for Clinical Excellence (NICE) guidelines and were working towards Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation. The Medical Advisory Committee were actively involved in reviewing patient outcomes and renewal of practicing privileges of individual consultants.

- Staff were competent and sufficiently skilled to deliver effective care and treatment.
- This hospital provided core training for staff in Mental Capacity Act, 2005, and Deprivation of Liberty Safeguards. Staff routinely considered patients mental capacity to make decisions about their care and treatment. Where staff were unsure about the capacity of a patient to consent to care and treatment, they would seek advice from senior staff in the first instance. Written consent records for surgery took account of Department of Health guidance.

Are services caring at this hospital?

- Staff treated patients with kindness and compassion. Staff treated patients courteously and respectfully, and patients' privacy and dignity were maintained.
- Feedback from patients about their care and treatment was consistently positive. Patients told us they had sufficient information about their treatment and were involved in decisions about their care. Results of the latest patient survey showed a high level of patient satisfaction, with the hospital scoring over 95%. Caring was good in the outpatients and diagnostic imaging service. This included the provision of emotional support.
- Staff verbally offered a chaperone to all outpatients and 95% of patients had accepted the offer of a chaperone. The same service received exemplary feedback from patients.

Are services responsive at this hospital?

- The hospital had service development plans for improvements at the hospital including meeting future demand. There were plans to upgrade the endoscopy service environment to achieve JAG accreditation.
- The medical service met national waiting times for endoscopy patients to wait no longer than 18 weeks for treatment after referral. The service was responsive to patients in the inclusion criteria, with waiting times of one to four weeks. There were no waiting lists for oncology services at this hospital. However, the hospital did not always meet national waiting times for surgical treatments.
- The needs of different people were taken into account when planning and delivering services. The provider planned and delivered services in a way that met the needs of the local population. The service reflected the importance of flexibility and choice. Staff took account of individual patient's spiritual, religious and emotional needs when delivering care and treatment. Suitable adjustments were made to meet individual needs. For example, we saw the use of dementia friendly clocks and picture signs on the ward.
- Complaints and concerns were always listened to, lessons learnt and shared.

Are services well led at this hospital/service

- Staff were clear about the vision and strategy for their services, driven by quality and safety.
- All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital.
- There was an open and supportive learning culture.
- There was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff knew the risks, and action taken to mitigate these risks for their individual department. The risk register was not fully embedded and did not always include well known risks. The hospital did not have an end of life care strategy, pathway, or a named leader.

Our key findings were as follows:

- Leadership at this hospital was strong. All staff were positive about their senior managers and there were daily meetings in place to ensure that concerns were escalated in a timely way.

Summary of findings

- Patients were protected from abuse and avoidable harm.
- Staffing was sufficient in all areas. There was low use of bank and agency staffing across all areas.Staff were competent, skilled and well supported by their managers to deliver safe and effective care and treatment.
- All clinical areas were visibly clean and equipment was well maintained.
- Infection control practices were mostly good. Staff in theatre recovery did not always adhere to bare below the elbow guidance but action was taken to address this during the course of our inspection.
- Patients' nutrition and hydration needs were met. The hospital offered a wide range of food choices, and could cater for individual dietary requirements.
- Patients reported staff managed their pain effectively and they had access to a variety of methods for pain relief.

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

The provider should ensure:

- The business plan to achieve Joint Advisory Group (JAG) accreditation is progressed.
- There is an end of life strategy, which informs pathway development.
- There is consistent staff compliance with WHO Safer surgery checklist in endoscopy.
- There is a strategy for the children and young peoples' service.
- That service risks hospital-wide are recorded and actions to mitigate are recorded and tracked.
- Recovery staff consistently adhere to the bare below the elbow policy in clinical areas.
- That all Patient Group Directions are in date and authorised by the required members of staff.
- The service meets national referral to treatment time targets for NHS surgical patients.
- Bank staff training compliance should meet the hospital's own target of at least 85%.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement 	Overall, we found medical care at this hospital requires improvement. The hospital did not have an end of life care strategy, pathway, or a named leader for end of life care. Outcomes of people's care and treatment following endoscopy procedures were not monitored at the hospital. The WHO safer surgery checklist was not consistently completed in endoscopy. Clinical risks were not included in the hospital risk register. For example, It was not possible in the current unit to provide separate clean and dirty areas in endoscopy. There was a slow response to audit findings. Endoscopy, oncology and the ward and were visibly clean and there were good infection prevention and control practices. Patient risks were assessed, reviewed and appropriately monitored during their stay. Staff were supported in their role and appraisals and mandatory training compliance were completed for nearly all staff. Medical staff obtained informed consent from patients prior to endoscopy procedures and chemotherapy. The service was taking action to be able to meet current evidence based guidance. The endoscopy lead and executive director had put a business plan in place to drive towards achieving Joint Advisory guidance (JAG) accreditation in gastrointestinal endoscopy. It was not possible in the current unit to provide completely separate clean and dirty areas which was prohibitive to JAG accreditation at that time. During the inspection, we saw that staff were caring, compassionate and sensitive to the needs of patients. Patients commented positively about the care provided from all of the endoscopy, oncology, and ward staff. Patients felt well informed and involved in their procedures and care. The service met national waiting times for endoscopy which meant patients would wait no longer than 18 weeks for treatment after referral.

Summary of findings

The service was responsive to patients in the inclusion criteria, with waiting times one to four weeks. Care and treatment was coordinated with other providers. The needs of different people were taken into account when planning and delivering services.
Staff in endoscopy and oncology were clear about the vision and strategy for their services, driven by quality and safety. The staff we spoke with described an open culture and leaders were visible and approachable. There was a governance structure for the endoscopy and oncology leads to report to for concerns/ issues to be discussed.

Surgery

Good

Overall, we found surgical services provided good care and treatment to patients. Nursing and medical staff were caring, compassionate and patient centred in their approach. Patients felt they received enough information about their treatment and were involved in decisions about their care.
We observed that staff maintained patients' respect and dignity at all times.
All areas of the service we visited were visibly clean, and there were systems in place to support the safe delivery of care and treatment.
Medical and nursing staff carried out effective risk assessments from pre-assessment through to discharge. They planned treatment, recovery and discharge in line with patients' specific needs.
Staff followed evidence based care and treatment, and monitored and reviewed patient outcomes.
Staff worked effectively across different disciplines and had good links with staff at other BMI hospitals and local NHS services.
Nursing and medical competence was good and trained professionals took pride in their work.
Nurse staffing levels were based on an assessment of patient needs and there was a low level of agency usage across the department. Consultants and the RMO provided 24 hour medical cover to respond to any clinical issues.
There was a strong sense of loyalty and teamwork among staff. Staff valued the support from their leaders and liked working in the service

Summary of findings

During our inspection, we observed recovery staff did not consistently adhere to the bare below the elbow policy in clinical areas.
Some Patient Group Directions for staff to administer and supply named medicines without a prescription were out of date and needed review.
Managers and staff did not use the risk register effectively to identify and manage risks within the service. The hospital had recently started to implement changes to address this.
The hospital did not produce formal action plans that detailed the person responsible for any actions in response to incidents.
The hospital did not always meet the referral to treatment time targets for NHS patients for surgical patients.

Services for children and young people

Good

Overall, we found services for children and young people were good. We did not rate this service for caring as there was insufficient evidence to do so.
The children and young people's service had a good track record on safety with no serious indents reported. The hospital safeguarded children and young people through offering care tailored to their needs. There are two fully qualified paediatric nurses employed by the hospital to manage the care of children and young people. A resident medical officer (RMO) with a current certification in paediatric advanced life support is employed whenever a child is admitted.
The hospital lacked specific waiting areas and consulting rooms for children, but staff minimised the potential impact of mixing children with adults by using dividing screens if needed.
The director of clinical services and the paediatric nurses were all qualified in safeguarding to level 3 and the director of clinical services took the role of safeguarding lead at the hospital. Children and young people's services are planned and delivered in line with best practice and guidance. The provider monitors outcomes and the service benefitted from the same standards of care and infection prevention and control measures activities afforded to adults in the hospital.
Children's and young people's services were responsive and provided access at times to suit children, young people and their parents.

Summary of findings

Child-friendly information was available for children about their procedures; nurses encouraged them to ask questions about their care. Nursing staff offered children and parents emotional support when needed. The paediatric nurses gave a feedback questionnaire to all children and young people and the results were collated annually and used to improve the service for children and young people.
Staff felt well supported by the paediatric nurse leads as well as the director of clinical services and the senior leadership team. There were no serious incidents related to the care of children or young people within the past year and there was a positive culture of reporting, investigating and learning from incidents across the hospital. There were no known risks associated with the care of children and young people at the time of our inspection.
The executive director told us the risk register was not fit for purpose in its current format but senior managers were aware of this and were in the process of reviewing their processes for recording, reviewing and tracking mitigating actions across the hospital. There was no written strategy for the care of children and young people at this hospital though staff shared the overall vision of providing excellent care and value for money.

Outpatients and diagnostic imaging

Good

Overall, this service was rated as good. We found outpatients and diagnostic imaging good for the key questions of safe, caring, responsive and well-led. We did not rate effective as we do not currently collate sufficient evidence to enable a rating.
Medicines were stored securely and well managed. However, the patient group direction was in need of review, as it was two years past its review date.
Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level. Staff undertook appropriate mandatory training for their role.
Patients were protected from the risk of abuse and avoidable harm. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections. Equipment was well maintained and

Summary of findings

tested annually or in accordance with manufacturers' guidelines. Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging services. Although the outpatient nurse manager had been under pressure, the situation had recently improved with posts being filled. Agency staff were not used. Longstanding bank staff were occasionally employed to provide cover. Staff received as a minimum training in basic life support to ensure they could respond appropriately in an emergency situation.

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

Staff followed national and local guidance when providing care and treatment. For example, guidance related to diagnostic imaging to ensure safe practice. Staff were supported in their role through a corporate performance review process. Staff were encouraged to participate in training and development to enable them to deliver good quality care. Patients' pain needs were met appropriately during a procedure or investigation. The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Clinics were available six days a week, Monday to Saturday.

We rated caring as good. During the inspection we observed care was provided compassionately by caring staff. Patients' feedback through interviews and comments cards was entirely positive; they commended the professionalism and kindness of staff. Patients praised all aspects of the service with comments such as "I am always listened to", "Great advice", "Brilliant", "Fantastic", "Welcoming and supportive" and "Exceptional care". Patients were treated with dignity and respect. They felt they were fully involved in planning their care and treatment. Staff took time to ensure they listened to and responded to patients' questions appropriately. This included the provision of emotional support. Staff verbally offered a chaperone to all outpatients. Signs were also clearly displayed in waiting areas and clinical rooms offering a chaperone and the patient's

Summary of findings

acceptance or rejection of the offer was recorded on the clinic list. Since the new chaperone service had been implemented over 95% of patients had accepted the offer of a chaperone.

We rated responsive as good. Services were planned and delivered in a way which met the needs of patients. Access to appointments was timely. Clinics were held on weekdays into the evening and Saturday mornings to suit patients' preferences. Interpretation services were available, however, staff could not recall the need to access this service for the patients they cared for. Staff made practical adjustments to accommodate patients' individual needs, for example, when caring for patients with hearing difficulties. Patients were aware of how to provide feedback and complain about the service if needed. Complaints were investigated and changes made if necessary.

We rated well-led as good. Effective governance and risk management systems were in place. Staff were well informed about issues relating to their department. They had opportunities to raise ideas and concerns when needed, which they were confident would be addressed by their managers. Service managers were committed to provide high quality care and facilities for patients. Local and senior managers were visible and approachable to all staff. There was an open and supportive learning culture. Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

Summary of findings

Contents

Good

BMI Sarum Road

Services we looked at

Medical care; Surgery; Services for children and young people; Outpatients and diagnostic imaging

Summary of this inspection

Background to BMI Sarum Road Hospital

BMI Sarum Road Hospital was opened in 1913, initially as a nursing home. It was later acquired by a hospital operating company, and later taken over by General Healthcare Group (BMI Healthcare Ltd) in 2006. At the commencement of our inspection, the new executive director had been in post for 53 days.

The hospital is purpose built and has been added to over the years. Most recently, in 1985, the current theatre department was opened which allowed expansion of work load and also provided laminar air flow for orthopaedic surgery. BMI Sarum Road Hospital has 48 registered beds (36 in use) with all rooms offering ensuite facilities, Wi-Fi, TV and telephone. The hospital has two main theatres with laminar flow, one minor operations room, one treatment room and 10 consulting rooms. There is no critical care or emergency facility at this hospital.

The hospital provides a range of services to patients who are self-funded or use private medical insurance. Services include general surgery, orthopaedics, cosmetic surgery, ophthalmology, general medicine, oncology, dermatology, physiotherapy and diagnostic imaging. Ophthalmology, endoscopy and orthopaedic services are available to NHS funded patients through choose and book. Endoscopy, diagnostic imaging and surgery were available to children and young people at this hospital.

The following services are outsourced:

- Agency Clinical staff
- Catering and kitchen services
- Infection Prevention and Control Nurse
- Instrument decontamination
- Microbiology
- Mobile MRI Scanner
- Pathology Service
- Radiation and Laser Protection support and advice
- Resident Medical Officer (RMO)

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at the four core services provided by the hospital: medicine, surgery, outpatient and diagnostic imaging and services for children and young people.

There was no registered manager at the time of our inspection. There was an application in process.

The nominated individual from BMI Healthcare Limited was Elizabeth Sharp.

Our inspection team

Our inspection team was led by: Emma Bekefi, Inspection Manager, Care Quality Commission (CQC).

The team of 14 included seven CQC inspectors, a pharmacist specialist and a variety of specialists; medical nurse, surgical nurse, surgical consultant, radiographer, and outpatient nurse.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Summary of this inspection

Before visiting, we reviewed a range of information that we held about the hospital. We carried out an announced inspection visit between 25 and 26 February 2016, and a routine unannounced inspection on 3 March 2016. We held focus groups for staff in the hospital. We spoke with staff and managers individually. We spoke with patients, relatives and staff from the ward, oncology day unit, physiotherapy department, operating department, endoscopy unit and outpatient services. We observed care and treatment and reviewed patients' records.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at BMI Sarum Road Hospital.

Information about BMI Sarum Road Hospital

The hospital provides a range of services to patients at any age though most commonly patients are aged 16 years and over. Between October 2014 and September 2015, five percent of the hospital's overall activity was care and treatment delivered to children between the ages of three and 15 years old. 20% of the overall activity was delivered to young people aged 16 or 17 years old. The total activity in the same reporting period for children under the age of three years old was less than one percent. 24% of all patients are NHS funded.

Hospital activity during the year October 2014 to September 2015 included:

- 1,014 overnight inpatients;
- 3,091 day-case patients;
- 3,868 visits to theatre;
- 7,145 outpatients (first attendees)
- 12,278 outpatients (follow up appointments)

Of the 3,868 visits to the theatre between October 2014 and September 2015, the five most common procedures performed were:

- Multiple arthroscopic operations on knee (including meniscectomy) (316)
- Facet joint injection (under x-ray control) - five to six joints (208)
- Image-guided injection(s) into joint(s) (199)
- Dorsal root ganglion block (local aesthetic or neurolytic) (150)
- Primary total hip replacement with or without cement (127).

The most common medical procedures were:

- 183 Diagnostic gastroscopy
- 176 Diagnostic colonoscopy
- 141 Diagnostic endoscopic examination of bladder (including any biopsy)

The Controlled Drugs accountable officer was Martin Page, Executive Director.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. We inspected but did not rate 'caring' for children and young people's services as we were unable to collate sufficient evidence.

Requires improvement

Medical care

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

Information about the service

BMI Sarum Road provided a small general medical service. During the past year, the hospital had 29 general medical patients, out of 4106 inpatients. The hospital treated patients with conditions including cellulitis, pneumonia and also provided palliative care and supported patients at the end of life. These patients were cared for on Chestnut ward. The majority of medical care provided by the service was oncology and endoscopy, and this core service report has focused mainly on these specialties. Staff told us there were very few palliative and end of life patients. The hospital did not provide us with exact numbers.

There were 501 gastrointestinal endoscopies over the last year. There were 141 diagnostic examinations of the bladder (including any biopsy) and 16 bladder instillation of a pharmacological agent (including a cystoscopy). The endoscopy unit consisted of a treatment room, a scope washer room and a small storeroom with an endoscopy drying cabinet.

The oncology day unit had five rooms with ensuite facilities. The oncology day unit was open five days a week 9am to 5pm. On a Tuesday, the oncology day unit remained open until 7pm. Oncology services included diagnostics, chemotherapy/ monoclonal antibodies therapy and supportive therapies, for example, blood transfusions.

We spoke with four nurses and two doctors in the endoscopy unit and two patients following an endoscopy procedure. On the oncology unit, we spoke with two patients, three nurses and a doctor. On the ward we spoke with two nurses and one patient. We reviewed 13 sets of patient records across endoscopy and oncology, and two records on the main ward. We received one feedback form about the endoscopy service and three about the oncology service.

Requires improvement

Medical care

Summary of findings

We found that medical care requires improvement for effective and well-led and was good for safe, caring and responsive.

The hospital did not have an end of life care strategy, pathway, or a named leader for end of life care. Outcomes of people's care and treatment following endoscopy procedures were not monitored at the hospital. The WHO safer surgery checklist was not consistently completed in endoscopy. Clinical risks were not included in the hospital risk register. For example, It was not possible in the current unit to provide separate clean and dirty areas in endoscopy. There was a slow response to audit findings.

Endoscopy, oncology and the ward and was visibly clean and there were good infection prevention and control practices to reduce the risk of infection. Patients were risk assessed to make sure only those that were suitable underwent an endoscopy procedure and chemotherapy at the hospital. Patient risks were reviewed and appropriately monitored during their stay.

Staff supporting endoscopy and oncology were 100% compliant with their mandatory training. New staff underwent a comprehensive induction. Ward staff were 93% compliant against a target of 85%. Staff had an awareness of safeguarding, and steps to take to prevent abuse from occurring.

Staff were supported in their role through appraisals. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care. Medical staff obtained informed consent was obtained from patients prior to endoscopy procedures and chemotherapy.

The service was taking action to be able to meet current evidence based guidance. The endoscopy lead and executive director had put a business plan in place to drive towards achieving Joint Advisory guidance (JAG) accreditation in gastrointestinal endoscopy.

During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Patients commented positively about the care provided from all of the endoscopy, oncology, and ward staff.

Patients were treated courteously and respectfully. Patients felt well informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, a chemotherapy treatment in oncology and on the ward.

The service met national waiting times for patients requiring an endoscopy to wait no longer than 18 weeks for their procedure after referral. The service was responsive to patients in the inclusion criteria, with waiting times of one to four weeks. Care and treatment was coordinated with other providers. The needs of different people were taken into account when planning and delivering services. For example, patients attending the oncology department were asked about their religious beliefs, in case these could affect their treatment options or care preferences.

Staff in endoscopy and oncology were clear about the vision and strategy for their services, driven by quality and safety. The staff we spoke with described an open culture and leaders to be visible and approachable. There was a governance structure for the endoscopy and oncology leads to report to for concerns/ issues to be discussed.

Requires improvement

Medical care

Are medical care services safe?

Good

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

We rated safe as good because:

- Endoscopy, oncology and the ward and were visibly clean and there were good infection prevention and control practices to reduce the risk of infection.
- Patients were risk assessed to make sure only those that were suitable underwent an endoscopy procedure and chemotherapy at the hospital. Patient risks were reviewed and appropriately monitored during their stay.
- Staff were aware of processes to follow in the event of an emergency.
- Equipment was well maintained and tested in line with manufacturer's guidance. Medicines were stored and handled correctly.
- Medical staff undertook the endoscopy procedures. The service adopted a flexible approach to rostering in response to scheduling of lists.
- Mandatory training targets were met and new staff received a comprehensive induction.
- Staff had an awareness of safeguarding and steps to take to prevent abuse from occurring.
- There were sufficient nursing and medical staff to provide safe medical care.

However:

- The Five Steps to Safer Surgery checklist in used in endoscopy was not consistently fully completed.
- Bank staff compliance with mandatory training ranged from 55% to 80%, against a target of 85%.

Incidents

- The hospital had reported 281 clinical incidents in the period October 2014 to September 2015 The overall rate of incidents reported during that period had fallen slightly from 8% in October 2014 to 6% in September 2015 per 100 inpatient discharges. The oncology service had reported 11 incidents which included 'no harm' and to 'low harm' incidents. The endoscopy service had reported six incidents which ranged 'no harm' to 'low harm'.
- Staff in the endoscopy suite, oncology and on the ward understood how to report incidents. The staff completed paper incident forms. The quality coordinator the screened them to check they had been categorised correctly. Administration staff added the information onto the provider's electronic database. The director of clinical services (DOCS) then reviewed all clinical incidents, and the hospital service manager reviewed non clinical incidents. The most appropriate person would then be requested to investigate the incident, for example, infection control lead would investigate incidents related to infection control practices.
- There were separate incident reporting streams for clinical and non-clinical incidents. At this hospital patient falls were being classified as non-clinical. However, the DOCS reviewed falls incidents to identify potential areas to improve patient safety or trends.
- Nursing staff in oncology had reported two incidents about the delay with chemotherapy being delivered to the hospital in July 2015. The hospital made a change immediately to a process to prevent a delay, due to transport, in the receipt of chemotherapy for a patient.
- The hospital reported serious incidents to the CQC in line with statutory requirements. These included three expected deaths between September 2014 and December 2015. The hospital had recorded one serious incident in September 2015 related to a medical patient. This was an unexpected death. The patient died unexpectedly 11 days after discharge. Senior staff reviewed and then documented the patient's care within their notification to the care quality commission. It was concluded the death was from natural causes and an unavoidable venous thrombus embolism. Senior hospital staff also carried out a venous thromboembolism root cause analysis, for review by the BMI Healthcare thrombosis board.
- Staff in endoscopy and oncology were aware of the Duty of Candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The DOCS

and ward manager understood their responsibilities in terms of offering an apology to patients and meeting with and writing to patients if harm had been caused. If an incident occurred in oncology or endoscopy, nursing staff were open and honest with patients.

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

- The hospital displayed safety data on the ward, showing any hospital acquired infections, falls, staffing levels, trends in staffing levels and patient feedback.
- The 'NHS safety thermometer' is a local improvement tool for measuring, monitoring, and analysing patient harms and 'harm free care' on one day each month. The hospital participated in the NHS safety thermometer for NHS patients but did not display the results on the ward or discuss them at clinical governance meetings, as this data was only available for NHS patients.
- The provider included NHS endoscopy patients in the NHS safety thermometer if they were admitted on the day of data capture for the month.
- Oncology staff have commenced auditing venous thromboembolism (VTE) assessments of their patients. The VTE screening rate was 100% against a target rate of 95% for the reporting period from October 2014 to September 2015.

Cleanliness, infection control and hygiene

- The hospital had policies and procedures in place to manage infection prevention and control. Staff were able to access the policies and procedures. We saw policies and processes for the management of waste and decontamination.
- All areas we observed were visibly clean.
- Disposable aprons and gloves were readily available. Staff used them when delivering care and treatment to patients, to reduce the risk of cross infection. Staff also wore disposable gloves and aprons as personal protective equipment when undertaking endoscopy.
- Staff adhered to the 'bare below the elbow' policy when providing care and treatment. Staff in the oncology and endoscopy units were 100% compliant with hand hygiene and 'bare below the elbows' in the saving lives audit in January 2016. Hand hygiene and bare below the elbow audits for the ward showed 90% compliance in November 2015 to 100% compliance in December 2015 and January 2016.
- The hospital scored 97% for cleanliness, compared to the national average of 97.6%, for the patient-led assessment of the care environment (PLACE) audit in 2015.
- The hospital had no incidences of clostridium difficile, meticillin-resistant staphylococcus aureus (MRSA) or meticillin-sensitive staphylococcus aureus (MSSA) in the period October 2014 to September 2015.
- Staff followed a cleaning schedule and maintained a record that was displayed in the endoscopy suite.
- Staff took weekly samples of the water in endoscopy to check for decontaminants. Results for week commencing 11 November 2015 had been unsatisfactory, and staff took appropriate action taken to improve the water quality. The level of contaminants since has ranged from acceptable to satisfactory.
- Endoscopy staff decontaminated the endoscopes on site. Due to the environment, it was not possible to have separate clean and dirty areas. The endoscopy lead had risk assessed this risk, and a process in place to reduce the risk of decontamination. Actions included the lead allocating staff during endoscopy procedures so that staff members would not handle both clean and dirty scopes during an endoscopy list, and a clean scope not being removed from the automated washer if a used scope brought into the scope washer room. The provider had a drying cupboard for the endoscopes. Endoscopy staff kept full scope tracking and traceability records.

Environment and equipment

- The number of endoscopes and size of scopes enabled the scheduled endoscopy lists to proceed uninterrupted. This meets the standards set by the Joint Advisory Group on gastrointestinal endoscopy. There were also a sufficient number of monitors, cameras and printers. Environmental risks were managed appropriately to ensure patient and staff safety was maintained. For example in the endoscopy treatment room, the endoscopy lead had covered trailing wires with appropriate surgical theatre flooring tape to remove a trip hazard.
- Maintenance and repair contracts were in place for the endoscopes, the washer disinfector and the drying cabinet. We saw maintenance records were up to date during our inspection.
- There were two resuscitation trolleys. One trolley was located in the main corridor close to the oncology day

case unit and the endoscopy unit. The other trolley was kept on the ward. Records showed that both trolleys were checked daily to ensure the contents were complete and in date. Both trolleys had tamper evident tags to prevent access by unauthorised personnel.
- Patients in the oncology unit had access to a scalp cooler, and all staff were trained to use this equipment. Scalp cooling can reduce hair loss caused by chemotherapy.
- Medical equipment was portable appliance tested (PAT) as part of annual servicing. We saw evidence on the asset register and equipment maintenance schedule that 98% of equipment maintenance was in date. The hospital maintenance team performed PAT testing of non-medical equipment every five years.

Medicines

- Patients attending the oncology day unit received intravenous chemotherapy.
- Medical staff were responsible for prescribing chemotherapy. The hospital pharmacist checked the chemotherapy, which was supplied by an outside pharmaceutical company, before delivery to the ward.
- Two nurses trained in the administration of chemotherapy checked the medicine before administration to a patient. Trained nurses administered the chemotherapy using a peripheral cannula or through a central venous access device into a patient.
- In the oncology unit, emergency medicines, including extravasation kits were available for use. An extravasation kit is equipment used to remove an intravenous (IV) medicine or fluid that has leaked from a vein into the surrounding tissue. Extravasation kits were found to be in date. Staff were aware of the procedure for managing extravasation and the procedure to follow if it occurred.
- An anaphylaxis kit, for treating anaphylactic shock, was present on the unit with the content clearly marked. The anaphylaxis kit was in date.
- Chemotherapy spillage kits were available in all patient rooms.
- A patient having an endoscopy may have the procedure under sedation. A reversal agent was available if required.
- We reviewed the storage of controlled drugs (prescription medicines that are controlled under Misuse of Drugs legislation). Controlled drugs were stored and recorded safely.
- Chemotherapy not requiring cold storage was kept in a locked treatment room.
- Oncology medicines requiring cold storage were kept in oncology in a fridge. Records showed that nursing staff checked the temperature each day to ensure medicines were stored at a safe temperature. Nursing staff were aware of actions to take if the fridge temperatures were not within an acceptable range.
- On the ward, medicines, including controlled drugs and intravenous fluids, were in locked cupboards inside locked rooms. Staff on the ward kept mobile medicine trolleys locked and secured to the wall when not in use.
- There was no guidance at the hospital about stopping non-essential medicines at the end of life. The resident medical officer and nursing staff were experienced and person centred in their approach, and the patient we saw was comfortable.

Records

- During our inspection, we reviewed 10 endoscopy patient care records. The pre-assessment questions, admission record, pre-procedure care, care during procedure, recovery, and post-procedure care were fully completed.
- An audit of five steps to safer surgery checklist forms at the hospital showed 100% compliance in January and February 2016. There were some gaps in the documentation of the completion of the Five Steps to Safer Surgery (World Health Organisation (WHO) checklist used in endoscopy. This is a tool for the relevant clinical teams to improve the safety in an operating theatre environment of a procedure, by applying a systematic checking process. A clinician did not sign two and one checklist was incomplete of the 10 safer surgery checklists reviewed. The endoscopy service had not had any incidents in relation safety during an endoscopy procedure, although this gap in completion of the documentation was evident during the inspection.
- There was a BMI audit programme supported by an audit calendar in place. This included medical and nursing records. The hospital patient health record audit in January 2016 was 90%. Two areas of noncompliance by nursing staff in two sets of records were nursing

entries not including designation of person, and in four records consultant entries were not dated, timed and signed. In February 2016 staff compliance with the patient health record was 98%.
- Nursing staff locked patient records in a filing cabinet in the oncology unit office.
- Patient notes were collated in different sets of records. A patient had two sets; consultant records and a set with the integrated BMI nursing assessments, results and letters from consultant. The records were thorough, but neither sets of records held multi-disciplinary team meeting records about patients.
- The oncology lead had been trying to have the MDT notes faxed to the oncology unit but this had not happened. This did not affect patient care due to the close working by the consultant with the nursing staff.
- The ward records for the palliative patient and the end of life patient were fully completed.

Safeguarding

- Nursing staff in oncology and endoscopy were aware there was a safeguarding adults policy in place incorporating mental capacity, deprivation of liberties and PREVENT (The Prevent Duty has "due regard to the need to prevent people from being drawn into terrorism").
- Nurses in the endoscopy and oncology departments confirmed there had been no safeguarding incidents in the last year. Staff could explain how they would respond if they witnessed or suspected abuse.
- Staff in endoscopy, oncology and on the ward were aware of the safeguarding lead for the hospital.
- Endoscopy, oncology, and ward nurses had completed level one and level two safeguarding training appropriate to their role. The DOCS was trained to level three so could manage safeguarding investigations if required.
- In the endoscopy department, three of the four permanent staff were 100% compliant with safeguarding training, with the fourth staff member still completing their induction.
- In oncology, the compliance was 100% except for a newly registered nurse who had started in January 2016.

Mandatory training

- Staff were required to complete mandatory training, which included resuscitation, health and safety, moving and handling and information management.
- Mandatory training compliance for the hospital was 93% against a target of 85%.
- The leads in gastroscopy and oncology advised us they had booked new staff in for training. Service leads ensured that staff were booked in to complete mandatory training during their induction period.
- For regular bank staff working in oncology and endoscopy compliance with mandatory training ranged from 55% to 80%. Service leads would review the mandatory training needs of irregular bank staff who worked regularly with NHS trusts. They ensured that all staff including bank staff, had received their own mandatory training programme, or that training had been undertaken in their NHS role.
- All bank nurses received annual immediate life support training.

Assessing and responding to patient risk

- Patients attending for endoscopy were asked to complete a postal pre-assessment heath check questionnaire. A registered nurse checked the returned questionnaires prior to the procedure to assess a patient's suitability and fitness for endoscopy. The pre-operative assessment nurse advised the consultant's secretary if there were any medical risk factors that the consultant needed to be made aware of.
- The endoscopy list order took account of a patient's health needs. For example, the lead said if a patient had diabetes, the patient would be listed first to prevent the possibility of low blood sugar in the pre-operative fasting period.
- We did not directly observe in use the five steps to safer surgery checklist in endoscopy. However, staff described the process to us, and there was a visible prompt to use the safer surgery checklist on a whiteboard within the endoscopy treatment room. Consultants reviewed patients who had undergone an endoscopy procedure prior to their discharge, to ensure they were fit to return home.
- The nurses completed an oncology nursing assessment for oncology patients prior to discharge. This assessment included information about the risks of chemotherapy, and how these could be managed.
- The doctor and nurse in oncology met with the patient together, to jointly discuss the treatment plans, any risks and concerns.
- Oncology nursing staff used a tool called the United Kingdom Oncology Nursing Society (UKONS) triage tool

to help identify the urgency of a particular problem. Nursing staff had used the tool 44 times in the period April to December 2015. Ward staff were currently having ongoing training, to ensure detailed understanding of the UKONS tool. Night staff we spoke with understood how to use the tool, to support telephone triage of calls received from patients who attended the oncology day unit. Night staff had effectively used the tool 18 times during the period April to December 2015.

- For the palliative and/or end of life patient, risk assessments included the malnutrition universal screening tool (MUST), falls prevention, pressure ulcer risk and pain assessment. Nursing had completed these assessments thoroughly, to support safe care. We were at a nursing handover a patient's discomfort being discussed, and the patient's pain control being reviewed to manage the patient's pain effectively.

Nursing staffing

- There were three dedicated registered nursing staff working in endoscopy, and since January 2016 a healthcare assistant. The service also used a bank registered nurse with endoscopy skills when necessary. The endoscopy lead confirmed the staffing skill mix and competencies were appropriate for the endoscopy procedure lists that were scheduled at the hospital.
- Two chemotherapy-trained nurses were always on a duty when a patient was booked for a chemotherapy treatment. The service was staffed to provide chemotherapy treatments on a Tuesday, Wednesday, and Thursday. If the oncology lead needed support on a Monday or Friday, she contacted the inpatient ward for additional nursing support. The oncology lead advised there was an 18 hour trained nurse vacancy in the department.
- The hospital used the BMI Healthcare nursing dependency and skill mix tool to plan the skill mix of staff five days in advance on the ward. The staffing was reviewed on a daily basis to reflect any changes in the patient lists. Ward staff told us staffing levels were adapted to meet the needs of the patients. For example, the hospital arranged extra, suitably trained staff for high dependency patients or patients who needed one to one nursing. Staff we spoke with said they were able to request additional staff when required.
- Staff displayed required versus actual staffing levels at the entrance to the ward and these showed a close correlation for the month of January 2016.
- On 18 out of 31 days in January, staffing levels exceeded the planned required level, due to specific patient needs on those days. There were always two registered nurses on duty on the ward, including nights and weekends, to enable staff to respond to emergencies. There was use of bank and agency staff across the hospital from October 2014 to September 2015 of less than 20%. The leads in oncology and endoscopy reported they used a consistent small number of established bank staff.
- Nursing staff conducted effective handovers of care when new staff arrived on duty. We observed a verbal lunchtime handover and taped evening handover from day to night staff, which the resident medical officer (RMO) also attended.

Medical staffing

- The medical staff, who undertook endoscopies, also regularly performed gastrointestinal endoscopy procedures within the NHS.
- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector. The consultants in oncology also worked in the NHS as oncologists.
- A Resident Medical Officer (RMO) provided 24 hour, seven day a week cover at the hospital. They confirmed effective communication between themselves, nurses, and consultants. The RMO worked either a two week or one week pattern, staying on site to provide medical advice and emergency support.
- The RMO had up to date advanced life support training.
- The endoscopist went to see a patient after the procedure on the ward, to feedback findings and ongoing plan of care. Nursing staff would then care for patients following a gastrointestinal endoscopy until their discharge. If an oncologist had left the hospital before a patient's chemotherapy treatment had completed, nursing staff would care for the patient. The leads reported timely access to the consultants if a patient's needs changed, and that the consultants would provide cover for each other's patients if required.

Major incident awareness and training

- The hospital had local and corporate business continuity plans for use in events such as internet or electricity failure.

- Staff tested the electricity generator each month to ensure it was safe to use in case of power failure.
- The hospital held regular fire drills and there was a fire evacuation procedure on laminated card in each patient room. Theatre staff performed a skills drill annually for the complete evacuation of the department in the event of fire, followed by a full debrief.

Are medical care services effective?

Requires improvement

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

We rated effective as requires improvement because:

- There was no end of life care plan in place to support effective care, or training to support staff.
- Outcomes of people's care and treatment following endoscopy procedures were not monitored at the hospital.
- There was not a Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation.

However:

- People's care and treatment was planned and delivered in a way that took account of current evidence based guidance, standards and legislation in oncology.
- Endoscopy staff took account of National Institute for Health and Care Excellence (NICE) guidance.
- Staff were supported in their role through appraisals. There was 100% compliance with staff appraisals. Staff were encouraged to participate in training and development to enable them to deliver good quality care.
- Informed consent was obtained from patients prior to endoscopy procedures and chemotherapy.
- Patient's pain was assessed, monitored and responded to promptly.

Evidence-based care and treatment

- Endoscopy staff followed National Institute for Health and Care Excellence (NICE) guidance but did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. JAG accreditation provides evidence that best practice guidelines are being followed for endoscopy. JAG measures quality and safety indicators, including outcomes. The structure, process and staffing levels and competencies are reviewed, and outcomes audited. A project led by the corporate team was about to commence to upgrade the endoscopy unit to meet JAG accreditation.
- The oncology unit followed best practice guidance in the care of their patients using NICE sources The BMI oncology development group reviewed and discussed clinical developments and results at their bi-monthly meetings. The oncology lead nurse attended these meetings and shared the information across the oncology and wider hospital team at BMI Sarum Road.
- The endoscopy lead explained that two of the policies in oncology were draft at present. This was the acute oncology policy and systemic administration of chemotherapy treatments. The hospital advised us a discussion about these policies was expected at the oncology steering group in London in March 2016. The service leads discussed new policies at the monthly heads of department meetings, to ensure staff awareness.
- An end of life care pathway was not in place. However, we saw a patient receiving good end of life care where sufficient priority was given to the patient's comfort and wishes in the dying phase of their illness. Following our inspection, service leads have developed a draft personalised end of life care plan. This had not been tested at the time of inspection, to assess the plan's effectiveness in practice.

Pain relief

- Staff offered patients undergoing gastroscopy a throat spray to numb the back of their throat, or intravenous sedation, to minimise their pain.
- Medical staff performed colonoscopies under intravenous sedation.
- Nurses monitored a patient's pain using a pain scale, and offered pain relief when appropriate. We saw a patient undergoing a procedure who was lightly sedated. The patient was relaxed and not experiencing pain.
- Nursing staff administered prescribed analgesia if required to endoscopy, oncology, and ward patients. We saw the RMO assess a patient immediately when contacted by nursing staff to say a patient was in pain.

- There was no guidance on the hospital intranet, about the prescribing of anticipatory medicines to manage any pain experienced by a patient at the end of life. The patient at the time our inspection did have appropriate pain relief prescribed. The resident medical officer (RMO) was also on site 24 hours a day seven days a week, if the patient did develop any pain, enabling the nursing staff to request an immediate review of the patient if needed.

Nutrition and hydration

- Patients having a gastroscopy were advised not to eat or drink anything for at least six hours prior to their appointment time, to enable good views of the stomach.
- Patients, who were due to attend for colonoscopy, were given advice on how to prepare for the procedure that included general guidance regarding pre-operative dietary and fluid intake.
- The oncology lead advised that if a patient needed to see a dietitian, a call would be made to a dietician who is permitted to work at the hospital. The lead confirmed urgent cases would be seen on the same day. Staff in oncology also advised that if the patient preferred, the dietitian would telephone them at home to provide dietary support.
- The hospital offered light snacks and drinks for day case patients before discharge home. There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets.
- Ward patients' nutritional status was screened using the malnutrition universal screening assessment tool (MUST).
- Palliative care patients received individual support directly from the chef regarding meeting their nutritional needs. The chefs would plan menus with individual patients if they were experiencing nausea or finding food hard to tolerate.
- The chefs catered for all diets and were willing to prepare any specific foods to meet patients' preferences and needs, such as lactose intolerant, and coeliac disease as well as religious diets.
- There was a recent decrease in hospital patient satisfaction survey scores with meal provision, due to a change in the catering supplier. However, during our visit patients described being satisfied with the food quality and menu choices.
- The patient led assessment of the care environment (PLACE) for food rated it as 97.2%, against a national average of 88.5%.

Patient outcomes

- A consultant advised us there was no system in place for the monitoring and review of clinical performance data, for endoscopy procedures performed at the hospital.
- Oncology nursing and medical staff monitored individual patient outcomes as patients came back for review and further chemotherapy treatment cycles in their medical notes.
- A consultant in oncology advised due to small numbers and different cancers it was not possible to measure outcomes formally.
- In oncology, a vascular device audit undertaken in January 2016 also showed 100% compliance with NICE quality standards.
- If an oncologist had any concerns with the outcome of a patient's treatment, they raised their concerns for professional discussion at a NHS trust's speciality mortality and morbidity meeting, for learning purposes.

Competent staff

- The leads in oncology and endoscopy advised us that all staff appraisals were up to date.
- Medical staff performed endoscopy procedures, supported by nurses with specific endoscopy skills.
- The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. The hospital had recently introduced a spreadsheet to support risk rating the evidence from practising consultants about the evidence being up to date, and the consultant's level of activity. Evidence included scope of practice, appraisals and references. The status of medical staff consultants' practising privileges was recorded in the minutes of the medical advisory committee notes. The executive director had written recently to two consultants to remove their practising privileges due to lack of compliance with evidence and/or no activity.
- Nurses in the oncology unit had competency in the administration of chemotherapy. The nurses working in the oncology unit were all appropriately trained and had completed competencies in the administration of intravenous chemotherapy

- Training records showed that oncology nurses received additional training when new procedures or equipment were introduced.
- Nurses in oncology were able to describe what they would do if a chemotherapy medicine leaked from a vein into the surrounding tissues.
- The oncology nurses were competent to use the catheters in a patient's vein to deliver chemotherapy medicine.
- Endoscopy nursing staff were competent in the decontamination of endoscopes.
- The director of clinical services (DOCS) had organised human factors training in March 2016, which the endoscopy staff were planning to attend. This was designed to enhance clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour.
- The oncology lead had started an accredited course on history taking and physical assessment of patients.
- The oncology lead was supporting a healthcare assistant in oncology with obtaining the 'care certificate.' The national Care Certificate was launched in March 2015 and aims to equip health and social care support workers with the knowledge and skills to provide safe, compassionate care.
- The resident medical officers (RMOs) completed training and appraisals through their employing locum agency. The DOCS oversaw their induction and completion of mandatory training. There were also eight to ten resuscitation scenarios organised annually by an external training company for all staff. The RMO led these to assess their skills and competency.
- Nursing staff on the ward told us at that there was no training regarding end of life care available at the hospital at the time of the inspection.

Multidisciplinary working (in relation to this core service)

- In oncology, a patient's copy of the multidisciplinary notes did not follow the patient from the local NHS hospital. The oncology lead was liaising with the local NHS trust to resolve this issue. This meant that not all the records relating to a patient's chemotherapy treatment were in one place with evidence to support plan for chemotherapy treatment.
- There was effective multidisciplinary working in the endoscopy suite. During our inspection, the administrative, pre-assessment, endoscopy, medical and ward nursing staff worked well together to ensure the patient pathway was effective.
- We observed there was effective team working between all staff groups. A daily morning 'huddle' meeting facilitated this, where a representative of each department was present. We observed one meeting, which enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.
- Formal heads of departments meetings took place monthly, where department issues and priorities were raised. Such as audit progress and health and safety matters.
- There was close working with the local NHS trust and community healthcare practitioners. For example, oncology nurses did not provide end of life care and referred patients to palliative care nurses to meet patients' needs.
- The resident medical officer (RMO) attended the ward staff handover each evening, and there was a handover every two weeks where any changes in policies and practice were also discussed.
- The hospital had an onsite pharmacy staffed by a pharmacist and a pharmacy technician.

Seven-day services

- The endoscopy procedures were planned interventions, and performed during the hours 8am to 6pm Monday to Friday. The hospital advised additional sessions could be organised. Patients we spoke to reported good access to appointments and availability at times that suited their needs.
- The oncology service was open Monday to Friday 9am to 5pm. Chemotherapy treatments were given Tuesday to Thursday. On a Tuesday, the oncology unit stayed open until 7pm.
- For patients who were receiving chemotherapy there was seven day support available, if any adverse side effects. The resident medical officer (RMO) could access the pharmacy out of hours if required.
- The hospital staffed the ward to provide nursing care seven days a week.
- The hospital operated an on-call system for senior managers seven days a week.

Requires improvement

Medical care

Access to information

- The patient, on discharge, received a letter that included the reason for the procedure, findings, medicines and any changes, potential concerns and what to do and details of any follow up. The nurse sent a copy of this letter to the GP and placed a copy in the patient's medical records at the hospital.
- Oncology patients were given information that included a contact number for the hospital in case they needed support with any symptoms and/or side effects. For example, a leaflet was given which detailed what to do if they developed a raised temperature. A patient showed us a record of the information they had been given, which they had found very helpful.
- The hospital kept records on site for two years after admission, after which they were sent to an offsite storage facility. The records were then scanned and put in to an electronic format that staff could access via the ward computer. Staff could access paper records stored offsite within 24 hours. This meant staff could access past clinical information about patients previously treated at this hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients received information prior to their endoscopy procedure. This allowed patients to read the information and, if understood, give informed consent when they came for their procedure. Consent forms appropriately detailed the risks and benefits to the procedures, and were signed.
- A patient's cognitive and perceptual ability was assessed by oncology staff. Consent forms for chemotherapy treatment and scalp cooling in oncology were fully completed and signed.
- Staff were aware about the processes to follow if they thought a patient lacked capacity to make decisions about their care. Staff told us they would contact the DOCS on another senior staff member in the first instance.
- The hospital provided training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. DoLS are to protect the rights of people, by ensuring that any restrictions to their freedom and liberty have been fully considered and authorised by the local authority. There was information about MCA and DoLS on a noticeboard on the ward.

Are medical care services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity, and respect.

We rated caring as good because:

- During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Patients commented positively about the care provided from all of the endoscopy, oncology, and ward staff. Patients were treated courteously and respectfully.
- Patients felt well informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, a chemotherapy treatment in oncology and on the ward.
- People were supported to cope emotionally with their care and treatment as needed.

Compassionate care

- The Friends and Family test demonstrated that over 95% of patients recommended the hospital between April and September 2015.
- We witnessed attentive and compassionate care delivered by the consultant and endoscopy staff. When a patient was sedated, staff maintained dialogue throughout procedures, with explanation and reassurance.
- Oncology patients we spoke with had a named nurse, which they found helpful. One patient commented, "I feel lucky to feel so well looked after".
- Staff treated patients with respect and dignity during our visit. We observed staff always introduced themselves to patients, and knocked on doors and waited for permission to enter patients' rooms.
- In the Patient Led Assessments of the Care Environment (PLACE) in April 2015 privacy, dignity, and wellbeing scored 92.7% compared to an England average of 87.7%.

Requires improvement

Medical care

Understanding and involvement of patients and those close to them.

- Patients in endoscopy and oncology commented about how well informed they felt about their care. “The treatment was first class and doctor was very informative.”
- Relatives also felt involved. When we were inspecting a relative of an oncology patient telephoned for advice on behalf of his wife. The relatives concerns were listened too and acted upon. The consultant was contacted to support with decision making.
- The hospital patient satisfaction survey showed a rating of 100% for “discussing patient care and treatment plans.”

Emotional support

- The oncology nurses contacted nurse clinical nurse specialists and counselling services as required to support patients emotionally. This included the clinical nurse specialist in breast cancer, who provided specialist emotional and practical support.
- Patients were able to have emotional support from family and friends at any time, as there were no restrictions to visiting times.
- Patients could telephone the ward after discharge, for further help and advice about any concerns or questions on their return home.
- Nursing staff also provided patient’s with information from the range of Macmillan leaflets, which contained details of support groups for emotional support.

Are medical care services responsive?

Good

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

We rated responsive as good because:

- The medical service met national waiting times for endoscopy patients to wait no longer than 18 weeks for treatment after referral. The service was responsive to patients in the inclusion criteria, with waiting times of one to four weeks.
- There were no waiting lists for oncology services at this hospital.
- Care and treatment was coordinated with other providers.
- The needs of different people were taken into account when planning and delivering services. Staff took account of individual patient’s spiritual, religious and emotional needs when delivering care and treatment.
- Complaints and concerns were always listened to, and lessons learnt.

Service planning and delivery to meet the needs of local people

- Consultants undertook most endoscopy procedures on an insured (private) and self pay basis. The consultants also undertook NHS funded endoscopy procedures.
- Four oncologists treated insured and self pay patients at the hospital on a planned outpatient based service. The oncology unit could take up to five patients a day.
- The senior team were engaged with the local clinical commissioning group to support effective planning of services.

Access and flow

- Consultants saw patients who were referred by their GP as an outpatient before an endoscopy procedure, to assess the patient and discuss a plan of treatment. This meant the flow of patients could be planned for in advance. Patients could also choose to have their NHS funded gastroscopy through the NHS choose and book system.
- Consultants undertook endoscopy procedures within two to four weeks of referral.
- Patients’ admitted for a day case procedure, were discharged on the same day.
- NHS consultants referred oncology patients to the hospital following diagnosis at an NHS hospital. A patient could have chemotherapy treatment Tuesday to Thursday and there was not a waiting list for this treatment. The oncology lead advised the most patients they would usually see in a day were five. We asked about a recent week, and there had been 16 patients in total. Depending on the needs of patients’ treatments could take 15 minutes to several hours.

Meeting people’s individual needs

- Patients received information relevant to their procedure prior to their attendance. For example, the information about gastroscopy included preparation

and time to arrive, the two ways it could be performed, the examination process and after care. For a colonoscopy, the information included guidance on preparation, arrival time, the procedure and aftercare.
- Patient's day surgery pre procedure questionnaire included a prompt about any special learning needs.
- A nurse and consultant at the start of their treatment reviewed chemotherapy patients jointly. They would give information about the plan of care and potential side effects from treatment and informed consent obtained. If the patient required further time, another appointment was made to enable further discussion.
- Oncology patients had their own rooms with ensuite facilities. They could choose to receive their treatment on a reclining chair with electric movement or a hospital bed.
- The oncology nursing assessment included a prompt regarding a patient's religious, cultural, and spiritual needs. This was to assist discussions relating to the patient's treatment plan
- The oncology unit had a well-stocked supply of leaflets and patients could access those that suited their individual needs.
- For patients whose first language was not English, telephone translation facilities were available.
- Staff screened all patients over 75 for dementia and ward staff described how they catered for these patients' needs. Staff would inform the patient's GP if screening results were suggestive of dementia. There was a dementia link nurse for the ward, who was responsible for the training of others. We observed a ward notice board with information about dementia. The ward had dementia clocks and special picture signs for rooms and bathrooms.
- We observed a chef sensitively exploring with a palliative care patient what they felt they could eat, rather than giving the patient a list of options.

Learning from complaints and concerns

- The hospital normally provided information about how to raise a concern or make a complaint, in a patient information brochure, which staff gave to inpatients. However, during our visit this was out of print. There were also 'please tell us' leaflets throughout the hospital which outlined the formal BMI complaints procedure.
- The hospital received 58 complaints in total for the period February 2015 to January 2016. One of the complaints related to endoscopy and three to oncology.
- The respective leads hospital had investigated the complaint in endoscopy and two of the complaints in oncology. They established that two complaints were due to communication misunderstandings, one in oncology and one in endoscopy. Investigation identified the need for clear information and arrangements, when appointments planned.
- The third complaint related to a mealtime, and ensuring alternative meals are considered with support from the chef.
- Senior staff discussed complaints at the clinical governance, senior nurse group and heads of department meetings. Senior nurses shared learning outcomes, recommendations and actions from new complaints at department meetings with staff. Staff reviewed any trends or themes at the meetings and findings were shared with consultants at medical advisory committee (MAC) meetings.

Are medical care services well-led?

Requires improvement

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

We rated well led as requires improvement because:

- This hospital did not have an end of life care strategy, pathway, or a named lead for end of life care.
- There were no clinical risks on the risk register. There was a slow response to audit findings.

However:

- Staff were aware of the BMI corporate vision and were keen to deliver high quality care.
- Staff in endoscopy and oncology were clear about the vision for their services, driven by quality and safety.
- The oncology lead had developed a strategy, which had been shared with staff in the oncology suite.
- Staff reported an open culture where leaders were visible and approachable.

- Governance arrangements ensured that incidents, complaints, audit results and policy development were reviewed and learning was shared appropriately.
- Staff achievement was valued through staff awards.

Vision and strategy for this this core service

- Staff we spoke with were aware of the BMI corporate vision which was 'We aspire to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent healthcare.'
- The new executive director (ED) had been in post for 53 days at the time of our visit. His initial aim was to provide a period of stability and to develop a clear view on the hospitals positon and future aims. The ED had shared this initial aim with staff at a staff forum.
- The endoscopy business plan developed in January 2016 provided a clear vision, and way forward for the endoscopy service. The business plan was presented as a project with nine steps, entitled 'provision of a new endoscopy unit for Sarum Road hospital'.
- The oncology lead had developed a strategy plan for the oncology suite at BMI Sarum Road. This included recruitment, audit and developments planned for the service. The oncology lead monitored progress at monthly oncology unit meetings, which staff from oncology unit attended, and discussed progress with the senior team at senior hospital clinical governance meetings. The provider had undertaken a review of the oncology service early in 2015, which was used to help shape the strategy plan.
- This hospital did not have an end of life care strategy or a named lead for end of life care. Ward staff reported they did not care for many patients who were palliative or at the end of life. However, there was an end of life patient at the time of our inspection. The lack of a strategy meant that there was no clear vision or aims regarding end of life care at this hospital. The director of clinical services (DOCS) said they were awaiting an end of life care position statement from corporate BMI, after the withdrawal of the Liverpool Care Pathway (LCP). The LCP was withdrawn nationally in 2013.

Governance, risk management and quality measurement for this core service

- There was a hospital wide risk register. The risk register included health and safety risks such as items of equipment that needed replacing. However, there were no clinical risks on the risk register. For example, the inability to provide complete segregation of clean and dirty areas in endoscopy. The ED advised us of a plan to review the management of risk at the hospital, to include the development of risk registers for individual departments.
- The oncology lead chaired bimonthly meetings in the oncology department. The meeting agenda included infection control, recruitment, and health and safety. This supported staff in understanding risks in the department, and how they were being managed. Many of the senior staff attended both heads of department meetings and clinical governance meetings. Information was communicated to all staff at team meetings and by newsletters/email. A daily 'huddle' took place each morning attended by the heads of department where they reviewed what was happening that day and any issues identified.
- Oncology, endoscopy and ward service leads attended the hospital wide monthly clinical governance meetings. Minutes of these meetings showed that standard items for discussion included incidents, complaints, audit results and policy development. A number of subcommittees including resuscitation and infection control also contributed to the clinical governance meetings.
- The MAC included representation from endoscopy and oncology. The MAC had bimonthly meetings, scheduled a week after the clinical governance meeting. This arrangement enabled issues identified at clinical governance to be carried forward for discussion with the consultants. The MAC meeting minutes indicated that members raised and discussed key issues, such as incidents and complaints.
- Leaders at this hospital did not always act on the results of local audits in a timely fashion. For example, we saw a pharmacy audit of the management of controlled drugs on the ward from November 2015 with multiple actions identified. There was no formal action plan from the November audit and a re-audit in January/February 2016 identified similar action points.
- The DOCS attended a monthly regional BMI governance meeting where sharing of governance issues, trends and learning were discussed. Indicators monitored included readmissions and falls.
- BMI had introduced a monthly clinical governance bulletin, which they circulated to all hospital staff. It

contained details and learning from never events and serious incidents across the BMI network. The bulletin also includes updates on new NICE guidance, medical device, medicine and patient safety alerts.
- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on the BMI intranet. Staff signed a declaration to confirm they had read and understood the policy relevant to their area of work.

Leadership and culture of service

- Staff in endoscopy and oncology said the ED and DOCS were visible and approachable. The DOCS undertook a walk round of all patients each weekday to ask if they had any concerns. For example, if a patient mentioned a concern with the food, the head chef was asked to come, meet the patient, and discuss concerns.
- Staff we spoke with were happy in their work and felt valued by the leadership team.
- Staff said they worked well as a team and felt supported by their immediate managers who lead their departments well.
- There were low staff sickness and vacancy rates across the service and a high record of staff stability during the reporting period. Staff spoke passionately about the service, they provided and the care they offered to patients.

Public and staff engagement

- The oncology lead was planning a 'biggest breakfast quiz' in March 2016 for staff to raise money for cancer research.
- The new ED recently introduced a staff forum. Staff told us they could put forward ideas and felt they were listened to. Results of the latest patient survey (December 2015) showed high levels of satisfaction with 100% recommendation. The hospital was placed 30 out of 59 BMI hospitals nationally and third place regionally across the BMI group for patient satisfaction scores.
- BMI carried out an annual staff survey in 2016, with a response rate of 74%. To the question 'How likely are you to recommend BMI Healthcare to friends and family if they needed care and treatment?' 88% of staff had said extremely likely or likely. The new ED was planning to continue to hold staff forums monthly, to provide opportunities for staff to discuss the survey findings.
- The hospital had a system of 'above and beyond awards'. This was to assist leaders in demonstrating their value and respect for staff. The ED nominated the oncology nurse lead in December 2015 for this commendation.

Innovation, improvement and sustainability.

- The ED and endoscopy lead had developed a business plan to support JAG accreditation and the sustainability of the endoscopy service. At the time of our inspection, the plan was for the ED to present this to BMI regional and board level managers.
- The oncology lead said the unit was working towards the Macmillan quality environment mark. This is a detailed quality framework, used for assessing whether cancer care environments meet the standards required for people living with cancer.

Good

Surgery

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

Information about the service

BMI Sarum Road Hospital provides elective surgery to patients who pay for themselves, are insured or are NHS funded patients. Between October 2014 and September 2015, there were 3868 visits to theatre. Surgical operations included general surgery, ophthalmology, ear, nose and throat (ENT), orthopaedic including spinal surgery, plastics, gynaecology, laser varicose veins, dental, genitourinary and chronic pain procedures.

The hospital has two operating theatres, both of which have laminar airflow ventilation systems (a system of circulating filtered air to reduce the risk of airborne contamination). There is a dedicated two bedded or three trolley recovery area within the main theatre complex. The hospital has 28 beds in use on the main ward, eight of which are for day case procedures. There are two high dependency beds available for level one and two care post-operatively, but no critical care facilities. In an emergency, the hospital transfers these patients to nearby NHS hospitals.

Between January and September 2015 there were 3092 day case treatments and 1014 inpatient treatments. The NHS funded approximately 35% of day case and inpatient treatments. The surgical operations most commonly performed were knee arthroscopy, facet joint injection, dorsal root ganglion block, image guided injection of joints, total hip replacement, cataracts, carpel tunnel release, knee replacement, shoulder decompression and epidurals. Surgeons carried out the majority of procedures on weekdays, with one theatre open on Saturday mornings.

The hospital carries out surgical treatments for children and young people over the age of three years, generally for ear, nose and throat, orthopaedic procedures and general surgery. In the period October 2014 to September 2015 there were 16 inpatient and 46 day case treatments for children and young people.

The inspection included a review of all the areas where surgical patients receive care and treatment. We visited the pre-assessment clinic, the surgical ward, anaesthetic rooms, theatres and recovery area. We spoke with eight patients and reviewed nine patient records. During the inspection we spoke with 30 members of staff, including managers, medical staff, registered nurses, health care assistants, operating department assistants, allied health professionals and administrative staff. Before, during and after our inspection we reviewed the hospital's performance and quality information.

Good

Surgery

Summary of findings

We rated surgical services as good for safe, effective, caring, responsive and well-led.

- We found surgical services provided good care and treatment to patients. Nursing and medical staff were caring, compassionate and patient centred in their approach.
- Patients felt they received enough information about their treatment and were involved in decisions about their care.
- We observed that staff maintained patients' respect and dignity at all times.
- All areas of the service we visited were visibly clean, and there were systems in place to support the safe delivery of care and treatment.
- Medical and nursing staff carried out effective risk assessments from pre-assessment through to discharge. They planned treatment, recovery and discharge in line with patients' specific needs.
- Staff followed evidence based care and treatment, and monitored and reviewed patient outcomes.
- Staff worked effectively across different disciplines and had good links with staff at other BMI hospitals and local NHS services.
- Nursing and medical competence was good, with trained professionals taking pride in their work.
- Nurse staffing levels were based on an assessment of patient needs and there was a low level of agency usage across the department. Consultants and the RMO provided 24 hour medical cover to respond to any clinical issues.
- There was a strong sense of loyalty and teamwork among staff. Staff valued the support from their leaders and liked working in the service.

However,

- During our inspection, we observed recovery staff did not consistently adhere to the bare below the elbow policy in clinical areas.
- Some Patient Group Directions for staff to administer and supply named medicines without a prescription were out of date and needed review.
- Managers and staff did not use the risk register effectively to identify and manage risks within the service. The hospital had recently started to implement changes to address this.
- The hospital did not produce formal action plans that detailed the person responsible for any actions in response to incidents.
- The hospital did not always meet the referral to treatment time targets for NHS funded surgical patients.

Good

Surgery

Are surgery services safe?

Good

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

We rated safe as good.

- There were no serious incidents or hospital acquired infections between October 2014 and September 2015.
- Staff understood their responsibilities to raise concerns and report incidents, and there was evidence learning occurred as a result.
- All clinical areas were visibly clean and appropriately equipped to provide safe care and treatment.
- Infection prevention and control practice on the wards was good Infection prevention and control link staff in all departments provided advice and guidance for staff.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Staffing levels were sufficient to provide safe care. Hospital managers responded quickly to address any staff shortages.
- Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate. There were appropriate transfer arrangements to transfer patients to a local NHS hospital if required.

However,

- Some clinical recovery staff did not routinely comply with the bare below the elbow (BBE) policy, and this could put patients at risk of a hospital acquired infection.
- Some Patient Group Directions for staff to administer and supply named medicines without a prescription were out of date and needed review.

Incidents

- The hospital reported 281 clinical incidents between October 2014 and September 2015. In the same period, the overall rate of incidents reported had fallen slightly from eight to six per 100 inpatient discharges. However, there was no breakdown of these figures. This meant it was difficult to easily define incidents that affected surgical services and those that affected medicine services. However, records of team meetings evidenced staff had a good understanding about which services incidents related to. There were no serious incidents reported during the same reporting period.
- Staff told us there was an open culture to reporting incidents, and they knew how to report them using the hospital's paper based incident forms. The director of clinical services (DOCS) reviewed all clinical incidents and arranged investigation by the appropriate person and department.
- Staff identified trends and discussed incidents at monthly clinical governance meetings and heads of department meetings. Actions for learning were included but there was not always a formal action plan developed. Staff reported they received feedback from incidents in their ward and theatre meetings and were able to outline learning and changes in practice from recent incidents.
- The medical advisory committee (MAC), a leadership group of 10 consultants, reviewed selected incidents at their bimonthly meetings to identify and share lessons learnt. The committee recently started to circulate the meeting minutes by email to the whole consultant body.
- Not all nursing staff had a full understanding of the Duty of Candour (DoC) requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. However, senior nursing and medical staff fully understood the DoC and could describe recent examples of when it had been applied.
- Staff told us they received a monthly bulletin from BMI that updated staff about any learning arising from incidents across the BMI group as a whole.

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

- We saw safety data displayed on the ward which showed any hospital acquired infections patient falls, staffing levels, trends in staffing levels and patient feedback.
- The 'NHS safety thermometer' is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free care' on one day each month. The

surgical ward participated in the NHS safety thermometer for NHS patients but did not display the results on the ward as the data available was only for NHS patient.

- Staff routinely assessed patients for venous thromboembolism (VTE). The VTE screening rate was 100% for NHS patients against a target rate of 95% for the whole of the reporting period from October 2014 to September 2015.

Cleanliness, infection control and hygiene

- There were no reported cases of methicillin-resistant Staphylococcus aureus (MRSA), methicillin-sensitive Staphylococcus (MSSA) or Clostridium difficile infections between October 2014 and September 2015. Staff routinely screened patients for MRSA at their pre-assessment appointment. There was an isolation policy and procedure for patients admitted from another hospital without screening, or patients with a suspected infection.
- There was an infection prevention and control (IPC) lead nurse for the hospital and IPC link nurses for the ward and theatre. Staff held regular IPC meetings and fed information back to the ward and theatre via the IPC link nurses. 100% of staff on the ward and in theatre had completed IPC training which was part of the mandatory training requirements at this hospital. We saw IPC folders containing policies and procedures in the ward office and theatre area. Staff knew they could access additional guidance and information on the intranet.
- Staff completed monthly audits including hand hygiene and BBE, high impact intervention care bundles, and operating theatre and scrub procedures. Staff at IPC meetings analysed results and fed these back to clinical areas and to clinical governance meetings. The hospital held workshops to improve staff knowledge of all the necessary steps required to comply with these audits.
- Hand hygiene and BBE audits for the ward showed 90% and 100% compliance with hospital policies respectively for November 2015, December 2015 and January 2016
- All clinical areas were visibly clean and we saw staff cleaning equipment after use. Staff used green 'I am clean' stickers on the ward to show equipment was clean and ready to use. We reviewed a random sample of blood pressure cuffs and trolleys in theatre, which were all clean and wiped clean after use.
- We saw daily, weekly and monthly cleaning rotas in all clinical areas, with guidance on schedules, methods and equipment. Staff used colour coded cleaning equipment to prevent cross infection.
- Personal protective equipment (PPE) was readily available on the ward and in theatre and recovery areas. We observed staff using PPE and changing gloves and aprons between patients to reduce the risk of cross infection.
- Hand sanitisers were available throughout the ward and recovery areas. Handwashing facilities were available in patient rooms and appropriate handwashing facilities and scrub areas were available in theatre. We observed staff followed hand hygiene and BBE policy in theatre and on the ward. However, on the first day of our visit some recovery staff were not BBE. They wore long sleeve theatre over jackets, which they did not change between patients. We brought this to the attention of the theatre manager and on the second day of the inspection recovery staff were BBE.
- Staff carried out scrub practices correctly and all theatre staff wore facemasks. Staff prepared and draped patients prior to surgery according to NICE guidelines to decrease the risk of infection.
- The provider displayed hand hygiene information for patients and visitors at the entrance to the ward and leaflets were available throughout the hospital.
- Clinical and domestic waste management was in line with guidance on the use of separate colours and receptacles. We observed staff handling contaminated waste and linen correctly.
- Clean linen was stored appropriately and readily available on the ward and in theatre.
- Both theatres had laminar airflow systems and staff changed anaesthetic breathing systems weekly according to Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.
- The hospital used local NHS CSSD services for decontamination and sterilisation of surgical instruments. The service collected and delivered equipment twice daily and returned equipment in four hours if needed urgently.

Environment and equipment

- All surgical areas were tidy, well organised and equipment stored appropriately.
- Medical equipment was portable appliance tested (PAT) as part of annual servicing. The asset register and

equipment maintenance schedule for the hospital showed that 98% of equipment maintenance was in date. The hospital maintenance team performed PAT testing of non-medical equipment every five years.

- The wards and theatre both had a mobile resuscitation trolley for use if a patient had a cardiac arrest. Records showed that staff checked the trolleys daily in line with professional guidance to ensure equipment was available and in date. Both trolleys had a tamper proof tag to prevent access by unauthorised personnel.
- Staff checked essential equipment to ensure all equipment was available and in working order. Staff checked anaesthetic machines in theatres and anaesthetic rooms on each day that theatre was operating. We saw record books to confirm that this occurred on most days. Staff checked the difficult intubation trolley weekly to ensure equipment was available and in working order in the event of difficulties intubating a patient.
- There were two operating theatres in the theatre suite, each with an adjoining anaesthetic room where staff prepared patients for their operation. Staff prepared equipment in advance for the next procedure in a separate lay-up room.
- There was a two bedded or three trolley recovery area with facilities to care for patients in the immediate post-operative period before they returned to the ward.
- There was an emergency buzzer in recovery and both anaesthetic rooms for use in an emergency. Records showed staff checked these daily.
- Theatre staff planned surgical equipment for operations in advance. Surgeons completed an equipment requirement form at patient booking, and no less than five days prior to surgery, to ensure the correct equipment and staffing for a procedure. Separate packed instruments were available quickly as the system was well staffed and organised. The hospital could meet additional requests for equipment by outsourcing to external companies.
- Staff had access to the use of a hoist. We saw slings available for training as well as disposable slings for individual use.
- Patient Led Assessment of the Care Environment (PLACE) for April 2015 showed the hospital scored 85.3% for 'condition, appearance and maintenance,' which was worse than the England average of 91.9% for all hospitals. The hospital management team had identified the hospital was an ageing building with a number of facilities issues. There was an ongoing program in place for refurbishment of the relevant areas, which included replacement of carpeted flooring for vinyl flooring in all clinical areas and refurbishment of the theatre areas, .
- Sharps bins in theatre were securely mounted and not overfilled. We observed staff handled and disposed of sharps safely.

Medicines

- On the ward and in theatre, medicines including controlled drugs, and intravenous fluids were stored securely in locked cupboards and inside locked rooms. Staff on the ward kept medicine trolleys locked and secured to the wall when not in use. Pharmacists held BMI private prescription pads securely.
- Staff monitored fridge and room temperatures and took appropriate action when temperatures were outside the recommended range to store medicines safely.
- Pharmacy and nursing staff monitored and managed stock levels of medicines and controlled drugs appropriately. Staff completed the controlled drugs registers in line with current national guidance and the hospital policy.
- Pharmacists completed medicine reconciliation (MedRec) for all inpatients on admission and prior to discharge.
- The hospital followed the local NHS trust antibiotic policy and formulary, and a microbiologist employed at the trust provided advice to the hospital on an as needed basis.
- We reviewed seven medicine charts, which staff had completed correctly. This included documentation of allergies, VTE assessments, and no omitted doses without the appropriate coding.
- There were piped medical gases in the theatre suite and HDU area of the ward. Portable oxygen cylinders were available for transfer of patients from theatre to the ward, and for use in patients' rooms.
- The patient group direction (PGD) used on the ward for administering eye drops was two years out of date. PGDs are formal arrangements for nurses to administer a named medicine to patients with a specific condition during treatment without a prescription from medical staff. The PGD did not have the correct signed authorisation for nursing staff to use them. Pharmacy staff were aware, but had not reviewed the process at the time of our inspection.

- Appropriately labelled and packaged medicine was available for patients to take home after their surgery.

Records

- The hospital kept patient records in paper format and stored them securely in the ward office while patients were on the ward.
- Staff used specific paperwork for each patient that ensured that records kept were appropriate to the care pathway being followed. For example, patients admitted for day surgery had their clinical entries recorded on the 'less than 23 hour stay' pathway documentation.
- The care records contained pre-operative assessments, records from the surgical procedure and anaesthetic, recovery observations, nursing and medical staff notes, and discharge checklists and assessments. The records also included multidisciplinary clinical notes, including those from physiotherapists and occupational therapists, to support safe care and treatment.
- We reviewed nine patient records and saw staff completed the required information and patient details on every page. The entries were readable, and signed and dated by the member of staff who made the entry.
- Theatre staff maintained a comprehensive log of implants on their prosthetics register. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.

Safeguarding

- The director of clinical services and the lead paediatric nurse were the safeguarding leads for the hospital. They were level three trained which meant they were able to investigate safeguarding issues if required.
- Safeguarding was part of mandatory training for all staff. The hospital provided training for clinical staff to level two. Staff we spoke with knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process, and how to seek support if they needed to. Flowcharts of the safeguarding process were on display in the ward office, including all the relevant local telephone numbers. Staff could access the BMI safeguarding policy on the intranet for reference.

Mandatory training

- A role-specific mandatory training plan was automatically assigned to each staff member in the BMI e-learn system. Staff completed most training electronically but this was supplemented by practical training where appropriate.
- Individual training records were kept in the ward and theatre offices, and staff could access this information on line. Senior staff regularly monitored and organised completion of mandatory training. Managers gave staff time at work to complete the training or they could be paid to complete at home.
- At the time of the inspection, 90.1% of ward staff and 94.5% of theatre staff were fully complaint with mandatory training.

Assessing and responding to patient risk

- Patients completed a health questionnaire which nursing staff reviewed at pre-assessment to assess the suitability of patients for surgery at the BMI Sarum Road hospital. Staff confirmed that if the pre-assessment raised concerns they would escalate the issue to the surgeon or anaesthetist by telephone or email for further assessment. Patients had to meet certain criteria before the hospital accepted them for surgery. For example, a consultant anaesthetist reviewed non-NHS patients with a body mass index (BMI) greater than 40 to determine whether they would be suitable for surgery.
- The anaesthetist could request a high dependency bed on the ward in advance of surgery if they identified a patient as high risk and required level 2 care post-operatively for a short period of time such as 24 hours. This was to ensure a bed and appropriate staffing levels were available to care for their needs. The hospital did not admit patients who required level 3 or prolonged level 3 care (post operatively). Level 2 care includes patients requiring higher levels of care and more detailed observation/intervention. Level 3 care includes patients who require advanced respiratory support alone or basic respiratory support together with support of at least two organ systems.
- Staff completed risk assessments appropriate to the length of patient stay. These included risks related to mobility, cognitive understanding, skin damage and venous thromboembolism (VTE). This meant they could quickly identify signs that a patient's condition maybe worsening.

- Theatre staff used the 'five steps to safer surgery' WHO checklist. This is a nationally recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. We observed staff performing the checklist correctly and consistently during our visit. Staff regularly audited completion of the checklist and results for January and February 2016 showed 100% compliance.
- Procedures were in place to monitor patients for any deterioration in their health. The hospital used the national early warning system (NEWS) after surgery to record patient observations, and a standard scoring system was in place across all patient pathways. Staff initiated the NEWS scoring in recovery and continued it on the ward. Staff we spoke to knew how to escalate concerns if a patient's observations deviated from expected ranges.
- There was an emergency transfer arrangement with two local acute NHS hospitals for patients who deteriorated and needed critical care, as there were only two high dependency unit beds on site. The hospital policy and procedure for unplanned transfer of deteriorating patients was available on the intranet. Staff explained the procedure clearly and described how they had dealt safely with recent cases. There was a grab bag in the HDU area with useful equipment for before, and during, transfer by ambulance. There had been two emergency transfers to the acute NHS hospital since September 2015.
- The hospital had an emergency blood transfusion procedure. All clinical staff received training to equip them with the skills and competencies to transfuse blood. Two units of blood suitable to use for all patients in an emergency were stored in the blood fridge. Staff took part in scenarios held annually on what to do if a patient had a major haemorrhage.

Nursing staffing

- The hospital used the BMI Healthcare nursing dependency and skill mix tool to plan the skill mix of staff five days in advance, with continuous review on a daily basis. Ward staff told us staffing levels were adapted to meet the needs of the patients and the type of surgery they had received. For example, the hospital arranged extra suitably trained staff for high dependency patients or other patients needing one to one nursing. Staff we spoke with said they did not experience problems when in getting additional staff. Regular bank staff were called to cover additional shifts and permanent staff were often happy to work extra hours as they were paid to do so.
- Staff displayed required versus actual staffing levels at the entrance to the ward and these showed a close correlation for the month of January 2016. On 18 out of 31 days in January, staffing levels exceeded requirement. There were always two registered nurses on duty on the ward, including nights and weekends, to enable staff to respond to emergencies. There use of bank and agency staff across the hospital from January to September 2015 was less than 20%.
- Student nurses worked on the ward in a supernumerary role. They were not counted in the shift numbers.
- There were two full time vacancies for theatre nursing and recovery posts with an occasional use of bank and agency staff (less than 10%) during the reporting period from October 2014 to September 2015.
- The occasional use of bank and agency staff meant theatre staffing ratios met the guidelines from the Association for Perioperative Practice (AfPP). Each theatre was staffed by an operating department assistant, a first assistant, two scrub nurses and a healthcare assistant (HCA) with no dual working by the scrub nurse. The theatre manager oversaw both theatres and the recovery area.

Surgical staffing

- Over 150 doctors, surgeons, anaesthetists and dentists had practising privileges at the hospital. Of these, about 50 worked at the hospital regularly and 93 had not carried out any treatments in the reporting period October 2014 to September 2015. The medical advisory committee (MAC) and DOCS reviewed their practising privileges every two years to check they continued to be suitable to work at the hospital. Managers recently introduced a spreadsheet to record consultants' records of professional indemnity insurance, recent appraisals and disclosure and barring service (DBS) checks. The registered manager told us they were in the process of assessing whether consultants who had not carried out any work at the hospital in the last 12 months should retain their practicing privileges.
- Consultant surgeons provided cover for their inpatients 24 hours a day, seven days a week. They arranged alternative cover by a named consultant if they were not available. An on call consultant anaesthetist rota

ensured there was anaesthetic support available 24 hours a day. Both consultant surgeons and anaesthetists were able to return to the hospital to reassess their patients within 30 minutes if required. There had been no reported incidents in 2015 where consultants had not been available within 30 minutes if needed.

- The RMO and nursing staff said consultants were always available out of hours for telephone advice and support.
- The hospital employed two RMOs who worked opposite each other in fortnightly blocks. They were resident on site and available 24 hours a day, seven days a week. Their role was to review patients when required, prescribe additional medicines and liaise with consultants responsible for individual patient's care.
- The RMO we spoke with said they preferred to review patients personally rather than giving telephone advice. We observed the RMO arriving promptly on the ward when called about a patient who was unwell. Ward staff did not call them frequently at night, and the RMO we spoke with said they achieved enough rest time to work effectively.

Major incident awareness and training

- The hospital had local and corporate business continuity plans for use in events such as internet or electricity failure.
- A generator was available for use in case of power failure and records showed staff tested this monthly.
- The provider held regular fire drills and there was a fire evacuation procedure on laminated card in each patient room. Theatre staff performed a skills drill annually for complete evacuation of the department in the event of fire, followed by a full debrief.

Are surgery services effective?

Good

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

We rated effective as good.

- Staff provided care and treatment that took account of nationally recognised evidence based guidance and standards.
- Patients reported staff managed their pain effectively and they had access to a variety of methods for pain relief.
- The hospital offered a choice of meals and drinks and the chef catered for patients requiring special diets.
- The hospital routinely collected and monitored information about patient outcomes for comparative analysis against the BMI corporate dashboard and national performance audits.
- Staff had good access to training and there were opportunities for staff to attend additional courses to extend their skills.
- Staff worked well within teams and across different services to plan and deliver patients' care and treatment in a coordinated way.
- Staff completed training in the Mental Capacity Act 2005 and there was appropriate guidance to assess a patient's mental capacity.
- The hospital consent forms complied with Department of Health guidance.

Evidence-based care and treatment

- Staff provided care to people based on national guidance, such as the National Institute for Care Excellence (NICE) guidelines, and were aware of recent changes in guidance. We saw evidence of discussion of NICE guidelines in meetings and on clinical governance bulletins.
- The hospital regularly referred to the BMI Healthcare Corporate dashboard to monitor indicators such as transfers, returns to theatre, readmission and infection rates, average length of stay and day case conversion rates against other hospitals in the BMI network.
- There was a local hospital program of audits undertaken using the Quality Improvement Tool (QIT). This included audits such as records, consent, Five Steps to safer surgical checklist, theatre, IPC, VTE assessment and resuscitation. Staff discussed results at clinical governance meetings, appropriate sub-committees and senior nurse group meetings at a BMI corporate level.
- Staff also undertook high impact intervention care audits looking at urinary catheter care, peripheral vascular access devices and surgical site infections. Audits for January 2016 and February 2016 showed a high level of compliance with NICE quality standards.

- The hospital followed NICE guidelines for preventing and treating surgical site infections (SSIs) using the SSI bundle. Audits of its use during January 2016 and February 2016 showed 100% compliance. There were seven SSIs in the reporting period October 2014 to September 2015. There was no evidence to indicate poor hygiene or infection control practices were a contributory factor to SSIs.
- There was a separate medicines management audit schedule including Med Rec, controlled drugs (CDs) and missed doses. However, we saw a CD audit done in November 2015 had no action plan. Staff identified many similar action points in the January/ February 2016 re-audit.
- There were different care pathways for staff to follow dependent on the type of surgical procedure. The care pathways covered day procedures (less than 23 hour stay) and inpatient procedures. There were also two dedicated care pathways for hip and knee joint replacement surgery.
- Staff assessed patients for VTE risk and took steps to minimise the risk where appropriate in line with the NICE guidelines. The hospital showed 100% compliance with VTE screening for NHS patients during the reporting period October 2014 to September 2015. We observed the use of mechanical VTE prophylaxis in theatre and on the ward during our visit.

Pain relief

- All patients spoken with said they were getting their pain relief as and when needed. One patient told us they had received 'excellent pain management.'
- Nurses discussed post-operative pain relief with patients at pre-assessment, and gave them information leaflets about pain control and anaesthesia. This included information about different types of pain relief and pain scoring. We also observed anaesthetic consultants discussing post-operative pain relief with patients.
- Staff recorded pain scores on a scale of 0-3 on the NEWS observation chart in the recovery area and on the ward.
- Staff were proactive in managing pain. They encouraged patients to ask for pain relief early on to allow them to mobilise after their surgery. We observed staff providing pain relief to patients before physiotherapy treatment.
- Nursing staff responded promptly to a patient in discomfort, including asking the anaesthetist to review the patient's pain management. Anaesthetic staff were on call 24 hours a day for post-operative pain management and ward staff reported that they were obliging, helpful and accessible.

Nutrition and hydration

- Staff advised patients about fasting times prior to surgery at pre-assessment and in their booking letter. The hospital aimed to ensure fasting times were as short as possible before surgery to prevent dehydration and reduce the risk of post-operative nausea and vomiting (PONV). Anaesthetic staff told us they prescribed medicine for patients who had suffered PONV previously to prevent this recurring.
- Staff monitored fluid intake and output for some major operations to ensure patients were adequately hydrated. We observed that staff correctly recorded this on fluid balance charts
- The hospital offered light snacks and drinks for day case patients before discharge home. There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets.
- There was a recent decrease in hospital patient satisfaction survey scores with meal provision, due to a change in the catering provision. However, during our inspection patients we spoke with described being happy with the food quality and choice.
- In the Patient Led Assessments of the Care Environment (PLACE) in April 2015 the hospital scored 97.8% for food compared to an England average of 89%.

Patient outcomes

- There were eight unplanned returns to theatre during the reporting period October 2014 to September 2015.
- In the year to September 2015 there were four unplanned readmissions within 29 days of discharge which was better than other independent hospitals.
- The rate of unplanned transfers of inpatients to another hospital was better than other similar independent hospitals. There were five cases during the same reporting period.
- Staff discussed the above figures at clinical governance and MAC meetings to identify any underlying trends.
- Staff asked all patients who were booked for joint replacement to consent to register on the National Joint Registry (NJR), which monitors infection and revision rates. This ensured their care and joint replacements were monitored at a national level.

- NHS Patients participated in the patient reported outcome measures (PROMS) data collection if they had undergone surgery for hip or knee replacement and inguinal hernia repair. PROMS measures the quality of care and health gain received from the patient's perspective. The PROMS results, published November 2015, for hip replacement surgery during the period April 2014 to March 2015 showed a mixed picture. The hospital performed better than the England average for two measured outcomes, and below the England average for the third measured outcome. There were insufficient numbers to report for inguinal hernia and knee replacement surgery. PROMS results published May 2016 for the period April 2015 to March 2016 showed for hip replacement surgery the hospital performed below the England average for one measured outcome and within the England expected range for the further two outcomes. For knee replacement surgery the hospital performed within the England average range for outcomes.
- BMI Healthcare was working with PHIN (Private Healthcare Information Network) to look at the better reporting of patient outcomes across the independent healthcare sector to assist with information transparency.

Competent staff

- All staff undertook a formal induction process and completed mandatory training.
- Senior staff conducted annual appraisals for nursing staff and operating department assistants (ODPs) to enable staff to discuss their development and training needs in a formal way. The data supplied by the hospital was inaccurate due to a recent change from paper to electronic recording of appraisals. We observed in folders on the ward and in theatre that all appraisals were up to date apart from one or two occasional bank and agency staff.
- There was a BMI external educator, who worked across the network to support training and learning. Staff told us they were encouraged by senior staff and management to attend courses and further training. Ward and recovery registered nurses completed practical competency booklets relevant to their role.
- Senior staff encouraged ward nurses to take on link nurse roles and act as a resource for other staff. They developed a special interest, for example in infection prevention and control, dementia and urological procedures and were encouraged to attend specialist courses.
- A ward healthcare assistant (HCA) had completed the nationally accredited HCA qualification. The hospital gave theatre HCAs time and support to complete the theatre HCA perioperative diploma. All scrub nurses in theatre were qualified first assistants with a recognised qualification.
- The RMOs completed training and appraisals through their employing locum agency. The DOCS oversaw their induction and completion of mandatory training. There were also eight to ten resuscitation scenarios organised annually by an external training company for all staff. The RMO lead these in order to assess their skills and competency. Consultants and anaesthetists worked under a practising privileges agreement. The medical advisory committee (MAC) and DOCS were responsible for granting and reviewing of practising privileges biannually. New consultants provided evidence of qualifications, training, accreditation and scope of practice plus a CV with two references. The hospital maintained a spreadsheet with a record of consultants' indemnity insurance, recent appraisal or revalidation and the disclosure and barring service (DBS) checks.
- All surgical staff including nurses, allied health professionals and staff working under practising privileges held valid professional registration for their role.

Multidisciplinary working (in relation to this core service only)

- Our observation of practice, review of records and discussions with staff confirmed effective multidisciplinary team working practices were in place. This included nurses, medical staff, pharmacists, physiotherapists and occupational therapists.
- We observed a morning ward team 'huddle' meeting where staff discussed patient care and plans for discharge, surgical lists, staffing and any other events of importance for the day. The DOCS, ward manager, ward nursing staff, RMO, pharmacist, physiotherapist as well as the booking clerk, ward clerk and patient services manager attended the meeting.

- Physiotherapy staff supported effective recovery and rehabilitation, including an appointment at pre-assessment for patients having orthopaedic surgery, and follow up at outpatient clinics. They visited the ward daily including weekends.
- Occupational therapy staff visited patients in their home before admission to arrange any home adaptations that would need to be in place for discharge after major surgery. They also liaised with community services and care agencies to ensure the arrangement of appropriate care packages.
- Theatre staff took a written record of patient details to the ward to collect a patient for surgery. We observed safe and effective handovers of care between the ward, theatre and recovery staff.
- There was an onsite pharmacy staffed by one pharmacist and a pharmacy technician.
- Nursing staff conducted effective handovers of care when new staff arrived on duty. We observed a verbal lunchtime handover and taped evening handover from day to night staff, which the resident medical officer (RMO) also attended.
- We observed detailed and comprehensive handovers between anaesthetists and ODPs and recovery staff, and again between recovery staff and the ward staff when the patient returned to the ward.
- There was an effective handover between RMOs and they attended the ward morning meeting and evening nursing handover.
- The hospital had practices in place to share the services of local NHS hospitals. This included blood transfusion, infection prevention and control, instrument decontamination, microbiology and pathology services and the services of specialist breast care nurses.
- The hospital sent discharge letters to GPs and district nurses about the patients' treatment and care. Staff liaised with GPs before admission if there were any queries about a referral.

Seven-day services

- Nursing staff were available on the ward seven days a week.
- The two main theatres were open for elective surgery between 8am and 6pm Monday to Friday, and on Saturday mornings until 2pm. An on call surgery team was available outside normal working hours.
- Consultants provided 24 hour on call cover for their patients or organised cover by a consultant colleague if they were not available. Those with patients on the ward conducted daily ward rounds.
- A RMO was available on site 24 hours a day, seven days a week.
- Physiotherapists were available during the working day and at nights and weekends.
- Pharmacy services were available between 9am and 5pm. Outside of these hours the RMO could dispense medicines and the hospital had a contract with a local pharmacy if required. Staff could obtain out of hours pharmacy advice from the local NHS trust.
- The hospital did not routinely offer out of hours radiological services. However, radiology staff were on call if urgent x-rays or scans were needed.
- The hospital operated an on-call system for senior managers seven days a week.

Access to information

- The hospital kept records on site for two years after admission, after which they were sent to an offsite storage facility. After eight years the records were scanned and put in to electronic format which staff could access via the ward computer. Staff could access paper records stored offsite within 24 hours. This meant that staff could access historical information about a patient they have treated before.
- The records contained a GP referral letter plus any notes from previous admissions to Sarum Road hospital. Staff did not have access to a patient's NHS notes unless a consultant asked for them.
- The hospital sent a discharge letter within 24 hours of discharge by post to GPs and district nurses, and gave a copy to the patient.
- The hospital used formal Intensive Care Unit (ICU) and inter-hospital transfer forms for unplanned transfers of care. Staff told us they would also contact the NHS hospital to provide a verbal handover.
- All patients we spoke to felt staff had given them sufficient information about their procedure, and were able to discuss it with their consultant and nursing staff. Staff gave patients information about their procedure at pre-assessment. This included procedure specific information leaflets and a patient information booklet about their stay. Staff discussed their care in detail and explained what to expect post-operatively including

length of stay, and involved patients in their plans for discharge. Ward staff gave patients a discharge pack with specific post-operative instructions and a copy of the discharge letter sent to their GP and district nurse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff assessed patients' mental capacity to make decisions about their care and treatment at pre-assessment. Staff were clear about the processes to follow if they thought a patient lacked capacity to make decisions about their care. Staff told us they would contact the DOCS on another senior staff member in the first instance.
- Patients consented for surgery both at pre-assessment and again on the day of surgery. Our review of written consent records showed they were completed and compliant with Department of Health guidelines. Staff told us they would seek the use of an interpreter where needed to sign consent forms and not rely on family members or friends.
- The hospital provided training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. DoLS are to protect the rights of people, by ensuring that any restrictions to their freedom and liberty have been fully considered and authorised by the local authority. There was information about MCA and DoLS on a notice board on the ward.
- Staff we spoke to were not aware of any DoLS referrals and were unable to give an example of when this had been put into practice.
- We observed staff discussing the DNACPR request of an elective surgical patient at the morning ward meeting. Records and discussion with staff showed that the patient's capacity to make this decision had been considered, though there was no formal mental capacity assessment process documented.

Are surgery services caring?

Good

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

We rated caring as good.

- We observed staff treated patients with kindness and compassion during our visit. Staff maintained patients' dignity and respect at all times.
- Feedback from patients about their care and treatment was consistently positive.
- Patients told us they had sufficient information about their treatment and were involved in making decisions about their care.
- Practices were in place to allow staff to provide good emotional support to patients.

Compassionate care

- We observed compassionate and caring interactions from all staff. Patients were positive about the care and treatment they received. They described staff as friendly, helpful, caring, considerate, kind and respectful. One said, "the care, treatment and support here is fantastic."
- We observed staff referred to patients in a caring way at handovers and ward meetings, and staff showed a keen interest in ensuring that patients had a pleasant and comfortable experience.
- Staff treated patients with respect and dignity during our visit. We observed staff always introduced themselves to patients, and knocked on doors and waited for permission to enter patients' rooms. We saw staff in theatres being mindful of patients' dignity when they were in a vulnerable condition.
- The director of clinical services (DOCs) visited inpatients daily, we observed her clear, unhurried discussion with patients about their care.
- The hospital participated in the 'friends and family test' (FFT). During the reporting period April to September 2015 the hospital reported consistently high levels (between 96% and 100%) of patients would recommend the hospital to their friends and families. The amount of patients who responded to the test was moderate (between 31% and 60%) apart from July 2015 and September 2015 when it was lower (less than 30%).
- In the Patient Led Assessments of the Care Environment (PLACE) in April 2015 privacy, dignity and wellbeing scored 92.7% compared to an England average of 87.7%.

Good

Surgery

Understanding and involvement of patients and those close to them

- Patients on the surgical ward said they understood their care and treatment and had adequate opportunities to discuss their surgery. Patients said, "Staff explained everything that was going to happen at every stage" and "I felt listened to and valued".
- Patients and their relatives were encouraged to be involved in decisions made about their care and treatment. We observed staff taking time to ensure that patients and relatives felt involved in the individual's treatment plan.
- We observed staff in the anaesthetic and recovery rooms explaining care and treatment to patients and asking about their wellbeing. If there was a delay to the operating list staff said they would visit patients on the ward to explain the situation and keep them informed.
- Patient records we reviewed showed detailed evidence of discussion with families and their involvement in decisions about care and treatment where appropriate.
- At the daily 'huddle' meeting we saw senior nursing staff also taking account of patients' wider family views when planning for discharge.
- The hospital patient satisfaction survey showed a rating of 100% for 'discussing patient care and treatment plans.'

Emotional support

- The hospital provided a high level of emotional support to patients. Patient appointment times at the pre-assessment were generous to allow sufficient time for explanation and reassurance. Staff said they liked working at the hospital because they had time to talk to patients, and try to relieve their anxieties.
- The breast cancer specialist nurses and cosmetic nurses provided additional skilled clinical and emotional support for patients and their families. The breast cancer nurses were specialists from the local NHS hospital who supported patients emotionally as well as practically throughout their care.
- For patients having cosmetic surgery, the cosmetic nurse met with them at pre-assessment and postoperatively at outpatient clinics. This gave patients opportunities to ask questions and for staff to identify any emotional support needs.
- Ward staff showed sensitivity towards the emotional needs of patients and their relatives. At the ward daily 'huddle' meeting we observed discussions about patients' anxieties and how to provide support.
- There was open visiting on the ward to allow patients to have emotional support from family and friends.
- Patients were able to telephone the ward after discharge, for further help and advice about any concerns or questions on their return home.

Are surgery services responsive?

Good

By responsive, we mean that services are organised so they meet peoples' needs.

We rated responsive as good.

- The provider and clinical commissioning groups determined the range of surgical services provided.
- The provider planned and delivered services in a way that met the needs of the local population. The service reflected the importance of flexibility and choice.
- Staff assessed patient's needs before surgery, and the hospital was able to take the needs of different people into account when planning and delivering services. For example, suitably trained staff ensured the hospital met the needs of patients living with dementia or a learning disability.
- The hospital dealt with complaints and concerns promptly, and there was evidence that the hospital used learning from complaints to improve the quality of care

However,

- The provider did not always meet the referral to treatment time standard for NHS patients.

Service planning and delivery to meet the needs of local people

- The hospital developed NHS services in conjunction with the local clinical commissioning groups (CCGs). The CCG checked the hospital provided NHS patients with services in line with agreed quality criteria at quarterly contract meetings.
- The hospital had an agreement with the CCG to provide specific treatment and care for NHS patients.

- The hospital pre-planned all admissions to allow staff to assess patients' needs prior to surgery. They accepted patients for treatments with low risks of complication, and whose post-operative needs were met through ward-based nursing care.
- There were no facilities for emergency admissions and commissioners and the local NHS trust understood this.

Access and flow

- There were 3868 visits to theatre during the reporting period October 2014 to September 2015. Over 50% of the activity was for orthopaedics and non-complex spinal surgery. There was an increase in the number of operations carried out as day cases in the year to September 2015.
- The provider met the national standard of 92% of all admitted NHS surgical patients beginning treatment within 18 weeks of referral for treatment during the reporting period October 2014 to September 2015, apart from in April and September 2015 when it fell to 91%.
- Theatre utilisation was 100% from Monday to Friday and there was a waiting list for theatre sessions. One theatre opened on Saturday mornings to meet demand. The theatre manager filled vacant theatre slots when consultants were on annual leave.
- Nursing staff discussed discharge plans at pre-assessment to ensure home adaptations and care packages were in place before surgery. This meant that staff were assured when offering surgical admissions that there would be no unnecessary delays in discharge due to obtaining specialist equipment or organising a care package.

Meeting people's individual needs

- Nursing staff assessed patients' individual needs at pre-assessment and communicated them to all departments using a communications form. Pre-assessment nurses alerted the ward about patients living with dementia or a learning disability so they could organise the required support to meet the patient's individual needs.
- Staff screened all patients over 75 for dementia. There was a dementia link nurse for the ward, who was responsible for the training of others. We observed a ward notice board with information about dementia. The ward had dementia clocks, 'hotboards' and special picture signs for rooms and bathrooms. Nursing staff were able to describe how they would alter their communication style to meet the needs of individual patients living with dementia. For example, allowing more time to explain procedures and asking relatives to be present.
- Recovery staff went to the ward to meet patients with learning disabilities or other specific needs. They could accompany the patient to theatre and be present in recovery to provide a familiar face if needed.
- The hospital often used family or friends for translation purposes. However, telephone interpreters were available if needed for consent, as it is not good practice to use friends or family for this purpose. Staff we spoke to knew how to access these services. We did not see any information leaflets in other languages or 'easy read' format. Staff said they were available if needed.
- The chef could cater for the needs of patients with specific dietary needs for religious or cultural reasons.
- The hospital employed specialist breast care and cosmetic surgery nurses to provide individual patients with tailored advice, support and care.
- Specialised support such as stoma nurse support was accessed through service level agreements with the local NHS trust.
- The hospital offered enhanced recovery and rehabilitation for orthopaedic and spinal patients, with physiotherapists who provided individualised care for patients. Staff planned care and treatment to allow early mobilisation and independence. The hospital was about to start a group 'joint clinic' pre-operatively for patients. The aim was to educate the patients about pre-operative preparation and plans for recovery and discharge within three to four days.
- Consultants discussed dates for surgery with patients at their outpatient appointment. Patients could choose to have their operation at a time suitable to them. Staff planned elective surgical admissions to take account of the need to carry out appropriate investigations.
- Staff planned staggered patient admissions through the day to ensure patients did not experience extended waiting times

Learning from complaints and concerns

- The hospital provided information about how to raise a concern or make a complaint in a patient information

brochure, which staff gave to inpatients. However, during our visit this was out of print. There were also 'please tell us' leaflets throughout the hospital which outlined the formal BMI complaints procedure.

- The DOCS visited each inpatient every morning to ask about their experience of care and treatment at this hospital and try to address any concerns they may have. For example, ward staff told us that if patients were unhappy with the food quality or menu choices the DOCS would organise for the chef to personally speak with the patient and offer alternative menu choices if appropriate.
- Staff told us they aimed to resolve concerns in a timely way to improve the patient experience at that time.
- There were 58 complaints in 2015, an increase from 48 in 2014. Complaints were mostly about transparency of patient charges and poor communication about fees with patients. In response, the provider published the price for the top 200 procedures on the BMI Healthcare website, which was also available from the National Enquiry Centre.
- Senior staff discussed complaints at the clinical governance, senior nurse group and heads of department meetings. Senior nurses shared learning outcomes, recommendations and actions from new complaints at department meetings with staff. Staff reviewed any trends or themes at these meetings and findings were shared with consultants at medical advisory committee (MAC) meetings. The hospital gave examples of changes made following recent complaints.

Are surgery services well-led?

Good

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

We rated well-led as good.

- There was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff knew the risks, and action taken to mitigate these risks for their individual departments.
- Staff across the service enjoyed working at the hospital. They described an open culture and felt supported by their management. They were extremely complimentary about their managers and positive about the recent changes in management at the hospital.
- The hospital gathered patients' views using patient surveys and the 'friends and family test'. They analysed results and made service improvements as a result.
- There was an ongoing refurbishment program in place. The provider aimed to increase the efficiency of patient pathways and the number of procedures carried out across the service.

However,

- Managers and staff did not use the risk register effectively to identify and manage risks within the service. Some key risks within surgery were not included on the risk register.

Vision and strategy for this this core service

- BMIs corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. BMI focused on the '6C's' to put their vision into practice. These were to demonstrate commitment, courage, communication, care, compassion and competence. In conversations, staff demonstrated commitment to delivering high quality care for patients by following the '6C's'. The DOCS aimed to incorporate these values into her daily visits to inpatients to ask them about their care.
- The new executive director (ED) had been in post for 53 days at the time of our visit. His initial aim was to provide a period of stability and gain a thorough understanding of the hospital's current position.

Governance, risk management and quality measurement for this core service

- The hospital had one risk register that detailed five risks that were identified as a potential risk to hospital as a whole. There some key risks relating to surgery were not on the risk register. Examples included theatre floors that needed to be replaced, a damaged theatre door that had caused injury to a member of staff needed to be repaired and capnography equipment was not available in recovery. This posed a risk that the hospital

did not have an overview of all risks to the delivery of services and their management. However, records of governance meetings showed risks relating to individual departments were discussed and monitored.

- There was a local hospital program of audits in place using the Quality Improvement Tool (QIT). The hospital regularly referred to the BMI corporate dashboard to monitor indicators such as transfers, returns to theatre, readmissions and infection rates, average length of stay and day case conversion rates.
- There was an appropriate clinical governance structure in place. Hospital sub-committees (medicines management, infection prevention and control, laser and radiation, health and safety, transfusion and resuscitation) reported to the clinical governance committee and medical advisory committee (MAC). Senior leaders then reported to the corporate BMI regional and national clinical governance structure. Outcomes from the clinical governance meetings were shared with staff via the heads of department and local department meetings.
- The ED recently introduced a daily communications meeting with the DOCS and all heads of departments. The aim was to raise awareness across all departments of daily activity, incidents and complaints and any concerns to action.
- We saw from records that staff at clinical governance meetings discussed complaints and incidents, including any learning and trends related to these events. They also discussed audits, staff training and vacancies, policy reviews, patient satisfaction scores and NICE guidelines. However, the hospital did not produce formal action plans that detailed the person responsible for any actions in response to incidents.
- The hospital did not always act on the results of local audits in a timely fashion. For example, we saw a pharmacy audit of controlled drugs from November 2015 with multiple actions identified. There was no formal action plan for the November audit and a re-audit in January/February 2016 identified similar action points.
- BMI Healthcare circulated a monthly clinical governance bulletin to all hospitals to share with staff. It contained details and learning from never events and serious incidents across the BMI network. The bulletin also included updates on new NICE guidance, medical device, medicine and patient safety alerts.
- Consultants from a variety of specialities attended the MAC meetings on a bimonthly basis. We saw from records that incidents, complaints, audits and practising privileges were discussed
- The MAC reviewed consultant practising privileges biannually. The hospital recently introduced a spreadsheet to record consultants' records of professional indemnity insurance, recent appraisals and disclosure and barring service (DBS) checks.

Leadership / culture of service related to this core service

- Many staff had worked at the hospital for a long time and said it was a good organisation and hospital to work for. They described it as "a lovely place to work" where "everyone is supportive and helps each other." Staff said they felt respected and valued at the hospital and senior staff and management encouraged them to complete further training and qualifications.
- All staff we spoke to were very positive about the new executive director and director of clinical services (DOCS). They said they were very visible on the wards and approachable. They both operated an 'open door policy' and encouraged staff to raise concerns directly with them. Staff could also report concerns anonymously on the intranet. The executive director recognised excellence and good work by the 'above and beyond' awards.
- Senior nursing staff described the DOCS as 'an excellent role model' who was knowledgeable, passionate and 'really cared about the patients.'
- Staff said they worked well as a team and felt supported by their immediate managers who lead their departments well. There were low staff sickness and vacancy rates across the service with a high record of staff stability during the reporting period.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- No whistle blowing concerns were reported to the CQC in the reporting period October 2014 to September 2015.

Public and staff engagement

- Staff encouraged patients to complete a patient satisfaction survey before discharge. An independent third party analysed the surveys and communicated the

results back to the hospital on a monthly basis for learning and action. The hospital used this with the 'friends and family test' feedback to evaluate their service provided to the patient.
- The provider asked staff to complete annual staff surveys. However, the results of the most recent survey were not available at the time of our visit.
- The new executive director (ED) recently introduced a staff forum. At the first meeting, staff discussed the vision for the service and the ED listened to staff feedback. Staff told us they could put forward ideas and felt they were listened to.

Innovation, improvement and sustainability

- The hospital was in the process of a significant refurbishment program to the general fabric of the building.
- The enhanced recovery program provided a comprehensive rehabilitation program for orthopaedic and spinal patients, including specialised physiotherapy to achieve earlier mobilisation and discharge.
- Service leads told us the priority for the surgical department was to upgrade the profile of the hospital within the wider community and increase the amount of NHS work carried out at the hospital. There were also plans to continue with refurbishment of the fabric of the hospital, including patient rooms on the ward and theatre doors and floors.
- The ED planned to monitor and prevent breaches of the 18 week referral to treatment time for NHS patients. There was also a business plan to create a minor procedures room in response to insurance company and CCG needs. The service planned to improve the efficiency of patient pathways to reduce further the average length of stay, and increase the amount of day case procedures.
- There was a plan to develop staff leadership training and a formal progression strategy within the hospital.

Good

Services for children and young people

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

Information about the service

BMI Sarum Road Hospital has 48 registered beds There was no emergency care facility at the service. The hospital has two theatre suites, a minor procedures room, one treatment room, 10 consulting rooms and a physiotherapy gym.

The children's and young people's service provided outpatient consultations for elective surgical procedures, and diagnostic tests. Physiotherapy is available for children and young people over the age of eight. Between October 2014 and September 2015 there were 61 surgical procedures performed on children and young people between the age of three and 17. No surgical procedures were performed on children under the age of three as per the BMI Healthcare Policy. There were 907 outpatient attendances by children and 258 by young people.

Surgery for children was planned as day case surgery, with provision if they needed to stay overnight. There were overnight stays for 11 children and five young people following ear, nose and throat (ENT) operations in the reporting period October 2014 to September 2015. The ward was arranged in single rooms with private facilities in each, which included facilities for parents to stay with their child. There were no wards or waiting areas specifically for children. Instead, staff adapted existing bedrooms with child or young person friendly items including pictures and books.

Consultant surgeons were responsible for the medical care of the child during their stay. A resident medical officer (RMO) was available at the hospital overnight whenever a child was on the ward, who was appropriately qualified to look after children and young people.

A children's nurse coordinates all children and young people's appointments and is responsible for their care during the day, and there is a minimum of two children's nurses on site for the care of in patients and young people.

Outpatients for children included consultations, pre-operative checks, investigations and appointments for psychological support.

As part of our inspection we visited the children and young people's service. We spoke with one parent and one child who were at the hospital for an outpatient follow up appointment. We also spoke to staff including children's nursing staff, a resident medical officer (RMO), a pharmacist, physiotherapists, radiographers, administration staff and senior management. Before the inspection, we reviewed performance information from, and about the service.

Good

Services for children and young people

Summary of findings

We rated the Children and young people's services as good for safe, effective, caring, responsive and well-led.

The children and young people's service had a good record of accomplishment on safety with no serious incidents; there was a positive culture of reporting, investigating and learning from incidents across the hospital. The hospital safeguarded children and young people through offering care tailored to their needs. There are two fully qualified paediatric nurses employed by the hospital to manage the care of children and young people. A resident medical officer (RMO) with a current certification in paediatric advanced life support is employed whenever a child is admitted.

The hospital lacked specific waiting areas and consulting rooms for children, but staff minimised the potential impact of mixing children with adults by using dividing screens if needed.

The director of clinical services and the paediatric nurses were all qualified in safeguarding to level 3 and the director of clinical services took the role of safeguarding lead at the hospital.

Children and young people's services are planned and delivered that took account of best practice and guidance.

Children's and young people's services were responsive and provided access at times to suit children, young people and their parents. Child-friendly information was available for children about their procedures; nurses encouraged them to ask questions about their care. Nursing staff offered children and parents emotional support when needed. The paediatric nurses gave a feedback questionnaire to all children and young people and the results were collated annually and used to improve the service for children and young people.

Leadership at this hospital was good. Staff felt well supported by the paediatric nurse leads as well as the director of clinical services and the senior leadership team. There were no known risks associated with the care of children and young people at the time of our inspection. The risk register was not fit for purpose in its current format but senior managers were aware of this and were in the process of reviewing their processes for recording, reviewing and tracking mitigating actions across the hospital. There was no written strategy for the care of children and young people at this hospital though staff shared the overall vision of providing excellent care and value for money.

Good

Services for children and young people

Are services for children and young people safe?

Good

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

We rated safe as good because,

- Incidents were reported, changes in practice occurred and learning was shared. Infection control procedures were routinely followed.
- Equipment designed for paediatric use was available and the paediatric resuscitation system was understood by clinical staff.
- When children were on site, appropriately qualified staff were available to care for them. Medical and nursing staff followed national guidance. The hospital policy states that the consultant in charge must be available at all times or provide equivalent cover.
- 99% of all clinical staff had completed safeguarding training to the required level.
- Children and young people were always under close observation by a paediatric specialist with nurse so that any changes in condition could be acted upon quickly.

Incidents

- Staff reported incidents, made changes to practice and shared learning. No serious incidents involving children and young people were reported during the last year.
- Discussions with staff confirmed that they were aware of how to report incidents and would not hesitate to do so .Staff were able to tell us of incidents that had occurred and how learning had taken place with practice change as a result. For example, one regular clinic was organised so that a paediatric specialist was available to support all patients when they saw the doctor.
- The paediatric nurses received national patient safety alerts for children and introduced practice changes when required
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents.' Staff were aware of the principles of duty of candour although no staff recalled any incidents where DoC had been triggered. The electronic reporting system included a specific prompt relating to DoC.
- The Medical Advisory Committee (MAC) included a consultant anaesthetist with paediatrics within his scope of practice; his contribution to the committee included issues affecting practice, equipment and safety alerts in the treatment of children and young people.

Cleanliness, infection control and hygiene

- All of the areas we visited were visibly tidy and clean. Cleaning schedules were on display in each area, which were signed as checked on a weekly basis by the domestic supervisor.
- Staff we spoke to were aware of the hospital policy on infection control. We observed nurses in outpatients and on the wards using hand gel frequently and washing their hands before and after attending to patients.
- Infection control risk assessments were conducted on all children and young people as part of their pre admission process. Any infection risks were highlighted at the earliest time in the patient's care pathway to ensure that correct infection prevention and control precautions were instigated.
- We saw there were sufficient hand-washing facilities and protective personal equipment, such as gloves and aprons, available. Hand sanitisers were provided in the consulting rooms and treatment areas at the point of care.
- The paediatric nurses took responsibility for cleaning the hospital supply of children's games and books which were kept in a locked cupboard.
- We observed staff adhered to the 'bare below the elbow' guidance which enabled thorough hand washing, and reduced the risk of spread of infection between staff and patients.

Environment and equipment

- Staff told us that they could only have one child in the recovery room at any one time and said that due to the low numbers of children being treated at this hospital this was sufficient and did not cause them any concern. There were no incidents within the last year of there being more than one child needing to be treated in the recovery area.

Good

Services for children and young people

- This hospital had dedicated children's resuscitation equipment. The hospital used a nationally recognised paediatric emergency system that is checked and prepared by the paediatric nurses for every child's operation. When children need emergency treatment, this system provides a fast, accurate method for equipment selection and medicine dosages. Paediatric emergency cases have clinical requirements very different from those of adults. First the child's length is measured and one of seven colour areas is assigned. Next, a coordinated colour pack is pulled from the system to begin a procedure with the right sized equipment. The system offers seven colour-coded packs for children weighing from 3-34 kgs.
- This emergency system was also available to all staff in the ward and clinical areas. Staff were trained to use them and simple instructions for use were available attached to the packs.
- Staff checked the emergency equipment on a daily basis to ensure they were sealed and tagged. We saw where these checks were recorded and when items had been replaced as a result of the checking system.
- When children were on site they were accompanied by parent/guardian along with the children and young person's nurse; therefore if they became disorientated at night, a carer would be alerted and prevent the child coming to any harm.

Medicines

- We saw that medicines were stored safely at this hospital in locked cupboards. We saw that fridges used to store medicines were locked and temperatures checked daily and logged, to ensure those medicines were stored at the correct temperature. The nurse in charge of each clinical area held the keys to the medicines cupboard.
- The RMO prescribed pain relief medicines such as liquid paracetamol, ibuprofen (and very occasionally oral morphine).

Records

- The hospital kept patient records in paper format and stored them securely in the ward office while patients were on the ward.
- The patient records we reviewed showed that staff completed the relevant assessments and patient details on every page. The entries were readable, and signed and dated by the member of staff who completed the assessment.
- The picture archiving and communications system (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital.

Safeguarding

- All staff providing care to children and young people were subject to a criminal record check through the Disclosure and Barring Service.
- Both paediatric nurses were trained to level 3 in safeguarding; 97% of all clinical staff were trained to level 1 in safeguarding and 93% of all staff were trained to level 2 in safeguarding.
- The director of clinical services and the lead paediatric nurse were the nominated safeguarding leads for the hospital. They were trained to level 3 and able to investigate safeguarding concerns if required.
- The children and young peoples' service at this hospital followed the Royal College of Nursing guidance "Caring for children and young people" Guidance for nurses working in the independent sector. This was a guidance document produced by the Royal College of Nursing in 2014 which sets out guidance for nurses working with children in the independent sector. The safeguarding leads reviewed every child or young person that was admitted for surgery to ensure that there were no safeguarding concerns and that they were receiving the correct age appropriate care and treatment.
- Every ward had a Safeguarding statement (a description of safeguarding which outlined the shared responsibility to protect children from harm and abuse) displayed on a noticeboard with clear instructions and contact details for staff raising a safeguarding concern.
- The director of clinical services attends the West Hampshire CCG regional independent safeguarding forum which promotes good links with the local authority, local NHS trusts and other relevant professional bodies involved in safeguarding children and young people.

Good

Services for children and young people

Mandatory training

- Staff were allocated a mandatory training plan through the BMI electronic learning system which was based on their role and required minimum competencies. Staff completed most training by e-learning but this was supplemented by practical training where appropriate, led by the paediatric nurses.
- Senior staff regularly monitored and organised completion of mandatory training. The hospital gave staff time at work to complete the training or they paid them to complete it at home. We saw where training records were kept in the ward office and updated by the ward administrator to ensure that staff were made aware when they needed to update their mandatory training.
- Regular bank staff were employed to look after children admitted to the hospital; they were required to update all mandatory training requirements as for permanent staff.
- The hospital quality coordinator monitored consultants' compliance with their practising privileges agreement. This included evidence of a current revalidation certificate.

Assessing and responding to patient risk

- Staff completed scenario based training, including resuscitation simulation bi-monthly. Staff received feedback during the session about how the team responded to the situation, with learning points and actions to take away. Staff reported the most recent simulation had involved a scenario of an unwell child in the mobile magnetic resonance imaging unit. The director of clinical services told us that they ensure that there at least 2 child based scenarios practised each year.
- All children and young people attending for surgery had a pre-admission risk assessment conducted by one of the paediatric specialist nurses.
- All children remained under the care of the treating consultant for the duration of their stay.
- A resident medical officer with up to date advanced paediatric life support skills is appointed when a child is admitted and is on site at all times.
- Children under the age of 12 admitted to the ward will have two paediatric nurses allocated to their care at all times who can continually assess the patient's condition and respond to any escalations in risk as they arise. Children and young people over the age of 12 will have one paediatric nurse allocated to their care. There was a paediatric early warning system (PEWS) in place to help manage a child whose condition deteriorates.

Nursing staffing

- The admissions coordinator organised children's elective surgery admissions once the required paediatric nursing staff had confirmed their availability.
- There are two fully qualified paediatric nurses employed by the hospital to manage the care of children and young people
- One of the paediatric specialists and one registered nurse cared for children and young people over the age of 12. Those under 12 were allocated two paediatric specialist nurses. There had been no recorded incidents of there not being sufficient paediatric nursing cover during the reporting period October 2014 to September 2015.
- The service had access to a bank of qualified, experienced paediatric nurses when required to support the two permanent part time nurses.

Medical staffing

- All children were looked after by consultant medical staff, whose practising privileges include paediatrics, during the day and by a suitably qualified RMO overnight as per the hospital's policy for the children and young peoples' service.
- The consultant in charge was accessible via the telephone and could attend the service within 30 minutes according to their practising privileges
- An anaesthetist with paediatric practising privileges was also available during the day and on call at other times.
- A resident medical officer (RMO) was on duty, who was trained in advanced paediatric life support to assist if a patient became unwell. Children and young people who became medically unwell could be transferred to the local acute NHS Trust by ambulance according to the patient transfer protocol.

Major incident awareness and training

- An identified member of the senior management team on duty each day was responsible for managing any major incident affecting the hospital that day. Senior staff participated in an on-call rota and staff we spoke to were aware of who to contact if there was a major incident.

Good

Services for children and young people

- Business continuity plans in the form of brief action cards were in place for all aspects of the loss of service. For example, loss of premises, loss of IT system and adverse weather conditions. Key contact personnel and actions to be taken were recorded.

Are services for children and young people effective?

Good

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

We rated effective as good because,

- Children's care and treatment took account of national guidance.
- Children received appropriate pain relief
- Multi-disciplinary team working resulted in positive outcomes for children and there was good partnership working with local NHS trusts. There were arrangements in place for parents and children to consent to operations and treatment.
- The service had access to x-rays and pharmacy for children 24 hours, seven days a week.

Evidence-based care and treatment

- Children's care and treatment took account of national guidance including those from the and Royal College of Nursing "Caring for children and young people" (April 2014) and "Clinical Guidance on the Care of Children in the Independent Health Sector" (October 2014)
- Sarum Road Hospital, as part of the BMI group, is part of the Association of Independent Healthcare Sector (AIHO). The children and young people's service demonstrated compliance with the general principles underlying the care of children in independent hospitals.
- Local policies and procedures used in caring and treating children were based on national guidelines and were up to date.
- The paediatric specialist nurses worked with the local NHS trusts to develop and maintain their skills. These are shared with other health professionals at regular education meetings and simulated training scenarios.
- Staff told us they knew how to access policies and procedures on the hospital's intranet system.
- The hospital did not have an identified audit plan in place specifically for paediatric care at the time of our inspection, which meant that learning from formal clinical audits, benchmarking or tracking clinical outcomes had not taken place.

Pain relief

- Basic pain relief was sometimes required such as liquid paracetamol or ibuprofen. Staff told us that the specialist paediatric anaesthetist, the consultant or the RMO prescribed these.
- The children and young people were always nursed by a specialist children's nurse, which meant that they could quickly act to manage any pain that developed.

Nutrition and hydration

- Children had access to a choice of refreshments when required and there were child appropriate menus available.
- The paediatric nurses advised the children, young people and their parents about pre-surgery fasting (that is omitting food and fluids except water before an operation) times during the pre-assessment appointment. The admissions coordinator tried to place children into the earlier surgical slots so that children did not have to fast for long periods of time.

Patient outcomes

- There were no recorded unplanned returns to theatre for children and young people during the reporting period October 2014 to September 2015.
- Children and young peoples' outcomes were not measured separately at this hospital.

Competent staff

- All consultant staff were required to provide evidence of their accreditation, validation and appraisal before practising privileges were granted. All of the consultants with practising privileges were also employed by local NHS trusts to perform surgical procedures on children and young people. The medical advisory committee (MAC) and DOCS were responsible for granting and reviewing of practising privileges biannually to ensure the consultants were competent in their roles.

- The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals
- Paediatric anaesthetics cover was always available from the local NHS trusts.
- The RMO on duty when children were admitted was trained in advanced paediatric life support.
- The nursing and physiotherapy staff who worked with children and young people were all trained and competent in specialist paediatric care.
- The paediatric nurses had developed a competency programme based on the Royal College of Nursing's (RCN, 2012) Core competencies for nursing children and young people. Other nursing and allied health professionals were required to complete this before working directly with children. All paediatric specialist staff completed paediatric advanced life support. 83% of staff completed annual training in paediatric basic life support, and 83% had completed training in paediatric immediate life support (PILS)
- The specialist paediatric nurses maintained good links with the local NHS trust children's services by regularly attending training sessions provided by NHS paediatric specialists.

Multidisciplinary working (in relation to this core service)

- The paediatric nurses took full responsibility for communicating the needs of all children under their care with the general nursing staff, medical staff and other healthcare professionals as appropriate.
- We observed there was effective team working, between all staff groups. This was facilitated by a daily morning 'huddle' meeting, where a representative of each department was present. We observed one meeting which enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary. Staff discussed each patient on the wards at this huddle meeting which would include any children and young people in the hospital at that time.
- The paediatric anaesthetist stayed on site during children's recovery period and we were told that they were supportive of nursing staff.

Seven-day services

- Records showed that children on the wards were seen by their consultant daily including weekends.
- The RMO was on site and available at night and at weekends.
- The diagnostic imaging department was available for routine x-rays and ultrasounds between 8am and 8pm weekdays. During the weekend and overnight, radiographers provided an on call service though they told us they were very rarely called out of hours.
- The hospital pharmacist was available between 9am and 5pm Monday to Friday. An agreement was in place between BMI Sarum Road Hospital and the local NHS provider for an emergency out of hours service.

Access to information

- Staff were able to access any necessary information on children's procedures via the hospital intranet and in files in the office.
- Patient notes were always available to ensure continuity of care. Medical staff mainly used their own private patient records during the outpatient consultation and took responsibility for ensuring the records were available.
- Diagnostic imaging results were available electronically, accessible by the clinician during clinic appointments.
- Discharge information was provided for the patient's GP and district nurses when appropriate and a copy was given to the patient.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records. For example, a copy of the record was transferred with the patient to the receiving provider for their treatment.

Consent

- The paediatric nurses were always available to attend pre-assessment clinics with children and young people. They kept child appropriate materials to help children understand any procedures they were about to undergo and supported them to consent to treatment and care.
- Staff told us they obtained consent from children and their parents or carers before starting care or treatment.
- Young people aged 16 or 17 were able to consent for treatment themselves.

Good

Services for children and young people

Are services for children and young people caring?

Not sufficient evidence to rate

By caring, we mean that staff involve and treat people with compassion, kindness, dignity, and respect.

We inspected but did not rate 'caring' as we were unable to collate sufficient evidence. We were unable to observe the interaction between nursing staff, children, young people, parents and/or carers. We spoke with one patient and their relative.

However,

- Surveys demonstrated positive feedback from children and young people who had used the service.
- The young person we spoke with told us they had been fully informed and involved in their care and treatment.
- Feedback from patients and their relatives consistently showed that children were supported and reassured if they were anxious or concerned.

Compassionate care

- Due to the low numbers of children being treated at this hospital, we were only able to speak to one patient and his mother during our inspection. However, we reviewed the log of completed surveys that children and their carers had completed and returned. All of them were full of praise for the staff who had cared for them.
- The child and parent we spoke with were very pleased with the care they received. The mother was impressed by the kindness shown and information provided to her son.
- Children were always chaperoned when seen by staff, this was usually a parent or someone known and trusted by the child.
- Young people were given the choice of having their parent/ guardian with them at consultation or their preferred chaperone as per best practice guidance. (Clinical Guidance on the Care of Children in the Independent Health Sector - October 2014)

Understanding and involvement of patients and those close to them

- One young person told us they had always found staff helpful and informative and they received relevant information to take home and read from his consultant. We spoke to another young person who told us they had been was fully informed about the procedure they were having and understood what was involved.

Emotional support

- Appointments were arranged to suit the patients and reduce any pressures or concerns.
- The paediatric nurses provided all aspects of care to reduce any anxiety felt by the children and young people. They took time to explain the procedure and encouraged them to bring in small items from home that helped them relax.
- Parents were able to accompany their children to theatres and recovery areas, which reduced anxiety for the children.

Are services for children and young people responsive?

Good

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

We rated responsive as good because.

- Children and young people attended the hospital for planned surgical procedures and an inpatient service was only offered to children age three and above, in line with national guidance.
- The culture is centred on the needs of the child using the service. The children and young people services were responsive to the needs of patients. We heard from parents and staff how hospital staff and doctors tailored treatment and hospital stays to the needs of the child.
- All children attended pre-admission clinics for an initial assessment that involved discussion with both the child and their parent or carer.
- The paediatric nurses created a child friendly environment within the available rooms when a child was admitted. Toys, books and age appropriate bedding were used to facilitate the child's stay.
- The paediatric nurses had developed a number of resources for children and young people to support their understanding of procedures and treatments.
- Young people were encouraged to bring in their own electronic tablets or DVDs.

Good

Services for children and young people

- Parents were encouraged to stay and a bed was made up for them in the child's room.

Service planning and delivery to meet the needs of children and young people.

- Children and young people attended the hospital for planned surgical procedures and an inpatient service was only offered to children age three and above, in line with national guidance.
- Paediatric surgical procedures were usually undertaken first on a surgical list. There was a recovery area for children immediately following surgery separate to the adult area.
- Consultants would liaise with local NHS providers to organise timely admission if a child's condition deteriorated or their needs were not able to be met at this hospital.
- Children and young people attending for outpatient appointments were cared for at times that suited them and their carers; for example outpatient appointments could be made after school.
- Most procedures were day case only and the numbers admitted for overnight care was very low. Between October 2014 and September 2015, 11 children were admitted and 5 adolescents.
- Educational support was not required for such short stays; any patient who required a longer in patient stay for medical intervention would be transferred to a local NHS facility.
- Age appropriate literature was developed by the paediatric nurse and made available when needed.
- Every child and carer was given a questionnaire to complete about the service they received. The comments were reviewed by the service regularly and the majority were positive. Any negative comments were considered and acted upon where possible.

Access and flow

- Children and young people attended Sarum Road Hospital as private patients and procedures were planned in advance.
- Paediatric procedures were booked at the beginning of the lists, which usually meant that patients could recover and return home the same day.
- The consultant reviewed the child prior to their discharge home.
- Outpatient appointments were available in the evening as well as during the day.

Meeting people's individual needs

- Parents were able to accompany their children to theatres and recovery areas. The recovery room had a specific area that was cordoned off from adult patients.
- If parents wanted to stay with their child, a bed was made up for them in the child's room.
- There was child-friendly information available for children and young people.
- Children and young people were usually able to order food to suit them from the kitchen.
- Each room had a television and children were encouraged to bring in toys or books from home to help them relax.

Learning from complaints and concerns

- Service leads were regularly reviewing the feedback gained through the children's questionnaire at the clinical governance meeting which was monthly.
- The director of clinical services saw all children and their families that stayed overnight during her morning round. During this round, she would speak to every patient and their relatives and would attempt to resolve any potential concerns as they arose. For example, staff told us that if there were concerns raised about the food quality or menu she would get the hospital chef to speak with the patient or their relative that same morning to address those concerns in a timely way.
- There were no complaints over the previous 12 months involving children or young people.
- Staff from across the hospital told the inspection team that they work hard to try and resolve any concerns that a patient or their relative had in a timely way rather than directing a patient towards making a formal complaint when the opportunity to improve their experience is then lost.

Are services for children and young people well-led?

Good

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

Good

Services for children and young people

We rated well-led as good because,

- The senior leadership team were visible and approachable. The paediatric nurses provided support to nursing staff when caring for children and young people. The director of clinical services met with the paediatric nurses on a frequent basis which ensured that specific issues about the care of children and young people could be escalated where required.
- There was a clear governance and reporting structure at this hospital. The director of clinical services and the quality coordinator reviewed risk incidents and any areas of concern at a weekly meeting and had good oversight of the risk issues at this hospital. There were no concerns about risks related to the care of children or young people at the time of our inspection.
- The director of clinical services, the ward manager and the paediatric nurses were working on a core standards document for children's services and a corporate paediatric steering group has been re-established.

However,

- Staff told us that the number of children treated at Sarum Road had reduced during the reporting period and the current strategic plan did not refer to children and young people's services. The executive director told us that children's and young people's services at this hospital were a potential area for business growth. However, plans for the children and young peoples' service were not clearly documented for staff.

Vision and strategy for this this core service

- The children and young peoples' service was led by the two paediatric nurses supported by the director of clinical services. The director of clinical services and the paediatric nurse we spoke with were both dedicated and passionate about the services provided at this hospital including provision for children and young people.
- The executive director told the inspection team of the hospital's overall vision which was to provide excellent care and value for money. The staff we spoke to shared this vision. However, service leads did not have a clear written vision or strategy which related to the care of children and young people.

Governance, risk management and quality measurement for this core service

- There was a clear governance and reporting structure at BMI Sarum Road, in line with the corporate governance framework. Heads of each department met monthly and could escalate any risk issues or concerns to the clinical governance meetings which were also held monthly. The director of clinical services also met with the two paediatric nurses on a frequently, which ensured that any issues specifically about care of children or young people could be discussed and escalated if required.
- The medical advisory committee (MAC) had a role in reviewing consultant contracts, maintaining safe practising standards among consultants and clinicians and granting practising privileges. Each consultant was required to complete biennial reviews with the MAC chair, where data on their clinical performance was discussed. The chair of the Medical Advisory Committee recently invited a paediatric anaesthetist to represent the interests of children and young people at the meetings; due to recent changes in paediatric practice he wished to be assured that the committee was regularly updated on all matters relating to the children and young people service.
- The executive director told the inspection team that they were in the process of revising their risk register. He acknowledged that their current risk register was not fit for purpose as it detailed mostly health and safety related risks and did not include clinical risks. However, the executive director, the director of clinical services and the quality coordinator had good oversight of the risks at the hospital. The quality coordinator and the director of clinical services met weekly and reviewed each incident, complaint or concern for that week and updated on any actions outstanding. There were no known risks associated with the care of children or young people at the time of our inspection.

Leadership / culture of service

- All staff we spoke to felt respected and valued and were positive about working at BMI Sarum Road. They described an open and supportive workplace culture where they had enough time to provide care for patients and raise concerns if needed. There was a positive attitude among staff with regard to wanting to share learning from incidents across the hospital and organisation.

Good

Services for children and young people

- Staff told us that senior leaders were visible at this hospital all staff we spoke with were very positive about the role of the director of clinical services.
- The staff we spoke with felt they could approach any of the leadership team and would be listened to. They said if they had any concerns they were raised and responded to. They told us the lead nurse for paediatrics was always available for advice and they felt supported in their care of children and young people.

Public and staff engagement

- Staff told us that the senior team were always accessible and open to new ideas and ways of working. The new executive director restarted the staff forum meetings recently which were open to all staff. At the time of our inspection, they had just held the first of the monthly planned forums which were well attended and well received by staff.
- The daily 'huddle' meeting was inclusive and all staff were encouraged to attend where possible, irrespective of their role or grade within their department.
- The provider asked staff to complete annual staff surveys. However, the results of the most recent survey were not available at the time of our visit.
- The hospital had a system of 'above and beyond awards'. This was to assist leaders in demonstrating their value and respect for staff.
- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. Patient feedback cards were available in the waiting areas and posters were clearly displayed to inform patients. Improvements made as a result of the 2014 survey included a children's activity table in the waiting area.
- The paediatric nurses developed their own child appropriate patient satisfaction forms which they reviewed along with any comments about the children and young people service that appeared on the friends and family test.

Innovation, improvement and sustainability

- Staff we spoke with were concerned that the numbers of children and young people being treated at this hospital had reduced over the last 12 months. We were not made aware of any reason why this may have occurred. The executive director spoke about children and young people being a potential area for business growth and opportunity but there was no formal action plan or strategy to reflect this.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department at the BMI Sarum Road hospital provides a wide range of speciality appointments including breast surgery, dermatology, gastroenterology and gynaecology. The diagnostic imaging service provides access to plain film x-ray, mammography, ultrasound and fluoroscopy. Between October 2014 and September 2015, the outpatient department provided 7147 new patient appointments and 12289 follow up appointments. The majority of patients seen (80%) were between the ages of 18 to 74 years.

The outpatient department is open between 8am and 8pm weekdays and Saturdays 8am to 2pm. Diagnostic imaging services also operate from 8am to 8pm weekdays and Saturday mornings when orthopaedic clinics are running.

The outpatient department has 10 general consulting rooms, one treatment room and a dedicated room allocated for minor operating procedures.

During the inspection we visited the outpatient department and diagnostic imaging services. We spoke with 11 patients, two relatives and 14 members of staff including, nurses, consultants, radiographers, health care assistants, radiography department assistants, administrators and managers.

Throughout our inspection we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment being used. We reviewed three patient care records and we observed interactions between staff and patients.

Summary of findings

Overall, this service was rated as good. We found outpatients and diagnostic imaging was good for the key questions of safe, caring, responsive and well-led. We did not rate effective as we do not currently collate sufficient evidence to enable a rating.

Medicines were stored securely and well managed. However, patient group directions were in need of review, as they were two years past their review date. Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level. Staff undertook appropriate mandatory training for their role. Patients were protected from the risk of abuse and avoidable harm. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.

Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging services. Although the outpatient nurse manager had been under pressure, however, the situation had recently improved with posts being filled. Agency staff were not used, longstanding bank staff were occasionally employed to provide cover. Staff received as a minimum training in basic life support to ensure they could respond appropriately in an emergency situation.

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

Good

Outpatients and diagnostic imaging

Staff followed national and local guidance when providing care and treatment. For example, guidance related to diagnostic imaging to ensure safe practice. Staff were supported in their role through a corporate performance review process. Staff were encouraged to participate in training and development to enable them to deliver good quality care. Patients' pain needs were met appropriately during a procedure or investigation. The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Clinics were available six days a week, Monday to Saturday.

We rated caring as good. During the inspection we observed care was provided compassionately by caring staff. Patients' feedback through interviews and comments cards was entirely positive; they commended the professionalism and kindness of staff. Patients praised all aspects of the service with comments such as "I am always listened to", "Great advice", "Brilliant", "Fantastic", "Welcoming and supportive" and "Exceptional care". Patients were treated with dignity and respect. They felt they were fully involved in planning their care and treatment. Staff took time to ensure they listened to and responded to patients' questions appropriately. This included the provision of emotional support. Staff verbally offered a chaperone to all outpatients. Signs were also clearly displayed in waiting areas and clinical rooms offering a chaperone and the patient's acceptance or rejection of the offer was recorded on the clinic list. Since the new chaperone service had been implemented over 95% of patients had accepted the offer of a chaperone.

We rated responsive as good. Services were planned and delivered in a way which met the needs of patients. Access to appointments was timely. Clinics were held on weekdays into the evening and Saturday mornings to suit patients' preferences. Interpretation services were available, however, staff could not recall the need to access this service for the patients they cared for. Staff made practical adjustments to accommodate patients' individual needs, for example, when caring for patients with hearing difficulties. Patients were aware of how to provide feedback and complain about the service if needed. Complaints were investigated and changes made if necessary.

We rated well-led as good. Effective governance and risk management systems were in place. Staff were well informed about issues relating to their department. They had opportunities to raise ideas and concerns when needed, which they were confident would be addressed by their managers. Service managers were committed to provide high quality care and facilities for patients. Local and senior managers were visible and approachable to all staff. There was an open and supportive learning culture. Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

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

We rated safe as good.

- Medicines were stored securely and well managed.
- Patients in the outpatients and diagnostic imaging departments were protected from the risk of abuse and avoidable harm. Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level.
- Staff undertook appropriate mandatory training for their role and were supported to keep this up-to-date.
- Clinical areas and waiting rooms were all visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging service. Agency staff were not used, longstanding bank staff were occasionally employed to provide cover.
- Patient records were available prior to a patient being seen. Staff received as a minimum training in basic life support to ensure they could respond appropriately in an emergency situation.

However,

- Patient group directions were in need of review, as they were two years past their review date.

Incidents

- In the reporting period October 2014 to September 2015, there were 281 clinical incidents reported across the hospital, 56 of which had been reported by outpatient department staff. Fifty five out of the 56 reported incidents were classified as low or no harm. All the low harm incidents related to where staff had reported a suspected superficial surgical site infection and commenced antibiotics. No serious incidents were reported over the same time period. The quality coordinator identified trends in surgical site infections for individual surgeons which were discussed and acted on. For example, a trend in reporting suspected surgical site infections by outpatient staff, meant the infection prevention lead was in the process of producing guidance to assist staff to correctly distinguish between surgical site infections and other types of infection.
- All staff we spoke with were aware of their responsibility to report incidents. Staff reported incidents on a paper incident report form which was submitted to the hospital quality coordinator for entry onto the corporate electronic reporting system.
- All incidents were reviewed by the director of clinical services. Investigations took place if needed to identify underlying causes and learning was shared at monthly clinical governance meetings.
- Staff discussed incidents reported in the previous 24 hours at the daily communication or 'huddle' meetings. These were attended by a representative of each department, the executive director and the director of clinical services.
- The notes of outpatient and radiology meetings showed incidents which had taken place in the hospital were discussed and brought to the attention of staff as learning points.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). There had been one IRMER incident report in the last year. This was investigated and learning was shared to improve and check communication procedures.
- Non-clinical incidents were discussed at the health and safety meetings. Ten non- clinical incidents were reported between October 2014 and September 2015. Examples of incidents related to personal accidents, resulting in low harm and environment or equipment failure.
- The director of clinical services received and disseminated medical and health regulatory (MHRA) safety alerts to relevant departments. These were noted in the minutes of the clinical governance meetings
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable

safety incidents.' Staff were aware of the principles of duty of candour although no staff recalled any incidents where DoC had been triggered. The electronic reporting system included a specific prompt relating DoC.

Cleanliness, infection control and hygiene

- All outpatient and diagnostic imaging waiting areas and clinical rooms were visibly clean and tidy. Cleaning schedules were on display in each area which were signed as checked on a weekly basis by the domestic supervisor.
- Hand sanitizer points were available to encourage good hand hygiene practice. We observed staff adhered to the national 'bare below the elbow' guidance which enabled thorough hand washing, and reduced the risk of spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures. We saw staff used them appropriately.
- Clean equipment was labelled to indicate it was ready for use, for example, blood pressure monitors.
- The probes for the ultrasound machine were cleaned between patients and this was checked through monthly audits which demonstrated 100% compliance.
- The infection control lead nurse produced quarterly infection control audit results for each department. Outpatient results in the latest newsletter (January 2016) showed 100% compliance with hand hygiene and 'bare below the elbow' practices.
- In line with current best practise the outpatient department had a 0% MRSA rate (December 2014 to December 2015).

Environment and equipment

- During the inspection, we observed equipment was labelled as serviced and electrical appliance tested. Staff we spoke with were clear on the procedure to follow if they identified faulty or broken equipment and who to report it to. The hospital services manager had carried out an audit of all the hospital equipment. The majority, over 90% of equipment was shown as meeting its service requirements. A few items which needed servicing were identified and scheduled for service.
- Equipment used during minor operations was single use items to reduce the risk of cross infection.
- Nursing and housekeeping staff safely managed clinical waste and non-clinical waste to ensure segregation and safe disposal.
- There was clear radiation hazard signage outside the x-ray rooms for staff and patients.
- Resuscitation equipment was maintained, in order and ready for use in an emergency. Trolleys were checked daily and records kept to demonstrate that checks had been completed. Expiry dates of items were recorded to easily identify items which were due for re-ordering. The trolleys were secured with tamper evident seals.
- The outpatient areas were well signposted and corridors were free from clutter. Rooms were maintained securely, all rooms were key pad entry or locked if not in use.
- The physiotherapy gym was well-equipped and equipment safely stored either on shelves or secured.
- An annual health and safety audit was undertaken by the BMI corporate lead for health and safety. The 2015 report for Sarum Road recommended a small number of areas for improvement, such as fire improvement works. However, overall it showed good control and risk management systems in place.
- The hospital fire officer carried out weekly fire alarm tests and bimonthly fire audits. Actions were monitored at the bimonthly health and safety meetings, such as planned works and fire drills.

Medicines

- Medicines were stored safely. All medicines cupboards were locked and the keys held by the lead nurse on duty. Fridges were locked and temperatures checked daily and logged, to ensure medicines were stored at the correct temperature.
- In the main outpatients department, prescription pads were stored in lockable drawers within the nurses station office, the office was accessed securely via a door key pad.
- Keys to medicines cupboards were held by the nurse in charge of the department.
- In the diagnostic imaging department, medicines and prescription pads were stored in locked cupboards, only accessible to authorised staff.
- Cupboards were not overstocked and medicines were well organised. Items due to expire in the next three months were identified with a red dot on the container to alert staff to use short dated items first and facilitate stock control.

- Patient group direction (PGD) was used by nurses who had completed their PGD training. PGDs are instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. However, there was no signed authorisation for these staff to use the PGD within the organisation, contrary to PGD legislation and NICE guideline (MPG2). The PGD was also past its review date of 1 October 2014. The provider was aware the PGD was due for review and a hospital plan was in place to address this.

Records

- Medical records and personal identifiable information was stored securely and only accessible by authorised staff.
- Outpatient consultations within the hospital were consultant-led. All patients attending outpatients had an accompanying GP referral letter or their current medical records from a previous appointment or admission. A consultant would retrieve their own patient records for patients who were self-funding or covered by medical insurance.
- Arrangements were in place to ensure all patients who attended nurse-led clinics, for example, for post-operative wound care, had their notes available. The week prior to the appointment, patients' notes were transferred to the outpatient department in preparation. If the patient had surgery elsewhere their notes were faxed to the department. No patient had a follow-up discharge procedure undertaken without a full set of notes available for reference.
- Patients' records were held securely on site in the department. There was an archive facility for patient notes that was located off site.
- The picture archiving and communications system (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital
- Monthly records audits were undertaken as part of the annual audit plan. Results of the latest audit showed compliance with record keeping standards were 89% to 96% between December 2013 and November 2014. Improvement actions such as reminding staff to date and time all entries, were highlighted at the monthly heads of departments meetings.

Safeguarding

- Safeguarding training for vulnerable adults was mandatory for all staff. All the staff we spoke with, were aware when to raise a concern and the process they should follow, but staff we spoke with could not recall raising any safeguarding concerns. Compliance with safeguarding training was 100% in diagnostic imaging and 90% within the outpatients department.
- All staff were required to complete safeguarding training appropriate to their role. For example, all staff were trained to level 1 safeguarding children and safeguarding vulnerable adults. Clinical staff were trained to level 2 safeguarding children and safeguarding vulnerable adults, in accordance with BMI policy.
- Staff were aware of who the hospital safeguarding lead was. Safeguarding information and contact numbers were displayed as a reminder and easy access for staff in the departments.
- Radiographers ensured seven criteria were met on the request form in line with BMI policy before proceeding with the radiological test, such as patient demographics and reason for examination request. An audit of request forms was undertaken to ensure compliance with the seven criteria. The most recent audit (June 2015) demonstrated good compliance except for two areas which did not achieve 100% including the date on the form and patient address. The audit was due to be repeated in 2017.

Mandatory training

- The BMI mandatory training matrix included training requirements for staff dependent on their role. For example, information security, fire safety and moving and handling was applicable to all staff whereas blood transfusion and medical gases training was only for staff who required the necessary skills in these areas. Most training was done by e-learning, in some cases followed by workshops and assessments. Staff completed their training during their work time and all staff we spoke with said they were up to date with their training requirements.
- Bank staff who worked less than 80 hours per year were not required to complete BMI mandatory training. However, they were expected to undertake mandatory training in their main workplace, which was checked by BMI.

Good

Outpatients and diagnostic imaging

- The designated Radiation Protection Supervisor (RPS) within the diagnostic imaging department received radiation protection training and support from the medical physics team, based at St George's Hospital in London. We saw up-to-date records which showed good compliance for radiation protection updates.
- The hospital services manager monitored overall mandatory training uptake for all staff. An automated system alerted managers and individual staff members when they were due for training.
- Mandatory training compliance for the hospital was 98% overall at the end of December 2015. This was consistent with the outpatient and diagnostic imaging staff achievement.
- The hospital quality coordinator monitored consultants' compliance with their practising privileges agreement. This included evidence of a current revalidation certificate.

Assessing and responding to patient risk

- A radiation protection internal inspection visit report (February 2016) showed a small number of areas for improvement regarding documentation, which had been actioned.
- Staff in outpatients were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. All radiographers and registered nurses in the outpatients and diagnostic imaging departments had received training in immediate life support, with all other staff trained in basic life support.
- Staff completed scenario based training, including resuscitation simulation, every quarter. Staff received feedback during the session about how the team responded to the situation, with learning points and actions to take away. Staff reported the most recent simulation had involved a scenario of an unwell child in the mobile magnetic resonance imaging unit.
- A resident medical officer (RMO) was on duty, who was trained in advanced life support to assist if a patient became unwell. Patients who became medically unwell could be transferred to the local acute NHS Trust by contacting the emergency services (999) if required. Two patients had been transferred by this method between October 2014 and May 2016.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation.
- There was one appointed and trained Radiation Protection Supervisor (RPS) within the diagnostic imaging department. The RPS role was to ensure that equipment safety, quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures. Evidence was seen that these checks and procedures were being completed correctly.
- It was a requirement of BMI Healthcare's practising privileges (PP) policy, that consultants remain available or arrange appropriate alternative named cover at all times when they have inpatients in the hospital. Practising privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. Outpatient staff reported no difficulties in contacting the consultants for patients who attended the department for a follow up appointment.

Nursing staffing

- Outpatient, diagnostic imaging and physiotherapy departments reported they had sufficient numbers of staff to meet the workflow and patients' needs in a safe manner.
- There were no vacancies in the outpatient department, imaging and physiotherapy services. In diagnostic imaging there were six radiographers and one radiography department assistant. In the outpatients department there were three registered nurses and 3.6 health care assistants.
- All outpatient staff reported that they did not use any agency staff for the period October 2014 to September 2015. However, when needed regular bank nurses were employed who were familiar with the service and local procedures. There were no agency staff used within outpatients or diagnostic imaging.
- In the previous six months the staff sickness and staff turnover had impacted on the small outpatient team. The outpatient nurse manager had been under pressure to meet their leadership responsibilities and to provide clinical cover when there was no other suitably skilled or qualified nurse available. However, the service had recruited to the vacant post to address the situation.

Good

Outpatients and diagnostic imaging

Medical staffing

- Ten radiology consultants provided cover for the radiology service. Radiographers reported there were no difficulties with availability or contacting consultants in the imaging department.
- Nursing and radiography staff called on the resident medical officer when required and said they were very responsive.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital outpatient and administration teams. Within the outpatient department, consultants covered all specialities for all clinics. There were no concerns raised about the availability of consultants to cover their clinics.
- In the diagnostic imaging department, there was a service level agreement for consultant radiologist support from the local NHS acute trust hospital. This allowed for timely reporting of scans and images to aid diagnosis.

Major incident awareness and training

- There was a member of the senior management team on duty each day who was responsible operationally for any major incident affecting the hospital. Out of hours there was an on call rota and staff were aware of who to contact in case of a major incident.
- Business continuity plans in the form of brief action cards were in place for all aspects of the loss of service. For example, loss of premises, loss of IT system and adverse weather conditions. Key contact personnel and actions to be taken were recorded.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

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

- Staff took account of national and local guidance when providing care and treatment. For example, guidance related to diagnostic imaging to ensure safe exposure.
- Staff were encouraged to participate in training and development to enable them to deliver good quality care. Staff were supported in their role through a performance review process and they all had regular appraisals.
- Patients' pain needs were met appropriately during a procedure or investigation.
- The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) audits were undertaken in line with regulatory requirements. Results indicated service performance was in line with local standards.

Evidence-based care and treatment

- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure. For example, radiation exposure/diagnostic reference levels were audited regularly as part of the service's quality assurance checks and were within the service standards.
- Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) audits were undertaken in line with regulatory requirements. We saw copies of these audits, outcomes, actions and results during our inspection. IR(ME)R incidents were all within normal ranges. The hospital was not an outlier for under or over reporting of IR(ME)R incidents.
- Audits carried out by the diagnostic imaging department, included request form audits and an analysis of rejected imaging scans. The request form audit (June 2015) demonstrated good compliance with seven out of nine of the criteria used for request. The audit showed two areas which did not achieve 100% which were the date and complete patient address. The audits of analysis of films for 2015 showed a very low number of rejected films which indicated high performance.
- Staff in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care. For example, prevention and treatment of surgical site infections.

Good

Outpatients and diagnostic imaging

- The Medical Advisory Committee (MAC) monitored and reviewed outcome data for all consultants as part of the biennial review of consultants' practising privileges.
- Radiographers checked all referrals to ensure patients were booked for the correct imaging tests and the requesting information was fully completed.
- The imaging manager participated in a BMI imaging user group. The user group met quarterly to share best evidence based practice across the organisation.
- There were no specific clinical audits related to the outpatient department. However, the 2015 BMI audit plan included monthly medical records audits which covered all hospital departments including outpatients.

Pain relief

- Staff discussed options for pain relief with patients prior to any procedure being performed. Many procedures were undertaken with the use of local anaesthetic, which enabled patients to go home the same day.
- Patients were given written advice on any pain relief medicines they may need to use at home, during their recovery from their outpatient procedure.

Patient outcomes

- The MAC monitored outcomes for individual consultants. This included readmission rates, development of venous thromboembolism (VTE) and hospital acquired infection.
- Patients were offered the opportunity to take part in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement and inguinal hernia repair. PROMS measures the quality of care and health gain received from the patients perspective. Between April 2014 and March 2015 PROMS data showed 90% of patients who responded reported improvement in their health (A patient-reported outcome measurement which contains 12 questions on activities of daily living that assess function and pain in patients undergoing certain procedures.)
- Staff reported that patient outcomes were monitored through patient satisfaction questionnaires and incidents such as suspected surgical site infections.

Competent staff

- Staff had access to training and development opportunities to advance their professional skills and experience and develop their service. For example, health care assistants received training to undertake phlebotomy.
- In the period October 2014 to September 2015, not all outpatient nursing staff and healthcare assistants had received an appraisal. However, this was due to staff sickness and staff turnover. In the same period, all the radiographers and radiography department assistants had received an appraisal.
- There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date.
- Nursing staff within the outpatient department told us that the hospital provided a revalidation study day to ensure that registered nurses were all aware of the revalidation process and what their responsibilities were in relation to this. All nurses were familiar with revalidation and felt well supported by their manager in maintaining their nursing registration.
- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed.
- Physiotherapists were members of different special interest groups and participated in clinical reasoning sessions to develop their knowledge, skills and share best practice.
- New staff underwent an induction programme and a performance review meeting at six weeks after commencement in employment. Staff we spoke with said the induction process was thorough and included a corporate and local induction to ensure they had sufficient support in their role. Staff were supernumerary for an agreed period during their induction phase.
- Outpatient department staff worked closely with the local NHS hospital to develop the skills of their healthcare support workers. For example, ophthalmology and dressings care.
- Regular communication between BMI Sarum Road Hospital MAC Chair and the various trust medical directors was maintained to ensure a coordinated approach to consultant engagement. Consultant concerns were discussed by the hospital management team with the MAC Chair, and if considered serious enough, with the BMI Group Medical Director. Concerns

that related to standards of practice, quality or patient safety were also shared with the consultant's responsible officer. A responsible officer is responsible for evaluating a doctor's fitness to practise.

- A process was followed by the MAC to ensure all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake the treatment they were performing at the hospital. The competencies and skills were reviewed biennially. At the time of the inspection the hospital had 142 medical staff working under rules or practising privileges. However, 93 had not carried out any episodes of care between October 2014 and September 2015. The executive director was aware of this and was taking action to reduce the numbers of consultants with practising privileges who were not actively treating patients at this hospital. Outpatient staff reported they would obtain assurance from the quality coordinator about the status of a consultant's practising privileges before they booked a clinic for a consultant they were unfamiliar with.

Multidisciplinary working (related to this core service)

- We observed, there was effective team working, between all staff groups. This was facilitated by a daily morning 'huddle' meeting, where a representative of each department was present. We observed one meeting which enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.
- Staff told us that medical staff were supportive and advice could be sought when needed.
- There was a service level agreement between the hospital and a mobile magnetic resonance imaging (MRI) provider (which was part of another organisation and not subject to this inspection process). The mobile MRI visited the hospital twice a week.
- Departments worked closely to ensure patients did not have to make unnecessary visits. For example, patients were offered same day x-ray as their OPD appointment, if needed.
- From the care we observed, there was effective team working, with strong working relationships between all staff groups.

Seven-day services

- The majority of outpatient clinics were held Monday to Friday 8am until 8pm. Clinics were also held on Saturdays between 8am and 2pm. Patients we spoke with reported good access to appointments and at times which suited their needs.
- In the diagnostic imaging department, x-rays and ultrasounds were available between 8am and 8pm weekdays. During the weekend and overnight, radiographers provided an on call service. They said they were very rarely called out of hours.

Access to information

- Patient notes were always available to ensure continuity of care. Medical staff used their own private patient records during the outpatient consultation and took responsibility for ensuring the records were available.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging. This enabled prompt discussion with the patient on the findings and treatment plan. Most results were reported electronically, accessible by the clinician at the hospital, with a written copy also being sent.
- Results were available electronically for consultants to view in the clinic.
- Diagnostic imaging results were available electronically, accessible by the clinician during clinic appointments.
- Physiotherapy staff kept their own patient records but ensured that a copy was always available in the hospital records for each patient.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records. For example, a copy of the record was transferred with the patient to the receiving provider for their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in the mandatory safeguarding training. Staff demonstrated in conversations an understanding about their role with regard to the Mental Capacity Act, although no staff recalled its formal use.
- Verbal consent was given for general x-ray procedures, outpatient procedures and physiotherapy treatments carried out.

Good

Outpatients and diagnostic imaging

- Consent forms were completed for all minor surgical procedures. Quarterly consent audits were carried out and showed an improvement in compliance with consent form completion between December 2013 (86%) and September 2014 (99%). Areas for improvement included recording extra procedures on the consent form, which had been addressed.

Are outpatients and diagnostic imaging services caring?

Good

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

We rated caring as good.

- During the inspection we observed staff provided care in a compassionate and respectful manner.
- All the patients we spoke with and the comments we received commended the professionalism and kindness of all staff. Patients praised all aspects of the service with comments such as "I am always listened to", "Great advice", "Brilliant", "Fantastic", "Welcoming and supportive" and "Exceptional care".
- Patient's privacy and dignity was maintained.
- Patients were kept up to date with and involved in discussing and planning their care and treatment. Patients were able to make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively.
- Staff encouraged patients to be involved in their care and patients commented they had been well supported emotionally by staff.
- The department had embedded a practice of verbally offering a chaperones to all outpatients. Signs were also clearly displayed in waiting areas and clinical rooms offering a chaperone and the patient's acceptance or rejection of the offer was recorded on the clinic list. Since the new chaperone service had been implemented over 95% of patients had accepted the offer of a chaperone.

Compassionate care

- Staff treated patients with dignity and respect. We observed patients' privacy was maintained. The main outpatient reception desk was located sufficiently away from waiting areas so patients could speak to reception staff confidentially, without their conversation being overheard.
- During our conversations with staff it was clear they were passionate about caring for patients and clearly put the patient's needs first.
- Nurses and consultants called patients personally from the waiting area and accompanied them to the consulting room.
- Patients we spoke with were very positive about their experience of the care from BMI Sarum Road. We received the following comments: "Excellent service", "Polite caring staff", "Friendly", "Cannot fault the services from start to end".
- We reviewed 32 comments cards from patients who had used the outpatient service. They all included praise, particularly for the physiotherapy service. Comments included: "Staff always courteous and polite", "I am always listened to", "Great advice", "Brilliant", "Fantastic", "Welcoming and supportive" and "Exceptional care".
- The department had embedded a practice of verbally offering a chaperones to all outpatients. Signs were also clearly displayed in waiting areas and clinical rooms offering a chaperone and the patient's acceptance or rejection of the offer was recorded on the clinic list.
- We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality. Patients attending gynaecology appointments were seen in consulting rooms which had adjoining examination rooms to allow an extra degree of privacy.
- The reception desk was located sufficiently away from waiting areas so patients could speak to receptionists and staff, without their conversations being overheard and maintain their confidentiality.
- Throughout the inspection, we witnessed numerous caring interactions between staff and patients. All the patients we spoke with told us that staff were friendly, helpful and caring. Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients.
- The hospital took part in the Friends and Family Test. For the reporting period April 2015 to September 2015 the hospital reported consistently high results. Between 98% and 100% of patients would recommend the hospital to their friends and families. The proportion of patients who responded to the test was variable over the same period between 26% and 51%.

Good

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- All the patients we spoke with, told us they had been provided with relevant information, both verbal and written, to make an informed decision about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- Comments from patients who received physiotherapy indicated they were fully involved in their plan of treatment.
- We witnessed interactions between staff and patients which demonstrated information was conveyed at an appropriate pace, understanding was checked by staff and patients asked if they had any follow up questions.

Emotional support

- Patients commented that they had been well supported emotionally by staff. For example, in relation to reassurance about the recovery process following outpatient surgery.
- Staff told us they always offered to chaperone patients undergoing examinations and we saw records that showed patients were supported in this way. We also observed medical staff requesting chaperones for their patients. Staff routinely offered a chaperone service to all patients. This meant that patients had access to emotional support before, during and immediately after they were examined.

Are outpatients and diagnostic imaging services responsive?

Good

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

We rated responsive as good.

- Services were planned and delivered in a way which met the needs of patients. Patients had timely access to appointments. Clinics were held on weekdays into the evening and Saturday mornings to suit patients' preferences.
- Patients were very complimentary about the efficiency of the service as a whole including feedback given about waiting times.
- Interpreting services were available; however, staff could not recall the need to access the service for the patients they cared for.
- Staff made adjustments to accommodate patients' individual needs, for example, patients with hearing difficulties.
- Patients were aware of how to provide feedback and complain about the service if needed. Complaints were investigated and changes made.
- The physiotherapy service had developed to provide Pilates, acupuncture and women's health classes to improve recovery for patients following discharge from hospital.

Service planning and delivery to meet the needs of local people

- Services were well planned and the facilities appropriate to support the running of clinics. Clinics were held Monday to Friday 8am to 8pm and Saturday mornings to accommodate patients with commitments during the week.
- Services were planned around the needs and demands of patients. Outpatient clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patients' needs.
- The hospital was a provider of Choose and Book. This is an NHS electronic booking system used by GPs for booking outpatient appointments. It offers patients a degree of choice in booking their appointment, including which hospital and date and time to suit their needs.
- The physiotherapy service had developed to provide Pilates, acupuncture and women's health classes to improve recovery for patients following discharge from hospital.

Access and flow

- Patients entered the hospital via the main entrance and were registered at the main reception desk. Staff used an electronic system which tracked patients from the time they arrived at reception and indicated how long they had been waiting.
- Staff asked patients to wait in the main waiting area or the smaller waiting area near the physiotherapy and imaging departments depending on their appointment.

Good

Outpatients and diagnostic imaging

- In the diagnostic imaging department there were three cubicles for patients to use to change before their appointment.
- NHS patients who used Choose & Book were subject to NHS waiting time criteria and were monitored by the NHS hospital's own administration team.
- Patient's appointments were arranged through the consultant's individual secretaries and with the outpatient reception team.
- All patients we spoke with felt the availability of appointments was good and appointments were provided at times that fitted in with their needs. Patients were very complimentary about the efficiency of the service as a whole including waiting times.
- For the reporting period October 2014 to September 2015, the hospital consistently met the target of 95% of non-admitted patients beginning their treatment within 18 weeks of referral. Specifically, all patients were seen within 18 weeks; 80.5% were seen within 13 weeks and 65% within nine weeks. For NHS patients the six-week diagnosis targets were consistently met. The majority of patients were given an appointment for x-rays, scans or ultrasounds within one week. Staff in the imaging department reviewed clinic lists daily to determine if any patients would require an x-ray. They liaised with outpatient staff accordingly to schedule patients for imaging. If patients needed procedures such as x-ray or ultrasound these could usually be carried out at the same time as their outpatient appointment, reducing the number of visits the patient made to the hospital.
- The radiographers booked patients appointments themselves as they had limited access to administrative support. The x-ray department was open 8am to 8pm and Saturday mornings. An on call service was provided when the department was closed. Ten radiologists provided cover and would attend if needed for a second opinion. The radiographers said there were no problems accessing a radiologist when needed.

Meeting people's individual needs

- Patients who attended for gynaecology appointments were seen in dedicated consulting rooms which had separate connecting examination rooms to ensure patients' privacy and dignity was protected.
- Patients were sent appropriate information prior to their first attendance, this contained information such as the consultant or clinic they were to attend, length of time for the appointment and written information on any procedures which may be performed at the first appointment, including the cost of the appointment and subsequent procedures (for self-funding patients).
- All staff had equality and diversity training as part of the mandatory training requirements. Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. However, staff said it was very rare for them to provide care or treatment to a patient with complex or additional needs, for example, dementia or a learning disability.
- There was ample seating in the waiting areas. All consulting rooms and communal spaces were wheelchair accessible. The main waiting area was furnished with a range of different height chairs to allow patients to opt for a suitable seat to meet their comfort needs.
- There were complimentary water and hot drinks for patients provided in the waiting area.
- All written information and signage, including pre-appointment information was provided in English only. Staff had access to an interpreting service; however, they said it was very rarely required for the patients who attended Sarum Road. Staff we spoke with never had cause to access the interpreting service.
- In diagnostic imaging, a range of leaflets were available and provided to patients about diagnostic imaging procedures. Patient information leaflets were sent to patients prior to their appointment.
- Patient Led Assessments of the Care Environment (PLACE) for 2015 showed comparable results to the previous year and this hospital scored above the England average.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by BMI Healthcare.
- Patient toilets were accessible for patients in wheelchairs and baby changing facilities were provided.

Learning from complaints and concerns

- Patients were actively encouraged to leave comments and feedback via the BMI patient satisfaction survey, 'Tell us how we did'.
- If a patient wanted to make a complaint, staff told us that they would ask their immediate line manager/ service manager to speak to the patient. Most complaints were resolved locally.

Good

Outpatients and diagnostic imaging

- During February 2015 to January 2016, the hospital received 58 complaints; this was an increase of 10 compared to the previous year. Nine out of the 58 complaints related to the outpatient department and the majority concerned patients not being aware of additional charges. Staff had responded by ensuring they clearly highlighted the expected costs for blood tests in advance. Staff felt this had resulted in a reduction in the number of complaints of this type.
- All complaints were monitored by the executive director and responded to in line with the hospitals policy. Complaints were investigated by the relevant head of department with involvement from consultants and nurses if needed. Complaints and compliments were shared at the heads of department meeting. Any trends or themes were reviewed at the Medical Advisory Committee.
- Staff we spoke with knew about the complaints procedure and how to respond to patient concerns.
- All staff received information about the complaints procedure as part of their induction.
- Complaints received in the previous 24 hours were discussed at the daily communication meeting to ensure all staff were aware and learning, if appropriate, was quickly shared.

Are outpatients and diagnostic imaging services well-led?

Good

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

We rated well-led as good.

- Effective governance and risk management systems were in place. Staff were well informed about issues relating to their department. They had opportunities to raise ideas and concerns when needed, which they were confident would be addressed by their managers.
- Managers were committed to provide high quality care and improve services and facilities for patients.
- Staff felt supported and were able to develop to improve their practice. Staff in all areas stated they were well supported by their immediate line managers. All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital
- There was an open and supportive learning culture.
- Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

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- Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

Vision and strategy for this core service

- Staff were aware of the strategy for the department in line with the overall vision of the hospital, which was to provide high quality services and value for money. The strategy for the outpatient department involved developing the service to improve facilities for patients and expand the procedures offered. This was included in the BMI Sarum Road 2015 business plan.
- Staff spoke of incorporating the '6 Cs' (care, compassion, competence, communication, courage and commitment) into their daily interactions with patients. The 6 Cs was included in the NHS England's Chief Nursing Officer's strategy, Compassion in practice, 2012.

Good

Outpatients and diagnostic imaging

Governance, risk management and quality measurement for this core service

- There was a clear governance and reporting structure at BMI Sarum Road, in line with the corporate governance framework. Issues identified at monthly heads of department meetings were escalated to the clinical governance meetings. Outpatient department and diagnostic imaging managers participated in these meetings. Risk management issues including incidents, complaints, audits and new policies were discussed at the clinical governance meetings. For example, the testing of panic alarms in the consulting rooms and a trend in reporting suspected surgical site infections.
- Senior staff discussed quality performance data at the monthly clinical governance meetings and actions were agreed, if appropriate. For example, a trend in complaints relating to patients not being aware of the charges resulted in staff clearly highlighting to patients the expected costs for blood tests in advance.
- There was a hospital wide summary risk register updated quarterly. The main items on the risk register which related to the outpatient and diagnostic service concerned replacement of diagnostic machines. For example, the mammography machine was due to be replaced imminently.
- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on the BMI intranet. Staff signed a declaration to confirm they had read and understood the policy relevant to their area of work.
- Staff had access to policies and standard operating procedures for radiological examination. Local rules (local instructions relating to radiation protection measures for the service) were on display in every x-ray room.
- An annual corporate audit plan was followed and monitored at local clinical governance committees along with specific relevant department audits such as diagnostic imaging department audits which were reported to radiation protection committee.
- The medical advisory committee (MAC) had a role in reviewing consultant contracts, maintaining safe practising standards among consultants and clinicians and granting practising privileges. Each consultant was required to complete biennial reviews with the MAC chair, where data on their clinical performance was discussed. The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals.

Leadership / culture of service

- Front line staff were very positive about the leadership at departmental and senior management level. The leadership team was visible and approachable. For example, the director of clinical services and executive director were on site and led a daily communications meeting where a representative (not necessarily the head or most senior person in the department) of each department attended; this encouraged a culture of openness and equality.
- The outpatient and diagnostic imaging departments held monthly meetings with a standard agenda which covered business and staff issues. Such as complaints, incidents, new policies and staff training.
- Although a new executive director was in post, the outpatient and diagnostic imaging departments had experienced sustained stable local leadership, who in turn had been supported by the director of clinical services. Staff spoke highly of the new executive director and were optimistic about the future of the hospital.
- Managers in the outpatient, radiology and physiotherapy departments had clinical leadership roles and were easily accessible. Staff reported good support and guidance from their managers. Managers in all three departments were passionate about their teams and caring for their patients.
- There was a small number of new staff in post, however, the majority of staff were long standing. All staff we spoke with were positive about working at BMI Sarum Road. They described an open and supportive workplace culture where they had enough time to provide care for patients and raise concerns if needed. There was a positive attitude among staff with regard to wanting to share learning from incidents across the hospital and organisation.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. Patient feedback cards were available in the

waiting areas and posters were clearly displayed to inform patients. Improvements made as a result of the 2014 survey included a children's activity table in the waiting area.

- Results of the latest patient survey (December 2015) showed high levels of satisfaction with 100% recommendation. The hospital was placed 30 out of 59 BMI hospitals nationally and third place regionally across the BMI group for patient satisfaction scores.
- BMI carried out an annual staff survey. At the time of the inspection the staff survey had been completed however, results were not yet available. Some senior staff told us they felt there were too many meetings and this had been raised with the executive director, who planned to review the frequency and membership of meetings to potentially save staff time.
- Staff gave examples where they had suggested improvements to the service. For example, reception staff wanted to manage the staff rota themselves and this was implemented. Another example was where staff suggested repositioning information behind the reception desk to ensure patients could not inadvertently see confidential information.
- BMI recognised staff in their corporate 'Above and Beyond' nominations. Senior staff had nominated staff in outpatients for this commendation.

Innovation, improvement and sustainability

- The hospital had secured funding for a new mammography machine which was due to be installed shortly after our inspection to upgrade the service provided for patients in the imaging department. There were also plans to refurbish the ultrasound room to improve facilities.
- The outpatient department had made improvements in the last year to its staffing model which enabled all patients to be offered a chaperone. We saw the process was now embedded in everyday practice.
- A programme of replacing carpets with vinyl washable flooring to infection control requirements was underway and this included outpatient consulting rooms.
- A business plan was in place to develop the minor operations room in the outpatient department. Service leads had recognised that this required refurbishment of the area and upskilling of staff.
- The physiotherapy service had introduced pilates and women's health classes to improve patients' recovery after discharge.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve
The provider should ensure:

- The business plan to achieve Joint Advisory Group (JAG) accreditation is progressed.
- There is an end of life strategy, which informs pathway development.
- There is consistent staff compliance with WHO Safer surgery checklist in endoscopy.
- There is a strategy for the children and young peoples' service.
- That service risks hospital-wide are recorded and actions to mitigate are recorded and tracked.
- Recovery staff consistently adhere to the bare below the elbow policy in clinical areas.
- That all Patient Group Directions are in date and authorised by the required members of staff.
- The service meets national referral to treatment time targets for NHS surgical patients.
- Bank staff training compliance should meet the hospital's own target of at least 85%.