

# BMI The Manor Hospital

## Quality Report

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

## Ratings

### Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

BMI The Manor Hospital is operated by BMI Healthcare. The hospital is registered for 23 inpatient beds. Facilities include one operating theatre with laminar flow, a dedicated endoscopy unit, and outpatient and diagnostic facilities.

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

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 24 and 25 April 2018, along with an unannounced visit to the hospital on 8 May 2018.

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

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

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

See the surgery section for main findings.

### Services we rate

We found safety, caring, responsive and well-led was good. Effective required improvement. This led to a rating of **good** overall.

### Summary of main findings:

- There were systems in place to keep patients safe, including the reporting and investigation of incidents. Learning from incidents was cascaded to all staff.
- Staffing levels were sufficient to meet the needs of patients and there was an effective multidisciplinary approach to care and treatment. Staff worked well together to benefit patients.
- Staff were proud of the hospital and were committed to providing the best possible care for their patients. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received.
- The hospital was focused on providing quality care and had a defined strategy, which was aligned to its vision. Staff were committed to providing a positive patient experience.
- The executive director was well respected, visible and supportive. Staff felt valued by their departmental managers and confident to report concerns.
- There were effective governance structures in place to ensure that risk and quality were regularly reviewed and actions were taken to address performance issues, where indicated.
- There was a comprehensive complaints management process with a culture of being open and honest with patients. There was a complaints policy and complaints were taken seriously, investigated and learning was shared with staff.
- When things went wrong, staff apologised and gave patients honest information and suitable support.
- There were effective arrangements in place for the management of medicines.

# Summary of findings

- Patients' views and experiences were gathered and acted on to shape and improve the services and culture.
- Staff ensured that patients' privacy and dignity was maintained at all times. Chaperones were available for patients during procedures as required.

However

- There was a lack of consistency with the consent process, with some patients being consented when they were admitted for treatment. This was not in line with national guidance. We raised this issue with the senior management team, and immediate action was taken to address our concerns.
- Mandatory and training completion rates were below those expected by the organisation.
- Some corporate policies and local standard operating procedures had expired their review date. This meant there was a risk that staff may not be following the latest evidence based guidance.
- Local risk registers lacked details and we were not assured they were regularly reviewed. However, we found the hospital risk register was detailed and included actions taken to minimise the risks identified.
- Not all staff had received an annual appraisal.

We found areas of **good** practice in relation to **surgery**:

- Patients had access to care and treatment in a timely way and cancellations to surgery were minimal.
- Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care.
- Audits were completed in line with the corporate audit programme and actions were taken to improve outcomes where indicated.

And some areas for improvement:

- Some competency frameworks were out of date and the assessment process was not robust in all areas.
- Not all staff were aware of feedback from audits.
- Some departmental managers did not always feel sufficiently supported and one-to-one sessions, which they found beneficial, were often cancelled.

We found areas of **good** practice in relation to **outpatient care**:

- There were robust systems in place to ensure that patients and staff were protected by adherence to national guidelines relating to ionising radiation and diagnostic imaging.
- Patient care and treatment was delivered in line with national guidance.
- There was bespoke written information provided to patients in the physiotherapy department.

And some areas **for improvement**:

- The outpatient risk register did not include all risks identified within the department and staff were referring to an out of date paper version.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

**Heidi Smoult**  
**Deputy Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Surgery

**Good**



### Summary of each main service

Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated this service as good because it was safe, caring and well-led, although it required improvement for being effective.

#### Outpatients and diagnostic imaging

**Good**



Outpatients and diagnostic imaging services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

We rated this service as good because it was safe, caring, responsive and well-led. We did not rate the service for being effective.

# Summary of findings

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Good



# BMI The Manor

**Services we looked at**

Surgery; Outpatients and diagnostic imaging

# Summary of this inspection

## Background to BMI The Manor Hospital

BMI The Manor Hospital was opened in 1983 and, following three ownerships, is now operated by BMI Healthcare. It was originally the manor house of Biddenham, a village near the town of Bedford, and is a grade two listed building. The additional ward, theatre extensions and the administration building were added in 1982. It is a private hospital, which primarily serves the communities of the Bedfordshire area. It also accepts patient referrals from outside this area.

The hospital is registered to provide the following regulated activities:

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

The hospital has a registered manager who has been in post since April 2017.

The registered manager is the accountable officer for controlled drugs.

The hospital is registered for 23 inpatient beds (with 19 currently in use), all with private en-suite facilities, Wi-Fi, television and telephone. The facilities are laid out over two floors. Situated on the ground floor of the main building is one operating theatre with laminar flow, a two-bedded recovery area, a dedicated endoscopy unit, the ward, and imaging department, which includes radiography and ultrasound scanning. Upstairs in the main house is the outpatient department, which includes six consulting rooms, one minor treatment room, pre-assessment, and waiting area. The 'Barns' part of the site houses the physiotherapy department and health screening services. Facilities include a physiotherapy gymnasium, one private treatment room, a two-curtained

cubicle and hand therapy station. Administration staff are housed in a separate building. The hospital is managed by BMI Healthcare and is part of a network of 59 hospitals and clinics across the UK.

The hospital provides surgery, outpatient and diagnostic imaging services for adults only. No persons under the age of 18 are seen and/or treated at the hospital. Prior to March 2018, the hospital did occasionally see young persons of 16 to 17 years of age. These were privately funded appointments.

The hospital offers services to NHS patients, self-pay funded patients and privately insured patients.

BMI The Manor Hospital has been inspected four times by the Care Quality Commission (CQC), between 2011 and 2015. At the last comprehensive inspection in October 2015, we rated the hospital requires improvement overall. We also issued the hospital three requirement notices in relation to regulations that were not being met, and where they needed to make significant improvements in the healthcare provided.

We inspected the services using our comprehensive inspection methodology. We carried out the announced (staff knew we were coming) part of our inspection on 24 and 25 April 2018, along with an unannounced (staff did not know we were coming) on 8 May 2018.

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

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

## Our inspection team

The team that inspected the service comprised of a CQC lead inspection manager, four other CQC inspectors, a

# Summary of this inspection

CQC assistant inspector and four specialist advisors with expertise in surgery, outpatient's and governance. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

## Information about BMI The Manor Hospital

BMI The Manor Hospital provides an inpatient and outpatient service for various specialities to both private and NHS patients. This includes, but is not limited to, orthopaedics, urology, gynaecology, general surgery, endoscopy, ear, nose and throat (ENT), cosmetic and oral maxillofacial. No persons under the age of 18 are seen and/or treated at the hospital.

During the inspection, we visited all departments within the hospital. We spoke with 36 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, radiographers, physiotherapists and senior managers. We spoke with nine patients. We also received nine 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed 15 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected four times, and the most recent inspection took place in October 2015, which found that the hospital was not meeting all standards of quality and safety it was inspected against.

### Activity (February 2017 to January 2018):

- In the reporting period February 2017 to January 2018, there were 622 inpatient and 1,838 day case episodes of care recorded at the hospital; of these 46% were NHS-funded, and 54% were other funded.
- 24% of all NHS-funded patients and 26% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 14,991 outpatient total attendances in the reporting period; of these 20% were NHS-funded and 80% were other funded.

As of November 2017, 96 doctors worked at the hospital under practising privileges. An agency provided four

regular resident medical officers (RMOs) who worked on a weekly rota. The hospital employed 16 full-time equivalent (FTE) registered nurses, 7.4 FTE care assistants and 25.1 FTE other hospital support staff, as well as having its own bank staff.

### Track record on safety (February 2017 to January 2018):

- Zero never events
- 105 clinical incidents; 92 no harm, 12 low harm, one moderate harm, zero severe, zero death
- Three statutory notifications regarding serious injury to a person who uses the service were submitted to CQC
- Zero incidences of hospital acquired Methicillin-resistant staphylococcus aureus (MRSA)
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (C.difficile)
- Zero incidences of hospital acquired E-Coli
- 45 complaints, none of which were referred to the ombudsman or independent healthcare sector complaints adjudication service (ISCAS)

### Services accredited by a national body:

- None

### Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Pathology and histopathology
- Magnetic resonance imaging (MRI) and computerised tomography (CT)
- Blood transfusion

# Summary of this inspection

- Interpreting services
- Laundry
- Maintenance of medical equipment
- RMO provision
- Catering

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We rated safe as good because:

- There were systems for the reporting and investigation of safety incidents that were well understood by staff. Incidents were investigated, actions were taken to minimise recurrence and lessons learned were shared with staff.
  - The hospital was visibly clean and tidy. Staff used personal protective equipment to minimise the risk of cross infection. The hospital reported no surgical site infections from February 2017 and January 2018.
  - There were sufficient numbers of nursing, radiology, medical and support staff to meet patients' needs.
  - There were effective arrangements in place for the management of medicines.
  - Medical records were well maintained and stored securely to maintain patient confidentiality.
  - Equipment in the radiology department was well maintained and had been screened to ensure it was fit for purpose.
  - There were robust systems in place to ensure that patients and staff were protected by adherence to national guidelines relating to ionising radiation and diagnostic imaging.
  - Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care.
- However:
- Mandatory training compliance rates were variable and did not always meet hospital targets.
  - Safeguarding adults and children training compliance rates were variable and did not always meet hospital targets. However, staff understood their responsibilities in relation to safeguarding vulnerable adults and children from suspected or actual abuse.
  - Some equipment in theatres was old and in need of replacement. This had been identified and was listed on the hospital's risk register.

Good



### Are services effective?

We rated effective as requires improvement because:

Requires improvement



# Summary of this inspection

- We found some corporate and local policies had expired their review date. This meant there was a risk that staff may not be following the latest evidence-based guidance. We raised this issue with the senior management team, and immediate action was taken to address our concerns.
- There was a lack of consistency with the consent process, with some patients being consented when they were admitted for treatment. This was not in line with national guidance. We raised this issue with the senior management team, and immediate action was taken to address our concerns.
- Not all staff had received an annual appraisal.
- Some competency frameworks were out of date and the assessment process was not robust in all areas.  
However:
- Audits were completed in line with the corporate audit programme and actions were taken to improve outcomes where indicated. However, not all staff were aware of feedback from audits.
- There was a good multidisciplinary approach to care and treatment. This involved a range of staff working together to meet the needs of patients. Staff communicated effectively and worked well together in order to benefit patients.
- There was a culture of staff development and learning. Staff were supported to access additional training and were competent in their roles.
- There was an awareness of best practice and national guidance, which was implemented well in the physiotherapy and imaging departments.
- There was availability of seven-day services in the imaging department and pharmacy. They both offered an on-call service 24-hours a day, seven days a week.

## Are services caring?

We rated caring as good because:

- We saw that staff were friendly, helpful and polite at all times. We saw that staff introduced themselves by name and fully explained procedures to patients.
- Patients and relatives told us that staff were kind, attentive and caring.
- Staff ensured that privacy and dignity was respected at all times. Chaperones were available and posters were displayed to inform patients of this option.
- Staff encouraged patients to be actively involved in the decision-making process for their care and treatment.

**Good**



# Summary of this inspection

## Are services responsive?

We rated responsive as good because:

- Services were designed around the needs of the local population. Clinics were held at different times of day to facilitate flexible appointment times that were convenient for patients.
- Patients had access to care and treatment in a timely way and cancellations to surgery were minimal.
- Patients were assessed prior to admission to ensure that the hospital could safely meet their needs.
- Written information about conditions and procedures was available and was provided to patients. There was bespoke written information provided to patients in the physiotherapy department.
- Reasonable adjustments were made to improve access to services for all patients. Each reception had a low height desk suitable for wheelchair users and a hearing loop available to assist communication with patients with a hearing impairment. Facilities ensured that services were accessible to wheelchair users.
- There was a comprehensive complaints management process with a culture of being open and honest with patients. There was a complaints policy and complaints were taken seriously, investigated and learning was shared with staff.  
However:
- None of the NHS patients we spoke with in the outpatient department had been offered a choice of appointment time.

Good



## Are services well-led?

We rated well-led as good because:

- Staff worked well together as a team and felt supported and respected by their colleagues. Staff took pride in their work.
- Staff felt valued by their departmental managers and found them approachable and told us they were visible leaders.
- The executive director was well respected, visible and supportive.
- The hospital was focused on providing quality care and had a defined strategy, which was aligned to its vision. Staff were committed to providing a positive patient experience.
- There were effective governance structures in place to ensure that risk and quality were regularly reviewed and actions were taken to address performance issues, where indicated.
- The hospital risk register was detailed and included actions taken to minimise the risks identified. However, the outpatient

Good



# Summary of this inspection

risk register did not include all risks identified within the department and we were not assured that staff always accessed the current risk register, as they referred to an out of date paper version during our inspection.

- Patients views and experiences were gathered and acted on to shape and improve the services and culture.
- Staff cared about the services they provided and were proud to work at the hospital. Staff were committed to providing the best possible care for their patients.

However

- Some departmental managers did not always feel sufficiently supported and one-to-one sessions, which they found beneficial, were often cancelled.






# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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

# Surgery

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

## Are surgery services safe?

Good 

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

In this section, we also cover hospital-wide arrangements such as how they deal with risks that might affect the hospital's ability to provide services (such as staffing problems, power cuts, fire and flood), the management of medicines and incidents, in the relevant sub-headings within the safety section. The information applies to all services unless we mention an exception.

We rated safe as **good**.

### Incidents

- We found the hospital managed patient safety incidents well and lessons learned from incidents were shared across the hospital. This was an improvement from our previous inspection in October 2015, when we found not all incident investigations were completed before being closed, serious incidents were not always categorised correctly, and staff did not always receive regular feedback or lessons learnt from incidents.
- The hospital used an electronic reporting system for reporting incidents. If a member of staff did not feel confident to use the electronic system, their manager would report the incident on their behalf.

- Staff told us they were encouraged to report incidents and received direct feedback when they had been involved in an incident. Most staff also told us they received feedback about incidents that had occurred within the hospital and other hospitals within the BMI Healthcare group. Information was cascaded in a variety of means including the daily communications cell, which was a meeting held every morning to review hospital activity and raise any concerns, staffing brief, emails, governance and team meetings, newsletters and noticeboards. We observed this during our inspection.
- Staff told us that following any incidents, they were debriefed, time would be taken to discuss them and there was a no blame culture. Staff told us that incidents were discussed at team meetings and minutes of meetings we reviewed corroborated this.
- There was an up to date incident reporting policy in place.
- Senior staff told us they had undertaken root cause analysis (RCA) training to investigate incidents. This was confirmed from the incidents we reviewed. This was an improvement from our previous inspection in October 2015, when we found staff had not undertaken RCA training.
- From October 2016 to September 2017, the hospital reported 105 clinical and 34 non-clinical incidents. Of the 105 clinical incidents, 104 (99%) were graded as having caused no or low harm (88% and 11% respectively). The remaining one incident was graded as having caused moderate harm. We saw evidence that incidents were investigated and actions were taken to minimise the risk of recurrence where indicated.

# Surgery

- During the same reporting period, the hospital notified the CQC of two serious incidents. One occurred in February 2017, and concerned a patient who sustained a fractured femur whilst undergoing surgery for a total hip replacement. The second occurred in March 2017, and concerned a missing knee component required for surgery, which resulted in a patient requiring extended anaesthesia whilst the correct sized knee component was sourced. We reviewed the investigation reports for these two incidents and found comprehensive investigations were undertaken, including the identification of lessons learned and action plans to minimise recurrence.
- There had been no never events reported during the period from October 2016 to September 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. However, the hospital reported one never event in February 2018, which was classified as 'retained foreign object post-surgical/invasive procedure', where the sheath from a balloon dilatation device had been retained following a procedure that was carried out at the hospital in November 2017. The foreign object was found to have caused no harm to the patient. We were unable to review the investigation report, as it was being completed at the time of our inspection (April 2018). However, the hospital had taken some immediate action to minimise the risk of recurrence. The 'sheath' had been added to the final count to ensure all items used during invasive procedures were accounted for.
- We saw evidence that the duty of candour regulations were followed in the incident reports we reviewed. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were aware of their roles and responsibilities with regards to duty of candour.
- The service gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes. There had been no incidents of methicillin-resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA), Escherichia coli (E-coli) or clostridium difficile (C.difficile) in the reporting period from February 2017 to January 2018.
- Patients were risk assessed for venous thromboembolism (VTE). The VTE screening rate from October 2016 to September 2017 was consistently 100% compliant.

## Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare associated infection.
- The service had policies in place to manage infection prevention and control. Staff could demonstrate how to access policies easily.
- The ward area was visibly clean and tidy. Most equipment had "I am clean" stickers on them. However, we saw a bed in one side room had dust on the bedframe and the date on the sticker was faded and unreadable. The floors had washable surfaces and most of the patient furniture was washable. The service planned to change all furniture, for example armchairs to washable materials.
- Housekeepers followed a weekly cleaning schedule. Bank and agency housekeeping staff provided cover for sickness and annual leave. The ward manager checked and signed off the weekly cleaning schedule. Staff escalated any concerns or issues to them.
- The main theatre areas were visibly clean and tidy. There was a cleaning schedule in place, however some days had been missed and it was not indicated whether these were the days that the hospital was closed. Managers told us that the hospital had not been closed on the days that checks were missed. They told us that they had been assured by the theatre team that the checks had been completed but the checklist was not signed due to human error. However, we could not be assured that all of the checks had been made. We saw rotas that demonstrated that there had been no further omissions on the checklist in the following months.

**Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)**

# Surgery

- Staff received annual training on infection prevention and control (IPC) as part of their mandatory training. Nursing, theatre and ward staff were required to complete two IPC training modules, IPC high impact interventions and IPC in healthcare. As of December 2017, data showed that IPC training completion rates were variable and generally did not meet the hospital target of 90%. We found 50% of nursing, 71% of theatre and 92% of ward staff had completed IPC high impact interventions training. Whilst 67% of nursing, 60% of theatre and 58% of ward staff had completed IPC in healthcare training. Ward staff were also required to complete IPC awareness part two training. As of December 2017, ward staff completion rates for this module were 100%. It should be noted that the training data provided by the hospital was split into 23 staff groups and the total full time equivalent (FTE) staff headcount as of November 2017 was 48.5, which included 16 FTE registered nurses, 7.4 FTE operating department practitioners and/or healthcare assistants, as well as 25.1 FTE other hospital staff. This meant staffing numbers per staff group were low, which reflects the compliance percentages and would explain the large variances in training compliance rates.
- The hospital did not have an infection prevention and control lead nurse nor link nurses in clinical areas as the previous post holder had left. However, a new member of staff was due to commence employment and would be taking on these duties. Link nurse responsibilities included collating audit data of cleaning schedules and producing actions to address compliance when necessary. For example, they were involved in hand hygiene audits.
- Handwashing facilities and hand gel were widely available and easily accessible. All hand wash dispensers that we checked were full and in working order.
- We observed staff compliance with key provider policies for example, being “bare below the elbows”, compliance with hand hygiene and the use of personal protective equipment (PPE), for example the use of gloves and aprons. PPE was available and hand wash gel was easily accessible in the clinical areas, individual patient rooms and the corridors. In the operating theatres new differently coloured theatre scrubs had recently been purchased to ensure staff who had undertaken some procedures, for example endoscopy, were clearly visible and would be required to change their theatre scrubs if they were required to assist with a different procedure.
- We saw that there were policies for the management of MRSA. Patients were screened for MRSA and MSSA at their pre-assessment appointment prior to admission. There were no incidents of MRSA, MSSA, E-coli or Clostridium.difficile in the reporting period from February 2017 to January 2018.
- No surgical site infections had been reported during the reporting period from February 2017 to January 2018. Patients and relatives told us that they had observed staff washing their hands or using hand gel. However, whilst staff wore gloves, on a few occasions hands were not always washed when gloves were removed. This occurred mostly in theatre. Monthly handwashing audits were carried out. Data supplied from December 2017 to January 2018 indicated that in theatres a member of medical staff did not comply with the hand hygiene policy whilst there was 100% compliance reported on the ward.
- Surgical site infections were monitored and reported to the clinical governance committee. There were no surgical site infections reported between February 2017 and January 2018. Monthly audits were undertaken with 20 patients per month surveyed, however the response rate was variable and staff did not always receive feedback from the audits.
- Sharps boxes were sealed and dated and had temporary closures in place.
- The service had processes for the disposal of waste and removal of dirty instruments. These were stored in a “dirty corridor” with access to the outside of the building. A transport trolley was used for dirty instruments awaiting collection for decontamination. During our last inspection in October 2015, decontamination of reusable medical devices, for example endoscopes, was not in line with national guidance. However, the service had revised the process of decontamination and all endoscopes and other dirty instruments were now sent off site for decontamination.

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Clean and dirty equipment were stored in separate areas therefore reducing the risk of cross infection. All equipment used for changing dressings on the ward was disposable so there was no need for it to be re-sterilised.

- The hospital had a service level agreement (SLA) for microbiology support and infection control advice with a third party. We saw evidence that the microbiologist attended alternate infection control meetings, and they were available to offer telephone advice as needed.
- The director of clinical services was the director of infection prevention and control (DIPC). The hospital had recently appointed a nurse to work in theatre who would take on the role as the hospital's infection control nurse; they would be allocated one day per week dedicated to infection control. Specific training was to be arranged once they had commenced in the role.
- The hospital's Patient-Led Assessment of the Care Environment (PLACE) audit for 2017 showed they scored 100% for cleanliness. This was better than the England average of 98%.

## Environment and equipment

- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- The ward and theatre areas appeared visibly clean but not all areas and equipment were well maintained. For example, we observed a trip hazard in the theatre area with trailing wires identified; this was stuck down with specialist floor tape. Managers told us that a formal assessment of the trip hazard was planned for the end of May 2018. Managers planned to discuss the additional placement of plug sockets in theatres to reduce the length of trailing wires when they received the assessment report. Control measures of trip tape were to remain in place until the risk was negated. Managers identified on their risk register that there was insufficient investment in facilities and critical equipment resulting in regulatory, reputation or operational issues.
- Resuscitation equipment was checked daily on the ward and documented as complete and ready for use. The checklist clearly indicated if the hospital had been closed and checks were therefore not made. In theatres, there was a weekly resuscitation equipment checklist.

The resuscitation trolley had tamper-proof tags in place. We requested records of the resuscitation trolley checklists following our inspection, which confirmed that theatre resuscitation trolley checks occurred weekly. We saw that the service audited compliance with resuscitation each month. From January to October 2017, we saw full compliance with weekly resuscitation trolley checks.

- We saw that anaesthetic machines were checked daily and the tubing checked weekly.
- We saw that theatre ventilation complied with national guidance HTM 03-01. This meant that there were sufficient air changes to reduce the risk of infection.
- Some theatre equipment had been identified on the risk register as being in need of replacement due to its age. For example, a camera stack, a piece of equipment used for surgical procedures was old and needed frequent repairs. Replacement parts had been purchased but a new piece of equipment was required as intermittent faults were reported. There was no piped suction in the operating theatre. Managers told us that this was because of the age of the building, which affected the ability to install piped suction. Portable suction equipment was used; however, the filters needed changing regularly when in use. This meant that there was a potential risk to patients if for example, a patient had a serious bleed during surgery. The service had trialled new suction equipment and planned to replace the current suction equipment but there was no date for this. A business case had been submitted for a replacement camera stack. These concerns were recorded on the risk register.
- Some equipment was stored in unused side-rooms and in the corridors. Some of these rooms were cluttered with equipment, however, there was limited storage space on the ward. Equipment was usually stored elsewhere but had been moved to accommodate the inspection.
- Three rooms on the ward had piped oxygen. Oxygen cylinders were available for patients in rooms without piped oxygen. Staff told us these were ordered externally and the supply was well maintained.
- Systems were in place for details of specific implants and equipment to be recorded and reported. There was

# Surgery

a national system of recording. We saw that all equipment, implants and prosthesis were tracked and traced. All records that we looked at had clear evidence of this with batch numbers recorded.

- No bariatric patients were seen by the service. However, a hoist and monkey poles were available to assist patients when needed.
- The hospital's Patient-Led Assessment of the Care Environment (PLACE) audit for 2017 showed they scored better than the England average for how the environment supports the delivery of care with regards to the patient's privacy, dignity and wellbeing. The hospital scored 90.5%, whilst the England average was 84%.

## Medicines

- There were effective arrangements in place for the management of medicines.
- The pharmacy department was open Monday to Friday, from 9am to 3pm. The pharmacy manager was on-site one day per month, a clinical pharmacist was on-site three days per week, and a senior pharmacy technician was on-site Monday to Friday. Out of these hours, a clinical pharmacist was on-call 24-hours a day, seven days a week to advise and support staff as needed.
- The hospital used a virtual pharmacy model, which was a technician-led service. A pharmacist on a weekly basis reviewed the medication needs of all planned patient admissions and medicines were ordered as needed. Stock of commonly used medicines such as antibiotics, analgesia and anticoagulants (medicines used to prevent the formation of blood clots) were also available. The majority of medicines were stored in the various departments such as outpatients, the ward and theatre. The pharmacy staff checked and maintained agreed stock levels in the departments and ensured there was appropriate stock rotation. The pharmacy department had one dedicated medicine cupboard situated in outpatients, which was only accessible to pharmacy staff. During our inspection, we observed this cupboard was locked and the key was securely stored in a locked safe.
- Medicines used within the surgery service were stored safely in a locked treatment room. However, we saw that intravenous (IV) antibiotics were stored next to intravenous fluids. The intravenous antibiotic was used infrequently and presented a potential risk of administering the wrong medication to patients as the fluid bags looked similar. This was raised with the ward manager at the time of inspection who discussed this concern with the pharmacist. The IV antibiotic was removed from the ward treatment room by the pharmacy technician the same day and placed in the locked IV cupboard. However, there had been no incidents reported where a patient had been given IV antibiotics or intravenous fluids in error.
- We observed a broken lock on a medicine cabinet in the treatment room. Staff had removed all medicines from this cupboard and stored them in another locked cupboard. Staff had reported this for repair but had not received a date for when it would be repaired.
- We did not observe the administration of medicines during the inspection but medicine charts were seen to be correctly completed. We saw that patient's weight and height were recorded and allergies identified. This meant that drugs could be prescribed appropriately for individual patients.
- The service had medicine policies in place, which were in date. We saw that staff followed the policy, for example, staff did not use a patient's own medication, as it had not been brought in its original box. This was in line with the hospital's safe management of medicines policy.
- We observed controlled drugs were stored, checked and reconciled accurately.
- Staff left boxes of emergency drugs out in the anaesthetic room for easy access in the event of an emergency. This had not been risk assessed. The theatre manager told us that drugs were not left pre-prepared in syringes. This reduced the risk of patients receiving incorrect medication. Staff locked all drug cupboards when the room was not in use.
- Treatment room and fridge temperatures were checked and recorded daily to ensure that medicines were kept at the correct temperature. Staff understood the procedures to follow if temperatures were not correct.
- Nursing staff were aware of and able to access guidance, for example the hospital's medicines policy and current British National Formularies.

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- Pre-packed take home medicines required for inpatients were prepared in advance, where possible. A small stock of regularly used take home medicines was also available from the ward and outpatient department.
- The pharmacist reviewed all medication prescriptions, to identify and minimise the incidence of prescribing errors. This included venous thromboembolism (VTE) assessments to ensure patients were prescribed the correct dose and/or duration of anticoagulant medication. If a pharmacy intervention was needed following the identification of a prescribing error, such as a medicine interaction, wrong dose, wrong frequency or inappropriate medication, the pharmacist would correct the prescription and discuss the error with the registered medical officer (RMO) or consultant who had prescribed the medication. These pharmacy interventions were also reported on the electronic reporting system, which meant any trends could be identified and acted upon.
- From Monday to Friday, the pharmacy team visited the ward daily to counsel inpatients on their prescribed medicines. Patients who were prescribed take home medicines were counselled the day before their expected discharge to minimise any delays. Staff told us there was no limit to how much time they spent with patients.
- We observed a strong reporting culture within the pharmacy department and saw that incidents, including near misses, were routinely reported. Pharmacy staff described examples of incidents they had reported and actions taken to minimise the risk to patients. Medicine incidents were reported via the hospital's electronic reporting system. From November 2017 to January 2018, the hospital reported seven medication incidents, which were graded as having caused 'no harm'. We saw evidence that action was taken as a result of incidents reported and learning was cascaded to staff.
- Staff told us that medicine incidents were reported to staff through ward meeting minutes. Managers spoke to staff regarding medicine errors. Managers formulated action plans and staff were reassessed as part of their learning.
- BMI Healthcare also held monthly pharmacy teleconference meetings, where medicine incidents reported across the BMI group were discussed and learning was shared. The teleconference meetings were repeated three times during the month to enable pharmacy staff to attend when they were available.
- Medicines management was a standard agenda item on the quarterly hospital governance meetings. We saw evidence of this from the meeting minutes we reviewed, which included information regarding medication incidents, national guidance updates, and drug safety alerts.
- In January 2018, an audit of medicines history and reconciliation showed 100% of patients had their medicines history completed on admission and their medicines reconciled within 24-hours of admission. This was in line with corporate guidelines.
- Blank NHS and private prescription pads were stored securely and robust monitoring systems were in place to ensure all prescriptions were accounted for. The prescriptions audit record detailed all prescriptions issued and included the name of the consultant who issued the prescription, the date it was issued, the patient name and/or identification number and the prescription number. This was in line with national guidance (Department of Health Security of prescription form guidance, August 2013).
- The pharmacy manager submitted a quarterly controlled drugs occurrence report to the local intelligence network (LIN). This was in accordance with national requirements (Department of Health, The Controlled Drugs (Supervision of management and use) Regulations 2013, February 2013).
- There were local microbiology protocols for the administration of antibiotics and prescribers used them. The hospital had adopted the local NHS trust's guidelines regarding the use of antibiotics and reported strong links with the local NHS pharmacy team.
- The pharmacy manager was the hospital's antibiotic steward. An antibiotic steward seeks to achieve the optimal clinical outcome related to antibiotic use, to minimise toxicity and other adverse events and limit the selection for antimicrobial restraint strains. This reduces the risk of antibiotics becoming less effective.
- An antibiotic stewardship audit carried out in December 2017 showed compliance was generally 100%. The two

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(out of 10) measures that did not score 100% compliance concerned whether there was a documented indication for antibiotic treatment (62.5%) and whether a valid reason for the start date of antibiotics was documented (87.5%). We saw the findings from this audit were discussed at relevant meetings and actions were taken to improve compliance.

## Records

- Patients' individual care records were accurate, complete, legible, up to date, and stored securely. There was a corporate retention of records policy, which stated that information has most value when it is accurate, up-to-date, and accessible when required.
- The service used a paper records system. We looked at nine sets of patient's records and saw that they were completed and written clearly.
- Medical and nursing records were integrated and contained information about the patient's journey including pre-operative assessments, investigations, results and treatment provided. There were separate pathways for each speciality or procedure. However not all of the paperwork was secured within the record, this meant that there was a risk of loose pages being lost and patient confidentiality being breached.
- During our previous inspection in October 2015, records had not been stored securely. At this inspection, we found improvements had been made and records were stored confidentially in a locked filing cabinet at the nursing station.
- Nursing staff undertook face-to-face pre-operative assessments of patients before their admission for surgery. Telephone assessments took place for patients being admitted for investigations for example endoscopies. The pre-operative assessment paperwork was fully completed and formed part of the paper record. We saw evidence of for example height, weight, body mass index (BMI) and allergy recordings.
- We observed that records contained stickers identifying equipment and implants used during surgery. This meant that they could clearly be tracked and traced.

- Staff sent discharge summary letters to GP's within 24 hours of discharge with full details of the patient's treatment and any medication changes to ensure continuity of care.
- GP's were able to contact the consultant or the registered medical officer (RMO) by telephone for advice or further information.

## Safeguarding

- There were processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements.
- Safeguarding adults and children policies were in-date and were accessible to staff via the hospital's intranet. They included clear guidance on how to manage suspected abuse and radicalisation, and details of who to contact for further support and guidance.
- Safeguarding training was provided via e-learning courses, with additional workshops held for female genital mutilation (FGM) training. Training covered all aspects of safeguarding adults and children, including professional responsibilities, the Mental Capacity Act, categories of abuse, safeguarding processes, child protection, and the Prevent strategy. Staff we spoke with knew how to access and complete safeguarding training.
- We were told clinical staff were required to complete safeguarding adults and children training at level three, which exceeded national requirements as persons under the age of 18 were no longer seen and/or treated at the hospital. Non-clinical staff were required to complete safeguarding training at level two.
- The director of clinical services was the dedicated safeguarding lead and had up to date level three safeguarding adults and children training.
- As of December 2017, the surgery service showed that safeguarding adults level two training completion rates were 92% for ward staff, and 100% for nursing and general nursing staff. However, the completion rate for theatre staff was 73%, which was below the hospital target of 90%. Safeguarding children level two training completion rates were 100% for nursing and ward staff.

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However, the completion rate for theatre staff was 73%, which was again below the hospital target of 90%. We were not provided with the completion rate for general nursing staff.

- For the same period, the hospital's overall safeguarding training completion rate was 86% for adult's level two and 97% for adults level one, and 80% for children level two and 94% for children level one. These figures covered all 23 staff groups within the hospital, such as engineering, porters, hotel services, pharmacy, health screening and reception. This meant we were not assured that all staff had completed level two safeguarding adults and children training.
- Staff we spoke with had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children and were able to explain how to respond to and escalate a concern or make a referral.
- There had been no safeguarding concerns reported to CQC in the reporting period from February 2017 to January 2018. However, the service identified one concern about a patient's mental capacity. Staff described the actions taken to reduce the risk to the patient in accordance with corporate policy.
- The hospital had a chaperoning policy and staff knew how to access it.
- The ward had a folder containing safeguarding information. Staff had displayed safeguarding information posters on office walls, which contained information on how to contact the local safeguarding authority.
- In 2017, an audit showed the hospital was 90% compliant with safeguarding practices. We saw evidence that actions were identified to improve compliance where indicated.

## Mandatory training

- The hospital had a mandatory training programme, which included topics such as infection prevention and control, moving and handling, fire safety, conflict resolution, safety, health and the environment, and information governance. The mandatory training programme was tailored to staff's individual needs and

relevance to their role. For example, clinical staff were required to complete adult immediate life support and medicine management training, and non-clinical staff completed basic adult life support training.

- Training was primarily provided via e-learning courses, with some face-to-face sessions. Staff could access e-learning courses at work or home, and were compensated for training they completed in excess of their contracted hours. Staff could view their individual training needs, current compliance and access e-learning courses through the hospital's electronic training system. The system also alerted staff when mandatory training was due to be completed.
- As of December 2017, data provided by the hospital showed that mandatory training completion rates for ward, nursing, general nursing and theatre staff were variable. Completion rates ranged from 0% for some topics such as medicines management and information governance, to 100% for topics such as conflict resolution, moving and handling, and safety, health and the environment. The overall mandatory training completion rates were 66% for theatre staff, 75% for nursing and general nursing staff, and 87% for ward staff. Therefore, we could not be assured that all staff were up to date with mandatory training. It should be noted that the training data provided by the hospital was split into 23 staff groups and the total full time equivalent (FTE) staff headcount as of November 2017 was 48.5, which included 16 FTE registered nurses, 7.4 FTE operating department practitioners and/or healthcare assistants, as well as 25.1 FTE other hospital staff. This meant staffing numbers per staff group were low, which does reflect the compliance percentages and would explain the large variances in training compliance rates.
- Clinical staff were expected to undertake immediate life support (ILS) training. As of xx, data provided by the hospital showed that 50% of theatre staff, 67% of nursing staff, and 100% of general nursing and ward staff were compliant with up to date ILS training. Basic life support training had been completed by the majority of staff (approximately 93%). The RMO's had up to date advanced life support training.
- The BMI Healthcare group had introduced care and communication of the deteriorating patient training for clinical staff, which included the recognition, diagnosis and early management of sepsis. As of December 2017,

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data provided by the hospital showed that only 42% of ward staff had completed this training. We were told that the reason for the low completion rates was because this training had recently been introduced. We observed that dates for this training course had been scheduled and staff were booked to attend.

- Clinical staff were required to undertake blood transfusion training, which was provided by the local NHS trust. However, we found compliance was variable and ranged from 44% for theatre staff, to 75% for nursing staff, 90% for ward staff and 100% for consulting room and outpatients staff.
- At the time of our inspection (April 2018), overall mandatory training compliance for the hospital was 87%. This was slightly below the hospital's completion rate target of 90%. We saw that action was taken to address non-compliance with mandatory training, which included letters sent to all non-compliant staff with a deadline for completion. Staff did not receive an annual pay review if they had not completed mandatory training.
- The senior management team and heads of department had oversight of training compliance. The director of clinical services received a weekly training compliance report, which was shared with the heads of department. Mandatory training compliance was also discussed at various meetings, including hospital governance and departmental meetings, and the daily communications cell meeting.
- There was an induction programme for new staff. Staff who had attended this told us that it met their needs.
- Agency staff had a brief induction, which covered the layout of the department, emergency procedures, paperwork and where to access essential information.

## Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Comprehensive risk assessments were carried out for specific patient groups and risk management plans were developed in line with national guidance.
- Senior staff were on-call out of hours if staff needed support. The service had an admission policy, which

was up to date. There was a strict admission criterion and bariatric patients or patients with complex co-morbidity were not accepted, as the service did not have facilities for complex care.

- All patients having a general anaesthetic were assessed in a nurse led pre-assessment clinic prior to their surgery. Patients for endoscopy or local anaesthetic had a telephone pre-assessment carried out.
- Patients were swabbed as per hospital policy to assess if they had any colonisation of MRSA at the pre-assessment clinic. When results were found to be positive the admission date, if necessary, was deferred and the patient provided with a treatment protocol to use at home, according to the hospital's MRSA policy.
- Risk assessments were completed using nationally recognised tools, such as the Waterlow score to assess patients risk related to pressure ulcers. Other risks assessed were those of mobility, moving and handling, venous thromboembolism (VTE) and the national early warning score (NEWS). The NEWS is a scoring system applied to a patient's physiological measurements to indicate early signs of deterioration in their condition. We saw that these were documented in the patient's records and included actions to mitigate any risks identified. NEWS audits had been undertaken in the previous three months.
- The service had a local protocol for the use of antibiotics, which was under review at the time of our inspection (April 2018). We saw evidence of a "sepsis six" pathway on the ward. The "sepsis six" is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- The theatre team used the five steps to safer surgery checklist, which was designed to prevent avoidable mistakes; this was an established process within the teams. We saw that this was generally audited monthly and good compliance was demonstrated. No audits were done in May and June 2017, but were completed for all other months. We saw that compliance with completion of the safer surgery checklist was 100%.
- We observed good nursing leadership in theatre to ensure that safety huddles and the five steps to safer

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surgery were undertaken. During our inspection, we saw that safer surgery checklists were completed.

Consultants were encouraged to stay and participate in the safety huddle meeting post-operatively.

- We saw that staff had assessed patients and there were clear care plans in the patient records. We saw that swab and needle counts were recorded on a white board in theatre, this meant that it was clear to both the surgeon and the scrub nurse that instruments or swabs that could be retained were clearly tracked to ensure patient safety during an operation. This was an improvement from the previous inspection in October 2015 when swab and needle counts were not clearly recorded.
- Nursing staff were able to describe how they would raise concerns about a deteriorating patient. Medical staff and a resident medical officer (RMO) supported them if a patient's health deteriorated. The RMO was a registrar level doctor who was on site and on duty 24 hours a day to provide medical attention and attend any emergencies. Staff could contact consultants 24 hours a day for advice or to raise concerns about patient care. Anaesthetists worked in a consortium and were always available for contact about any patient.
- The service had an on-call theatre team in case a patient had to be returned to theatre. On-call radiology arrangements were also in place.
- The hospital had a transfer agreement in place with the local acute NHS trust should a patient require a higher level of care. However, if the patient required a nurse escort this could not be supplied at night, as there were routinely two nurses only on the night shift. There was an on-call system, but this may have defaulted to a non-clinical manager, who would be unable to assist. Staff told us that they would contact the consultant who would call 999 for an ambulance and a paramedic crew would be requested to ensure an appropriately trained clinician accompanied the patient. From October 2016 to September 2017, the hospital reported one unplanned transfer to the local acute NHS trust.
- There was access to the minimum requirement of two units of O Rhesus negative emergency blood. This blood type can be given safely to most patients. The blood fridge temperature and stock was checked and recorded daily.
- At our previous inspection in October 2015, we identified that unplanned late theatre list finishes occurred and staff were not aware of any policy regarding this. At this inspection, we saw a policy regarding late finishes was in place. Senior managers and consultants told us that late theatre finishes occurred rarely and patients were not operated on after 7.30pm with patients leaving the recovery area by 8.30pm. We saw the theatre log, which identified that between 22 January 2018 and 13 March 2018 there were five late theatre finishes with three patients leaving recovery at 9pm. The anaesthetist remained in the department until the last patient had returned to the ward. In addition, other services were available on an on-call basis, such as pharmacy and x-ray.
- The service had access to psychologists if necessary for those patients undergoing cosmetic surgery who needed referral for a psychological assessment.
- Each patient room and bathroom had emergency call bells, which were used to alert staff when urgent assistance was required. These were routinely tested to ensure they were fit for purpose. We saw documentation from January to March 2018, which identified that checks had occurred weekly.
- The practising privileges arrangement required the named consultant to be contactable at all times when they had in patients within the hospital. Furthermore, they needed to be available to attend the hospital within an acceptable timeframe, when needed. It was also a requirement for consultants to arrange appropriate, alternative named cover if they were unavailable at any time when they had inpatients within the hospital.

## Nursing and support staffing

- At the time of our inspection in October 2015, there was no baseline staffing tool used on the ward to monitor staffing levels. During this inspection, we saw the hospital had introduced a nursing dependency and skill mix planning tool to support the management of a safe staffing level and skill mix. An electronic roster tool was used across all departments in line with the BMI rostering policy.
- Staffing levels were planned in advance and were reviewed by managers on a daily basis. Managers used an evidence based acuity tool to enable patient acuity

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and dependency to be assessed and ensure that nursing establishments reflected patient needs. This tool was used to plan skill mix five days in advance, with continuous review on a daily basis. The actual hours worked were also entered retrospectively to understand variances from the planned hours and the reasons for these.

- Two registered nurses were always on duty on the ward, one of whom was a substantive member of staff, plus a health care assistant (HCA). This ensured there was an appropriate skill mix. We saw nursing rotas from January to April 2018, which corroborated this. This was an improvement from the last inspection when there was only one member of trained staff on duty on the ward. A minimum of four staff were on duty in theatres, plus an on-call team each day. We reviewed theatre nursing rotas over 10 days, which were compliant with safe staffing levels. Senior nursing staff told us that they would work in the clinical areas if there were insufficient staff on duty. Managers did not leave shifts uncovered.
- The service used the theatre utilisation tool (TUT) in the theatre department. The tool was designed to automate analysis of a number of key theatre department process measures. The TUT increases the efficiency of the department by refining staff allocation to patient numbers and procedure mix and therefore reducing staffing costs, creating capacity for additional caseload, improving patient safety and ultimately increasing satisfaction for patients, consultants and staff.
- Patient admissions were known in advance and staffing levels calculated using an electronic labour monitoring tool, this ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs.
- Managers told us that there were ongoing difficulties with recruitment. They used bank and agency nurses but these were generally regular and familiar with the hospital. Both the ward and theatres used about 20% agency staff. This was recorded on the hospital risk register. Staff were recruited from specific agencies with which the hospital had a preferred provider arrangement. This ensured staff provided met key requirements such as having completed manual handling training and competencies to administer

medicines safely. Agency staff, when used, were provided with an orientation when new to the hospital, which included access to and the location of emergency equipment and fire exits

- We observed effective handovers between nursing staff at the change of day and night shifts. Staff attended a safety huddle in theatres in the morning to ensure all patient needs and risks were identified. Heads of department attended a daily communications cell meeting. We saw that there was clear analysis of hospital activity; this included staffing, current risks, sickness levels, patient cancellations and the identification of staff cover for resuscitation as necessary.

## Medical staffing

- Patient care was consultant led. The hospital practising privilege agreement required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical need, or at request of the executive director, director of clinical services, or registered medical officer (RMO).
- Registered medical officers (RMOs) were employed through an external agency and provided immediate medical support 24 hours a day, seven days a week. They slept on site and worked a shift pattern of one week on and three weeks off. A handover took place between RMO's at the start/end of each week. Handover included a structured discussion of each patient and details of any work to be done and/or followed-up. Routine work was completed before 10pm and the RMO was only contacted overnight to attend emergencies.
- The hospital reported they had generally used the same four RMO's since 2016; additional RMO's were used to cover annual leave, when needed. RMO's received a hospital induction before they commenced any duties. The RMO could contact the patient's named consultant and/or anaesthetist if further advice or support was needed. They could also access clinical and non-clinical advice and support 24 hours a day, seven days a week through their agency. A standby RMO was also available if required.
- The RMO told us they had sufficient time to handover to the new RMO coming on duty, to nursing staff and to the consultant.

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- Nursing staff and the RMO had found the consultants to be supportive and responsive when they were contacted for advice. Nursing staff told us that it was easy to contact consultants.
- The hospital maintained a medical advisory committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice. It is a requirement of BMI Healthcare's practising privileges policy, that consultants remain available both by phone and, if required, in person, or arrange appropriate alternative named cover if they were unavailable. This was to ensure that a consultant was available to provide advice or review patients at all times when there were inpatients in the hospital. The staff confirmed that this happened.

## Emergency awareness and training

- The hospital had an up to date major incident policy and business continuity plans were in place. These included the loss of mains electricity and generator power, fire alarm activation or system failure, and loss of staffing. We saw business continuity action cards for each major incident (25 in total), which detailed the actions staff should take, and useful contacts and telephone numbers. The action cards were kept in the main reception.
- We saw evidence of effective emergency 'scenarios' to support training, which demonstrated how staff were able to respond to emergency situations. These included emergencies such as fire and cardiac arrest. Staff were provided with feedback and any lessons learnt were shared.
- The hospital's resuscitation team was reviewed at the daily communications cell meeting. We observed that each member of the team was allocated a specific role such as leader, airway management, defibrillation, recorder and floater. This was in line with best practice guidance. Each member of the team carried a bleep, so they could be contacted immediately in the event of an emergency. Following the meeting, the daily resuscitation team list was distributed to each department.
- We saw evidence of weekly checking of fire equipment. There were six monthly scenarios and practice. These were documented and learning was identified in the

reports. Staff were able to tell us about drills and the feedback they received. The fire brigade carried out an independent fire safety risk assessment of the hospital in July 2017. The report made 14 recommendations. As of February 2018, nine of the recommendations had been completed. Actions required to meet the remaining five recommendations had also been completed but had not yet been signed off. We saw evidence that weekly fire alarm checks were carried out.

- We found staff compliance with fire safety training was variable. Hospital data provided for mandatory training was split into 23 staff groups. As of December 2017, compliance ranged from 33% for administration staff to 100% for 11 staff groups, which included engineering, nursing, health screening, hotel services, pharmacy and patient services. Overall compliance was approximately 80% for clinical staff and 83% for non-clinical staff. This was below the hospital target of 90%.

## Are surgery services effective?

Requires improvement 

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

In this section, we also cover hospital-wide arrangements such as the use of current-evidence based guidance and how they ensure staff are competent to carry out their duties, in the relevant sub-headings within the effective section. The information applies to all services unless we mention an exception.

We rated effective as **requires improvement**.

## Evidence-based care and treatment

- The hospital used evidence-based guidance and quality standards to inform the delivery of care and treatment. Staff could access national and local guidelines through the hospital's intranet.
- Not all policies were up to date, which we also reported following our last inspection of the hospital (October 2015). We found 38 national (corporate) policies and 11 local standard operating procedures (out of 202) had

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expired review dates, some of which dated back to 2015. The expired policies included consent, duty of candour, passing a naso-gastric tube and an observation policy. We raised this with the senior management team, who took immediate action to address our concerns. When we returned to the hospital for our unannounced visit, we saw action had been taken both corporately and locally. We were told a newly appointed corporate quality and risk lead was planning to rollout two updated guidelines a week. This was confirmed during our unannounced visit when we saw that recently updated versions of the consent and duty of candour policies were available. The hospital had updated or archived six local standard operating policies and the remaining five were being reviewed.

- Staff were informed of updated policies via email, the weekly corporate newsletter and staff noticeboards. Each department also had a policy co-ordinator, who was responsible for ensuring staff read updated guidance. We observed policy checklists in various departments, which had been signed by staff when they had read a new or updated policy.
- Hospital policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.
- The hospital had an audit programme, and collated evidence to monitor and improve care and treatment. We were provided with the local audit programme for the hospital, which was set corporately by the BMI Healthcare group. The hospital was able to benchmark the results from the audits with other hospitals within the BMI Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the WHO safer surgery checklist, and medicines management. We saw evidence that actions were taken to improve compliance where indicated.
- The audits were based on national guidance, standards and legislation, including the National Institute for Health and Care Excellence (NICE), the Royal College of Surgeons (RCS), and the Health and Safety Executive (HSE).
- The service participated in national audit programmes for example: Patient Reported Outcome Measures (PROMS), National Joint Registry (NJR) and the surgical

site infection surveillance programme conducted by Public Health England. BMI Healthcare participated in the Private Healthcare Information Network (PHIN). This enabled effective comparison with data available from NHS providers to assist with information transparency and patient choice. However, we found staff awareness of feedback from these audits was variable.

- Staff within surgery undertook local audits for example surgical site infection, the WHO safer surgery checklist, national early warning score (NEWS), venous thromboembolism (VTE), consent and record keeping. However, not all staff were aware of feedback and actions taken as a result of audits.
- Patients undergoing cosmetic surgery such as breast implant surgery were given information about the breast registry at their outpatient's appointment and this was followed up at their pre-assessment consultation. The theatre administrator and all the registered breast implant surgeons had access to the breast registry. The prosthesis used was recorded in the patient's notes, theatre register and on the breast registry documents. Completed copies of the breast registry information including consent were kept in the patient's notes and in a folder in the theatre department. The service could access psychological support for patients undergoing cosmetic surgery if necessary. No patients were having breast implant surgery at the time of our inspection.

## Pain relief

- The surgical care pathway used prompted staff to assess, record and manage pain effectively. Patient's records showed that pain had been assessed using the pain scale within the NEWS charts, appropriate medicines given as prescribed and effect of analgesia individually evaluated. Staff assessed patient's pain pre and post operatively; however, we saw that two patients had not had their pain scores recorded preoperatively.
- Ward staff used a pain scoring tool to assess patient's pain. We saw that pain scores were recorded in patient records and that analgesia was offered regularly as prescribed. Patient's told us that they had had effective pain relief when they needed it.

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- The service had access to a dedicated pain nurse who was available to provide advice over the telephone. The registered medical officer (RMO) was available to provide pain relief and advice for patients 24 hours a day, seven days a week.
- Staff carried out six-monthly audits of pain management for inpatients and day case patients. In February 2017, pain management assessments scored 100% for both inpatients and day case patients. In August 2017, day case pain assessments were 96% and inpatients 99%.
- Pharmacy staff told us they reviewed all patients' pain relief needs and gave them advice on how best to take them, in order to optimise their effect. On discharge, patients were given contact numbers to call if their pain relief medicines were not sufficient or they needed more.

## Nutrition and hydration

- Staff completed an assessment of patient's nutritional status and their needs when they were first admitted and updated this during their stay.
- Nausea and vomiting were formally assessed and recorded.
- Pre-operative fasting guidelines for adults were aligned with the recommendations of the Royal College of Anaesthetists, (RCA) which states that food can be eaten up to six hours and clear fluids can be consumed up to two hours before surgery. Information regarding fasting was provided to patients during pre-operative assessment stating that they needed to fast for six hours prior to surgery. Staff reviewed patient's fasting times at the booking appointment and reviewed theatre list start times. Patients were informed by letter to have no food or drink six hours pre-operatively but could have clear fluids up to two hours before surgery. The service held a weekly capacity meeting to clarify admission times so that patients were not nil by mouth for longer than necessary. Staff confirmed times with patients at the pre-assessment appointment. Patients undergoing some operations for example total knee, total hip, and total abdominal hysterectomy were given a carbohydrate pre-load before surgery with the last sachet given two hours pre-operatively. This meant that

they did not spend long periods without nutrition. However, the service did not audit the length of time patients were fasting pre-operatively to ensure that fasting times were in line with current guidelines.

- Intravenous fluids were prescribed as appropriate and recorded according to hospital policy. We observed that fluid balance charts were used to monitor patients' hydration status.
- The malnutrition universal screening tool (MUST) was used to assess and record patient's nutrition and hydration, when applicable.

## Patient outcomes

- BMI The Manor participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- Results on patient outcomes were compared with other locations within the region and across BMI Healthcare through the corporate clinical dashboard, which used data from the incident and risk reporting database. The service was able to review their data and compare it with hospitals of a similar size within BMI Healthcare. For example, PROMS identified that patients who had undergone hip and knee replacement surgery at BMI Manor had reported a higher satisfaction rate than BMI nationally and the national average. Patients who had groin hernia repairs reported a satisfaction rate just below the BMI and national averages.
- The hospital did not have a quality assurance system such as Joint Advisory Group (JAG) accreditation for collecting data for endoscopy patients but did have a global rating score (GRS). The GRS is a tool that enables hospitals to assess how well they provide a patient-centred service. The system automatically calculates the GRS scores, which provide a summary view of the endoscopy service. The outcomes for endoscopy patients were not measured therefore we could not be assured of the effectiveness of the service or patient outcomes. Managers identified that the service was unlikely to acquire JAG accreditation due to the configuration of the building. However, managers told us that they were continually improving their processes and pathways to provide high standards of care.

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- There had been one case of an unplanned in-patient transfer to another hospital from October 2016 to September 2017. There had been three cases of unplanned readmissions within 28 days of discharge in the reporting period. There were no unplanned returns to the operating theatre.
- The service had commenced private patient reported outcomes collection. This covered hip, knee and hernia surgery. All private patients billed data was sent to the Private Healthcare Information Network (PHIN). All the minimum data sets were submitted and available to the public via the PHIN website. The service provided this through an external provider alongside the BMI patient satisfaction survey. The service had worked on the BMI patient administration system to facilitate patient coding, NHS number look up and allocation of consultant to patient episode. Consultant engagement had commenced with presentations given to the national medical advisory committee. BMI was submitting full data submission, which met the requirements of the Competition Markets Authority (CMA) Order in accordance with legal requirements.
- Patients we spoke with considered their outcomes good and were satisfied with their treatment.

## Competent staff

- We saw that new hospital staff undertook an induction, which included a corporate introduction and a local orientation. New staff had to complete e-learning and face-to-face training.
- We reviewed four staff files and found they all contained relevant information such as an up to date disclosure and barring service check (DBS), references and evidence of registration with the Nursing Midwifery Council (NMC) or Health and Care Professions Council (HCPC). We saw that the hospital had a process to check when staff information was due for renewal for example DBS.
- Staff had midterm and annual appraisals, 100% of registered nurses and health care assistants on the ward had had an appraisal in the appraisal year to October 2017. In theatres, 12% of registered nurses and 0% of healthcare assistants and/or operating department practitioners had had an appraisal. However, it should be noted that staffing numbers within each department were low, which does distort the compliance percentages. The theatre manager had recently taken up her post and told us that they wanted to work with staff and get to know them better before doing their appraisals. However, we were told that no time scale for completion had been set. Staff we spoke to told us that they found the appraisal system helpful and were able to identify any training or development needs through this process. Managers discussed competencies with staff at this meeting.
- The service had competencies in place, which were general to BMI. These included blood transfusion, intravenous drug administration, use of display equipment and ward equipment. Competencies were self-assessed and then assessed by the ward manager or a competent or experienced practitioner. Nurses who had undertaken a mentorship course had annual updates from the university. We saw that the ward manager ensured that competencies were up to date. However, some competency frameworks, for example endoscopy were out of date. A new framework had been developed but was not yet in use. Competencies were self-assessed and then peer reviewed. Some staff undertaking endoscopy had not had any formal endoscopy training and had not had all of their competencies assessed. Staff that we spoke to were not aware of any formal standard operating procedures for endoscopy. During our unannounced inspection on 8 May 2018, we saw that there were some endoscopy procedures filed with endoscopy competencies but could not find full details for all processes. In theatre, staff undertook self-assessment, which included the use of equipment and were peer reviewed by experienced staff. We could not therefore be assured of the rigour of competency assessment or how new staff would be assessed. However, all staff working in theatre were seen to be competent but were not able to evidence this formally.
- The process of assessment at the hospital was for self-assessment graded against a competency framework followed by peer review. This meant that staff may identify a learning need to develop their competency. The service did not have regular endoscopy updates although there were monthly educational half days in theatres and endoscopy for all staff to attend. The manager in endoscopy was

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developing links with the local NHS hospital to develop their skills and planned to start a learning and information sheet for staff to keep them updated on new information.

- The service had some link nurses. Link nurses provided education and support for staff in areas of special interest. There were link nurses for dementia and first aid. An infection control link nurse was due to commence in post. The director of clinical services was the safeguarding lead and provided support for staff in the event of any safeguarding concerns.
- The service had access to clinical nurse specialists for example a pain specialist nurse, tissue viability nurse and resuscitation officer. Staff knew how to access advice from nurse specialists if necessary.
- RMO's had their competencies assessed and mandatory training provided and updated by the external agency provider. Before commencing work at the hospital, the RMO's curriculum vitae (CV) including employment history, training certificates, qualification certificates, references and certificate of enhanced DBS were forwarded to the director of clinical services. These were kept in the RMO induction packs, which were completed within their first week working at the hospital and updated as appropriate. Any gaps in knowledge for example from resuscitation scenarios were fed back to the external agency provider who were proactive in arranging update training as soon as possible.
- Procedures were carried out by a team of consultant and anaesthetists who were predominantly employed by other organisations such as the NHS. Their annual appraisals were carried out with their employer. It was the responsibility of the registered manager, with advice from the medical advisory committee (MAC), to ensure consultants were skilled, competent and experienced to perform the procedures they undertook. The hospital checked registration with the General Medical Council (GMC) and the relevant specialist register. In addition, in line with the BMI practising privileges policy, checked that consultants had no criminal record through DBS checks and that they had up to date indemnity insurance. DBS is a criminal record check and indemnity insurance is designed to protect professionals when

they are found to be at fault for a specific event. We saw evidence that there was a system in place to check all information was up to date and this was discussed and reviewed in the MAC meeting minutes.

- Practising privileges for consultants were reviewed every other year. The review included all aspects of a consultant's performance. The review included an assessment of their annual appraisal, volume and scope of practice, plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges. We saw the hospital used an electronic system to check when privileges were due to expire. We reviewed four consultant files and found they all had the relevant information such as up to date DBS, annual appraisal and indemnity insurance.
- The hospital provided training and development opportunities for staff. At the time of our inspection (April 2018) for example, two healthcare assistants were undertaking additional training to become assistant practitioners, and two radiographers were undertaking mammography training.
- Learning and development needs were identified during appraisal. We were told the BMI Healthcare group provided a wide range of courses that staff could access. Staff were also supported to undertake external training courses, if they were relevant to the needs of the hospital.
- Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice.

## Multidisciplinary working

- We observed good internal multidisciplinary team (MDT) working. For example, medical, nursing staff, allied health professionals (AHP's), and clerical staff collaborated well and reported effective working relationships.
- Medical and nursing staff reported good working arrangements and relationships with the local NHS trust. There were service level agreements (SLAs) in place for the transfer of patients to an NHS hospital if

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their condition deteriorated. An SLA was also in place with the local ambulance service to transfer patients promptly to an NHS hospital if their clinical condition deteriorated.

- The service had an escalation policy for patients with sepsis who require immediate review. Staff could describe the process if they needed to contact the RMO, anaesthetist or consultant quickly.
- Staff commenced discharge planning at the pre-assessment appointment so that effective plans would be in place to meet patient need when discharged.
- Staff spoke with families and carers to discuss care and discharge planning. We saw effective discharge plans in patient's notes. Patients and relatives that we spoke to told us that they were involved in all aspects of decision making and care planning.
- Discharge letters were sent to patient's GP's on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided.
- We saw evidence of multidisciplinary team communication across all departments. The hospital had introduced a daily communications cell meeting, which took place at 9am and was attended by the senior management team and a representative from each department, including theatre, endoscopy, pharmacy, outpatients, imaging, patient services, and catering. We observed a brief overview of hospital activity, utilisation, staffing, incidents and complaints reported over the last 24 hours, medical alerts, mandatory training compliance, and potential risks to the service were discussed. This was documented on a whiteboard in the staff dining area for all staff to view and was updated daily. This information was then taken back to each department and cascaded to the remaining staff.
- The hospital reported good multidisciplinary working with the local NHS trust, where the majority of consultants were employed. The pharmacists had regular contact with the local trust's pharmacy department and were included in the trust's communications.

## Seven-day services

- The hospital only undertook elective surgery, with lists planned in advance.
- Consultants were on call 24 hours a day for patients in their care. There was 24-hour RMO cover in the hospital to provide clinical support to consultants, staff and patients.
- Consultants provided details of cover arrangements for when they were not available. This was a requirement of their practising privileges.
- A senior nurse was always available for advice and support during working hours. Furthermore, the management team operated a 24-hour, seven day a week on-call rota system. Staff could access them for advice and support as needed.
- The hospital had planned closure periods over Christmas, New Year and Easter. During this time if a patient needed medical assistance, they contacted their own GP or local accident and emergency services. All patients were informed of the hospital closure at discharge and written information was provided to support this.
- The physiotherapy department was staffed Monday to Friday, 8am to 5pm and there was a weekend rota to provide physiotherapy to inpatients as required. This was planned in advance and staff only worked at the weekends if there was a pre-identified need. There was no on-call physiotherapy service available.
- The pharmacy was open Monday to Friday, from 9am to 3pm. Out of these hours, the patients were given prescriptions to take to the chemist or were asked to return when the pharmacist was on site.

## Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- There were pathways for different types of procedures. These pathways ensured that the progress was made, and any deviation from the prescribed pathway could be identified and an appropriate intervention made swiftly.

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- The service used paper records. Nursing and medical patient records were combined within the same record; this meant that all health care professionals could follow the patient pathway clearly.
- The service had introduced a new system to store all records, which allowed full traceability and scanning of documents. This meant that private patients' records could be accessed by the service at all times where previously they had been held by the consultants.
- Results of x-rays and blood tests were readily available.
- The service sent discharge letters to the patient's GP with details of their care and treatment on the day of discharge. Details for follow up appointments and medication were included.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found the corporate consent policy was under review and had expired its review date in September 2016. Furthermore, we were not assured that consent to treatment was always obtained in line with national guidance. For example, four out of seven patient records we reviewed showed that consent was obtained on the date of admission for treatment. This was not in line with best practice, which states that the process of consent should begin well in advance of the treatment and should be signed at the end of the initial outpatient discussion, provided the patient has reached the decision to go ahead with the proposed treatment (Royal College of Surgeons Consent: Supported Decision-Making. A Guide to Good Practice, 2016). We raised these issues with the senior management team, who took immediate action to address our concerns. When we returned to the hospital for our unannounced visit, we saw action had been taken both corporately and locally. A recently updated version of the consent policy was available, which was based on national guidance and relevant legislation. It included guidance for staff on obtaining valid consent, patients who lacked capacity to consent, and refusal of treatment. Furthermore, the hospital had written to all consultants reminding them of their responsibilities in relation to obtaining valid consent. The hospital had also carried out a consent audit of all patients booked for treatment from 30 April to 12 June 2018. Patients without a completed consent form in their medical records were invited to attend a second consultation. This was corroborated in the medical records we reviewed during our unannounced inspection on 8 May 2018. We looked at three patient records and saw that two consents had been signed in advance. The third consent form had been signed on the day of admission because the patient had been unable to revisit the hospital. There was clear evidence in the medical records that the patient was aware of all risks and benefits of the planned treatment.
- The seven patient records we reviewed at our announced inspection showed that consent forms were fully completed, signed and dated by the patient and the consultant. The forms identified the procedure planned and potential risks and benefits were discussed. The hospital consent forms complied with Department of Health guidance.
- Managers told us that there was no consistency to consent in the endoscopy department with some patients signing consent on the day of their investigation.
- The service ensured there was a two-week cooling off period between patients being seen in outpatients and the procedure taking place. This gave the patient time to decide whether to go ahead with a cosmetic procedure and allowed time to cancel if needed. This was in line with national guidance from the General Medical Council and British Association of Aesthetic and Plastic Surgeons.
- Staff we spoke to were clear about their responsibilities in relation to gaining consent from people including those who lacked capacity to consent to their care and treatment.
- The theatre manager told us that patients were never allowed to sign a consent form in theatre.
- The hospital had an up to date policy regarding the Mental Capacity Act 2005 and deprivation of liberty safeguards. Staff could access this via the hospital intranet.
- Training on mental capacity and deprivation of liberty safeguards was included in the mandatory safeguarding adults training.

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- Staff were briefly able to describe how DoLS might be required. They explained they would contact the director of clinical services and involve the consultant and relatives as appropriate.

## Are surgery services caring?

Good 

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

We rated caring as **good**.

### Compassionate care

- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. Patients and relatives told us that staff were kind and attentive. They felt that they were kept well informed about their care and were involved in making decisions about their treatment at each stage. Staff explained the costs of treatment before admission.
- The service gathered patient feedback through three patient questionnaires. These were analysed by an independent provider, and the results were published and shared monthly. The friends and family test feedback results from June to November 2017 scored between 97% and 100%, however the response rate was between six and 28%. The patient feedback response rate had significantly dropped since October 2017, following the corporate decision to use electronic feedback forms only. This had been recognised as an issue and we were told the BMI Healthcare group had subsequently reintroduced the use of paper feedback forms, as well as electronic.
- Patient feedback from the CQC “tell us about your care” comment cards collected prior to and during our inspection included remarks such as “the service was excellent, nothing was too much trouble” and “staff were exceptionally caring and I was very, very well treated. Sparkling clean and welcoming. Every effort was made to accommodate wishes and explain treatment. Very impressed with the overall experience.”
- Patients told us they would be happy for their family to come to the hospital for treatment.
- We observed that patients were spoken to in a courteous manner and their permission was sought before providing treatment, for example before having observations done.
- We observed good interaction between nurses, allied health professionals and patients.
- Staff told us that they felt they had sufficient time to spend with patients and their relatives. The patients we spoke with and the satisfaction survey results we saw supported this.
- Patients’ privacy and dignity was maintained for example staff would knock on the patient’s door before entering their room and the door would be closed when requested and curtains closed.

### Understanding and involvement of patients and those close to them

- Patients told us that they were involved in their care planning. We saw care plans that reflected this. Relatives told us that they were given the opportunity to ask questions about care and treatment. Staff provided leaflets to support the verbal information given.
- Patients we spoke to could name the nurse caring for them and knew who their doctor was.
- Patients told us that staff clearly explained the risks and benefits of treatment to them before admission. Staff discussed costs and payment methods with patients before admission.

### Emotional support

- Staff told us that they had time to spend with patients to reassure them and provide emotional support.
- Pre-admission assessments included consideration of patient’s emotional well-being.
- Patients had access to counselling services if needed and staff would liaise with the GP as necessary.
- There was a chaplaincy service available for patients if required

## Are surgery services responsive?

# Surgery

Good 

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

In this section, we also cover hospital-wide arrangements such as service planning and learning from complaints, in the relevant sub-headings within the responsive section. The information applies to all services unless we mention an exception.

We rated responsive as **good**.

## Service planning and delivery to meet the needs of local people

- The services provided reflected the needs of the population they served and ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including orthopaedic surgery, general surgery and endoscopy.
- The hospital had a commitment to private patients as well as agreements with the local commissioners to provide services for NHS patients, and it ensured that services commissioned from them were safe and of a good quality. Staff told us that all patients were treated equally.
- The hospital worked collaboratively with NHS commissioners to ensure future planning of services were developed to meet the needs of the local population. The hospital also assisted with additional work from the local NHS hospital to assist with increased demand. The hospital's main activity was orthopaedics and they planned to develop ambulatory care pathways that would enable them to increase their capacity, and improve patient experience and outcomes.
- The booking system was conducive to patient needs in that where possible, patients could select times and dates for appointments to suit their family and/or work commitments.
- Theatre lists for elective surgery were planned with the theatre manager and bookings team. This ensured all

aspects of patients requirements were checked and considered before booking a patient on to the list and ensured that operating lists were utilised effectively. A staffing acuity tool was used to ensure that sufficient staff were on duty to meet the needs of patients.

- We saw the hospital had a service level agreement with a local acute hospital to provide pathology services, blood products and critical care services. This was in date and reviewed every two years.

## Access and flow

- Patients had timely access to initial assessment and treatment.
- National waiting time targets for referral to treatment (RTT) times in surgery were within 18 weeks (admitted pathway). The hospital met the target of 90% of admitted patients beginning treatment within 18 weeks of referral, for each month in the reporting period from February 2017 to January 2018, except September 2017 when it was 88%.
- Delays and cancellations were minimal and usually only happened if the patient was unwell on the day of the planned admission. Patients were always rebooked as promptly as possible.
- All patients having a general anaesthetic were assessed in a nurse led pre-assessment clinic prior to their surgery. The National Institute of Health and Care Excellence (NICE) guidelines were used to assess patient's anaesthetic risk in the clinic. The service had strict admission criteria and did not admit patients with complex co-morbidity or bariatric patients.
- Patients undergoing endoscopy or local anaesthetic had a telephone pre-assessment carried out. This meant patients were identified as being safe for surgery and unnecessary cancellations were avoided.
- When procedures had to be cancelled or were delayed, this was recorded as a clinical incident and appropriate actions taken. Cancellations were rescheduled within 28 days and there was no distinction made between NHS and private patients. The service would make up to three attempts to contact the patient to agree a new time and date. If the service was unable to contact the patient after three attempts, an appointment would be made and sent out in the post. From October 2016 to

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September 2017, three procedures were cancelled for non-clinical reasons; two of which were rescheduled within 28 days. The remaining patient was offered a date for surgery within 28 days but requested a later date.

- The number of admissions and planned treatments reduced at weekends with the provision of only one operating list on Saturdays.
- The service provided an on-call theatre team however, in the event of a patient deteriorating and requiring further intervention there was a service level agreement (SLA) in place with the local NHS trust and ambulance service to transfer patients for more complex care and treatment.
- Discharge planning started at the patient's pre-assessment appointment so that any specific needs could be met and planned for. Good relationships with GP's were reported and discharge information was provided

## Meeting people's individual needs

- Services were mostly planned and delivered to take account of the needs of different people.
- Patients with mobility difficulties had easy access to the ward as it was situated on the ground floor. The corridors were wide, which meant there was easy access for wheelchairs.
- The service had dementia link nurses to support staff if patients with dementia were admitted. Services for patients with complex needs were limited. There was one "dementia friendly" room, which had been adapted to meet the needs of patients with dementia and included posters and labels to identify objects within the room. Staff demonstrated a variable understanding of complex needs.
- Patients told us that they were given detailed explanations about their admission and treatment in addition to written information. We saw clear explanations and reassurance being given to patients who were anxious about their care treatment. The service had access to an interpreting service for patients whose first language was not English. There were five telephones on the ward set up directly to the interpreting service; a face-to-face service was also available. This meant that staff were assured that patients fully understood the information that was provided to them.
- Staff answered call bells promptly; patients also told us that nursing staff responded quickly to their needs for example to help them to the toilet. Relatives needs were considered and we saw them offered food and drinks when they visited patients.
- The service had achieved accreditation from Action for Hearing Loss "Louder than words" quality standards and certification to support patients who were hard of hearing. The service was able to facilitate the provision of signing services for patients with hearing difficulties and had hearing loops installed at the main reception and a portable loop in the outpatient department.
- Staff provided information leaflets for a range of conditions and to support care given. These were written in English but could be obtained in other languages.
- Staff displayed health promotion posters on the walls in the pre-assessment room. These included information about reducing alcohol intake, smoking cessation and health awareness.
- The hospital's Patient-Led Assessment of the Care Environment (PLACE) audit for 2017 showed they scored in line with the England average for how the environment supports patients living with dementia or a disability, with scores of 77% and 84% respectively. The England average score was 77% for how the environment supports patients living with dementia and 83% for disability.
- Patients had access to drinks by their bedside. Staff checked that regular drinks were taken where required.
- Snacks were available if required.
- The catering arrangements were outsourced to an external provider and most food was cooked off site, chilled and reheated in the hospital.
- Patients we spoke with told us the quality of the food was good and they mostly received the food they had selected from the menu provided. Staff offered relatives food and drinks, however relatives had to pay for a meal.

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- We saw water dispensers on the ward for patients and relatives use.
- The hospital's Patient-Led Assessment of the Care Environment (PLACE) audit for 2017 showed they scored better than the England average for food and hydration. The hospital scored 97%, whilst the England average was 90%.

## Learning from complaints and concerns

- The hospital had a clear process in place for dealing with complaints. There was a complaints policy in place, which was under review at the time of our inspection. Staff we spoke to were aware of the complaints procedure. We saw complaints leaflets, 'Please tell us', were available throughout the hospital and saw the hospital website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email.
- The complaints policy stated that complaints would be acknowledged within two working days, and routine complaints investigated and responded to within 20 working days. Where the complaint investigation took longer than 20 working days, a holding letter was sent to the patient, explaining why the response was delayed. If the complainant remained dissatisfied with the response, stage two of the complaints process was instigated and BMI Healthcare would review the complaint.
- The executive director had overall responsibility for the management of complaints. Complaints were logged on the electronic incident reporting system. This alerted staff that there was a new complaint and heads of department would investigate the complaint as appropriate. Complainants were offered a face-to-face meeting or a telephone call with the executive director and appropriate staff such as the director of clinical services.
- The hospital had reported 45 complaints in the reporting period from December 2016 to November 2017. None of these complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). We saw evidence that all complaints had been logged and investigated in accordance with the hospital complaints policy.
- The service had received six complaints. The ward had received three, theatres two, and the pre-assessment unit had received one complaint. Managers had sent full responses to patients. Staff identified that themes included poor communication and service charges. Managers informed staff about complaints and outcomes at ward meetings.
- We reviewed five complaints and found that acknowledgement letters and a complaints leaflet was sent to each patient. Most complaints were closed within 20 days. The complainant was informed of any delays in responding, which may have been due to staff leave or the complexity of the complaint.
- Complaints were reviewed at the hospital governance meeting, heads of department (HODS) meeting, medical advisory committee (MAC) and department meetings. We also observed complaints being raised at the daily communications cell meeting. To raise awareness there was a monthly notice attached to each staffs wage slip with brief details of new complaints. Outcomes and any actions taken were discussed at departmental meetings.
- Trends identified from complaints included billing information provided to patients. We were told actions taken included providing information about costs in advance and the patient administration lead discussing self-pay processes with patients prior to any admission and investigation.

## Are surgery services well-led?

Good 

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

In this section, we also cover hospital-wide arrangements such as, leadership, the management of risks and governance processes, in the relevant sub-headings within the well-led section. The information applies to all services unless we mention an exception.

We rated well-led as **good**.

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## Leadership / culture

- The hospital had a clear management structure in place with defining lines of responsibility and accountability. The hospital's senior management team consisted of an executive director, who had overall responsibility for the hospital, the director of clinical services and the operations manager. The MAC chair and heads of department supported the senior management team. All the heads of department reported to one of these three leaders.
- The executive director attended regular meetings with other executive directors within the region, and told us they were well supported by the corporate senior management team.
- Staff told us that the executive director was well respected, visible and supportive. However, we were told other senior leaders were not seen so frequently. Some departmental managers did not always feel sufficiently supported and told us that one-to-one sessions, which they found beneficial, were often cancelled.
- Departmental managers told us they were supported by their peers. For example, the theatre manager could contact a theatre manager in another BMI hospital for advice and support as needed, and the endoscopy manager had linked up with their peers at the local NHS hospital for support and to enhance their learning and development.
- The ward, theatre manager and endoscopy lead were visible and demonstrated clear leadership. For example, the theatre manager ensured that processes such as safety huddles were embedded in practice. Staff told us that they felt departmental managers were approachable. Departmental managers worked clinically and would provide clinical cover for sickness as appropriate. We saw that ward and theatre staff worked together effectively.
- The service had a caring culture. Staff told us that they enjoyed working in the department and felt well supported by their departmental managers. Department managers told us that they had an open door policy and that they were proud of their staff and their departments.
- The senior management team spoke with pride about the work and care their staff delivered on a daily basis.
- The hospital supported staff to develop leadership and management skills, with courses available for all levels of staff. At the time of our inspection (April 2018), we were told an administration assistant and senior manager were both undertaking management courses.
- Staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care for their patients.
- The hospital culture encouraged openness and honesty. Staff told us they were able to raise concerns and felt the hospital had a "learning culture, not blame culture". Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.
- The hospital celebrated staff success. The BMI Healthcare group ran an annual recognition awards scheme entitled "above and beyond". The categories included "true inspiration", "outstanding care", "brilliant leadership", and "amazing support". Staff were invited to nominate a colleague who they felt had gone "above and beyond" and deserved recognition. We saw that compliments were shared with staff via the staff newsletter, noticeboards and meetings. The hospital also held annual long service awards, which recognised every staff member who had worked at the hospital for five years.
- There were arrangements in place to promote the safety and wellbeing of staff. For example, a porter would drive staff to and from the off-site car park when needed to ensure staff were safe. Furthermore, at night, when there were limited staff on duty, alarms were set and the front door was locked. A security company patrolled the grounds once during the night. A duty manager was always available in the event of any concerns being raised.

## Vision and strategy

- The hospital was committed to the BMI Healthcare corporate vision, which was to offer "the best patient experience and best outcomes in the most cost-effective

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way". All staff we spoke with told us they were committed to providing a positive patient experience. The vision had been translated into eight strategic priorities, which were entitled:

- Governance framework
- Superior patient care
- People, performance and culture
- Business growth
- Maximising efficiency and cost management
- Facilities and sustainability
- Internal and external communications
- Information management
- We saw the hospital's operational business plan was aligned to the corporate vision and strategic priorities. It included a quality improvement action plan, which detailed specific objectives the hospital had set in order to deliver the strategic priorities. Progress against achieving the objectives was reviewed and monitored at various committee meetings, including hospital governance and heads of department meetings.
- The hospital's 2018 strategy for service development outlined a number of proposals aimed at increasing capacity and service provision for NHS, self-insured and private patients. These included the development of an ambulatory and endoscopy theatre, and the purchase of a camera stack system for theatres. However, these proposals were dependent on the hospital being given additional capital and had not been approved at the time of our inspection (April 2018).
- Staff were aware of the vision and strategy and understood their role in achieving it. We observed the BMI Healthcare vision was prominently displayed throughout the hospital.

## Governance, risk management and quality measurement

- We found improvements in the hospital's governance and risk management arrangements had been made, since our previous inspection in October 2015. There was a clear governance structure in place with a variety of committees, such as resuscitation, infection prevention and control, and health and safety, which fed into the hospital's governance meetings and ultimately reported to the BMI corporate board. All these committees had terms of reference, which reflected their role in the hospital, their structure and purpose. We reviewed four sets of governance meeting minutes and saw they were well attended by the senior management team, heads of department and clinical leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks.
- The medical advisory committee (MAC), which was chaired by one of the consultants with practicing privileges, received reports from all the committees and reviewed all medical staffs practicing privileges. The MAC would also discuss new procedures to be undertaken to ensure they were safe, equipment was available and staff had relevant training. The MAC chair met with the hospital executive director regularly to discuss the MAC agenda and review complaints and incidents. Information from meetings was cascaded to staff through departmental meetings.
- Additionally, there were clinical service lead meetings between the director of clinical services and all clinical service leads, and departmental meetings on the ward and theatre. These meetings were structured and minuted.
- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department according to an audit schedule and results were shared at relevant meetings such as the hospital clinical governance meetings. Audit records and meeting minutes we reviewed confirmed that this process was embedded. For example, staff undertook monthly local audits of the national early warning score (NEWS) chart for completion. From November 2017 to January 2018, omissions were identified and we saw that staff discussed the findings at ward meetings. From January 2018, the audit results had improved with all NEWS documentation fully completed.
- The hospital's risk register was managed through the electronic reporting system. We reviewed this during our inspection and found each risk was adequately detailed, with a description of mitigation and controls in place. The dates when risks were added or reviewed, an assessment of the likelihood of the risk materialising

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and its possible impact was included. We saw that risks were reviewed regularly and updated when changes to mitigation had been taken. We also found that key risks, such as the failure to recruit adequate and appropriate staff, were included on the hospital's risk register. This was an improvement from our previous inspection in October 2015, when we found key risks were not included. This meant we were assured a systematic approach to the hospital risk register was in place.

- Staff we spoke with were aware of the main risks within the surgery service, which included staffing levels, the suction equipment in theatres and the ageing camera stack system. Information regarding the hospital's risks was shared with staff in a variety of ways, such as the daily communications cell meeting, newsletters, meetings and staff noticeboards.





## Public and staff engagement

- Patients views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought in various means, including the Friends and Family Test (FFT), NHS Choices website, BMI patient satisfaction survey, and Patient-Led Assessment of the Care Environment (PLACE) audits. From June to November 2017, the response rate varied from six to 28%. It had significantly dropped since October 2017 (to six percent), following the corporate decision to use electronic feedback forms only. This had been recognised as an issue and the BMI Healthcare group had subsequently reintroduced the use of paper feedback forms, as well as electronic.
- We saw the FFT results were publicly displayed throughout the hospital, and were also detailed on the hospital's website. In 2017, feedback showed 99% of patients would recommend the hospital to their family or friends.
- The service engaged with the local Healthwatch, clinical commissioning group (CCG) and an integrated care provider who commissioned elective orthopaedic service. Staff reported good communication and links with local GP's.
- The service had developed close links with a local school and displayed student art on the walls on the ward and patient bedrooms.
- At the time of our inspection (April 2018), the hospital was trying to recruit service users to join their patient participation group. Once established, the group would then meet with the senior management team to discuss how the hospital could improve. We were told that one patient had expressed an interest in joining the group, and the senior management team were hoping to encourage more patients to join by liaising with a local health and social care consumer group.
- Patients and the public could access a wide range of information from the hospital's website, including information on treatments, self-funding options and performance outcomes.
- Members of the public were invited to attend open events held at the hospital throughout the year, where a consultant would speak about a particular health topic including the various treatment options available.
- In the 2017 BMI staff survey, 78% of staff would recommend the hospital. This was higher than the national average. We saw that an action plan had been developed to address concerns raised in the 2017 staff survey, which included staff recognition and benefits and improving internal communication.
- Managers held regular departmental team meetings in both theatre and the ward. This enabled staff to discuss any areas of concern, be informed about incidents or risks and to be kept up to date about any issues within the hospital.
- Staff told us they had regular team meetings, and we saw evidence of this in meeting minutes we reviewed. Information was shared with staff in a variety of ways, such as face-to-face, email, newsletters and noticeboards.
- Staff were offered a free lunch once a month as a means of thanking of them for their hard work and continued support.

## Innovation, improvement and sustainability

- Managers in theatre and endoscopy were both new in post and developing into their roles. The endoscopy manager was making links with the local NHS hospital endoscopy unit to support both their own and staff development. The theatre manager had made links with a peer in another BMI hospital to support her development and the development of the theatre.

# Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

## Are outpatients and diagnostic imaging services safe?

Good 

We rated safe as **good**.

### Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- All staff were able to give examples of when they would need to report an incident.
- There had been no serious incidents reported for outpatient and diagnostic imaging services in the period from October 2016 to September 2017.
- There were no never events in the reporting period from February 2017 to January 2018.
- During the period from October 2016 to September 2017, there were 37 clinical incidents and eight non-clinical incidents reported within outpatients and diagnostic services. We saw that ineffective communication and human error were identified by staff as themes and that actions to improve these were discussed at departmental meetings. There were no incidents reported which had resulted in patient harm.
- The hospital had an incident policy, which stated that all incidents should be reported directly onto the risk management system by the person who discovered the incident, before the end of their shift. Staff told us they were aware of how to report an incident, although, several staff members told us they would verbally report incidents to the department lead who would enter the incident onto the risk management system on their behalf. One member of staff told us that they would record incidents in an incident reporting book, however, we were told by managers that such a book no longer existed.
- Staff told us that learning from incidents was shared at team meetings and that all staff received a summary of recent incidents reported attached to their pay slip each month.
- The radiography lead informed us that there had been no reportable imaging incidents in the past year. We were told that there were radiation protection processes in place to reduce the possibility of radiation incidents; these included annual quality assurance (QA) tests, justification of all referrals, an annual audit by the radiation protection adviser (RPA), and the use of diagnostic reference levels (DRL). We saw that the department displayed a poster relating to the ionising radiation (medical exposure) regulations (IR(ME)R 2017) for local rules for ionising radiation safety for diagnostic imaging. These regulations laid down basic safety standards for protection against the dangers from exposure to ionising radiation.
- When things went wrong, staff apologised and gave patients honest information and suitable support. Staff were knowledgeable regarding the duty of candour and described how they applied the principles by being open and honest with patients at all times and admitted any mistakes. 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

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patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Cleanliness, infection control and hygiene

- We found the outpatient department waiting areas were visibly clean and dust free and consultation rooms were tidy and appeared clean. This was an improvement from the last inspection when we found visible dust in the consultation rooms.
- During the last inspection, the outpatient department was undergoing refurbishment. There were concerns raised around failure of the refurbished rooms to comply with some health building note (HBN) requirements. The new laminate floor did not comply with HBN 00-10 Part A: Flooring. The flooring in the treatment room did not comply with HBN 00-99. The hand wash sinks in the consultation rooms did not comply with HBN 00-10 Part C: Sanitary Assemblies. Sinks in clinical areas did not conform to the HBN 95 standard. During this inspection, we saw that all flooring, sinks and taps in outpatients and diagnostic imaging complied with relevant HBN requirements. However, the flooring in the physiotherapy gym was not compliant due to gaps being evident between the floor and skirting board area (Department of Health Health Building Note 00-10 Part A: Flooring, 2013).
- We noted that there were handwashing facilities and hand gel dispensers in every treatment room in the outpatients, physiotherapy and diagnostics departments. We noted hand washing technique information posters displayed above each sink. We did not have opportunity to observe many occasions of staff hand hygiene, however, of the five clinical patient interactions that we did observe, we noted two occasions when medical staff did not wash their hands or use hand gel prior to patient contact. We saw hand gel dispensers and posters promoting and encouraging hand hygiene with visitors at the entrance to the outpatients department.
- Hand hygiene audit results from November 2017 to March 2018 showed that in both the outpatients and imaging departments there was 100% compliance with hand hygiene techniques.
- Staff received annual training on infection prevention and control (IPC) as part of their mandatory training. As of December 2017, we found 100% of diagnostic imaging staff and 80% of outpatient staff had completed IPC high interventions training. Whilst 0% of diagnostic imaging and 80% of outpatient ward staff had completed IPC in healthcare training. However, staff were also required to complete IPC awareness training, of which 100% of diagnostic imaging and 100% of outpatient staff had completed. This meant we were assured staff had up to date infection prevention and control knowledge.
- Staff were observed to be 'bare the elbows' in line with the hospital infection control policy.
- We noted some single use consumables in the outpatient department, which were stored in sterile packaging and were intact and in date.
- There were cleaning schedules displayed in each consulting room within the outpatients' department and within the physiotherapy gym area. We noted that these were all signed and dated to evidence regular cleaning took place. This was an improvement from our last inspection when we found that there were no cleaning schedules displayed in the outpatient department.
- We saw that there was a daily cleaning schedule within the diagnostic imaging department. There was a separate cleaning list for the environment and for clinical equipment; housekeepers were responsible for environmental cleaning and the radiography staff cleaned the clinical equipment. Clinical equipment included all x-ray machinery, lead aprons and ultrasound machinery. We noted that this schedule was fully completed and evidenced that regular cleaning of both the environment and clinical equipment took place.
- We noted that 'I am clean' stickers were used to indicate that equipment had been cleaned and these stated the date that the equipment had last been cleaned.
- We noted that personal protective equipment (PPE) such as gloves and aprons was readily available in each consulting and treatment room through the use of wall

# Outpatients and diagnostic imaging

dispensers. This was an improvement from our last inspection when we found that although gloves were available, all the apron dispensers in the consultation rooms were empty.

- There were packs of disinfectant wipes available in the outpatients and physiotherapy departments to wipe down treatment couches between each patient and we observed that this was completed.
- Staff in the diagnostic imaging department told us that they wiped down all equipment that had been in direct contact with a patient with disinfectant wipes after each use, for example the x-ray table and x-ray imaging cassettes. White paper roll was used to cover the treatment couch during ultrasound investigations and this was disposed of after each patient use and replaced. For equipment that had been used for intimate investigations, such as ultrasound probes, a three-stage decontamination process was used, which was in line with national guidance.
- We were told that for patients with communicable diseases staff would follow the hospital policy on the intranet and seek advice from the director of infection prevention and control on any special decontamination processes required. Staff informed us that nurses were responsible for cleaning the examination bed and work surfaces between each patient, using disinfectant wipes. For patients with infectious diseases there were specific wipes and chlorine tablets, which were used for cleaning. Housekeeping staff described when and how they would deep clean and steam clean rooms when an infectious disease was known or suspected.
- We observed that disposable curtains were in use around areas that contained patient treatment couches. These were dated with the date on which they were last changed and we noted that all the curtains we checked had been changed within the last month, in line with hospital policy.
- We noted that there were sharps bins on the wall in the outpatient, diagnostic and physiotherapy departments and there was a hospital wide sharps disposal policy, which staff adhered to. We saw that sharps bins were emptied every three months in line with hospital policy and that temporary closure mechanisms were used appropriately. We were assured that sharps were disposed of safely.

- We observed good waste management processes with offensive and hazardous waste bags being readily available and regularly disposed of.
- We saw that there was a biohazard spill kit (containing relevant equipment to manage blood and other bodily fluid spillages), which was easily accessible and was in date. There was a cupboard for secure storage of chemicals in line with control of substances hazardous to health (COSHH) regulations.

## Environment and equipment

### Outpatients:

- In the outpatient department there was a small patient waiting area. We noted that all patient furniture such as chairs and couches was in a good state of repair and was compliant with HBN 00-09 (that is it was fully wipeable). There was a reception desk where patients booked for appointments, but no confidential information was discussed at the desk. There was one toilet in the outpatient department for use by male and female visitors, which we saw was clean and regularly inspected for cleanliness.
- We saw five individual consulting rooms, which each had a couch surrounded by disposable privacy curtains, appropriate hand wash and hand sanitiser facilities, personal protective equipment dispensers, pocket masks for resuscitation, emergency call buttons and chaperone posters on display. There was limited clinical equipment in the rooms, which was stored on consumable items trollies. These were clean, appropriately stocked, had all equipment in date and sheets were used to avoid clinical items becoming dusty. None of the consultation rooms were lockable. In addition, there was a treatment room, which contained a range of clinical equipment and the department's drugs cupboards. The clinical equipment was stored securely and was well organised. All equipment we checked was within its expiry date.
- We saw several items of electrical equipment such as observation monitors and fans, which had been electrical safety tested to ensure they were safe for use. However, there was an air conditioning unit in one of the consulting rooms, which did not have a sticker to evidence when it was last safety tested. We raised this with the nurse in charge who told us that it would be reported and actioned.

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- In one of the outpatient consulting rooms, we found a box of equipment belonging to an ear, nose and throat (ENT) consultant. The outpatient lead confirmed that the consultant had their own equipment that remained onsite. They explained that the consultant was responsible for ensuring this equipment was maintained and that copies of records evidencing that the equipment had been maintained and calibrated had been received as required.

## Physiotherapy barn:

- There was a reception area by the entrance to the barn, which was manned by a receptionist and provided a waiting area for patients attending for physiotherapy or health screening appointments.
- We saw that there was a physiotherapy gym area, which housed minimal equipment such as treatment couches, balance equipment and an exercise bike. There was a plan to work with a local BMI hospital to access additional therapy equipment. The gym area had two treatment couches separated by privacy curtains and a separate treatment room used for women's health treatment. We were told that the gym area was only used for outpatients and that inpatients were not brought from the ward to use the facility. The area was clean and tidy and had handwashing and hand sanitisation facilities. There was a desk and computer in the gym, which served as an office area for staff.
- There was clinical equipment such as the splinting water bath, adjustable height treatment plinths and a physiotherapy ultrasound machine, which required medical device testing in addition to electrical safety testing. We noted that these were in date for testing.
- During our inspection, the health screening area was undergoing refurbishment and was not in use. Health screening was, however, still being carried out in the outpatient department consulting rooms.

## Imaging department:

- The imaging department consisted of one ultrasound room and one x-ray room. The x-ray room contained a computed radiography (CR) x-ray machine and a digital mammography machine (for breast imaging). In addition, there was a portable C arm image intensifier machine for use in theatres and a portable x-ray machine for use on the wards. The ultrasound machine

was installed in 2015, the mammography machine was new in 2016, and the x-ray machines were around 20 years old. The need to replace the x-ray machine with a more up to date digital radiography machine had been identified and was on the hospital's risk register. There has been an assessment of the work and cost required to replace the x-ray machine and although this work has not yet been completed it has been identified as a priority for the hospital. When asked about breakdown of the x-ray machinery, the radiography lead explained that this was a rare occurrence and that engineers were able to visit promptly to repair any problems. The portable x-ray machines could be used as a backup or patients had the option of going to another nearby BMI hospital for an x-ray. The table for the main x-ray machine was of a fixed height, which meant that patient's may have to use a foot step to get up onto the machine, which staff told us could be problematic if they were not able bodied.

- There was a separate process for equipment testing in the diagnostic imaging department in line with the ionising radiation (medical exposure) regulations (IR(ME)R) 2017. We saw that there was a bimonthly quality assurance process and annual servicing contracts in place for all imaging equipment. There was an asset register kept of all equipment, which logged when service dates were completed and this log was reviewed monthly by the radiography lead.
- Lead aprons used to protect staff from radiation exposure were individually asset numbered and safety marked and stored hung up on rails to prevent tearing of the fabric. They were well maintained and had a monthly visual inspection check and an annual x-ray assessment of fitness for purpose, which was well documented.
- We saw that staff were monitored for radiation exposure and all wore radiation dose badges, which were changed every two months. The used badges were sent off to the radiation protection advisor who sent them for analysis and returned dose exposure figures to the imaging department. These were reported back to staff at team meetings. There had been no situations of excess staff exposure reported.
- It was not possible to get a hospital bed into the x-ray room as there was insufficient turning space in the corridor. This meant that only patients able to be

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transported in a wheelchair could access the x-ray room. However, the department had a portable x-ray machine, which could be used on the wards if patients were unable to access the x-ray department.

- Space in the imaging department office was limited. The imaging office shared its environment with the ultrasound machine and we saw that a privacy curtain was used around the treatment couch so that patients did not feel like they were in an office. This room was lockable. Staff told us that the area was cramped when all staff were working in the office area.

## Resuscitation equipment:

We inspected the resuscitation trolleys within the outpatient and diagnostic imaging services. These were located in the corridor of the outpatient department and in the waiting area in the physiotherapy and health screening department. There was a policy that all resuscitation trolleys should have a daily visual check, which included ensuring that it was sealed with a tag, and that the oxygen cylinder, defibrillator and suction units were all in working order. These daily checks generally were only done Monday to Friday unless a clinic was running on a Saturday. In addition, all trolleys should have a weekly check documented where the seal was broken on the tag and all items were checked against a checklist to ensure they were available and in date. We saw that the records kept for checking the resuscitation trolley in outpatients were complete and that there was a process for ensuring daily and weekly checks were carried out. There was no record of daily checks at weekends but we found that there had not been any Saturday clinics held this year. During inspection we performed a full check of this trolley and found all items to be available and within their expiry date. When we looked at the records for the trolley in the physiotherapy barn, we found that they had not always been completed consistently. There was one weekly check date missed in December 2017 and 12 daily checkdates missed between January and March 2018. In the records for both resuscitation trollies there was some confusion caused by the introduction of a separate sheet to test the suction machine, which meant recording of daily checks were either duplicated or recorded on separate sets of paperwork rather than on a single sheet. This was raised with senior staff during our inspection and when we returned for our unannounced visit the additional sheets had been removed and recording of daily checks was being

documented on a single sheet. The imaging manager confirmed that the nearest resuscitation trolley for the imaging rooms was on the ward (this was part of the surgery team inspection).

## Medicines

### Records

- There was a virtual pharmacy located on the first floor within the outpatient department. A small stock of medicines was kept in the pharmacy within a locked fridge and three medication cupboards. There were no controlled drugs kept in the outpatients or diagnostic imaging departments.
- We saw that the fridge temperature was monitored daily and recorded. The pharmacy technician had daily responsibility (Monday to Friday, from 9am to 5pm) for the medication management and this was overseen by a part time pharmacist and a weekly visit from a lead pharmacist. There were two medication cupboards situated in the treatment room, which contained a small amount of limited medications such as analgesics (pain killers), anticoagulants (blood thinning drugs) and antibiotics. Pharmacy staff held the keys to these cupboards and gave them to registered nursing staff as required. The third cupboard was a pharmacy stock cupboard, which only the pharmacy team held keys for as this was used for dispensing medicines prescribed for patients to take home.
- There were robust systems in place to ensure that medicines were safely managed and accounted for. The pharmacy technician regularly checked stock levels and had processes to monitor expiry dates
- NHS prescription pads (FP10s) were kept securely in a double locked cupboard. Doctors could only request a single prescription form and a record was kept of the form number issued noting which doctor had received it and on which date. FP10 pads could be ordered from the clinical commissioning group (CCG) by pharmacy using a unique code to identify the hospital so that prescriptions issued could be traced back. The process for management of FP10s was safe.
- If an outpatient was prescribed a medicine that was not stocked by the hospital they could either be issued with a prescription to collect the medication themselves

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from their chosen pharmacist, or the hospital would arrange for a porter to collect the medicine on their behalf from a local pharmacy with whom they had a community account, whilst they waited.

- For our detailed findings on medicines, please see the Safe section in the surgery report.
- We saw that patient's records in all departments were stored securely.
- In the imaging department, all referrals were scanned onto the digital patient data and recording system alongside information about radiation doses and sites for each individual exposure performed. Images and image reports were stored on a picture archiving system. Radiography staff also had access to a portal where they could request images taken at other hospital sites to be transferred to their own picture archiving system.
- In the outpatient department, patient records for those attending clinic were kept in folders stored in a locked cabinet at the reception desk and collected by nursing staff prior to a patient's appointment time and given to the consultant.
- There was a new process being implemented to store copies of consultant records in the administration block of the hospital. Previously consultants had kept the patients' consultation notes, although copies of the patient pathway (nursing document) were kept at the hospital. The new process involved creating a trackable patient folder whereby a copy of all the patient's consultation notes was held in a folder within the administration block and would be scanned in and out of each location when it was transferred. This would ensure that a complete set of the patient records were always traceable and available. We were told that there were times when patient records had not been available for clinic appointments, although this had not prevented the patient from being seen. The new process related to consultant records but did not include the nursing care records (patient pathway document) in the folder, although there was a plan to do this once the process was fully established. We saw that the patient pathway documents were stored in several places. Those for patients awaiting follow up appointments were stored in a folder in the outpatient staff office. This folder was stored on a shelf and not in a locked

cupboard; however, the room was always locked when unattended. For those patients recently seen and discharged the pathway documents were stored in a locked drawer in the outpatient office. These folders were then regularly processed as a type of photographic film permitting miniaturised storage, in order to reduce storage space requirements.

- We looked at six sets of outpatient records for patients who had undergone minor surgery and found that they were generally well completed. In each set of records, the World Health Organisation (WHO) checklist for safer surgery, consent and allergies information was completed. However, in two out of the six records the patient pathway form had not been signed by the patient to confirm that their information was correct.
- In the physiotherapy department, all records were paper records and were stored in a locked filing cabinet at the reception area in the barn.

## Assessing and responding to patient risk

- We saw that emergency call bells were located in all treatment rooms and areas in outpatients, diagnostic imaging and physiotherapy. These sounded an alarm when activated, which triggered a 'crash' response from staff across the hospital so that an unwell or deteriorating patient could receive prompt assistance. We were told that these alarms were tested weekly. If patients required emergency treatment that could not be provided at the hospital, staff told us they called a 999 ambulance to blue light transfer the patient to the local NHS hospital.
- There was a named radiation protection advisor (RPA) who provided advice and support from an NHS trust in a different area. RPA support consisted of a formal arrangement of site visits in addition to the provision of telephone or email advice and support as required. There was a named radiation protection supervisor (RPS) at the hospital, who worked closely with the RPA in securing compliance with the ionising radiations regulations in respect of work carried out in the imaging department, which was subject to local rules. This included an annual audit of quality assurance testing of equipment, testing and calibration of all new equipment prior to use and monitoring of personal dosimeters. The RPA was easily accessible for advice and provided an annual radiation protection report for

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the hospital. This was discussed at an annual meeting, which was attended by the RPA. The RPS was the radiography lead, who told us there were plans to train one other radiographer as a second RPS.

- The imaging department had the local rules for ionising radiation safety displayed within the x-ray room. These facilitated safe working with radiation and included vetting protocols and patient identification verification. The vetting process was completed by radiographers prior to exposing a patient to radiation in order to justify that the exposure was appropriate and the benefits outweighed the risks. This included consideration that the investigation met referral criteria and that similar recent investigations had not already been carried out. Patient identification was verified prior to exposure by asking patients to confirm their name and date of birth and the intended investigation was agreed with the patient. The department followed the 'pause and check' guidance issued by the society of radiographers to minimise the risk of any unnecessary dose exposure.
- We saw that there were controlled x-ray signs outside the x-ray room warning visitors that it was a radiation controlled area and was accessible by authorised personnel only. The room was kept locked and was only accessible under the supervision of a radiographer. In addition, there were 'do not enter' lights, which were activated during the use of the x-ray equipment.
- There was a policy to check the date of all female patient's last menstrual period if they were between the ages of 12 and 52 in order to exclude the risk of pregnancy prior to radiation exposure. We saw that the policy provided clear guidance on what actions should be taken if there was a risk of pregnancy. There was a section on the referral form to document that this check had taken place. This was confirmed in the patient records we reviewed.
- We saw a poster displayed in the imaging office, which gave details on where to find information on the updated local IR(ME)R rules based on the recent changes to the IR(ME)R regulations in February 2018.
- All reporting of x-ray images was completed by radiologists; however radiographers were able to screen the images taken and would escalate any unexpected or unusual findings immediately. For example, the lead

radiographer told us they had recently spotted a perforation of the cortex following hip replacement surgery and this was raised with the patient's consultant in order that urgent treatment could be provided.

- The lift to the first floor was small and could not accommodate an ambulance trolley. In the event of the need to evacuate a patient in an emergency there was a slide device that could be used to safely and quickly transport a patient down the stairs. All staff had received training in the use of this equipment.

## Safeguarding

- Staff were able to name the safeguarding lead for the organisation.
- Most staff we spoke to told us they had completed safeguarding training for adults and children and were able to describe what would constitute a safeguarding concern. Staff described an escalation process for safeguarding concerns through their manager or the safeguarding lead. Safeguarding training data showed that there was 100% compliance with safeguarding vulnerable adults level two and safeguarding children level two training.
- We saw that safeguarding posters with contact details for the local safeguarding authority and the police were displayed in each clinical area.
- Staff showed an awareness and understanding of recognising female genital mutilation (FGM) concerns and although only two staff had received formal training in FGM, we were told that this training was being rolled out to all staff. We saw posters with the dates for this training displayed in staff areas throughout the hospital.
- For our detailed findings on safeguarding, please see the Safe section in the surgery report.

## Mandatory training

- Staff told us that they had completed mandatory training in subjects such as infection prevention control, fire safety and manual handling, and were generally up to date with training requirements. Data provided by the hospital showed that in the diagnostic imaging department, training compliance ranged from 0% to 100%, with an overall compliance of 91%. There was 0% compliance for infection prevention and control (IPC) in healthcare training for staff working in this department.

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However, compliance for the other two IPC modules (IPC high impact interventions and IPC awareness part two) was 100%. For the outpatient department training compliance ranged from 0% to 100%, with an overall compliance of 89%. There was 0% compliance for safeguarding female genital mutilation training for staff working in this department. For the physiotherapy department training compliance ranged from 0% to 100%, with an overall compliance of 85%. There was 0% compliance for information governance training for this staff group.

- There were monthly sessions held to update mandatory training topics and managers had an oversight of which staff needed to attend training updates. We were told that the personal assistant (PA) to the executive director provided a monthly list of staff training compliance to managers.
- In order to encourage staff to remain up to date with their mandatory training, their annual incremental pay rise was dependant on them being up to date with their mandatory training.
- For our detailed findings on mandatory training, please see the Safe section in the surgery report.

## Nursing staffing

- Staffing levels were determined on historical data, trends and professional judgement. An electronic roster tool was used across all departments in line with the BMI rostering policy.
- The outpatient department manager told us that there were safe staffing levels in the department and that there was a full establishment of staff in post. Data provided by the hospital showed that there were 2.9 whole time equivalent registered nurses in post and 3.5 whole time equivalent health care assistants. There was one registered nurse on long-term sickness absence but bank nurses covered these shifts. The bank nurse staff that were used were staff members who used to work at BMI The Manor and had since retired. The staffing rota was completed two weeks in advance and it was rare to need agency staff to cover shifts. Hospital data showed that there had been no agency staff use for registered nurses or health care assistants from December 2016 to November 2017. The outpatient manager told us that staff within the department covered any short-term sickness by working additional hours.

## Radiographers / Physiotherapy staffing

- There were three radiographers in post, one of whom was the imaging department lead. This was the full establishment of radiography staff and staff reported that staffing levels were adequate for the demands of the service. Bank and agency staff were not used. Staff working in the imaging department covered leave and sickness by working additional hours if necessary and by offering outpatients alternative appointment times.
- The physiotherapy department had recently employed its own staff at the hospital, having previously used a sub-contractor company who supplied the physiotherapy service to The Manor. There was a team of six physiotherapy staff who were led by a physiotherapy manager. The team also worked at a neighbouring BMI hospital, and provided cover Monday to Friday.

## Medical staffing

- There were a total of 96 medical staff employed within the hospital under practising privileges rules. These staff worked across the outpatient department and inpatient wards and included a group of radiology staff who worked in the diagnostic imaging department. In the outpatient department medical staff delivered clinics for specialities, which included orthopaedics, urology, gynaecology, general surgery, ear nose and throat, cosmetic surgery, dermatology and rheumatology.
- Radiology support in the imaging department was provided by a team of radiologists working at a local NHS hospital. These staff were managed by a radiology lead and they worked closely with the radiography staff to provide a safe service in the imaging department.

## Emergency awareness and training

- Staff were aware of the business continuity plan which was held at main reception and detailed how essential services would be maintained in the event of disruption from identified risks. For example, staff were able to tell us about the plans in place for managing the risk of flood.
- For our detailed findings on emergency awareness and training, please see the Safe section in the surgery report.

# Outpatients and diagnostic imaging

## Are outpatients and diagnostic imaging services effective?

The effective domain for outpatient and diagnostic imaging services was inspected; however, this domain is not currently rated.

### Evidence-based care and treatment

- There was a regular audit programme for all departments across the hospital. This included hand hygiene, health and safety, fire inspections, and cleaning schedule audits. The imaging department additionally completed a bimonthly audit of the information held on the patient information system and of medical equipment servicing compliance, as well as annual diagnostic imaging and radiation protection advisor audits. We saw that there was good compliance with completion of these audits and that there were action plans in place following the annual audit results. For example, we saw that the action plan from the November 2017 diagnostic imaging audit listed the need to develop some standard operating procedures and create a radiation protection training booklet. The plan identified the responsible named person and timescales for target completion of actions and we saw that these had been achieved.
- The outpatient department lead explained that National Institute for Health and Care Excellence (NICE) guidelines were followed for pre-assessment of patients prior to surgical procedures, for phlebotomy procedures and that breast guidelines were followed for breast cancer patients. However, when asked if there were any local policies or standard operating procedures based on these national guidelines, they were not aware of any such local policies being in place.
- In the physiotherapy department, there was an orthopaedic special interest group open to staff across all BMI hospitals. This group reviewed research and national guidance and used it to agree and establish standardised, evidence based treatment protocols for patients. For example, this special interest group had reviewed new acupuncture guidelines and developed a standard operating procedure for staff to follow based on the national guidance.
- The imaging department used diagnostic reference levels to optimise x-ray doses used in medical exposure. All doses of radiation delivered to patients were recorded on a digital patient data and reporting system. The radiation protection advisor (RPA) could access this and provided quarterly diagnostic reference levels (DRL), which indicated if doses delivered were within safe and nationally comparable dose limits. These DRLs were discussed at team meetings, which raised awareness of doses amongst staff and helped prevent any unnecessary x-ray exposure. The current DRL figures showed that slightly higher than average doses were being delivered because the equipment was ageing, however, the doses were still within an acceptable safe range and there was no risk to patients.
- For our detailed findings on evidence-based care and treatment, please see the Effective section in the surgery report.

### Pain relief

- Patients attending for appointments were outpatients and only required analgesia if they were undergoing minor surgery procedures in the outpatient department. We saw that local anaesthetic was routinely used to ensure that patients did not experience unnecessary pain during minor surgery procedures.
- We observed a consultation in outpatients between a patient and a doctor where the patient's experience of pain was discussed and a visual analogue scale of pain scoring was used to establish the severity of pain.

### Nutrition and hydration

- We noted that there were hot and cold drinks machines available in all waiting areas for use by patients attending for appointments.

### Patient outcomes

- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The outpatient and diagnostic imaging departments contributed to the hospital's corporate audit programme. This included audits of patient health records, infection prevention and control, hand hygiene, and dose reference levels.

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- The outpatient department participated in national Patient Reported Outcome Measures (PROMS) and in the National Joint Registry (NJR). Results were monitored and discussed at the hospital's governance and medical advisory committee on a monthly basis, as well as at regional and corporate level. Outcomes were benchmarked against other comparable services and, where poor outcomes were identified, we saw actions were in place to improve performance.
- The physiotherapy department had introduced a health questionnaire for measuring health status before and after treatment, in order to measure patient outcomes and effectiveness of treatments given. This had been recently introduced at the time of our inspection (April 2018), which meant data was not yet available for the purpose of analysis.
- For our detailed findings on patient outcomes, please see the Effective section in the surgery report.

## Competent staff

### Multidisciplinary working

- Staff in all departments told us that they received an annual appraisal with their line manager and that this process was used to identify any learning needs for the next year. Data provided by the hospital showed that appraisal completion rates were variable. However, it should be noted that staffing numbers within each department were low, which does distort the compliance figures. Appraisal completion data showed that in outpatients, 60% of registered nurses and 83% of healthcare assistants had had an appraisal in the appraisal year to October 2017. For physiotherapy and diagnostic imaging department, 100% of staff had had an appraisal. However, none of the staff that we spoke with reported having any regular one-to-one or supervision meetings with their managers.
- Health care assistants in the outpatient department completed competencies in different specialty areas to ensure they had the right skills to work in different clinics. We saw evidence that staff had completed competencies and a record of these was kept, which was signed off and dated on completion.
- We were told that additional training opportunities were available and supported by the hospital. Staff were encouraged to develop new skills. For example, in the imaging department two of the radiography staff were completing their mammography training, which had been financially supported by the hospital. In physiotherapy, staff had regular opportunities to attend specialist training days and attendance was funded by the hospital. In outpatients, two staff were being supported to complete management training courses.
- All staff in the imaging department were fully qualified and appropriately trained in the use of all x-ray equipment. We saw that records were kept to evidence staff training on each piece of equipment; the equipment manufacturer and the radiation protection advisor provided training.
- A radiologist completed all ultrasound investigations as the radiographers did not have additional sonography training. Each radiologist had a specialist area of sonography and appointment clinics were arranged around radiologist availability to ensure that staff with the right skills were available to perform investigations.
- The team of radiologists who provided daily support to the imaging department reported all x-ray images. There was no outsourcing of radiology reporting.
- We observed good multidisciplinary team (MDT) working across departments with heads of department from nursing, radiography, and physiotherapy attending a weekly debrief meeting to discuss patient updates and relevant service delivery issues. The physiotherapy staff visited the ward on a daily basis, to identify new referrals and to facilitate effective communication between themselves and the nursing staff. Physiotherapy staff wrote updated information in the patient's medical records to ensure the MDT were aware of patient's rehabilitation progress.
- Radiography staff had good working relationships with the radiologists who provided cover from the neighbouring NHS trust. They were able to contact them easily for advice and support. Additionally there was an honorary contract arrangement with a local NHS trust to enable the radiographers training in mammography to gain further experience and undertake sufficient procedures to complete the training programme.
- Staff told us about partnership working across the BMI hospital group. We heard about a monthly teleconference between all pharmacy leads working for BMI where information and learning was shared. The

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radiation protection supervisor (RPS) had a meeting arrangement with other radiation protection supervisors working in local BMI hospitals to review and standardise practises and share learning.

- We were told that there had been a one-stop clinic for suspected breast cancer patients where a radiologist, radiographer and breast surgeon worked together in order that the patient could have all investigations and consultations at one appointment. This service had recently become unavailable due to the radiologist leaving the area, although the hospital hoped to find a replacement.

## Seven day working

- The outpatient department offered appointments Monday to Friday, 8.30am to 9.30pm. We were told that Saturday clinics could be arranged in order to manage waiting lists if necessary.
- The physiotherapy department was staffed Monday to Friday, 8am to 5pm and in addition, there was a weekend rota to provide input to inpatients if required; this was planned in advance and staff only worked at the weekends if there was a pre-identified need. There was no on-call physiotherapy service available.
- The imaging department offered outpatient x-ray appointments Monday to Friday until 9pm (when orthopaedic clinics were being held). Staff worked weekends to cover theatre lists if required. They also provided a 24-hour, seven days a week on-call service on a rota basis. The radiologists were able to provide cover Monday to Friday for planned clinic appointments and offered an on-call service for emergencies, such as the need for an ultrasound scan in the case of a suspected blood clot.

## Access to information

- We found that there were limited records kept on site, although a new record filing and tracking system was being developed for record storage in the administration block. This was in response to some instances where patient records had not been available for clinic appointments. Consultants kept their own records for private patients but the new records tracking system included a copy of all consultant records being kept on site to ensure that staff always had access to relevant information and a full set of patient records.

- The imaging department was not able to provide electronic access to diagnostic results and sent diagnostic test results to GPs by letter or fax. Imaging results were stored along with reports on the picture archiving and communication system and were readily accessible by BMI staff and visiting radiologists. If previous images were required, staff could request these through an imaging exchange portal and we were told these could be viewed within 24 hours of request.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that appropriate consent was sought prior to patients undergoing a minor surgery procedure. We saw evidence of this documented in the patient care pathway records. We reviewed six sets of records of patients who had undergone a minor surgical procedure and saw documentation that the procedure had been explained to them, including risks and benefits and both the patient and consultant had signed and dated a consent form. The outpatient lead gave an example of when a minor surgical procedure was cancelled as the patient did not appear to understand the explanation and refused to sign a consent form. This was investigated and the procedure was rescheduled after a further consultation to explain the procedure and ensure the patient was fully informed, willing and able to provide informed consent.
- In the imaging department staff told us that the usual method of consent for diagnostic investigations was implied consent. Part of the 'pause and check' process was to confirm with the patient what investigation they were attending for; we saw this process completed during several clinical observations. The department had a poster displayed from the society of radiographers, which provided information on obtaining consent.
- Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training was mandatory for all staff, however mandatory training records provided by the trust did not list MCA and DoLS training as a separate training topic. Figures were requested for MCA and DoLS training compliance and the hospital told us that MCA and DoLS training was not a separate course but that it formed part of the safeguarding level two training that all staff working within the hospital had to undertake. Information from the training overview document

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provided by the hospital demonstrated that an awareness of MCA and DoLS issues was covered within this training course. However, when we spoke with staff about their understanding of mental capacity, they had limited knowledge of how to apply the principles of a capacity assessment to patients who may have capacity issues. Staff told us that they rarely worked with patients with a diagnosis of dementia or a learning disability. When questioned, staff said they would ask a relative to help a patient provide consent if they had concerns. There was no comprehensive MCA and DoLS training and limited staff understanding of capacity issues, therefore we could not be assured that all staff understood the requirements of the legislation of the Mental Capacity Act 2005.

- For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please refer to the Effective section in the surgery report.

## Are outpatients and diagnostic imaging services caring?

Good 

We rated caring as **good**.

### Compassionate care

- We saw that the reception staff greeted patients warmly and ensured that privacy and dignity was respected at all times. Patients were asked to complete a registration form and health summary on arrival. Personal information was not discussed at the reception desk in case other patients in the waiting area overheard the conversation; all personal conversations happened in the private consultation rooms.
- Most patients we spoke with told us that staff were friendly and polite and one patient was particularly complimentary about the consultant they had seen. One completed comment card about patient experience in the physiotherapy department said 'the physio team have been absolutely brilliant, they have been very informative, encouraging and caring. I can't praise them enough.'

- We observed that staff were friendly and helpful towards patients and aimed to put them at their ease during consultations and investigations. We saw that staff introduced themselves by name and fully explained procedures to patients.
- Staff maintained patients' privacy and dignity at all times. Privacy curtains were used during all examinations and there were posters in each consultation room offering patients the option of a chaperone. In the imaging department, all ultrasound investigations completed by a radiologist were chaperoned by a radiographer as routine.
- In the imaging department patients were offered the choice of changing into a gown or remaining in their own clothes. Paper towel was used to maintain dignity during intimate investigations.
- Staff took extra time and care to ensure patients were as comfortable as possible throughout investigations. For example, we observed one patient undergoing an ultrasound appointment who was in discomfort and who had mobility problems. Staff took extra time and care to ensure the patient was as comfortable as possible throughout the investigation, providing assistance to reposition on the treatment couch and offering extra pillows.

### Understanding and involvement of patients and those close to them

- We observed staff in the imaging department explain to patients that their results would be sent to their GP. We heard them provide reassurance to patients about the findings of the investigation after it had been carried out.
- We heard that any fees associated with a patient's treatment were discussed with them prior to any intervention.

### Emotional support

- Staff told us that the length of appointment times was variable according to the type of consultation and the level of support each patient needed. Additional time was allowed for new patient appointments and certain specialties.

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## Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as **good**.

### Service planning and delivery to meet the needs of local people

- There were three waiting areas for patients; one downstairs in the main hospital, one in the outpatients department on the first floor and one in the barn for physiotherapy and health screening appointments. There was sufficient seating, and drinks machines were available for hot drinks and water. There were a range of information posters and leaflets on display in the waiting area.
- The outpatient clinics were held in rooms on the first floor and there was a lift available for patients. The staircase was wide and had a bannister on one side to assist patients climbing the stairs. However, there was no second hand rail on the other side, which may have prevented some patients with mobility difficulties from using the stairs safely.
- There was a car park at the hospital, which patients reported to be busy at times. Several patients told us that they had experienced difficulty parking on previous visits. There was no charge for car parking. Staff told us there was car parking accessible for them off site to keep all available space for patients and visitors.
- Outpatient clinics were held throughout the day and into the evening to facilitate flexible appointment times that were convenient for patients. We were told that sometimes clinics were held on Saturdays if there was a need to meet NHS waiting time targets, however, no clinics had been held at weekends for several months.
- The hospital had a service level agreement for magnetic resonance imaging (MRI) and computed tomography (CT) scans with a third party. This demonstrated that the hospital worked with local providers to ensure patients received a streamlined service. There were proposed plans in place for the hospital to purchase its own MRI scanner.

- Patients attending the hospital outpatient department were a mix of privately funded and NHS funded patients (these patients had chosen the hospital as a location for their appointment through the NHS e-referral system). The local clinical commissioning group (CCG) set criteria within their contract for NHS patient's attendance at the hospital. This meant that local commissioners were involved in the planning of local services.

### Access and flow

- The hospital had a contractual target to meet 95% of patients on non-admitted pathways within 18 weeks of referral to treatment (RTT). During the reporting period from July 2017 to February 2018, for which data was provided, the hospital met the target for only one out of the eight months for standard NHS e-referral patients. The average percentage number of NHS e-referral patients seen within 18 weeks RTT during this period was 90%. For patients referred through the musculoskeletal non-admitted referral route, such as for pain management, the target of 95% seen within 18 weeks RTT was achieved for two out of the eight months in the same reporting period. The average percentage number of musculoskeletal patients seen within 18 weeks during this period was 83%. The hospital cited consultant annual leave, patients choosing to delay appointments, and receiving late referrals, as reasons for non-compliance with the 95% target. The commissioning arrangements allowed for an 8% threshold on achievement of targets within the service contract and fines were issued for results outside of this threshold. The hospital told us that there was a process whereby each breach of the 18-week RTT target was investigated. There was an agreement with the local commissioning body that any breaches outside of the hospital's control, such as late referrals, would be exempt from a fine. The hospital reported that they had not received any fines in the last 12-month period.
- Patients we spoke with told us that they had not had any significant wait for their outpatient appointments. However, none of the NHS patients we spoke with had been offered a choice of appointment times.
- We found that three of the six patients we spoke with in the outpatient waiting area had been waiting for 20 to 30 minutes beyond their appointment time. Although

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reception staff told us that they informed patients of any delays in clinic appointment times, none of the patients we spoke with had been told that clinics were running late.

- In outpatients, if a patient did not attend their appointment they were contacted to query if the appointment was still required. If it was then a further appointment was offered but if a patient did not attend for the second appointment they would be discharged and a record made on their file of the non-attendance.
- For diagnostic imaging, post-operative patients on the wards were prioritised for x-ray and would be seen on the same day. In addition, patients were referred for x-ray by the consultant during their clinic appointment. These images were taken whilst the patient was at the hospital for their appointment and reviewed by the consultant. Most outpatient referrals in diagnostic imaging were for ultrasound scans. Radiologists held daily clinics for ultrasound scans, which offered four appointments per session. Staff told us that they could see all patients referred for ultrasound scan within a few days and that patients never had to wait more than a week for an appointment. Patients we spoke with confirmed they had not had to wait for an ultrasound scan appointment.
- There was a small backlog of reporting for x-ray images; the target for reporting was within 24 hours of the image being taken for ward patients, although there was no target for clinic patients. Data showed that at the end of March 2017 there were seven unreported x-rays. During inspection there were 40 x-rays waiting for reporting which staff told us was due to a radiologist being off sick. There was a process to try and clear any backlog of reporting at the end of each month, however there was not a process in place for monitoring and reporting average and longest wait information. Staff told us that radiologists could be contacted to request additional hours cover at the hospital to carry out an extra reporting session if required.

## Meeting people's individual needs

- Staff told us about how they worked with a local organisation that support people with hearing impairments to help a patient understand information provided during a consultation. The hospital had accreditation from the organisation 'action for hearing

loss', which is a nationally recognised for organisations striving to offer excellent levels of service and accessibility for people who are deaf or have a hearing loss.

- Each reception had a low height desk suitable for wheelchair users and a hearing loop available to assist communication with patients with a hearing impairment.
- Wheelchair users were able to access the outpatient department on the first floor by using the lift facility. All imaging facilities were accessible to wheelchair users as they were located on the ground floor.
- Interpreting services were available through the use of language line, which staff told us they used as required.
- There was limited experience of staff working with patients with dementia or learning disabilities. Staff appeared to have limited knowledge and understanding of how to meet any special support needs required by patients living with these conditions.
- Staff in the imaging department told us that information about investigations was sent out to patients with a letter confirming their appointment time. We saw that in the imaging department a range of information leaflets had been developed for patients to provide information about the investigations they were undergoing. We saw copies of these information leaflets and patients confirmed that they had received this information prior to their appointment. However, in the outpatient department, very few patients reported receiving any information, other than their appointment details, prior to their appointment.
- We saw that the physiotherapy department provided bespoke information booklets, which provided patients with information about their condition, details of their exercise programme and general health promotion and lifestyle advice. These were created on an individual basis and the content was discussed with patients to make sure they understood the information and had an opportunity to ask any questions.

## Learning from complaints and concerns

- Patients we spoke with knew that there was a complaints procedure but told us that they were happy with the service they had received.

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- Staff told us that they received very few complaints and that they tried to resolve verbal complaints informally in the first instance. Staff understood the principles of duty of candour and could describe them. They explained how they would admit any mistakes made, be open and honest and not cover anything up, and try to deal with issues locally where possible.
- The hospital listed eight complaints across outpatients, imaging and physiotherapy services from September 2017 to February 2018. We reviewed these complaints for themes and found that three were about incorrect charges, three related to poor communication about appointments and two were delays in scan report availability. We saw that the hospital had appropriately investigated the complaints and apologised to all patients involved.
- For our detailed findings on learning from complaints and concerns, please see the Responsive section in the surgery report.
- Several staff told us they enjoyed their job and felt a sense of pride in their work stating they had worked happily at the hospital for many years.
- Staff felt well supported in their roles; for example, the radiography lead told us that they received support from a range of sources including the lead radiologist, the local radiation protection group and the national imaging director for BMI hospitals.
- We heard that senior leaders in the hospital, such as the executive director and director of clinical services were visible and did regular walk rounds of all departments to ensure they were aware of operational issues and gave staff an opportunity to communicate with them. Department managers told us that the senior managers used this as an opportunity to say thank you to staff in order to demonstrate that they valued and appreciated staff.

## Are outpatients and diagnostic imaging services well-led?

Good 

We rated well-led as **good**.

### Leadership and culture of service

- There were named and experienced departmental leads for outpatients, imaging and physiotherapy services. Each lead was passionate about the service they led and worked well with the team of staff in their department. There was a strong sense of team working in each department and all staff worked well together, whatever their role.
- Staff we spoke with told us they felt well supported by their department managers. They told us that they were approachable and available to help, regularly working clinical shifts within the departments. Staff reported that they felt valued and respected by other staff. Staff described having positive working relationships with peers and managers and talked of colleagues as friends. We were told that all staff worked together well and that everyone from housekeepers to consultants was part of 'the team'.

### Vision and strategy for this core service

- There was a clear vision and strategy for the hospital, which had been communicated to staff. When asked about the vision, staff told us that there was a plan to focus on specialising in orthopaedic surgery in order to maximise revenue. There was a plan to develop an ambulatory care room for use for recovery from local anaesthetic procedures in order to enable more theatre time to be used for orthopaedic surgery (joint replacements). Staff reported that they were not involved in developing the hospital vision, but were aware of what the vision was.
- The executive director described priorities for hospital objectives, which included replacement of x-ray equipment and scoping the feasibility of installing a magnetic resonance imaging (MRI) scanner in the hospital. Staff confirmed that these were plans that had been communicated to them.

### Governance, risk management and quality measurement

- There were clear reporting structures in place with each department having a named lead and individual responsibility for that department. All department leads told us they reported directly to the director of clinical services.
- There were regular meetings attended by the department leads and the executive director, which

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included clinical governance meetings, infection prevention and control meetings and heads of department meetings. We saw that these meetings were minuted including documenting attendance, confirming previous minutes and reviewing outstanding actions. There were standing agenda items, for example, health and safety, review of incidents, staffing, audit results and the risk register and an opportunity for staff to discuss any other business. We saw that the meetings were comprehensive and took a systematic approach to reviewing performance, safety and quality. However, we noted that sometimes these meetings were cancelled due to a lack of availability of the quorum membership to attend. We saw that two out of four infection prevention and control meeting dates from March 2017 to January 2018 were cancelled and two monthly heads of departments meetings from August 2017 to December 2017 were cancelled. The hospital told us that this may be caused through sickness, annual leave, or the need for managers to provide clinical cover rather than attend the meeting.

- Additionally, there were clinical service lead meetings between the director of clinical services and all clinical service leads, and departmental meetings in outpatients and diagnostic imaging. These meetings were structured and minuted.
- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department according to an audit schedule and results were shared at relevant meetings such as the hospital clinical governance meetings. We saw that action plans for improvement in audit results were presented and reviewed at clinical governance meetings. Audit records and meeting minutes we reviewed confirmed that this process was embedded.
- There were annual radiation protection committee meetings between the radiation protection advisor, the radiation protection supervisor, the radiology lead and the executive director. These meetings reviewed the results of the annual radiation protection audit and compliance with ionising radiation medical exposure regulations (IR(ME)R) procedures. We saw that the minutes of the meeting identified required actions and

named the person responsible for the action as well as a target completion date. Radiation protection was also a standing agenda item at the hospital clinical governance meetings.

- The outpatient department lead told us there was a departmental risk register but when we asked to see a copy of this, the only copy that could be provided was a hard copy, which was out of date, having a date range from 1 January 2017 to 5 July 2017. It was unclear who had overall responsibility and ownership of this risk register. There were no details of action plans documented on this risk register. The outpatient departmental risk register did not match the 'worry list', which the department lead had told us about. For example, the lead told us the biggest risks included the risk of the lift breaking down and the lack of a second handrail on the staircase; however, neither of these were listed on the risk register. The risk register did list two facilities issues (the small outpatient staff office and lack of secure filing for outpatient information) but neither of these issues was identified as a risk by the department lead. Staffing was identified as a departmental risk both on the risk register and by the department lead, yet we were told that the department was fully staffed. This therefore appeared to be an out of date risk, which had not been updated on the departmental risk register. This meant that we could not be assured that there were sufficient governance systems in place in outpatients to assess, monitor and mitigate current risks. However, we reviewed the electronic hospital risk register and saw it was regularly reviewed and updated.
- The imaging department had a local risk register, which the department lead had oversight of. The risks identified by the imaging lead matched the risks identified on the imaging risk register, such as the x-ray equipment. We reviewed the electronic hospital risk register and saw that it included actions taken to minimise each risk and dates when risks were added and reviewed. Therefore, we were assured that risks were appropriately managed by the hospital.
- For our detailed findings on governance, risk management and quality measurement, please see the Well-led section in the surgery report.

## Public and staff engagement

- The hospital told us that before any change was implemented they spoke with staff about the benefits

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and reasons for the proposed change and sought staff feedback. This engagement happened through departmental and staff meetings and information was provided in the hospital monthly newsletters.

- Staff told us that managers at all levels were approachable and that they felt comfortable to raise any concerns with them.
- For our detailed findings on public and staff engagement, please see the Well-led section in the surgery report.

## **Innovation, improvement and sustainability**

- There was a culture of continuous staff development across the departments. We were told that two health care assistants had started their assistant practitioner training and that two radiography staff were completing

their mammography training. A senior manager was in the process of completing a level five management training course. This demonstrated the hospital's commitment to continuous staff learning and improvement.

- We saw that the outpatient department refurbishment programme which was underway during the last inspection had been fully completed. In x-ray, the ultrasound and mammography machines had been replaced since the last inspection. The refurbishment of the health screening area was in progress during our inspection and there were plans to develop the physiotherapy gymnasium facilities.
- Managers told us that they were scoping the feasibility of installing an MRI scanner at the hospital, although there was no target date for this to happen.

# Outstanding practice and areas for improvement

## Outstanding practice

- The provider promoted a holistic approach to safety, quality and engagement. Since our previous inspection, the provider had introduced a daily communications cell meeting as a means of improving safety, staff engagement, communication, and multidisciplinary team working. The senior management team and a representative from each clinical and non-clinical area such as engineering, catering, housekeeping and reception, attended this.

A brief overview of the day's activity, utilisation, staffing, incidents, complaints, medical alerts and potential risks to the service was discussed. Staff were also advised of any visitors, such as contractors, who were on site. The managers then took this information back to their department and shared with the rest of their staff. The information was also documented on a whiteboard in the staff dining area for all staff to view.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The provider should ensure that all staff have completed mandatory training.
- The provider should ensure that staff have completed the appropriate level of safeguarding adults and children training.
- The provider should ensure that local risk registers are detailed, up to date, reviewed regularly, and reflect the risks within each service.
- The provider should ensure that staff have received an annual appraisal.

- The provider should ensure that consent to treatment is obtained in line with best practice.
- The provider should ensure all policies and standard operating procedures are up to date and reflect current evidence-based guidance.
- The provider should ensure there is a robust competency assessment process in place within theatres, and that competency frameworks are up to date.
- The provider should ensure the flooring in the physiotherapy gym conforms to building regulations.