

BMI The Droitwich Spa 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		Requires improvement	
Are services safe?		Requires improvement	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive?		Good	
Are services well-led?		Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Droitwich Spa Hospital was purpose built and constructed in 1985. In 2013, the hospital opened an additional wing, which provided additional bedrooms and consulting rooms. The hospital has 46 registered beds, three operating theatres, 11 outpatient consulting rooms and an endoscopy suite.

The hospital provides outpatient consultations and a range of surgical procedures for adults aged 19 and over, to privately funded, insured and NHS patients.

We carried out this comprehensive inspection, as part of our national programme to inspect and rate all independent hospitals under our new methodology. We carried out an announced inspection of BMI The Droitwich Spa Hospital on the 16, 17 of August 2016 and an unannounced inspection on 31 August 2016.

We did not inspect the MRI or CT scanning services as these are provided and managed by another registered provider.

Our key findings were as follows:

We rated the hospital as requires improvement overall, with surgery rated requires improvement and outpatients and diagnostic imaging rated as good. Three of the five key questions we always ask, namely is the hospital effective, caring and responsive were rated as good overall, with safe and well-led rated as requiring improvement.

Are services safe at this hospital/service?

- The provider did not have robust procedures to ensure that invasive equipment (naso-endoscopes) were decontaminated in line with national guidance.
- Clinical areas were observed to be clean and tidy. However, we did observe some individual instances of poor infection control and prevention practice.
- The service complied with the completion of the five steps to safer surgery checklist. However, consultants had to be encouraged by the theatre nursing team to complete this in a consistent way.
- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance.
- The hospital did not have an in-date service level agreement with local hospitals regarding the emergency transfer of patients should they deteriorate and require additional intervention. However, subsequent to our inspection, the hospital has provided a copy of an SLA for transfer of critically ill patients to a nearby NHS trust, signed in January 2017.
- We found that safe medicines management procedures were not consistent with hospital policy at all times, in the operating theatres. However, the issues we identified had been rectified at our unannounced inspection.
- The director of clinical services was the lead for safeguarding at the hospital and was trained to level three in both safeguarding children and vulnerable adults. There were arrangements in place to safeguard adults from abuse that reflected relevant legislation and local requirements. Staff knew how to recognise and report a safeguarding incident.
- Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff had awareness of the importance of the duty of candour regulation.
- Handovers were well structured within the service with both safety and resuscitation huddles taking place each morning in theatres and on the ward.

Are services effective at this hospital/service?

- Patients received care according to national guidelines such as National Institute of Health and Care Excellence (NICE) and Royal College of Surgeons.
- Patients had their needs assessed, care goals identified, care planned and delivered in line with evidence-based guidance, standards and best practice.

Summary of findings

- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits. There was evidence of actions and audit results being shared with staff.
- There were processes and procedures in place for staff to manage patients' pain and ensure that patients' nutrition and hydration needs were met.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA).
- There were effective arrangements for the admission and discharge of patients. Discharge planning began during the pre-operative assessment process.
- All personal files of consultants with practising privileges at the hospital contained details of indemnity insurance and evidence of registration with the GMC. However, out of 151 consultants with practising privileges, 51 consultant's files required their biennial review, as per the hospital's policy. This meant that we could not be assured that all the practising agreements terms were being met.
- Staff appraisal rates were low within theatres. We saw that 35% of registered nurses and 40% of operating department practitioners had received their annual appraisal.

Are services caring at this hospital/service?

- Patients were unanimously complimentary about the care they had received. This was also reflected in the positive feedback in patient satisfaction surveys.
- Patients felt that they were part of the decision making process regarding their treatment plan. We saw that staff provided an unhurried approach and treated patients with respect.
- Patient's privacy and dignity was maintained at all times during our inspection.
- There were appropriate arrangements to support and meet the emotional and spiritual needs of patients including an open visiting policy and access to chaplaincy.

Are services responsive at this hospital/service?

- Patients' specific requirements such as learning disabilities or mental capacity issues were identified at pre assessment. This included screening for patients living with dementia to ensure appropriate arrangements were made to meet individual patient needs, such as longer appointments or arrangements for relatives or carers to stay with them in hospital.
- The hospital met its national (admitted) target with 94% of NHS funded patients being treated within 18 weeks from referral.
- Patients had short waiting times in departments prior to consultations or appointments.
- Complaints were handled effectively and confidentially. Themes from complaints were communication of fees and consultant's attitude. We saw that action had been taken to address these issues.

Are services well led at this hospital/service?

- Practising privileges were not being reviewed as per hospital policy. This meant the appropriate systems and processes were not in place to ensure consultants with practising privileges met required standards to practice.
- Leaders had not ensured that there was an in-date service level agreement in place for patients who became critically ill and required transfer to a local NHS hospital. Subsequent to our inspection, the hospital provided a copy, confirming that this was now in place (January 2017).
- There were improvements that were required related to infection prevention, medicines management and storage at the hospital. We could not always be assured that identified quality and performance issues were being addressed.
- The hospital's risk register was at a corporate level. This meant that it did not always describe risks found at a local or departmental level.
- The vision and values were clearly displayed in the hospital and had been shared with staff across the ward and theatre areas. Most staff had an awareness of these and knew where to find the information.

Summary of findings

- There was clear and visible leadership at both an executive and head of department level. Staff including administrators, nurses and catering staff told us they were highly motivated and felt valued and supported by their immediate line managers
- The team safety “huddle” meeting, had been introduced within the hospital to improve communication across departments. This appeared to have been positively received by staff from different departments and disciplines.

Importantly, the provider must:

- Implement procedures to ensure that invasive equipment (naso-endoscopes) are decontaminated in line with national guidance.
- Ensure that all members of clinical staff work within infection prevention and control guidelines.
- Ensure that all staff consistently participate and complete the five steps to safer surgery checklist.

In addition the provider should:

- Ensure the safe management of medicines at the hospital complies with policy and guidelines. This includes the procedure for managing the medicine keys within the ward area.
- Ensure all staff receive a regular appraisal to support and promote development.
- Ensure all consultants practising privileges are reviewed in line with company policy
- Ensure that sinks and taps which conform to Health Building Note 00-10 Part C Sanitary Assemblies are available in clinical areas to allow correct hand hygiene practice.
- Ensure carpets in clinical areas are replaced with flooring that meets the requirements of Health Building Note (HBN) 00-09: Infection control in the built environment.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Surgery

Requires improvement



Staff did not always comply with infection prevention and control guidelines, such as wearing personal protective equipment.

The service complied with the completion of the five steps to safer surgery checklist. However, consultants had to be encouraged by the theatre nursing team to complete this in a consistent way.

Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance, such as clinical hand basins and flooring type in patient rooms.

We found medicines management issues including medicines prepared for patients in advance for operations. However, during our unannounced visit on 31 August, we did not find any issues with medicines management and the theatre manager had been undertaking spot check audits to ensure consistent good practice.

The hospital did not have an in-date service level agreement with local hospitals regarding the emergency transfer of patients should they deteriorate and require additional intervention. However, subsequent to our inspection, the hospital provided a copy, confirming that this was now in place (January 2017).

Staff appraisal rates were low within theatres. We saw that 35% of registered nurses and 40% of operating department practitioners had received their annual appraisal.

All personal files of consultants with practising privileges at the hospital contained details of indemnity insurance and evidence of registration with the GMC. However, out of 151 consultants with practising privileges, 51 consultant's files required their biennial review as per the hospital's policy. This meant that we could not be assured that all the practising agreements terms were being met.

Summary of findings

Staff understood their responsibilities to report incidents and were aware of the duty of candour regulation of being transparent, open and honest. Lessons learned from incidents were shared among the team.

The areas we visited were visibly clean and tidy. Mandatory training levels on subjects such as infection control and both intermediate and basic life support training consistently met compliance standards across the service.

Medical staffing was appropriate and the hospital used a staffing tool to ensure safe levels of nursing care. There was a staff induction and competency framework in use across the service.

Most treatment and care was provided in accordance with evidence-based national guidelines. We saw all policies were up-to-date and followed the relevant guidance such as from the National Institute of Health and Care Excellence (NICE).

There was good practice, for example, in the monitoring of nutrition and hydration of patients. Healthcare records were easy to access and contained information on the patient's journey through the hospital, which included the use of care pathways.

Patients told us they were pleased with the care received and were kept informed and involved in the treatment plans. We saw patients being treated with dignity and respect during the inspection. The hospital had an open visiting policy.

There were effective arrangements for the admission and discharge of patients. Discharge planning began during the pre-operative assessment process.

Written information was available in different languages and staff could access an interpreting service when required.

There was a governance structure within the service. The hospital audited and monitored avoidable harm caused to patients.

Staff felt supported by their team and the hospital leaders. Complaints were handled effectively and confidentially.

Summary of findings

Outpatients and diagnostic imaging

Good



Staff were actively encouraged to report safety concerns and incidents. There was a high level of low or no harm incidents reported. There had been no serious incidents or never events reported in the outpatients and diagnostic imaging department in the twelve months ending March 2016.

Staff were able to give examples of when practice was changed following learning from incidents or concerns. They understood the principles of the duty of candour.

Equipment we checked was clean and maintained appropriately, with 'I am clean' sticker used to show that the item was ready to use.

Appropriate environmental measures, including signs, were in place to identify areas where radiological exposures were taking place in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The imaging department had clear processes in place to ensure that the right patient received the correct radiological procedure.

The outpatient's manager undertook regular multiple quality audits within the department. The imaging department followed best practice guidance by checking radiation levels against national diagnostic reference levels.

During the inspection, patients' consent was obtained in line with the hospital policy and the Mental Capacity Act (2005).

Local and hospital policies and guidance we checked, were within review date and based on relevant national or professional guidance.

Staff had access to the information they needed to deliver effective care and treatment.

There were short waiting times from referral being made to treatment being provided. Between 99%-100% of NHS funded patients began treatment within 18 weeks of referral (April 2015 to March 2016).

Patients had short waiting times in departments prior to consultations or appointments.

There was clear signposting to the departments and staff available to provide advice and assistance at the reception areas.

Summary of findings

10 formal complaints had been received in seven months (ending July 2016) themes included poor communication of fees and consultant's attitude. However, we saw that action had been taken to address these issues.

Patients were unanimously complimentary about the care they had received in the departments. This was also reflected in the positive feedback in patient satisfaction surveys.

Patients felt that they were part of the decision making process regarding their treatment plan. We saw that staff provided an unhurried approach and treated patient with respect.

Patient's privacy and dignity was maintained at all times during our inspection.

Staff were aware of the corporate vision and strategy of the BMI group.

Risk assessments had been completed for areas of concern that we found during the inspection. This meant that managers were aware of the areas of risk in their departments.

Staff morale was good and local leadership was supportive.

Daily 'huddle' meetings were used as a forum to alert daily risks to the senior management team. The departments sought feedback from patients who used the services and were proud of the positive satisfaction survey scores.

Clinical areas at the hospital that had not been refurbished, were not compliant with current Health Building guidance.

These included the flooring type and coverage in some rooms, positioning or lack of hand wash sinks and an examination couch with a ripped cover.

There were plans for refurbishment areas of non-compliance to infection control and prevention policies such as flooring. Timescales for this were not clear.

There was a general lack of hand cleansing gels throughout the clinical departments. However, during our unannounced inspection, we found hand sanitiser gels dispensers had been installed for staff and patients to use when moving between areas.

Summary of findings

Naso-endoscopes, which were flexible fibre optic tubes used for ear, nose and throat (ENT) procedures were not being decontaminated in a separate room from the clean scopes. This posed a risk of cross infection.

There were not processes in place to ensure that all staff in the outpatients and diagnostic imaging services had an annual appraisal.

Summary of findings

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Requires improvement



BMI The Droitwich Spa Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to BMI The Droitwich Spa Hospital

BMI The Droitwich Spa Hospital was purpose built and constructed in 1985. In 1990, the hospital opened an additional wing, which provided additional bedrooms and consulting rooms. The hospital is located in Droitwich Spa town centre and treats patients from a wide catchment area including the Wyre Forest, South Worcestershire and Redditch and Bromsgrove.

The BMI The Droitwich Spa Hospital has 46 registered beds. During the inspection, 36 of these were being used for inpatients. The hospital has three operating theatres and an endoscopy suite.

In the outpatients department there are 11 consulting rooms, which include dedicated ear, nose and throat (ENT) and ophthalmology rooms and a treatment room. The diagnostic imaging department includes an x-ray and a non-obstetric ultrasound.

The hospital has a computerised tomography (CT) and magnetic resonance imaging (MRI) suite. However, this operated by another registered provider and therefore did not form part of this inspection.

There are administration and management teams on site.

The hospital managed by BMI Healthcare Limited and is part of a network of 59 hospitals across England, Scotland and Wales. The Registered Manager of the hospital had been in post for over three years.

The hospital provides private, insured, self-pay and NHS services. NHS funded care is mostly through the NHS electronic referral system.

Our inspection team

Our inspection team was led by a Care Quality Commission Inspection Manager

The team also included CQC inspectors, a CQC assistant inspector and a variety of clinical specialists: a clinical governance manager, a consultant anaesthetist, two senior nurses and a radiographer.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out this inspection as part of our comprehensive inspection programme.

Before visiting, we reviewed a range of information we held about the hospital and both core services.

We visited the hospital on the announced inspection on 16 and 17 August 2016. We returned on 31 August 2016 to carry out an unannounced inspection.

We talked with patients and their relatives and visitors during the visit and provided comment cards for people to provide us with feedback. We received 21 completed comment cards.

We held two drop in sessions, where staff could talk to inspectors and share their experiences of working at the hospital.

We interviewed the senior management team and chair of the Medical Advisory Committee. We spoke with a wide range of staff including nurses, resident medical officer, radiographers and administrative and support staff.

Summary of this inspection

We also observed care being provided, checked the environment, looked at patients' healthcare records and considered data about the hospital services.

Information about BMI The Droitwich Spa Hospital

BMI The Droitwich Spa Hospital is a location registered with the Care Quality Commission to provide the following regulated activities; Diagnostic and screening procedures, Family planning, Surgical procedures and Treatment of disease, disorder, or injury since 2011.

BMI The Droitwich Spa Hospital provides outpatient services for various specialties to both private and NHS patients. There were a total of 19,100 outpatient cases from April 2015 to March 2016. Of these 53% were NHS funded and 47% were funded through insurance or self-pay.

There were 4,385 inpatient and day cases recorded at BMI The Droitwich Spa Hospital from April 2015 to March 2016.

Of these, 70% were NHS funded and 30% funded through insurance or self-pay. 21% of all NHS funded patients stayed overnight at the hospital compared to 26% of all other funded patients.

All patients were admitted and treated under the direct care of a consultant and medical care was supported 24 hours a day, seven days a week by an onsite resident medical officer (RMO). Patients were cared for and supported by registered nurses, healthcare assistants, allied-health professionals, such as physiotherapists and support staff, who were employed by the hospital.

The Registered Manager of the hospital was the Controlled Drug Accountable Officer.

Detailed findings from this inspection

Overview of ratings






Our ratings for this location are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Surgery

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

Information about the service

BMI The Droitwich Spa provided day surgery and inpatient treatment for both NHS funded and private patients across a range of surgical services, including cosmetic surgery, orthopaedics, ear, nose and throat (ENT), general surgery, gynaecology, ophthalmology, urology, gastroenterology and endoscopy.

Surgical services available to children and young people ceased in 2016. The hospital did not carry out any invasive surgical procedures on patients under the age of 19.

The hospital had three laminar flow (a system of circulating filtered air in order to reduce the risks of airborne contamination) operating theatres and an endoscopy theatre suite. The recovery area had three bays with the ability to flex to four bays when required. The hospital had 46 registered beds, with 36 of these used as patient bedrooms. This was due to a move to providing more day case and outpatient services.

We visited the hospital as part of our announced inspection on 16 and 17 August 2016 and an unannounced inspection on 31 August 2016. As part of the inspection, we visited the pre-assessment clinic, the three operating theatres, the theatre recovery area, the endoscopy suite and the surgical ward.

During the inspection, we spoke with 18 staff at different grades including ward and theatre managers and nurses, allied health professionals, consultants, healthcare assistants, pharmacist and housekeepers. We spoke with six patients and their families, observed care and treatment

and looked at 13 patient's medical records. We received comments from people who contacted us to tell us about their experiences and reviewed performance information about the hospital.

Surgery

Summary of findings

Overall, we rated the surgical services as requires improvement. We rated the service as requires improvement for safe and well-led and as good for being effective, caring and responsive.

We found:

- Staff did not always comply with infection prevention and control guidelines, such as wearing personal protective equipment.
- The service complied with the completion of the five steps to safer surgery checklist. However, consultants had to be encouraged by the theatre team to complete this in a consistent way.
- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance. Therefore, separate clinical hand basins and clinical flooring was not provided in all patient rooms.
- There were concerns with the management of medicines, including lack of processes for controlled drug keys and medicines prepared for patients in advance of operations. However, during our unannounced visit on 31 August, we did not find any issues with medicines management and the theatre manager had been undertaking spot check audits to ensure consistent good practice.
- The hospital did not have an in-date service level agreement with local hospitals regarding the emergency transfer of patients should they deteriorate and require additional intervention. However, subsequent to our inspection, the hospital provided a copy, confirming that this was now in place (January 2017).
- Staff appraisal rates were low within theatres. We saw that 35% of registered nurses and 40% of operating department practitioners had received their annual appraisal.
- All personal files of consultants with practising privileges at the hospital contained details of indemnity insurance and evidence of registration with the GMC. However, out of 151 consultants with

practising privileges, 51 consultant's files required their biannual review, as per the hospital's policy. This meant that we could not be assured that all the practising agreements terms were being met.

However, we also found:

- Staff understood their responsibilities to report incidents and were aware of the duty of candour regulation, of being transparent, open and honest. Lessons learned from incidents were shared among the team.
- The areas we visited were visibly clean and tidy.
- Mandatory training levels on subjects such as infection control and both intermediate and basic life support training consistently met compliance standards across the service.
- Medical staffing was appropriate and the hospital used a staffing tool to ensure safe levels of nursing care. There was a staff induction and competency framework in use across the service.
- Most treatment and care was provided in accordance with evidence-based national guidelines. We saw all policies were up-to-date and followed the relevant guidance such as from the National Institute of Health and Care Excellence (NICE).
- There was good practice, for example, in the monitoring of nutrition and hydration of patients.
- Healthcare records were easy to access and contained information on the patient's journey through the hospital, which included the use of care pathways.
- Patients told us they were pleased with the care received and were kept informed and involved in the treatment plans. We saw patients being treated with dignity and respect during the inspection. The hospital had an open visiting policy.
- There were effective arrangements for the admission and discharge of patients. Discharge planning began during the pre-operative assessment process.
- Written information was available in different languages and staff could access an interpreting service when required.
- There was a governance structure within the service. The hospital audited and monitored avoidable harm caused to patients.

Surgery

- Staff felt supported by their team and the hospitals leaders. Complaints were handled effectively and confidentially.

Are surgery services safe?

Requires improvement 

We rated the surgical services as requires improvement for being safe because:

- Staff did not always comply with infection prevention and control guidelines, such as wearing personal protective equipment and some medical staff did not decontaminate their hands immediately before and after every episode of direct contact of care.
- The service complied with the completion of the five steps to safety surgery checklist. However, consultants had to be encouraged by the theatre nursing team to complete this in a consistent way.
- There were concerns with the management of medicines, which included lack of processes for controlled drug keys, unsecure storage, medicines drawn up in advance and medicines left out unattended in an anaesthetic room. We saw that actions had been taken and no further issues we found during our unannounced visit on 31 August 2016.
- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance. Therefore, separate clinical hand basins and clinical flooring was not provided in all patient rooms. The hospital had a refurbishment plan but no timescales as to when these would be completed.
- There was no in-date service level agreement in place for patients who became critically ill and required transfer to a local NHS hospital. However, subsequent to our inspection, the hospital provided a copy, confirming that this was now in place (January 2017).
- The hospital had a never event and two serious incidents from April 2015 to March 2016 relating to surgery. However, the incidents had been investigated and action plans completed.

However, we also found that:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff had awareness of the importance of the duty of candour regulation.

Surgery

- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care.
- The staffing levels and skill mix was sufficient to meet patients' needs and staff assessed and responded to patient risks.
- The environment was visibly clean and staff followed the hospital policy for infection control. Equipment was cleaned after use and an 'I am Clean' sticker placed on to it.
- Handovers were well structured within the service with both safety and resuscitation huddles taking place each morning in theatres and on the ward.
- Patient records were completed appropriately and risk assessments were completed using nationally recognised tools.
- Resuscitation equipment for use in an emergency was regularly checked and ready for use in theatres and the ward area.
- Pre-operative assessments were carried out in line with National Institute for Health and Care Excellence (NICE) guidelines.

Incidents

- There had been one strategic executive information system (STEIS) reportable 'never event' from April 2015 to March 2016 relating to surgery. Never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The never event occurred when incorrect size prosthesis was implanted into a hip joint during surgery. This incident was investigated and we saw the outcome of the root cause analysis (RCA), which identified that consultants and staff had not followed BMI policy for checking prosthesis. The recommendations from the RCA, included tidying up the prosthesis stock, swab boards to be ordered so the size of the prosthesis could be recorded and human factors training for theatre staff

involved in the incident. We saw during our visit that all of these recommendations had been implemented and human factors training was undertaken in November 2015.

- The BMI hospital group also identified behaviour between staff and consultants could lead to over familiarity and complacency, which was identified as a contributory factor to the never event. As a result, the hospital re-issued a theatre etiquette policy, which we saw on display.
- The hospital reported two serious incidents relating to surgery from April 2015 to March 2016. We saw both serious incidents had been appropriately investigated and RCA reports and action plans produced. We checked during our inspection that the action plans related to the investigations had been implemented. All serious incidents were analysed at clinical governance meetings to ensure that lessons were learned. Serious incidents were investigated by staff with the appropriate level of seniority, such as the director of clinical services. This information was disseminated to staff via head of department meetings, ward handovers, staff meetings, and safety briefings.
- Staff understood their responsibility to raise concerns, to record safety incidents and near misses and to report them internally and externally. Details of incidents were filled in on paper forms, which were entered onto a computer system by the quality and risk coordinator, and discussed at monthly staff meetings so shared learning could take place.
- The rate of reported clinical incidents was higher than average. This was due to the high level reporting of low harm incidents. For example, there were 257 clinical incidents (68%) and 27 non-clinical incidents (19%) reported from April 2015 to March 2016.
- There had been an incident reported when a resident medical officer (RMO) incorrectly requested two x-rays for the same patient, one straight from theatre and the other day after surgery. Following this, the hospital had incorporated additional checks to ensure this did not happen again. The imaging team meeting minutes identified that these concerns had been discussed with staff.
- From November 2014, providers of NHS care were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and

Surgery

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. Staff we spoke with during the inspection were aware of the duty of candour regulation. We also saw evidence this had been applied when we reviewed incidents reported by the hospital. However, the Medical Advisory Committee (MAC) minutes for May 2016, identified a concern about consultants resisting applying duty of candour when things went wrong. As a result, an action was identified for the medical director to put together a network of disclosure coaches for professionals and peer support. Additional in-house training was also provided. Senior staff confirmed that there had been an improvement in the approach and the implementation of duty of candour and the in-house training was ongoing. We saw that there was a display board informing staff.

- The provider informed us that duty of candour was an agenda item on BMI's national MAC. As part of a national drive, all hospitals were asked to report how they complied with the duty of candour at MAC meetings.
- The ward used information boards to support lessons learned from incidents and to increase knowledge of patient safety issues. The boards were completed monthly by staff. We saw the theme for August 2016 was duty of candour. Staff confirmed their awareness of the display and how they had contributed to it.
- We saw a copy of the Safety Health and Environment (SHE) news on display within the service. We saw the SHE news included near misses and incidents to ensure lessons learned and issues were addressed.
- The hospital had a tracker for all national safety alerts. We saw a copy of the clinical governance, quality and risk bulletin for August 2016, which covered specific learning from national safety alerts.

Safety thermometer

- The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data is collected on a single day each month. The safety thermometer looks at risks such as falls, pressure ulcers, blood clots and catheter acquired urinary tract infections.
- Information relating to the safety thermometer was clearly displayed in the ward area we inspected.
- Staff carried out venous thromboembolism (VTE) screening on admission to the hospital. VTE is a

condition where a blood clot forms in a vein. An audit carried out from April 2015 to March 2016 showed that 100% of patients had received a risk assessment either on admission or within 24 hours. This was based on a review of 20 records. The audit also identified the VTE prevention medicine used, its dosage and duration together with the appropriate evidence. The audit provided showed there was one hospital acquired VTE in the reporting period July 2015 to September 2015.

Cleanliness, infection control and hygiene

- The hospital employed an infection control lead nurse who was supported locally by the director of clinical services and corporately by the BMI Healthcare groups' head of infection control. There were no regional infection control leads for the BMI hospitals.
- The hospital had an infection prevention and control audit programme, which involved both clinical and non-clinical staff. Audits included hand hygiene, the use of anti-microbial agents (an agent that kills microorganisms or inhibits their growth), environmental assessments and the use of the National Infection Prevention Society Quality Improvement Tools (IPSQIT). Participating in the IPSQIT programme enabled the hospital to record the data gathered in audits and produce reports.
- The hospital had conducted an infection prevention week and world hand hygiene day. During infection prevention week, a stall was set up and manned by the infection prevention and control (IPC) lead, which focused on hand hygiene. A quiz was also undertaken by staff to test and increase awareness.
- The hospital had a number of infection control policies available on the hospital intranet, including management of patients with MRSA and an infection outbreak. We saw these policies had been reviewed and were in date.
- Most staff followed the hospital's policy on infection control. Hand hygiene audits were carried out across each department and the records seen showed the service was 97% compliant. However, during our inspection, we observed four medical staff who did not decontaminate their hands immediately before and after every episode of direct contact of care. This contravened NICE QS61 Statement 3 guidance. This was brought to the attention of senior staff within theatre.

Surgery

During our unannounced visit on 31 August 2016, the theatre manager confirmed they were undertaking additional audits to ensure compliance. We did not see any issues or concerns during our unannounced visit.

- We found during our inspection, there was a general lack of alcohol hand cleaning gel dispensers throughout the hospital. Staff explained that new dispensers were about to be fitted. In the meantime, gel was available at the point of care in patient's bedroom and staff had been provided with personal dispensers. At the unannounced inspection, the alcohol hand cleaning gel dispensers had been installed throughout the hospital departments.
- We observed staff complying with 'arms bare below the elbow' policy across the services visited.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. However, during our inspection we observed an anaesthetist inserting a cannula without the use of gloves. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend the use of 'standard precautions, which incorporate additional safeguards for specific procedures and patients, including single-use gloves. Precautions are recommended for all patients regardless of their diagnosis or presumed infectious status and must be implemented when there is a possibility of contact with: blood, all other body fluids, non-intact skin and mucous membranes. This was brought to the attention of the theatre manager who confirmed they would investigate our concerns. During our unannounced inspection, the theatre manager confirmed that the matter had been addressed with the individual and spot checks were being carried out to ensure the service was compliant with national guidance.
- Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Perioperative Practice stated there must be arrangements made to ensure that there is a sufficient supply of clean cover gowns available and footwear worn in theatres should be for that use only. The hospital provided us with their policy to guide staff regarding infection prevention and control in the theatre department. However, we found that staff did not comply with all aspects of this policy. We observed for example, some staff wearing theatre attire in the dining area.
- The hospital had infection and prevention care bundles that assisted them in demonstrating the infection

prevention and control procedures and policies within the hospital. Staff confirmed that any areas of non-compliance could be challenged quickly and further training provided to those staff that needed it. Examples of care bundles included; catheter care and surgical site care.

- We observed a lack of clinical hand washing facilities in the patient rooms that had not been refurbished. Clinical hand basins were provided in utility areas but not in all patient rooms. This meant that at the point of care, in the rooms that had not been refurbished, staff washed their hands in patient's private bathrooms. Although the sinks in patient bathrooms had wrist operated taps, best practice would be to have dedicated clinical sinks within each en-suite room. Department of Health Guidelines (2013) HBN00-09 stated that 'en-suite single bed rooms should have a general wash-hand basin for personal hygiene in the en-suite facility in addition to the clinical wash-basin in the patient's room'. Therefore, the hospital was not compliant with infection control guidelines in all rooms. Health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaption/extension of existing facilities. The guidance was not available when the hospital was built in 1985, therefore clinical areas at the hospital that had not been refurbished, were not compliant with current Health and Building Note regulations. The hospital was aware of this and had risk assessed it, and recorded it on the risk register. The implementation of clinical sinks was included in planned refurbishment of patient bedrooms; however there were no timescales for this.
- Of the 36 patient bedrooms, eight were carpeted. This did not meet the requirements of Health Building Note (HBN) 00-09: Infection control in the built environment. Carpet should not be used in treatment rooms or areas where body-fluid spillage is anticipated. Housekeeping staff also confirmed it was often difficult to ensure that carpets were adequately clean. The BMI corporate infection control precautions policy provided guidance to staff for decontamination of the environment. This included vacuuming carpets at least twice weekly and steam cleaning after contamination with body fluid. The flooring had also been entered on the hospital's risk register. There were also risk assessments in place for the infection control issues related to the flooring. We saw that some rooms on the ward where carpet had been replaced with vinyl flooring. The hospital planned

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to continue with flooring replacement during the next hospital refurbishment, although it was unclear as to when this would be. However, clinical areas at the hospital that had not been refurbished, were not compliant with current Health Building guidance.

- Within the theatre department, there were designated clean and dirty areas. Due to the design of the building, we saw processes in place to minimise the risk of cross infection. The theatre manager had implemented a procedure for all clean equipment to be stored in specific areas to prevent contamination.
- We visited a very small room adjacent to the endoscopy suite, which staff used as their changing room. The room had limited space for separating clean and dirty clothing (outside clothing and scrub suits) and we found dirty clothing in a bag on the floor. There was no hand washing facilities in this room. We also saw dirty crockery and food in this room. This meant there was a risk of cross infection and we could not be assured that staff maintained good hygiene and infection control procedures in order to ensure the safe care and welfare of patients.
- The infection rates recorded by the hospital were low. There were no incidents of *Clostridium difficile*, MRSA, Methicillin Sensitive *Staphylococcus Aureus* or E-Coli recorded from April 2015 to March 2016.
- The records showed the hospital had introduced and trained clinical staff in aseptic non-touch techniques. The aim of the competency was to ensure clinical staff maintained the highest standards of infection control. However, during our inspection, this practice was not maintained by one consultant within theatres; to minimise the introduction of micro-organisms, which may occur during preparation, administration and delivery of intra venous therapy. For example, the insertion of a cannula without the use of gloves to reduce infection.
- Surgical site infection data was collected and submitted to Public Health England on a monthly basis. There were 12 patients who developed surgical site infections (SSIs) from April 2015 to March 2016. These included one from gynaecology, three from upper gastro intestinal (GI) and colorectal and one from cranial surgery. Seven were from the orthopaedic and trauma procedures (none were hip and knee joint surgery). There were no SSIs reported for the orthopaedic procedures of hip and knee joint surgery, spinal, breast, urological, cardiothoracic or vascular procedures. We saw the SSIs

had been investigated with no themes identified. The systems, processes and practice regarding SSIs, reflected the National Institute for Health and Care Excellence (NICE) CG74 guidance.

- During the pre-admission appointment, patients were swabbed to assess if they had MRSA. Where results were found to be positive the admission date was deferred if necessary, and the patient provided with a treatment pack to use at home. A further appointment for the patient was rearranged once a clear swab result was received.
- Within the endoscopy department, there was a decontamination process and pathway for endoscopes after use. All endoscopes were electronically tracked. This meant that in the event of a failure in the decontamination cycle/process, they were traceable for infection control reasons.
- The preoperative assessment and recovery areas ward and theatres were visibly clean and had current infection prevention and control guidelines in place.
- Dedicated housekeeping staff had clearly defined roles and responsibilities for cleaning the environment. They had all undergone infection control training and used different coloured mops and buckets for clinical and non-clinical areas. A daily checklist was used to ensure all aspects of required cleaning were met. This was in line with national guidance and best practice.
- The patient led assessment of the care environment (PLACE) results regarding cleanliness showed a satisfaction level of 100%.
- We spoke with catering staff, responsible for food preparation, in the ward area. They explained they were responsible for cleaning their own work area after food service was completed. They assured us they were never asked to clean other areas of the ward such as patient rooms or clinical areas. To ensure patient safety, staff whose roles involved handling food had completed food hygiene training.

Environment and equipment

- The hospital was aiming to achieve joint advisory group (JAG) accreditation for endoscopy. JAG accreditation is an assessment with the aim of improving services, care and safety for patients undergoing endoscopy procedures. However, at the time of inspection, the service was not JAG accredited.

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- Reusable endoscopes (which are used to look inside a body cavity or organ) were cleaned and decontaminated in a dedicated decontamination room with separate entry and exit points.
- The endoscopy decontamination machine was checked daily and we saw the filed, validated check slips. There was also a checklist completed for ensuring all equipment was ready and working appropriately.
- Decontaminated endoscopes were scanned and tagged with a unique number that could be tracked. This number was documented in the endoscopy patient register, which recorded the patient details, the consultant, the endoscope used, the decontamination cycle and the date. A risk assessment had been completed regarding endoscopy decontamination. In order to minimise the risk to patient safety, training was provided to staff working in the decontamination room and arrangements were in place with the decontamination equipment manufacturer, to repair or replace faulty equipment in a timely manner.
- Staff tested the endoscopes weekly to ensure there was no detection of residual protein within the equipment. This conformed to BS EN ISO 15883 protein residue tests.
- Processed (clean) endoscopes were hung in a scope drying cabinet until required.
- The medical advisory committee (MAC) minutes for March 2016, identified endoscopy equipment failures with both the endoscopy stack system (required for the endoscopes to produce images) and the scopes, resulting in the gynaecological consultants not booking hysteroscopies (a procedure used to examine the inside of the uterus) preferring to refer these patients to other hospitals. The equipment was identified as being outdated and the two scopes were not identical. The surgical consultants also confirmed that they had to use two stacking systems; one with a light source and another with a camera which left little room to manoeuvre within the theatres. The MAC identified that the hospital planned to trial different machines and put together a business case. During our inspection, we found the service was trialling these new machines and a business case was to be created and presented by October 2016.
- The governance review for June 2016 identified issues with the environment, which we also observed during our inspection. These were documented on the risk register and formed part of a refurbishment plan. During our visit we found;
 - Dents and cracks on some theatre walls and doors.
 - Flooring in the sterile storeroom had lifted and a tear in the flooring was stuck down with tape.
 - The call bell to the entrance to the theatre department was not working, which meant that unauthorised people could access the area. We brought this to the attention of senior staff on 16 August 2016. When we returned to on 17 August 2016, the theatre call bell had been fixed.
- Routine checks of anaesthetic equipment were undertaken in accordance with recognised guidance by the AAGBI, 'Checking Anaesthetic Equipment' 2012 guidance. We observed that checks were completed and recorded. Daily equipment checks of essential equipment such as anaesthetic and resuscitation equipment in operating theatres were completed and recorded. This meant that we were assured of the safe management of operating theatre equipment.
- Equipment was visibly clean and well maintained. Staff told us that all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- Equipment servicing was managed by a centralised maintenance team that arranged for equipment to be serviced by external contractors. Equipment such as hoists, operating theatre equipment and blood pressure monitors had labels showing they had been serviced and when they were next due for servicing.
- There was sufficient equipment to maintain safe and effective service, such as anaesthetic equipment, theatre instruments, blood pressure, and temperature monitors, commodes and bedpans.
- There was a dedicated room on the ward for the storage of equipment, which was found to be tidy with equipment stored safely. Equipment was labelled with a green sticker to show it had been cleaned and was ready for use.
- Emergency resuscitation equipment was available for all areas and checked on a daily basis by staff. The resuscitation audit for January 2016 and March 2016 achieved 93% and 100% compliance respectively with no issues or concerns identified

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- Reusable surgical instruments were sterilised by an external contractor. Staff in the theatres told us they always had access to the equipment they needed to meet patients' needs.
- Single use sterile instruments were stored appropriately and kept within their expiry dates. Although the amount of storage space within the theatres was small, surgical procedure packs, implants and consumable items were appropriately stored in a tidy and organised manner. The recommendations from a RCA following a never event, included tidying up the prosthesis stock. We observed that this had taken place and demonstrated that staff were learning from incidents and taking action to prevent reoccurrence.
- Equipment to assist people with their mobility was available for use on the ward. Some of the patient rooms had baths rather than walk in showers. The senior managers advised of planned refurbishment with the provision of showers.
- There were arrangements in place for NHS patients with a body mass index of 40 or under to be seen in a consulting room in accordance with the contractual arrangements within NHS. The hospital ensured equipment was suitable for patients with a body mass index over 50, as there were no body mass index limitations for privately funded patients, although each patient was individually assessed for their clinical suitability.
- Both the ward and operating theatres had appropriate arrangements for managing waste. Waste was correctly segregated, labelled and disposed of. For example, containers were available for the disposal of sharp medical instruments.
- We saw copies of the weekly water sampling tests from July 2016 to August 2016, for both surgical and endoscopy equipment. The results had met all the requirements with no issues or concerns highlighted. We also saw the certificate for testing Legionella dated May 2016. The results showed that all areas tested had met the requirements.

Medicines

- The hospital had a pharmacy department, which was open Monday to Friday 8.30am to 4.30pm. Outside of these hours the pharmacy could be accessed by the RMO. We saw there were appropriate security controls in place to monitor when the pharmacy had been accessed and a stock item removed. There was an

on-call service which covered the ward out of hours and at the weekend. The hospital had recently created a Service Level Agreement (SLA) with the local pharmacy to provide pharmacy services should a medicine not be available within the hospital.

- There were effective arrangements for the receipt, storage, dispensing and disposal of unwanted medicines, which was managed by the pharmacist.
- The hospital undertook quality audits of medicines management, areas covered included; general storage, temperature monitoring, the administration of medicines and emergency medicine stocks. The data provided shows compliance was 96% in February and 100% in May of those areas that undertook the audit. However, the records showed the completion rate for the audit in February 2016 as 55% and, this deteriorated to 15% for May 2016. The pharmacist oversaw all the medicine management audits and we saw action plans had been developed to address the audit completion issues identified. The pharmacist confirmed this was a work in progress and they were working alongside the service to improve the management of medicines.
- Medicines were mostly contained in locked cupboards. Medicine cupboards in anaesthetic rooms were left unlocked while the associated theatre was in use to provide quick access to medicines. However, we found the following concerns which were brought to the attention of senior management:
 - Within the anaesthetic room, 10 boxes of medicines were left out, including adrenalin (a medicine whose effects can reverse severe low blood pressure and severe allergic reactions) unattended on the counter surface and not within the unlocked cupboard.
 - Medicines were being drawn up in advance for the next and subsequent operation. This contravened the BMI Preparation of Anaesthetic Drugs policy, which stated that it was 'not acceptable to draw up multiple patient drug regimens at the start or during the operating list.'
 - During our visit on the 16th August 2016 to the recovery room, we found the medicine cupboard and fridge were both unlocked and left unattended. The following day we found the medicine cupboard was locked. Initially we also found the fridge was unlocked but this was later locked.
 - The flammable liquid store cupboard was found unlocked in theatre and the door left open on our visit on the 16th August 2016. However, the following day the cupboard was found to be locked.

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- There was a missing consultant signature required for the administration of a controlled drug in May 2016. We saw a reminder note on the front of the Controlled drug (CD) book. This had not been completed at the time of our inspection.
- During our unannounced visit on 31 August, the theatre manager confirmed they were currently undertaking spot checks and weekly audits to address the concerns raised. We did not find any medicines left unattended on the counter surface or medicine cupboards left unlocked, during this inspection.
- We saw the April 2016 controlled medicine audit for the ward. There was an action required to address the CD register not filled in correctly. We noted the action plan had been completed.
- We saw the controlled medicine audit for theatre three for March 2016. There were actions required regarding discrepancies with documentation, which included; page numbers in registers not carried forward, balances in registers brought forward but did not have two signatures and entries in the register not dated and the time not recorded. We saw the actions had all had been completed and we did not identify any concerns with this during our inspection.
- The ward keys, including medicine keys and controlled drug keys were stored in a key cabinet in the treatment room. All registered nurses working on the ward were given the security code to the cupboard. This process had not been risk assessed. There was no process for signing keys in and out of the key cupboard and there was no end of shift check completed. There were no daily checks. Therefore, there was no process to ascertain who had access to the keys at any particular time.
- The senior staff stated that all patient medicines were reconciled within 24 hours of admission. The aim of medicines reconciliation is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission and to reduce the risk of medicine errors. This was undertaken by the nursing team at pre-admission assessment or admission. Patient's own medicines were recorded on the current medicine prescription chart. The provider had introduced a process whereby reconciled medicines were assessed by formally trained staff. However, the hospital confirmed they did not currently audit this process and therefore we could not be assured of the effectiveness of this system.
- The provider conducted an audit of the turnaround times (system to assess every discharge prescription of "to take out" (TTO) medicines. We saw the TTO audit data of 53 prescriptions for June 2016, which had been collected over a five day period. Of the 53 prescriptions, five required either interventions or contact with the prescriber, which included; patient's height, weight, allergies not recorded and wrong eye drops prescribed. However, the audit did not include any action plan to address these issues. Therefore, we could not be assured that lessons were learned from this audit.
- Ambient temperature of medicine' storage rooms and fridges were recorded on the ward and operating theatre department and were within acceptable limits. There was a procedure to follow should temperatures fall out of the defined range, which staff explained during our inspection.
- We did not observe the administration of medicines during our inspection. We looked at the medicine charts for seven patients and found these to be complete, up-to-date and reviewed on a regular basis. Allergies were clearly recorded on the patients medicine chart and in their records. We observed that known patient allergies were discussed at the daily resus huddle.
- We saw the ward medicine audit for June 2016. The audit looked at areas such as; storage, temperature monitoring and the medicine trolley. The audit identified concerns, which led to an action plan that included ensuring the ward manager informed the staff concerned. An example included the completion of the second page of the temperature log. The registered medical officer (RMO) was also reminded to indicate the maximum dose for all "as required" medicine prescriptions. There was no indication on the audit of how the action plan's outcomes were being monitored or if they had been addressed. However, we found no issues or concerns in the records reviewed during our inspection.
- We saw the theatre medicine audits completed for November 2015. Areas looked at included; environmental control, security and storage and the administration of medicines. There were no issues or concerns identified.
- On visiting the endoscopy unit, we saw the medicines cupboard was locked and that all room temperature checks had been completed.

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- Nursing staff were aware of and were able to seek guidance from the hospital's medicines policy and British National Formulary (BNF), which was the latest up to date edition. The BNF was a pharmaceutical reference book and contained advice on prescribing and pharmacology.

Records

- The hospital used a paper based system for recording patient care and treatment. A complete set of record of care and treatment were kept on site, including a record of the initial consultation and treatment provided by the admitting consultant.
- The hospital complied with data protection and patient confidentiality. Staff signed to say they had read and accepted information security policies. Any security breaches were reported as incidents and discussed at clinical governance meetings. E-mails were password protected through the BMI Healthcare secure e-mail system.
- Healthcare records contained information of the patient's journey through the service including pre assessment, investigations, test results and the treatment and care provided.
- Some healthcare records were kept in patient's rooms at their bedside, such as care plans and fluid balance charts. These were found to have been completed and up-to-date. Records were accurate, complete, legible and up to date and stored securely within the services we visited.
- A clerk was employed to manage records and ensure they were available as required. A tracking system was used, which required records to be signed in and out. The tracking record was found to have been used consistently and correctly to retrieve and return patient notes.
- The care pathways were used, which included risk assessments such as risk of falls and mobility. These pathways ensured that there were systems and procedures to manage any deviation in the patient's progress.
- We looked at nine sets of patient's records on the ward. These included day case patients and inpatients and we found them to have been appropriately completed. They were formatted with a standard layout to allow ease of access to relevant information.
- Operating theatre records were appropriately completed and included the 'Five Steps to Safer Surgery' checklist. The 'Five Steps to Safer Surgery' checklist was audited, the results of which showed a high level of compliance (98%).
- The patient health record compliance audit from May 2015 to December 2015, showed poor compliance with regard to consultants completing the discharge summary and completion of relevant consultant clinic records. During the inspection, we looked at 13 records across the service and found no issues or concerns with the recordings.
- The MAC minutes for May 2016 identified concerns with RMO's not documenting patient reviews. We reviewed nine records on the ward during the inspection and found no issues or concerns.
- When changes were made to theatre lists, they were reprinted in a different colour and the wards were informed. This was considered good practice.
- The National Joint Registry (NJR) records were kept and entered onto a database by the administration staff in theatres. Records of all other prosthesis were also recorded. A prosthesis record sticker was placed in the patient records and on an individual patient form which was retained within the department.
- There were arrangements to ensure that all breast and implants used were recorded on the National Breast and Implant Register. We saw that the theatre department maintained the implant folder, which contained the patient details, surgeon date, prosthesis stickers/size and side, and details of the theatre team involved in the procedure. Records were kept on site for one year and then archived for up to 10 years.

Safeguarding

- The director of clinical services was the lead for safeguarding at the hospital. There were arrangements in place to safeguard adults from abuse that reflected relevant legislation and local requirements. They had an established link with the local safeguarding boards. Staff knew who the safeguarding lead was and how they could be contacted.
- Children were not treated at the hospital. However, children did on occasion accompany relatives to visit patients in the ward area. National guidelines state that all staff interacting with children should have level two safeguarding children training. 88% of staff at the hospital had completed safeguarding children level two

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training at July 2016. This was below the 95% target. The director of clinical services was the lead for safeguarding at the hospital and was trained to level 3 in both safeguarding children and vulnerable adults.

- Staff understood their responsibilities and knew how to identify potential abuse and report safeguarding concerns. Staff completed training on safeguarding through electronic learning and had a good understanding of their responsibilities in relation to the safeguarding of vulnerable adults.
- Ward and theatre staff had completed 100% of mandatory training modules in safeguarding adults and children at both level one and two.
- Staff had undertaken Prevent training. The purpose of Prevent is to identify when a vulnerable person is at risk of radicalisation, how to raise concerns and what a proportionate response looks like. This was mandatory and 98% of staff at the hospital had completed this (July 2016).

Mandatory training

- There was a BMI Healthcare mandatory training policy, which specified a 95% compliance target rate at any one time. For the majority of topics the service had exceeded this target. The overall training figures for August 2016 showed the ward had achieved 98% and the theatre had 94% for trained staff and 88% for untrained staff. Training levels were monitored and reviewed at clinical governance meetings. Heads of departments were supporting staff to attend sessions to ensure compliance.
- Staff explained they received mandatory training to ensure safe care was provided. Examples included adult basic life support, consent and equality and diversity training. Most of the mandatory training was completed through e-learning. Some training such as manual handling was provided through onsite training. Staff on the ward confirmed they had recently undertaken their moving and handling training.
- Mandatory training was discussed during induction for all new starters. Staff signed an agreement on appointment about their responsibility to ensure they undertook the mandatory training relevant to their role.
- Training timetables were on display so staff could clearly see what training was outstanding. The ward manager confirmed they followed up staff members who had failed to complete their training, or were having difficulties.

- The hospital also had a policy for sepsis management, which staff were aware of and had received the relevant training.

Assessing and responding to patient risk

- A pre-admission assessment was completed for all patients prior to their admission to hospital. Not all patients attended a pre-assessment clinic before their admission for surgery. Patients were assessed according to their clinical needs by completing a preoperative questionnaire. On receipt of the questionnaire, patients were triaged to determine who required a face-to-face or a telephone consultation.
- The records showed that 100% of patients from January 2016 to July 2016 had been pre-assessed at least two days before their procedure by either telephone or face to face triage. This was based on an audit of 10 records each month.
- All patients having planned major surgery, for example, a hip replacement, attended a preoperative assessment clinic. Any preoperative investigations, for example; blood tests were carried out during the clinic visit. Preoperative assessments were carried out in line with the National Institute of Health and Care Excellence (NICE) guidelines. If there were any concerns about a patient's condition or fitness for surgery, the pre assessment team liaised with the consultant anaesthetists.
- Patients who were planning to undergo surgery, were seen by the consultant who explained the procedure and the risks and benefits.
- Staff explained that during pre-assessment they recorded base line observations such as temperature and blood pressure. They checked the patients' understanding of the treatment they were being admitted for, discussed discharge arrangements, and completed a range of risk assessments such as; falls and pressure ulcers.
- The hospital used nationally recognised risk assessments such as Malnutrition Universal Screening Tool (MUST) and Waterlow score. MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition (under nutrition) or obese. The Waterlow score gives an estimated risk for the development of a pressure sore in a patient. Patients identified at risk of were placed on care plans and were monitored more frequently by staff to reduce the risk of harm.

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- Patients with known allergies wore a bracelet, which acted as an alert to any staff providing care or treatment.
- A National Early Warning system (NEWS) tool was used to identify the deteriorating condition of patients. This system alerted nursing staff to escalate patients for review if routine vital signs were out of safe parameters. We reviewed nine patient charts and saw eight of the nine had been correctly calculated. We saw audit results for July 2016, which showed 100% for the completion of the NEWS score with 91% calculated correctly. However, only 57% of staff had recorded the respiratory rate and 77% the temperature recording. The audit did not identify any actions of how the low scores were being addressed. This was brought to the attention of the ward manager who confirmed they were currently reviewing the completion of NEWS records monthly because of these audit findings. They also confirmed the NEWS was discussed at ward meetings and additional training was being provided to staff as required.
- There were alarm systems to alert medical and nursing staff when immediate assistance was required in the case of an emergency.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by the resident medical officer and if necessary reassessed by the admitting consultant or anaesthetist where required.
- Patients were transferred to other local NHS hospital if the patient required critical care. However, there was no in-date service level agreement in place, with patients being “blue coded” (medical emergency) to the nearest convenient hospital. Subsequent to our inspection, the hospital confirmed that this was now in place (January 2017).
- Patients we spoke with confirmed they had been told by the nursing staff what to do if they felt unwell following their discharge home.
- We saw Situation, Background, Assessment and Recommendation (SBAR) pads in use. SBAR is a communication tool to share patient information in a clear, complete, concise and structured format.
- The ‘Five Steps to Safer Surgery’ checklist was used. We attended four safer surgery briefings and observed the checklist being completed appropriately. The briefing sessions included for example, checking that all ordered equipment had been received, staffing arrangements and allocated responsibilities were understood, staff were aware of any changes to operating lists and any concerns. However, we found inconsistencies in the approach to the completion of the checklist. Theatre nursing staff had to intervene and encourage the consultants, to complete this in a consistent way. For example, we observed the anaesthetist and surgeon had left the operating area whilst the checklist was being completed and had to be called back.
- The endoscopy unit used a safety checklist, which had been adapted from the WHO checklist. We saw checklists were completed appropriately.
- The endoscopy unit assessed the risk to patients. The audits we looked at reviewed for example; the patient’s wellbeing by monitoring if analgesic gas had been used and the level of the patient’s sedation and discomfort. We found no issues or concerns within the records seen.
- If changes to an operating list had to be made, there was a process understood by operating theatre and ward staff. Once a change had been agreed with the consultant, the original list was destroyed and a different coloured revised list was issued to relevant departments. This process was used to ensure staff worked to the same list to reduce risks to patient safety.
- There were arrangements for visitors to theatre to sign in at reception. Medical representatives visited the theatres by pre-arranged appointments. Their identity was checked by the surgeon and the theatre manager. We saw the confidentiality policy which provided the service with guidance on representatives visiting theatre.
- There were appropriate arrangements for ensuring blood required for elective surgery was available. There was access to the minimum requirement of two units of emergency supplies of O Rhesus negative blood. We saw that the blood fridge temperature and stock was checked and recorded daily.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Immediate post-anaesthesia recovery (2013) states while a patient has an airway device in place, continuous capnography monitoring should be used. Capnography is the monitoring of carbon dioxide in the respiratory gases and is used to assess how well the patient is breathing. At the time of the inspection capnography monitoring was available in the three recovery bays. We discussed this with staff who said that they had access to capnography but this device was rarely required.

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- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues. There was daily involvement by the ward and theatre managers and the director of clinical services to address these risks.
- We saw copies of the Control of Substances Hazardous to Health (COSHH) risk assessments for both the surgical and endoscopy areas, which included guidance on the handling and storage of items such as disinfectant. The risk assessments also covered the precautions for safe handling, which included the use of personal protective equipment and within well-ventilated areas.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff across the surgical services and responded to in a timely manner. Records showed 100% of Medicines and Healthcare products Regulatory Agency (MHRA) alerts had been completed from April 2015 to March 2016.

Nursing staffing

- The hospital used a staffing tool, which was in line with NICE staffing guidelines and helped the hospital to support safe staffing acuity levels based on the patients' needs. From this the number of nurses and health care assistants (HCA) required for each shift were calculated. Additional staffing could be implemented to support patients with increased needs for example; living with dementia, or at high risk of falls. Staffing figures were also discussed in daily huddle meetings.
- Duty rotas were planned four weeks ahead and reviewed on a weekly basis. Changes to rotas were clearly recorded to ensure accuracy.
- Details of daily required staffing and actual staffing levels were displayed on a notice board in the main ward corridor for relatives and visitors to see.
- The records provided by the hospital informed us there were currently four whole time equivalent (WTE) staff vacancies within the theatre department and one in the ward. Recruitment had been identified as an issue for clinical posts, particularly in theatre. To increase the awareness of vacancies, the hospital attended a job fair in early March 2016 followed by an on-site recruitment open day.
- Contracted staff worked flexible hours to cover the rota and gaps were met by a separate team of bank and agency staff familiar with the hospital. The ward manager explained they strived to keep agency use to a

minimum and tended to use bank staff at weekends when the occupancy and dependency levels were lower. We reviewed staffing rotas and these reflected the explanation provided.

- Recruited agency staff came from specific agencies which the hospital had a preferred provider arrangement. This ensured temporary staff met key requirements such as having completed mandatory training, for example, manual handling and competencies to safely administer medicines. We spoke with an agency nurses who confirmed they had received an induction. We saw written evidence that induction had taken place in both theatre and on the ward.
- The hospital undertook elective (planned) surgery, which meant the number of nursing and care staff required on any particular day could be calculated and planned. During the inspection and unannounced visit, planned staffing numbers were met for each department.
- The operating theatre staffing tool followed the recommendations by the Association of Perioperative Practitioners. In June 2016, the hospital introduced a new staffing model called "Management of Operating sessions for Elective and Scheduled Surgery." We checked rotas during the inspection and those seen did not identify any issues or concerns.
- The endoscopy suite employed three part time staff. The remainder of the staff were bank staff. Staff confirmed they were actively recruiting to two new posts. We looked at the rotas and did not find any issues or concerns with the exception of one day in August 2016, where there was staff shortage. Staff explained this had affected the running of the unit that day, with processes having to be slowed down to accommodate the capacity of staff.
- Handovers took place between each ward shift. This was done by the nurse caring for the patient to the nurse taking over the shift, who disseminated information to the staff team. We observed a handover and it was detailed and succinct.

Surgical staffing

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists, who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges with the hospital.

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- The hospital had a database of consultants who had been granted practising privileges, which was monitored both locally and centrally. The database included the status of each consultant about their indemnity, appraisal, General Medical Council registration and Disclosure and Barring Service (DBS) checks (which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups).
- At the time of our inspection, the hospital had 151 doctors with practising privileges. In the year ending March 2016, all of the doctors with practising privileges had carried out procedures and 55 of the doctors had carried out 100 or more procedures at the hospital.
- Practising privileges were granted by the executive director following consideration by the MAC. The applicant must be licensed, on the specialist GMC register and demonstrate relevant clinical experience. They were granted by the executive director following consideration by the MAC.
- We checked 12 consultants practising privileges records during the inspection. We found that all contained details of indemnity insurance and evidence of registration with the GMC. However, only three out of 12 records had been reviewed as per the hospital's policy, which was every two years. At the time of our inspection, there were 151 consultants with practising privileges and 51 consultant's files that required their biennial review. The information had been collected for these reviews but the final sign off had not been completed. This meant that we could not be assured that all the practising agreements terms were being met. We discussed this with the SMT during the inspection. They acknowledged that the biannual reviews were required and a plan was in place to complete the reviews.
- The MAC periodically reviewed existing practising privileges to ensure continued compliance with the agreement and advised the hospital about continuation of practising privileges. The process for review of practising privileges ensured consultants were practising within their scope of practise. Any requests to carry out additional procedures had to be approved by the MAC to ensure they were safe and appropriate. If there was non-compliance with practising privileges, the executive director would suspend the consultant's privileges so that they were not able to practice at the hospital until all the required information had been provided. From April 2015 to March 2016, there had been three suspensions of practising privileges.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. They also needed to be available within a 30 minute journey of the hospital if they had day case or in-patients under their care. If, on occasions this was not possible, they nominated another named consultant to provide cover. This was a formal process and staff were aware who was covering.
- Patient care was consultant led. The hospital's 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 the request of the facility executive director, director of clinical services, or resident medical officer (RMO).
- RMOs were rostered to work a maximum of 14 days on shift. The hospital said they had low patient occupancy overnight and the RMO stated they had sufficient rest time. Should the RMO become unwell or report tiredness, the hospital had arrangements in place to replace the RMO. There was a review with the RMO on a daily basis to assess on-call commitment.
- The RMO was available 24 hours a day seven days a week and discussed any concerns with the patients' consultant. If there was a requirement for a medical review of patients in hours, the responsible consultant would be sought. If the consultant was not available, then the escalation of care policy would be implemented and, if required, the patient would be transferred to an appropriate hospital. Senior staff confirmed they could not recall an incident when this had happened and we saw no evidence of incidents reported of patients being transferred out due to lack of appropriate senior medical availability.
- To ensure effective planning and continuity of service, consultants were required to provide the hospital a minimum of six weeks' notice of leave such as holidays. However, during our visits on the 16 August and 31 August, we were aware of two separate occurrences where patients had to have their surgery rescheduled due to two consultants being on holiday and not available. This meant that we could not be assured that

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there were appropriate procedures and processes in place to manage the cover arrangements of consultants. However, the hospital advised that these were isolated incidents. They also provided information, which included evidence that discussions had taken place with one of the consultants and ongoing monitoring of late starts and cancellation of surgical procedures would be undertaken. Nursing staff explained if a required consultant was not immediately available, for example if they were operating, staff could refer to another consultant of the same speciality who had practising privileges for advice, but they rarely had to do this.

- Nursing staff and the RMO had found the consultants to be supportive and responsive when they were contacted for advice.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services such as electricity and water supply.
- The theatre manager and an ODP were part of the hospital's resuscitation team. Emergency bleep holders were designated each morning at the daily resuscitation meeting.
- We saw regular testing of generators occurred in case there was a failure of the electricity supply to the hospital.
- Senior managers operated an on call system out of hours so staff could contact them if there was an issue that needed escalating.

Are surgery services effective?

Good



We found the service was good for effectiveness because:

- All Patient Reported Outcome Measures (PROMS) health scores showed that they matched or exceeded BMI healthcare corporate group and National average scores for patient outcomes.
- Patients received care according to national guidelines such as National Institute of Health and Care Excellence (NICE) and Royal College of Surgeons guidelines.
- Patients had their needs assessed, their care goals identified, care planned and delivered in line with evidence-based, guidance, standards and best practice.

- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits. There was evidence of actions and audit results being shared with staff.
- There were processes and procedures in place for staff to manage patient's pain and ensure that patients' nutrition and hydration needs were met.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA).

However, we also found that:

- All personal files of consultants with practicing privileges at the hospital contained details of indemnity insurance and evidence of registration with the GMC. At the time of our inspection, there were 151 consultants with practising privileges and 51 consultant's files that required their biennial review. This meant that we could not be assured that all the practising agreements terms were being met.
- Staff appraisal rates were low within theatres. We saw that 35% of registered nurses and 40% of operating department practitioners had been appraised.

Evidence-based care and treatment

- The hospital had a system of internal audits and the results of which were benchmarked against other hospitals in the BMI Healthcare corporate group, with corresponding action plans as required. Examples of audits included; pathology, health and safety, resuscitation, infection prevention and control, hand washing, patient records, safeguarding and consent.
- The hospital submitted Commissioning for Quality and Innovation (CQUIN) data to the local Clinical Commissioning Group (CCG) on a quarterly basis. A CQUIN payment framework enabled commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. For 2015/16 the following CQUINS had been identified which the hospital monitored and supplied data to the CCG; MRSA screening, VTE risk assessment, the Patient Reported Outcome Measures (PROMs), incident reporting, safeguarding compliance, medicines management and the world health organisation (WHO) checklist.
- The hospital had systems in place to provide care and treatment in line with best practice guidelines (NICE

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CG50: Acutely ill patients: recognition of and response to acute illness in adults in hospital). For example, an early warning score system was used to alert staff should a patient's condition start to deteriorate.

- The hospital referenced the Marsden manual, which is an evidence-based clinical skills and procedures manual relating to essential aspects of a patient's care. This was available to staff online.
- Policies were relevant and provided evidence based guidance, standards, best practice and legislation. These were used to develop how services, care and treatment were delivered. This included guidance such as the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons (RCS). Policies were current and referenced in accordance with the hospital clinical governance policy. Policies were available on the intranet and staff demonstrated how they gained access to them.
- The service ensured there was a two week cooling off period between patients being seen in outpatients and a cosmetic procedure taking place. This allowed the patient time to decide whether to have their procedure. This was in line with national guidance from the General Medical Council and British Association of Aesthetic and Plastic Surgeons.
- Staff used integrated care pathways for surgical procedures such as, hip or knee replacement. Staff in the ward and theatres used enhanced care and recovery pathways, in line with national guidance. Patients' needs were assessed using clinical pathways which were evidence based and used recognised risk assessments.
- Adherence to local policies and procedures were monitored with a schedule of local audits, for example, NEWS, five steps to safer surgery and medical documentation audits.
- Completion of the 'five steps to safer surgery' checklist, designed to prevent avoidable harm was audited and findings shared with the appropriate teams. We saw the audits completed from January 2016 to June 2016, based on 10 records reviewed. Areas covered included whether the site has been marked, a nurse had reviewed the key concerns for recovery and management of the patient and if patient had been checked for any allergies. The audit showed 100% completion of the checklists. This meant the hospital had processes and procedures in place to monitor the completion of the checklist whilst ensuring patient safety and wellbeing.

- VTE assessments were recorded and were clear and evidence-based, ensuring best practice in assessment and prevention. Assessments were audited and showed 100% compliance.

Pain relief

- The surgical care pathway document prompted staff to assess and record if a patients' pain was being managed effectively. This was commenced in the pre-assessment clinic where actions to deal with pain management were discussed. A pain advice booklet was also given to patients for use post-operatively. Specific requests for more specialist pain relief, such as epidurals, were highlighted on the booking forms.
- The effectiveness of pain relief was evaluated and recorded in the patients' records by using the pain scale within the NEWS charts. Any pain control issues were referred to the RMO, anaesthetist or consultant who re-assessed the patient and amended the medicine prescriptions as required.
- Patient controlled analgesia (pain relief) equipment used for some patients, post-operatively was available and staff felt they had sufficient quantities to meet the needs of the patients at any one time.
- The pharmacy team supported pain management at ward level providing advice and support to the clinical teams.
- During our inspection, we observed staff asking patients about their pain. Patients we spoke with had been offered pain relief and felt their pain was being managed appropriately.
- Feedback on pain management was also requested on the patient satisfaction survey.
- We saw a pain management audit for the day case unit and inpatient wards dated February 2016. They achieved 83% and 74% respectively. This was based on looking at ten patient records and checking pain score assessments, whether a patient had been prescribed regular analgesia and if the patient's pain management was planned and evaluated throughout their stay. The results of the audit included that four of the ten records did not include evidence that the patient was asked if they had pain on admission and what they took to ease the pain. Three of the ten records showed that a patient's pain management had not been planned or evaluated throughout the day. However, there were no

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actions included to address these findings. The ward manager explained they were monitoring the completion of the pain score weekly, when checking the NEWS charts.

Nutrition and hydration

- An external company was employed by BMI hospitals to provide catering services. Meals were all provided on a cook/chill basis.
- The hospital restaurant menu provided a range of choice to patients and the quality of food in the Patient Led Assessment of the Care Environment (PLACE) audit for 2016 scored 87%. This was below the England average of 93%. Patients we spoke with were positive about the food they had received.
- Nursing staff completed an assessment of patients' nutritional status and their needs as part of their initial assessment.
- Staff described the pre-operative fasting guidelines used for adults. These were aligned with the recommendations of the Royal College of Anaesthetists (RCOA). However, the order of theatre lists was not clarified until the day of surgery. This meant that depending on where patients were on the theatre lists, some patients could have been fasting for long periods of time. Staff were aware of this and told us that advice would be sought from the anaesthetist in such cases and patients offered fluid and light diet if appropriate. We did not see any evidence of fasting audits being conducted by the hospital. This meant that we could not be assured care was compliant with the recommendations of the RCOA.
- Intentional rounding by care staff was completed throughout the patients' stay. This meant staff visited patient's rooms hourly to check for example, if call bells and a drink were in reach, if the patient had pain or had any other requests.
- Nausea and vomiting were assessed and prescribed treatment given as required.
- Intravenous fluids were prescribed and recorded as appropriate.

Patient outcomes

- The hospital participated in some national audits to monitor patient's outcomes, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme and the National Joint Registry (NJR).

- The hospital's annual PROMS report and data from April 2015 to March 2016, (released May 2016), showed that for the Oxford knee score, which measures improvement following a knee replacement, of the 98 patient records reviewed, 98% of patients reported an improvement in health after their procedure. Data for Oxford knee score, which measures improvement following a knee replacement, showed that of the 61 patient records reviewed, 94% of patients reported an improvement in health after their procedure. Data on groin hernias showed that of the 64 records reviewed 47% of patients reported an improvement in their health following the procedure with 41% reporting a worsening of their health. All PROMS health scores showed that they matched or exceeded BMI Healthcare corporate group and national average scores for patient outcomes.
- The hospital participated in the National Joint Registry audit for orthopaedics. The data for 2016, showed the hospital was 100% compliant and had undertaken 180 operations of which 79 were hip procedures, 98 knee procedures and three shoulder procedures.
- From April 2015 to March 2016, there were 4,385 day cases and inpatient attendances of which nine required unplanned transfer to other hospitals. The number of unplanned transfers was not high when compared to other independent acute hospitals that we hold data for. We saw that all unplanned transfers were discussed at clinical governance, theatre department and MAC meetings. No trends had been identified following the review of these cases.
- There were three cases of unplanned return to the operating theatre from April 2015 to March 2016. Two incidents occurred from July 2015 to September 2015 and the other from October 2015 to December 2015. We saw these had been discussed at the appropriate meetings. No trends had been identified in the review of these cases.

Competent staff

- The hospital provided local induction for temporary staff, new starters and student nurses.
- Agency staff received an induction programme when new to the hospital, which included access to and the location of emergency equipment and fire exits. We saw records of signed, completed inductions.

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- New recovery and anaesthetic staff to the theatre department also rotated to the endoscopy suite, to ensure they had the appropriate skills. This was because theatre recovery staff routinely also worked in the endoscopy recovery area.
- The ward manager had created an induction programme for all students. We saw this in use during our inspection.
- We saw staff competency folders during the inspection. In the theatre department a competency framework had been created for theatre nursing staff. The staff had either commenced or completed this competency framework. Ward nursing staff also had competencies that they were completing for their role. We saw records which showed competencies included the use of clinical equipment, for example the bladder scanner.
- Staff were required to receive an annual appraisal to ensure development needs were identified and addressed. The appraisals covered subjects such as staff understanding their objectives and how they fitted within the department and hospital objectives and vision.
- The hospital had identified that completion of staff appraisals was one of their weaknesses. Overall 100% of nursing staff, 78% of health care assistants and 41% of other staff within the inpatient services at the hospital, had an appraisal. However, within the theatre team 35% of registered nurses and 40% of ODPs had been appraised. We spoke with the theatre manager who confirmed processes had been implemented to ensure all staff had received their appraisals. We saw arrangements in place for staff to receive their appraisals that included a spreadsheet with allocated dates. Staff spoken with also confirmed they had been given dates for their appraisals.
- The records provided showed that staff did not receive any clinical supervision, which was confirmed during our visit. However, senior staff were aware of this and said they wished to ensure all staff had received an appraisal before reviewing the clinical supervision process.
- There was evidence that all registered nurses and professional staff that worked in the wards and theatres had valid registrations. This confirmed that nurses and other practitioners, such as ODP and physiotherapists, were trained and eligible to practise within the UK. There was a process in place to check registrations were renewed. If for example a nurse's registration had

expired, the head of department was notified and the employee was not permitted to undertake nursing duties. Nursing staff had received training to support revalidation, which included reflective practice.

- The records seen showed that the validation of registration for doctors was 100% complete.

Multidisciplinary working

- Medical and nursing staff reported good working arrangements and relationships with the local NHS hospital.
- There was effective daily communication between multidisciplinary teams within the ward and theatres. Staff told us they had a good relationship with consultants and the RMO.
- The admissions officer worked closely with the operating theatre team to prepare operating lists to ensure appropriate arrangements were made. For example, if specialised equipment needed ordering for a specific operation or if there were patients or procedures on the operating list who required prioritisation.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff, so patient care could be coordinated and delivered effectively. Staff described the multidisciplinary team as being very supportive of each other. Staff told us they worked hard as a team to ensure patient care was effective and that their contribution to patient care was valued. Patient records also showed that there was routine input from nursing, medical staff and allied health professionals, such as physiotherapists.
- We observed effective team working among heads of departments, administrative, clinical, nursing, pharmacy, allied health professionals and ancillary staff during our inspection.
- We saw staff working together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, discharge and transitions.
- Discharge letters were sent to the patient's general practitioner (GP) with details of the treatment provided, follow up arrangements and medicines provided on the day of discharge.

Seven-day services

- The hospital undertook elective surgery six days a week, with lists planned in advance.

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- The hospital had on call arrangements for imaging and therapy services if required. Physiotherapists visited the ward at the weekend.
- Consultants were on call seven days a week for patients in their care. Staff we spoke with confirmed that consultants reviewed patients at the weekend.
- There was 24 hour RMO cover at the hospital to provide clinical support to surgeons, staff and patients.
- Out of hours, a pharmacist was available to contact for advice and if a prescribed medicine was not available on the ward and was required urgently, the RMO could access the pharmacy with a nurse present.

Access to information

- There were arrangements to ensure staff had all the necessary information to deliver effective care. Staff had access to patient records, for those treated in recent months as well as those who may be readmitted. Staff had access to NHS notes for patients receiving treatment commissioned by the NHS. This meant when a patient was admitted for surgery clinicians had all the necessary information such as test results and recent treatment available.
- Computers were available in the ward and theatre areas. All staff had secure, personal log-in details, with access to e-mail and all hospital systems. A member of staff was able to log on to the intranet system and show us how policies and procedures were accessed. It was clear they were familiar with this process.
- Staff accessed information on the hospital's intranet system. New and amended policies came through on the weekly newsletter. The hospital's policies were reviewed at the executive team meeting prior to distribution.
- Staff had access to files in the relevant department offices such as information about Control of Substances Hazardous to Health (COSHH) relevant to their working environment.
- The minutes of a MAC meeting (March 2016) identified that some consultants were experiencing problems obtaining x-rays that had been taken elsewhere, during consultations. This had resulted in the patient having to return for a second appointment. The director for clinical services reviewed this issue with the outpatient manager. It would be arranged by the pre-assessment clinics, to enable the availability of NHS x-rays for first appointment with consultants. The MAC minutes (June

2016) reported a vast improvement with the availability of x-rays within the pre-assessment clinics. Staff confirmed there were no issues or concerns with obtaining x-ray results during our inspection.

- Information about a patient's care and treatment was sent to the patient's GP, following discharge from hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent and another for patients who were not able to give consent. However, there were no consent forms available in other languages, although interpreting services were available via telephone.
- We saw the hospital achieved 86% and 90% respectively in consent audits carried out in March 2016 and June 2016. However, the audit showed that for example, four out of 10 records audited for both March and June 2016 did not show that information had been provided to the patient about their procedure. Three of the 10 records did not contain evidence that a signed copy of the consent form had been given to and accepted by the patient. The audit did not include an action plan to address any concerns identified. During the inspection, we checked 13 records and found they had the relevant consent forms signed by the patient.
- The (MAC) clinical report for May 2016, discussed an issue with the wrong patient identification label being placed on the consent form. This was not recognised until the patient had been anaesthetised. A repeat incident was identified two weeks later. There was no patient harm as a result of either occurrence. However, because of the incident, an audit was undertaken on the checking process regarding consent. Changes were made to the process including ward clerks no longer attaching identification labels in advance to consent forms. No further issues had been identified since this change.
- The consent process generally occurred during the patient's initial consultation with the consultant. Patients were asked to verbally re-confirm their consent at the time of surgery.
- All patients aged over 65 years undertaking a surgical intervention were asked a series of questions based on the Mental Capacity Act 2005 (MCA) comprehensive

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framework for decision making. The records seen showed that 100% of patients of the appropriate age had been assessed using this framework to ensure they had the capacity to make decisions for themselves.

- The mandatory e-learning provided to staff regarding safeguarding, included information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). At the time of inspection, there was 100% compliance. Staff we spoke with were clear about their responsibilities in relation to gaining consent from patients, including those who lacked mental capacity to consent to their care and treatment. However, staff acknowledged that they did not have much experience with this. Staff said they would seek advice from a senior member of nursing staff should a formal assessment of mental capacity require completing. The ward had created a “buddy” system where a registered nurse would be paired with a health care assistant to advise and mentor each other. For example, we observed staff supporting each other in the preparation and completion of a best interest decision for a patient who lacked mental capacity.

Are surgery services caring?

Good



We found the surgical service to be good for being caring because:

- Patients were supported, treated with dignity and respect and were involved in planning their treatment and care. Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- Patients were given time to understand their care, condition and treatment options and were communicated with and received information in a way that they could understand.
- There were appropriate arrangements to support and meet the emotional and spiritual needs of patients including an open visiting policy and access to chaplaincy.
- Patients were allocated a named nurse, which meant they knew who was caring for them and who to approach if they needed assistance.

Compassionate care

- Staff respected patient’s privacy and dignity for example, we observed that they knocked on doors before entering and introduced themselves. Patients told us they felt safe and valued the frequent checks by care staff.
- The hospital used the “Hello my name is” scheme. The aim of the introduction was to help preserve patients’ dignity, promote respect and the best practice in the way they were approached.
- Gowns were provided when patients walked to the operating theatre to ensure their dignity was protected. Once patients were taken to the recovery department curtains were used to ensure their privacy.
- The PLACE audit 2016 score for ensuring patients were treated with privacy and dignity was 90%, which was above the national average of 86%.
- Patients spoke warmly about the caring approach and thoroughness of making safety checks on arrival to the operating department by operating theatre staff.
- We observed positive interactions between nurses, allied healthcare professionals and patients. One patient told us how they appreciated the time staff took to help them settle. We observed staff taking time to interact with patients and those close to them in a respectful and considerate manner.
- The hospital submitted data to the Friends and Family Test (FFT). This is a method used to gauge patient’s perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. This is a widely used tool across the NHS. The data provided showed the FFT scores were similar to the England average of 99% from October 2015 to March 2016.
- We saw inpatient questionnaire results for May 2016. This was based on 268 responses. Areas covered included; nursing care, catering, access to other hospital departments and going home. We saw that dignity and respect and involvement in decision about care and/or treatment scored 100%. The area that scored the least was variety and choice of food at 85%

Understanding and involvement of patients and those close to them

- Patients told us they had been given opportunities to discuss their surgery and the risks and benefits involved with their consultant, and felt actively involved in decision-making.

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- Staff confirmed they recognised when patients and those close to them required additional support to help them understand and be involved in their care and treatment.
- Patients were orientated to their rooms on arrival so they could become familiar with the room and services available.
- Patients were allocated a named nurse on admission who managed the admission process and supported the patient during their pre and post-operative period.
- All patients and relatives spoken with stated that they had been given the opportunity to discuss their concerns and preferences and felt well informed about their diagnosis, care, and treatment.
- Patients assessed for treatment as a day case, signed a document to say they understood the advice they were being provided. This included that they must not eat and drink for a specified time pre operatively, should have someone at home and should not drive post operatively.
- The physiotherapist was observed explaining and ensuring a patient understood what would be happening, before taking them through an exercise.
- We observed consultants visiting their patients throughout the day. They were available to answer any questions they had. In addition, they were able to inform patients what to expect and their plan of treatment.
- The hospital had open visiting this meant that patients could be supported by their friends and family.

Emotional support

- Pre admission assessments included consideration of patients' emotional well-being.
- Patients felt staff had time to listen and provided reassurance if they had any concerns.
- There was a list of chaplains for staff to contact to meet patients' different spiritual needs when required.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.
- Patients said they were encouraged and supported to manage their own health, care, wellbeing and independence.

Are surgery services responsive?

Good 

We found the surgical services good for responsive because:

- The hospital met its national (admitted) target with 94% of NHS funded patients being treated within 18 weeks from referral.
- Patients' care and discharge plans took account of their individual needs, circumstances, and ongoing care.
- Patients whose surgery had been cancelled for non-clinical reasons were offered another appointment within 28 days.
- An interpreting service was available for patients who did not speak English and staff knew how to access this.
- Information leaflets were available explaining how to complain if patients were dissatisfied with any aspect of their care and formal complaints were investigated with actions and learning shared with staff.

However, we also found:

- Not all booking forms were fully completed to allow appropriate listing for theatre.
- Endoscopy lists were not single sex. However, the hospital had procedures in place to reduce the risk of patients being placed in an area with members of the opposite sex.

Service planning and delivery to meet the needs of local people

- We saw that the hospital had developed close links with surrounding NHS providers and other independent sector hospitals to meet the needs of local people.
- The booking system was flexible to patient needs, and where possible patients could select times and dates to suit their family and work commitments.
- Consultants had planned and dedicated theatre lists, which enabled patients to be booked onto these lists in advance. Operating theatre lists for elective surgery were planned in conjunction with the operating theatre manager and bookings team. This was to ensure aspects such as, type of operation and equipment required were taken into account before booking patient on to the list. This also ensured that the service met patients' needs and available operating time was

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used effectively. The operating theatre manager explained that when they were approving operating theatre schedules, checks were also made to ensure the availability of other services such as imaging.

- An admission pack was sent to patients with instructions for preparation for surgery, together with leaflets explaining their planned procedures.
- The ward staff maintained patient confidentiality by not identifying their name on the notice board in reception. Each patient was recognised by a colour coded system and their consultant. For example, a blue dot represented a day case and white denoted the patient was in theatre.

Access and flow

- The hospital saw 4,385 inpatient and day cases from April 2015 to March 2016. Of these 70% were NHS funded and 30% were private insured or self-paying patients. The majority of NHS funded patients were referred to the hospital by their general practitioner (GP) via the NHS referral system.
- In line with the hospital's contract with the NHS, they had an admissions policy, which detailed the criteria for NHS patients that could be safely treated at the hospital. These criteria had been agreed with the clinical commissioning groups that commissioned NHS care at the hospital.
- The service checked a minimum of 10 records each month to check whether patients were pre assessed. We saw that 100% of patients had been pre-assessed a minimum of two days before procedure by either a telephone or face to face.
- Incomplete booking forms were identified as an issue in the January 2016 and March 2016 MAC meeting minutes. The theatre department said missing information included site of procedure. During our inspection, the theatre manager confirmed there were still some incomplete booking forms. To mitigate the risk, the forms that were not correctly completed by the consultant were returned to them. This meant that surgery would not be booked or proceed unless the form had been correctly completed. The theatre manager confirmed they would be piloting a new electronic booking system in September 2016 to address this problem.
- The hospital received patients for planned admissions. The inspection did not highlight any concerns relating to

the admission, transfer or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns regarding their admission, waiting times or discharge arrangements.

- There was daily communication between the pre-operative assessment staff, ward and theatre staff to manage patient flow, from admission to discharge.
- Discharge planning was commenced during pre-assessment including planning estimated length of hospital stay required and assessing whether patients were likely to require additional support at home when they were discharged.
- Patient records showed that staff completed a discharge checklist that covered areas such as, medicines and communication to the patient and other healthcare professionals.
- We observed that discharged patients received a follow-up telephone call within 48 hours. We saw the ward had an achievement rate of 100% regarding this.
- The hospital met its national (admitted) target with 94% of NHS funded patients being treated within 18 weeks from referral from June 2015 to March 2016.
- Day case patients that were assessed as not being fit for discharge following surgery were kept on the ward for overnight care if needed. The bed occupancy figures for March 2016 identified 44% usage at midday, dropping to 19% of beds used overnight. If a patient had an unplanned overnight stay, we saw this was reported as a clinical incident.
- From April 2015 to March 2016, 52 operations were cancelled for clinical reasons. During this time period there were 30 procedures cancelled for non-clinical reasons. Most of the patients (27) were offered another appointment within 28 days and three were referred back to the original NHS trust.
- The hospital enabled patients' choice in respect of when they accessed the care they needed. Periodically, the hospital reviewed the internal databases to ascertain the patients' waiting times from outpatient to surgical episodes.

Meeting people's individual needs

- The hospital was accessible to patients with a physical disability. There were disabled access toilets on the ground floor and wheelchairs available at each entrance. Staff told us that a member of staff would escort those with a sensory or learning disability to the relevant department if this was required.

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- Patients' specific requirements such as learning disabilities or mental capacity issues were identified at pre assessment. This included screening for patient's living with dementia to ensure appropriate arrangements were made to meet individual patient needs.
- Any specific dietary requirements were identified at pre admission. Catering staff told us they were notified in advance of a patient's specific dietary needs or allergies. Following this, patients' completed menus were checked on a daily basis to ensure the correct diet was provided.
- Patients had access to hot drinks and snacks as required. From April 2015 to March 2016 70% of patients were satisfied with the catering service provided.
- Patients were discharged at an appropriate time and when all necessary care arrangements were in place. Patients discharge plans took account of their individual needs, circumstances, and ongoing care arrangements. For example, one patient we spoke with said that the discharge arrangements had been discussed with them and a discharge time had been given when they would have the appropriate support at home.
- If patients with a learning disability or complex care needs were admitted to the hospital, staff would be aware in advance because this would have been identified at pre assessment clinic. This meant that staff were able to plan care to meet a patient's needs and accommodate their carers and relatives. The endoscopy suite was made up of four bays in one room with additional rooms available on the ward. Staff said they aimed to have single sex endoscopy lists but on occasions had mixed lists. The hospital had procedures in place to reduce the risk of patients being placed in an area with members of the opposite sex. We spoke with senior management of the risk of mixed sex breaches in endoscopy. They confirmed they had assurances that no mixed sex breaches occurred. However, there were no audits undertaken to verify that this did not happen.
- The catering staff told us that a range of meals were provided to meet the individual dietary needs of all patients. When the catering department was closed, patients who came back from theatre in the evening had access to food, for example sandwiches and fruit. The catering department ensured the ward had suitable supplies to meet patients' needs.
- Patients who required additional support to be involved in their care and treatment had access to language interpreters, sign language interpreters, specialist advisors and/or advocates as required. Staff knew how to access an interpreting service.
- The ward manager explained the allocation of rooms was done according to the patients' requirements. For example, the majority of patients who were admitted for orthopaedic treatment were allocated the use of a room with a shower rather than a bath.
- Information was provided pre operatively that described what patients needed to do before and after surgery to ensure a desired outcome. Examples included stopping smoking before anaesthesia and wound management following surgery.

Learning from complaints and concerns

- The hospital received 48 complaints from April 2015 to March 2016. No complaints were referred to the Parliamentary and Health Service Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service. Complainants received an acknowledgement letter within two working days of a complaint being received. Complaints were sent to the relevant head of department or consultant for investigation, with a timeframe for response indicated. Complaints were monitored to ensure that timescales were not breached. All complaints received in the six month ending July 2016 were responded to in the target timescale of 20 days.
- We reviewed the complaints tracker and there were a variety of issues raised, which included appointment delays, consultant's attitude, cancelled surgery and discharge issues. These appeared to have been addressed appropriately and discussed at the quality meetings. We saw that the outcomes of complaints were shared with individual departments through departmental meetings and staff briefings. This meant that staff had up to date knowledge of complaints, which enabled them to review the lessons learnt.
- Formal complaints were logged onto the hospital's database where they were monitored. Recommendations and themes from complaints were cascaded to staff to ensure learning was shared across the service. Staff were empowered to respond proactively to resolve issues locally where possible, or to escalate any concerns for support and advice.

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- The hospital had a 'please tell us' leaflet, which provided guidance on how to raise concerns and outlined the hospital's complaints procedure.
- Patients told us they did not have any concerns but would speak with the staff if they wished to raise a complaint. Staff understood the process for receiving and handling complaints.
- Patients who had made complaints about their care or the service provided were given the opportunity to meet with the director of clinical services to discuss concerns and assure them of the hospital's intention to provide high quality care.

Are surgery services well-led?

Requires improvement 

We found well-led for the surgical service to be requires improvement because:

- There were improvements that were required related to infection prevention, medicines management and storage at the hospital. We could not always be assured that identified quality and performance issues were being addressed.
- Leaders had not ensured that there was an in-date service level agreement in place for patients who became critically ill and required transfer to a local NHS hospital. Subsequent to our inspection, the hospital confirmed that this was now in place (January 2017).
- Practising privileges were not being reviewed as per hospital policy, meaning the appropriate systems and processes were not in place to ensure staff with practising privileges met required standards to practice. Leaders were aware of the backlog and had a plan; including implementing an electronic database, to ensure that all the practising privileges would be reviewed as per the policy.
- There were not effective arrangements in place for staff to receive their annual appraisals.
- The hospital's risk register was at a corporate level. This meant that it did not always describe risks found at a local or departmental level.

However, we also found:

- Staff were positive about the culture and the support they received from managers and this was reflected in staff survey results.

- Staff confirmed the senior management team were visible, conducted daily walkabouts and often visited the ward and theatres to observe practices. The daily 'huddle' meetings were improving communication between the leaders and department staff.
- The senior management team were forging relationships with external bodies including NHS and clinical commissioning groups.
- There was a governance structure in place with committees including, clinical governance and health and safety, feeding into the medical advisory committee (MAC) and hospital management team meetings.
- Most staff had a good understanding of the hospital's vision, values and were aware of the hospital's strategy.
- Response rates for patient satisfaction surveys were good with a high satisfaction rate for the service.

Vision and strategy for this core service

- The BMI corporate group had a clinical strategy which was made up of six themes:
 - Putting patients at the heart of what we do
 - Patients are our most important attribute
 - Quality should underpin everything we do
 - Working together to grow our business
 - Engaging with our consultants
 - Being as cost effective and efficient as possible.
- The focus for the hospital was that patients were essential to everything they did. Senior staff told us that they "strive to meet and exceed patient expectation whether that is in an outpatient setting or as an inpatient."
- The vision and values were clearly displayed in the hospital and had been shared with staff across the ward and theatre areas. Most staff had an awareness of these and knew where to find the information.
- We saw the hospital's values were incorporated into the appraisal process and staff understood the aim to improve quality and surgical activity.

Governance, risk management and quality measurement for this core service

- There was a governance structure within the hospital, which consisted of various committees such as medicines management, health and safety and clinical governance. The clinical governance committee met

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monthly. This committee had an overview of governance risk and quality issues for the departments. The committees had terms of reference, which reflected their role in the hospital, their structure, and purpose.

- There was a governance strategy and quality improvement plan (2015/16), which included specific performance targets and actions relating to patient safety, clinical effectiveness and patient experience.
- We saw that incidents and outcomes were reviewed and monitored through the clinical governance committee and the medical advisory committee (MAC). Examples included transfers out of hospital, return to theatres, surgical site infection rates, average length of patient stay, readmission rates and complaint themes. However, the incidents were reported via a paper based system triaged by one member of staff. The senior management team (SMT) advised that an electronic incident reporting system was about to be launched which would improve transparency and review for themes.
- We saw that minutes for MAC meetings demonstrated that key governance areas were discussed including incidents, complaints and practising privileges. However, the MAC chair had limited knowledge of the overall governance structure function of the committee.
- The MAC carried out checks before granting new consultant's practising privileges, including checks on their scope of practice to ensure they were only undertaking procedures that they were competent to perform. However, we found that the practicing privileges were not being reviewed as per the hospital policy. This meant the appropriate systems and processes were not in place to ensure staff with practising privileges met required standards to practice. This was raised during the inspection. The executive director advised that prior to joining the team at the hospital; no reviews of practising privileges had taken place. A plan was put in place to tackle the backlog. At the time of our inspection, there were 151 consultants with practising privileges and 51 consultant's files that required their biennial review. The information had been collected for these reviews but the final sign off had not been completed. We saw that the details of the files were also being transferred to an electronic database to further assist with monitoring in the future.
- Senior staff told us that, if they needed to suspend an NHS consultant holding practising privileges, then the executive staff, along with the support of the MAC

chairman, would inform that consultant's responsible officer at the NHS organisation and the GMC. The hospital explained to us that this had happened, and the process was followed.

- The hospital had strategic systems in place to assess and control its risks. For example, they used key performance indicators, which allowed the executive board to monitor when performance fell below acceptable levels. Routine audits and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and shared with staff through performance dashboards that were displayed on noticeboards. However, not all audits had actions or outcomes to improve performance. This meant that we could not always be assured that identified quality and performance issues were being addressed.
- There was a risk management plan and a risk register for the hospital. This had been developed in consultation with the BMI Healthcare Governance Committee to provide a framework for risk management across BMI Healthcare group. The hospital wide risk register highlighted key risks to the services. Senior staff could provide examples of what their main risks were. These included staffing levels and recruitment, infection control and environment and estates. Actions taken to control or minimise the risks were included in the risk register. During the inspection, we noted that there were areas related to infection prevention and control that required improvement, for example, medical staff poor adherence to hand washing practises. We found that the register included a risk related to infection control. However, the risks were pitched at a corporate level. This meant that it did not always describe risks found at a local or departmental level. There were also plans in place to refurbish the wards to ensure there was appropriate flooring and hand washing facilities and many staff informed us of this. However, there was no definite timescale for when this would occur.
- There was no in-date service level agreement in place for patients who became critically ill and required transfer to a local NHS hospital. However, the BMI Healthcare corporate policy stated that this was essential. We raised this during the inspection and it was acknowledged that this would be addressed. The SMT also stressed that should a patient require transfer

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this would be arranged in conjunction with the patients consultant. Subsequent to our inspection, the hospital provided a copy, confirming that this was now in place (January 2017).

- We found there were inconsistencies with the management of medicines at the hospital. Including medicines left unattended in theatre, medicine cupboards left unlocked in the recovery room while the theatre was not being used and store for flammable items unlocked. We also found that the process for handing the controlled drug keys on the ward was not formalised. This meant that the senior management team had not taken reasonable practicable actions to ensure the safe management of medicines at the hospital. During the unannounced inspection, we saw that there had been an improvement in medicines management and storage. Senior staff had also put in place spot-check audits to maintain this.
- We saw an internal governance review had been undertaken at the hospital for June 2016. The review looked at areas such as clinical governance, audits, risk register and assessments and training. The findings were risk rated red, amber and green. The governance review had a resulting action plan. One example of an area that required immediate action was to include the discussion of incidents at daily huddle meetings. During our inspection, we attended daily huddle meetings and observed that incidents were discussed. Staff told us and we could see that the huddle meetings encouraged communication between teams throughout the hospital. This appeared to have been positively received by staff.
- We saw a copy of a quality meeting minutes for April 2016. Staff contributed to the quality meeting by completing a “circle of concern and influence.” Areas identified included theatre lists running over, issues with booking patients to have surgery and waiting for medicines on discharge. We saw action plans to address these concerns, which included who was responsible and timeframes. For example, additional training was required for the booking department to ensure a smoother transition for patients. This demonstrated that the staff were involved in identifying issues and involved in solutions.
- There was an ISO 27001 audit undertaken in October 2015, regarding information security. The ISO 27001 helps the provider to identify the risks to important information and put in place appropriate controls to

reduce these risks. The external company who undertook the audit reported that the BMI Healthcare Group had applied efforts to improve the information security management system with consistent implementation across all hospitals.

- Externally, the hospital’s standard acute contract (SAC) meetings provided the Clinical Commissioning Group (CCG) with the opportunity to feedback on patient outcomes and performance. This was done through the SAC audit and monitoring process. Any variances were reviewed and reported back to the CCG team. The hospital also produced annual quality audit accounts, which were shared with the CCG. This included medicines management, infection control and health and safety.

Leadership / culture of service related to this core service

- The hospital was led by, an executive director, a director of clinical services and an operations manager. They were the senior management team (SMT). There were also heads or managers for services at the hospital including imaging, theatres, outpatients, pharmacy, administration and the ward.
- We found there was clear and visible leadership at both an executive and head of department level. Members of SMT had relocated their offices to ensure that they were easily accessible and open to staff communication. Staff including administrators, nurses and catering staff told us they were highly motivated and felt valued and supported by their immediate line managers. Staff were positive about their work and described the managers as approachable, visible, and friendly with an open culture policy. The SMT had identified development needs relating to the leadership and management skills of some of the department leads. We saw these were being addressed through internal workshops and external courses such as the Institute of Leadership Management, which two HODs were currently attending with internal support from the senior management team (SMT).
- We observed the SMT conducting daily walkabouts. Staff confirmed this had improved staff morale and made the SMT more visible. Both the director of clinical services and executive director had visited theatres and

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observed theatre practices. Staff confirmed this during our inspection, and said it was “nice to see” the SMT participating in theatres and made them feel “part of a team.”

- There was a good working relationship between the consultants and senior management team (SMT) of the hospital and any issues with regard to competency or behaviour were discussed with the MAC chair and representatives. We could see evidence of this during our review of consultants’ files and practising privileges. We could track when an issue had been raised, for example from a formal complaint and then the associated correspondence with the consultant and planned actions.
- The overall lead for the surgical services at the hospital was the director of clinical services. The surgical ward was led by a ward manager and the theatre manager was responsible for the day to day management of the theatres and the endoscopy unit. Staff spoke positively about the leadership of both the ward and theatre manager. Staff said the managers had made positive improvements in the planning and organisation of the ward and theatre areas. The ward manager had also received an award from a local university for being an outstanding mentor.
- Staff sickness rates in the wards and theatres were generally low (below 10%) from April 2015 to March 2016. Staff turnover was also low (below 5%) during this period.
- The SMT felt that they had a good relationship with the clinical commissioning group (CCG).

Public and staff engagement

- The hospital used three patient questionnaires, which included inpatient and outpatient postcards as well as detailed long-form questionnaires for inpatients. The results were published centrally and shared monthly with the hospital team. There was positive feedback from patients with 98% saying they had received excellent care. To ensure that the hospital focussed on continuous improvement based on patient feedback they undertook quality meetings. The results of patient feedback were also discussed at the clinical governance meetings and the MAC. Minutes of meetings of the MAC were circulated to each consultant with practising privileges to ensure they were aware of items discussed and agreed actions.

- The hospital also focused on feedback from staff and consultants, which were collected through a staff survey. The latest staff survey for 2015 showed that staff had confidence in their line managers and felt their role was very important to the organisation. However, the hospital staff recommendation results were at 66%, which was below the national average of 70%. This meant that 66% of staff who responded to the survey would recommend the hospital as a place to have care and treatment.
- The hospital had implemented an action plan to improve staff engagement, which included good practice stories being shared at daily communication meetings and included in the hospital weekly update. We saw that new induction programmes and staff forums had also been introduced with SMT involvement.
- In each department we inspected, leaders held regular staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Senior members of staff felt involved and were consulted regarding any proposed organisational changes. Staff felt they had an influence with the overall development of services and were encouraged to contribute their ideas.
- There were not effective arrangements in place in theatres for staff to receive their annual appraisals. We saw that 35% of registered nurses and 40% of operating department practitioners had received their annual appraisal. Following the inspection, we asked the hospital what the target level was for appraisal rates. They stated that the target rate for completion of appraisals was to be 100% by end of December 2016.
- No whistleblowing concerns were reported to the Care Quality Commission in the 12 months ending August 2016.
- Social interaction between the staff, consultants and the public were encouraged through a range of events throughout the year. For example, in July 2016 the trust held a fair with various games and stalls in the hospital restaurant and garden, which were open to the public.
- In March 2016, BMI Healthcare group were accepted to participate in the ‘sign up for safety’ campaign. The aim of the campaign is to put safety first, continually learn from incidents, be honest, collaborate with other organisations and teams and be supportive.





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- The hospital team recently supported a 'Big Bandage Day'. This involved wearing bandaged knees, arms, fingers, hips and heads as part of the campaign to raise the awareness of safety and raise money for a local children's hospital.

Innovation, improvement and sustainability

- The team safety "huddle" meeting, had been introduced within the hospital to improve communication across departments. This appeared to have been positively received by staff from different departments and disciplines.
- The hospital had a scheme where good practice was rewarded each month. We saw staff received acknowledgement (May and June 2016) for the work carried out, which included good response to an incident and learning, good communication problem solving between the ward and theatre and a thank you from an external hospital regarding the support given to student nurses. The ward had created and implemented a student nurse induction programme to support their time within the hospital.

Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Information about the service

Outpatient services at BMI The Droitwich Spa Hospital provided a wide range of specialities including orthopaedic, general surgery, gynaecology, ear nose and throat (ENT), urology, ophthalmology, cardiology, dermatology, and plastic surgery for both private and NHS patients. There were 19,100 outpatient attendances from April 2015 to March 2016. Of these 53% were NHS funded and 47% privately funded.

There were nine consulting rooms, a physiotherapy department and a minor procedures room. There were separate rooms including a phlebotomy room (where blood samples were taken), and rooms for ear, nose and throat (ENT) and ophthalmology patients. There was a dedicated reception area for outpatients and two waiting areas located close to the consulting rooms. A physiotherapy department was situated off the outpatient reception, with three private treatment rooms.

BMI The Droitwich Spa Hospital imaging department provided plain film radiography and ultrasound scans. There was a separate waiting area and dedicated changing facilities within the imaging department. The computerised tomography (CT) and magnetic resonance imaging (MRI) service was not inspected because it was a separately regulated provider.

We visited BMI The Droitwich Spa Hospital during an announced inspection on 16 and 17 August. We also carried out an unannounced inspection on 31 August 2016. We spoke with nine members of staff including managers, consultants, nurses and healthcare assistants. We spoke with six patients and two relatives. We checked 10 sets of healthcare records and inspected the environment and equipment in the outpatient and imaging departments.

Summary of findings

We rated outpatients and diagnostic imaging services as good overall. We rated outpatients and diagnostic imaging services as good for being safe, caring, responsive and well-led.

We inspected, but did not rate the service for effectiveness.

We found:

- Staff were actively encouraged to report safety concerns and incidents. There was a high level of low or no harm incidents reported. There had been no serious incidents or never events reported in the outpatients and diagnostic imaging department in the twelve months ending March 2016.
- Staff were able to give examples of when practice was changed following learning from incidents or concerns. They understood the principles of the duty of candour.
- Equipment we checked was clean and maintained appropriately, with 'I am clean' stickers used to show that the item was ready to use.
- Appropriate environmental measures, including signs, were in place to identify areas where radiological exposures were taking place in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- The imaging department had clear processes in place to ensure that the right patient received the correct radiological procedure.
- The outpatient's manager undertook regular multiple quality audits within the department.

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- The imaging department followed best practice guidance by checking radiation levels against national diagnostic reference levels.
- During the inspection, patients' consent was obtained in line with the hospital policy and the Mental Capacity Act (2005).
- Local and hospital policies and guidance we checked, were within review date and based on relevant national or professional guidance.
- Staff had access to the information they needed to deliver effective care and treatment.
- There were short waiting times from referral being made to treatment being provided. Between 99%-100% of NHS funded patients began treatment within 18 weeks of referral (April 2015 to March 2016).
- Patients had short waiting times in departments prior to consultations or appointments.
- There was clear signposting to the departments and staff available to provide advice and assistance at the reception areas.
- 10 complaints had been received in seven months (ending July 2016) themes included poor communication of fees and consultant's attitude. However, we saw that immediate action had been taken to address these issues.
- Patients were unanimously complimentary about the care they had received in the departments. This was also reflected in the positive feedback in patient satisfaction surveys.
- Patients told us that they felt that they were part of the decision making process regarding their treatment plan. We saw that staff provided an unhurried approach and treated patient with respect.
- Patient's privacy and dignity was maintained at all times during our inspection.
- Staff were aware of the corporate vision and strategy of the BMI group.
- Risk assessments were completed for all areas of concerns that we found during the inspection. This meant that managers were aware of the areas of risk in their departments.
- We found that the staff morale was good and local leadership was supportive.
- Daily 'huddle' meetings were used as a forum to alert daily risks to the senior management team.

- The departments sought feedback from patients who used the services and were proud of the positive satisfaction survey scores.

However, we also found:

- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance. We found areas that did not comply infection control and prevention policies. These included the flooring type and coverage in some rooms, positioning or lack of hand wash sinks and an examination couch with a ripped cover.
- There were plans for refurbishment areas of non-compliance to infection control and prevention policies such as flooring. Timescales for this were not clear.
- We found there was a general lack of hand cleansing gels throughout the clinical departments. However, during our unannounced inspection, we found hand sanitiser gels dispensers had been installed for staff and patients to use when moving between areas.
- Naso-endoscopes, which were flexible fibre optic tubes used for ear, nose and throat (ENT) procedures were not being decontaminated in a separate room from the clean scopes. This posed a risk of cross infection.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good 

We rated outpatients and diagnostic imaging services as good for being safe because:

- Staff were actively encouraged to report safety concerns and incidents. There was a high level of low or no harm incidents reported. There had been no serious incidents or never events in the twelve months ending March 2016.
- Staff were able to give examples of when practice was changed following learning from incidents or concerns. They understood the principles of the duty of candour.
- Equipment we checked was clean and maintained appropriately, with 'I am clean' stickers used to show that the item was ready to use.
- Appropriate environmental measures, including signs, were in place to identify areas where radiological exposures were taking place in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- The imaging department had clear processes in place to ensure that the right patient received the correct radiological scan.

However:

- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance. We found areas that did not comply with infection control and prevention policies. These included the flooring type and coverage in some rooms, positioning or lack of hand wash sinks and an examination couch with a ripped cover. There was a lack of a robust plan and date for completion for the refurbishment to the ultrasound room.
- We found there was a general lack of hand cleansing gels throughout the clinical departments. However, during our unannounced inspection, we found hand sanitiser gels dispensers had been installed for staff and patients to use when moving between areas.
- Naso-endoscopes, which were flexible fibre optic tubes used for ear, nose and throat (ENT) procedures were not being decontaminated in a separate room from the clean scopes. This posed a risk of cross infection.

Incidents

- The hospital had an incident reporting policy in place. This included guidance on how to report incidents and how to investigate concerns. Details of Incidents were filled in on paper forms, which were entered onto a computer system by the quality and risk coordinator.
- Staff were aware of how to report an incident and explained the process that they would follow. Staff across the outpatient (OPD) and imaging departments told us they felt confident in reporting incidents and were encouraged to do so by senior staff.
- The service had not reported any never events from April 2015 to March 2016. A never event was a serious incident that was wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers were available at a national level and should have been implemented by all healthcare providers.
- From April 2015 to March 2016 there were no serious incidents reported within outpatient and diagnostic imaging services. There were 117 clinical incidents reported by the staff in outpatients and diagnostic imaging from April 2015 to March 2016 and 22 non-clinical incidents during the same period. All the incidents were classed as resulting in either low or no harm. The rate of both groups of incidents was higher than other independent acute hospitals during the same period of time. Managers told us this was because the staff had a good incident reporting culture.
- The service had not reported any Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) events from April 2015 to March 2016. The senior radiographer in the imaging department confirmed that the radiation protection advisor (RPA) carried out a review in relation to radiation doses and any abnormalities would be reported. We saw evidence of documented reviews during the inspection.
- The outpatient department held monthly meetings where incidents were discussed with staff. During the inspection, we saw evidence of this in minutes of the meetings.
- The outpatient department could demonstrate when they had learned from and made changes following an incident. For example, a patient's allergy status had not been communicated to the surgeon from the pre-operative assessment clinic and as a result their procedure had been cancelled. Following this incident,

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they had changed their pre-operative assessment paperwork to prompt nurses to document that they have informed the surgeon and anaesthetist of any allergies the patient may have.

- From November 2014, all providers were required to comply with the Duty of Candour. Regulation 20 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. 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. Staff told us that if there had been any problems in a patient's care or treatment this would be investigated. This would also be discussed with the patient and their representative and an apology given whether there was resulting harm or not. Staff provided inspectors with examples when this had taken place. Both departments had posters promoting the duty of candour on display. The staff had also been given their own leaflet explaining what to do if there was a patient safety incident in their area. Staff we spoke with could describe the principles of being open and honest with patients. Staff explained there was regular discussion about the principles of duty of candour at the monthly staff meetings and we observed this to be the case when looking at meeting minutes.

Cleanliness, infection control and hygiene

- The departments we visited were visibly clean and dust free. We saw completed cleaning schedules within the departments. The consulting rooms cleaning schedules included items of equipment in the room. At the time of inspection, staff had recorded daily cleaning and we saw no gaps in these schedules. The rooms had disposable curtains, which were visibly clean and were dated to show they had been changed in line with their policy.
- We observed that 'water flushing records' were completed in line with local policy. This showed compliance with the Department of Health, Health Technical Memorandum 04-01: Safe Water in Healthcare Premises 2016, to reduce the risk of Legionella infection.
- During our inspection, we observed minimal use of the hand sanitisers. We found that they were not generally available throughout the departments. We saw that hand sanitiser gels were available in the consulting rooms and the reception desks. However, we did not

observe prompting of staff or patients to use the hand sanitisers or any posters encouraging their use. We highlighted the general lack of available hand sanitisers to the management team during the inspection. When we returned during our unannounced inspection, we found hand sanitiser gels dispensers had been installed for staff and patients to use when moving between areas.

- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance. We found flooring in two out of 11 rooms in the outpatient department did not have a continuous return between the floor and the wall for easier cleaning. This meant that effective cleaning could be difficult and therefore bacteria could be harboured leading to a risk of cross infection. We also found that the ultrasound room floor was carpeted. Staff showed us an action plan for completing refurbishment of the rooms in the future, to comply with standards. We highlighted the non-compliance to the management team during the inspection.
- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance. We found the hand wash sinks two out of 11 rooms in the outpatient department could not be operated without the use of hands and did not have separate hot and cold taps. In the imaging department, we also found that the sink in the ultrasound room had an overflow hole and a plug attachment, both of which could harbour bacteria and a risk of cross infection. We highlighted these to the management team during the inspection. They informed us that risk assessments had been completed and there were plans to refurbish these areas.
- We found that the chairs in one of the outpatient waiting areas had fabric covers, which did not meet infection prevention standards, as they were difficult to clean. Staff informed us that new chairs had been ordered for this area with seat covers, which could be removed and washed.
- We found that the examination couch in the minor procedures room had a ripped cover. This meant that it posed an infection prevention and control risk because it could not be cleaned properly. We saw that there had been a risk assessment completed regarding this and staff told us that a new examination couch had been ordered.

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- We checked the minor procedures room in the outpatient department. This room was not used for minor operations (which would need multi-layer skin closure) as these would be undertaken in main theatres. However, we found areas of non-compliance with infection prevention and control standards for this type of clinical room. We found that there was an adjacent annexe room with a hand wash sink located next to a sluice sink. A sluice sink was for contaminated waste disposal and therefore handwashing for a procedure was not appropriate in this area. We raised this with staff in the department at the time of the inspection. They explained that staff did not use this annexe area for preparation for procedures and instead used the hand wash sink in the minor procedure room. However, this meant using a sink that could not be operated without the use of hands and did not have separate hot and cold taps. There were also toilet facilities accessible from this room. Staff told us this was not used. However, its location was not appropriate for a room used for minor procedures. The manager of the outpatient department showed us the plans for the refurbishment of this room. This was planned for September 2016 and once completed would meet infection prevention and control standards. In the meantime, there was a risk of cross infection.
- The outpatient department used naso-endoscopes, which were flexible fibre optic tubes for ENT procedures. The hospital had a policy from 2014, (with a review date in 2017) which contained guidance for staff about the decontamination of naso-endoscopes. They used appropriate techniques to decontaminate the scopes in between each patient's procedure including 'three part' wipes to decontaminate scopes used for invasive procedures. This process was specifically designed for cleaning medical devices and contained a high level of disinfectant, sporicidal (a substance used to kill bacteria spores) and a rinsing wipe. We also saw training records showing that staff had completed decontamination training. However, the decontamination of the scopes was taking place in the same room as clean scopes. This meant there was a risk of cross contamination and infection. There was a risk assessment completed regarding the decontamination process. This acknowledged that a separate cleaning room was required. In order to mitigate the risk in the meantime, the staff segregated an area in the ENT room, by using curtains, for cleaning the naso-endoscopes.
- During the inspection, we observed that the needles used in the departments were compliant with the European Directive 2010-32-EU Safer Sharps Directive. This stated that all needles should have a safety sheath to minimise the risk of needle stick injuries. The clinical rooms had appropriate facilities for the disposal of clinical waste and sharps. This was in line with the Health and Safety Regulation 5 (1) d, which required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. Staff signed and dated a label on the bins used for the disposal of sharp objects (sharps bins) to indicate who they were constructed by and when for traceability.
- Waste was handled appropriately in the departments, with separate colour coded arrangements for general waste and clinical waste. During our inspection, the clearly marked foot pedal operating bins were not overfilled.
- The outpatient manager carried out a weekly 'walk around' of the department to check compliance with cleaning. The results of this were reported to the clinical governance meeting, which we saw in the meeting minutes.
- Personal protective equipment (PPE), including gloves and aprons, were available in the consultation rooms. Eye protection goggles were also available if required.
- In the imaging department, there was a separate dirty utility room, for the disposal of clinical waste and storage of bedpans and vomit bowls.
- We observed that the clinical staff were 'arms bare below the elbow' in line with the hospitals infection prevention and control policy. However, a member of staff was wearing their work jacket in the outpatient department. We highlighted this to another member of staff and they removed their jacket.
- The consulting rooms appeared visibly dust free and 'I am clean' labels were seen on equipment, to show items had been cleaned and were ready for use.
- Both outpatient and imaging departments had processes in place for if a patient had an infection control risk, such as diarrhoea, or a known infection. For example, the patient would be taken straight into a consulting room rather than use the waiting room. After the consultation, the room was deep cleaned and the disposable curtains changed.

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- The hospital's patient led assessments of the care environment (PLACE) indicators, from February 2015 to June 2015, were better than the England average for cleanliness, scoring 100%.
- The hospital's infection prevention and control training rates were at 93% as of July 2016.

Environment and equipment

- The main outpatient department was open plan and well lit. Patients who arrived at reception were sign posted to the specific waiting area nearest to the consultation room. The reception desk was large and at a height accessible for wheelchair users to communicate effectively with the receptionists.
- During our inspection, we observed there was adequate seating in the waiting areas.
- Appropriate environmental measures, including signs, were in place to identify areas where radiological exposures were taking place in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000. This reduced the risk of patients and staff entering a controlled area.
- The imaging department had a range of specialist aprons for protection against radiation. There were clear guidelines on which specialised personal protective equipment (PPE) such as lead aprons should be used for specific procedures. Staff told us that they had access to appropriate PPE to carry out procedures.
- Emergency resuscitation equipment was located on the main corridor between the outpatient and imaging departments. This was in a large 'grab' bag, which could be moved easily to either location. The bag was secured with non-tamper tags. These were removed every Monday to check the equipment. During the inspection, we checked that the equipment was present, in date and stored correctly. We found that staff had completed full weekly checks of the resuscitation equipment, including a portable oxygen cylinder and suction.
- There was equipment available to take clinical observations, including an electrocardiogram (ECG) machine, blood pressure and temperature monitors and specific ophthalmology equipment such as a visual field machine.
- There were systems to maintain and service equipment appropriately. Maintenance records were kept for the equipment used in both departments. We found that equipment we checked had been electrical equipment tested to ensure they were safe to use. Staff told us the

turnaround time for faulty equipment was good. We saw evidence of repairs for a faulty ECG machine in less than 24 hours. The team were also supplied with another machine to use while the repairs were taking place. Both departments kept records of engineering reports and logged faults and breakdowns.

- The hospital had contracts in place for the servicing of radiology equipment by the supplier. The radiation protection supervisor carried out quality assurance checks.
- There was a range of exercise equipment in the physiotherapy department. Training and assessment of competence of staff in the use of the equipment was seen in staff training records.
- At the time of the inspection, the corridors were kept free of clutter and fire escapes accessible.

Medicines

- The hospital had an onsite pharmacy that was open from 8.30am to 4.30pm. Staff told us the pharmacy team dispensed outpatient prescriptions and were available to offer support and advice to staff and patients.
- Medicines were stored in locked cupboards or refrigerators and monitored appropriately in both departments. Nursing staff held the keys to the cupboards to prevent unauthorised personnel from accessing the medicines. In the imaging department, staff kept the keys in a locked safe accessible with a code. There were no controlled drugs or intravenous fluids stored in either area.
- We saw evidence in the outpatient department that daily temperature checks of medicine refrigerator and the ambient room temperatures were recorded. Medicines in the imaging department were kept in a temperature controlled cupboard. The temperature was checked and recorded daily.
- A registered nurse checked and recorded the stock of medicines in the outpatient department each week.
- Batch numbers and expiry dates of medicines that were used in the imaging department, were recorded and scanned onto the computerised radiology information system (CRIS). This meant that any medicine issues could be traced back and appropriate actions taken.
- Consultants in the outpatient department provided private prescriptions for patients. The private

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prescription book was stored in a locked cupboard to prevent theft and abuse. We checked the private prescription book and found the prescription sheets were completed appropriately.

- Nursing staff in the outpatient department used patient group directives (PGDs). PGDs are documents permitting the supply of prescription only medicines to groups of patients, without individual prescriptions. We found these to be in date and appropriately completed in both departments.
- Senior staff received safety alerts relating to medicines. We saw that these were shared with staff via clinical governance bulletins.

Records

- The hospital used a paper based healthcare records system, with the exception of digital images of x-rays and ultrasounds. We reviewed 10 sets of healthcare records in the outpatient department. We found the records were accurate, complete, legible and up-to-date. This meant that staff were complying with the hospital's record keeping policy and an accurate record of patients' care was being maintained.
- We saw that records were stored appropriately within the OPD, in lockable cupboards. There was also a dedicated, secure medical records room within the hospital.
- Staff told us that it was unusual for patients' records not to be available for appointments and they could access the office and the medical records room if needed. The provider told us that this was not an issue for the hospital and therefore audits were not carried out.
- Once records were no longer required, they were stored on site.
- We observed surgical pre-operative assessment and physiotherapy records. They were appropriately completed, with patient identifiable stickers and specific forms for each patient. All of the notes we reviewed contained detailed explanations about the care and treatment received.

Safeguarding

- The hospital had safeguarding policies and procedures available for staff on the intranet; including how to manage suspected abuse and details of who to contact.
- The outpatient department had a safeguarding folder, which contained the details of local services and authorities.

- Staff in both clinical areas could tell us about what steps they would take if they were concerned about any patients or relatives. The outpatient department manager would provide potential scenarios at monthly meetings for the staff to discuss.
- Staff were required to undertake level one and two safeguarding adults training. Both departments were 95% compliant with this training. 100% of staff had carried out level one safeguarding children module and 88% had completed level two. The clinical director held level three in safeguarding children training, this enabled a process of escalation if required.

Mandatory training

- There were systems in place for staff to complete mandatory training in a range of subjects. The topics covered included fire, infection control, moving and handling and information governance. Heads of departments were responsible for ensuring staff completed the modules.
- Information provided for July 2016, showed us that 98% of trained staff and 95% of untrained staff in outpatients and imaging departments had completed their mandatory training. We saw evidence of this in the staff training records during the inspection.
- 88% of outpatient department staff had completed their fire prevention mandatory training as of July 2016.
- Staff informed us that they had completed mandatory training, which was delivered either online or face-to-face sessions. The outpatient manager told us that staff had enough time away from the department to complete these modules and if they chose to do the online learning at home, they would get this time back.
- We saw the training records that showed that the staff in both departments had completed basic life support and immediate life support. The outpatient manager was the dedicated resuscitation trainer for basic life support.

Assessing and responding to patient risk

- Reception staff told us if they identified any patients who were unwell they would call the nurse to see them urgently. However, they had said that this had never happened whilst they had been working there. There were emergency call buzzers situated at the reception desk in the OPD.
- Emergency equipment was available for use in the event of an emergency for example, oxygen and suction.

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- The staff we spoke with were clear and knowledgeable about the procedures to follow if a patient deteriorated when using the services, in either outpatients or imaging. This included using the emergency call bells situated in both departments and using the emergency bleep system. This alerted the hospital 'crash' team to attend. The hospital held 'crash huddles' every morning, assigning each member of staff a role so they had a clear process when attending an emergency call. This included staff from outpatients and imaging. We saw the emergency bleep system was tested during the inspection.
- Staff told us if a patient became unwell whilst either in the outpatient or diagnostic imaging department, they would be reviewed by the appropriate consultant or the RMO and then transferred to the local NHS hospital an emergency ambulance if needed. However, there was no evidence of a formal agreement with the local NHS hospital or ambulance service. Subsequent to our inspection, the hospital confirmed that a service level agreement with a local NHS trust was now in place (January 2017).
- We saw that the emergency bleep number was displayed in the clinical areas of the departments. This included details of the location where the person would be making the emergency call to direct the resuscitation team.
- The imaging department had clear processes in place to ensure that the right patient received the correct radiological scan. Staff used PAUSED guidance that encourages staff to pause and follow a checklist prior to proceeding, which was observed to be used during the inspection. The PAUSED checklist included for example, Patient-checking verbally with the patient their details, Autonomy-checking the correct site to be x-rayed, User checks-confirm the examination is on the right date and time, Systems and settings-select the correct imaging protocol, Exposure-recording dose, Draw to a close-ensure images are stored correctly and inform the patient how they can get the results. We saw this being used during the inspection. The senior radiographer in the imaging department informed us that administration staff would check before an appointment to see if the patient had undergone a recent x-ray. If they had, this would be shown to the radiographers and referring clinician to see if the new test was still required. This reduced the risk of patients being exposed to radiation unnecessarily.
- The radiographers recorded the doses of radiation a patient received. The x-ray equipment gave a print out of the dose given, which we saw would be attached to the patient's referral form. We saw during our inspection, that for screening tests, such as barium meals, the doses were also recorded in a separate book.
- The imaging department had systems in place to highlight abnormal radiological findings, for example, cancer and fractures. They would first highlight the image with a 'red dot', to identify image as abnormal and then would notify the referring clinician urgently. The radiologist was also informed to carry out an urgent report of the image.
- There was a specific section on the radiology referral forms to complete for women of childbearing age. The hospital's policy required imaging staff to question a female of child bearing age about the possibility of pregnancy and sign a form to confirm this. The radiographers could also ask for a urine sample from the woman, which could be pregnancy tested by the nursing staff in outpatients if she was unsure. The radiology staff we spoke with were confident about this process and we observed completed forms indicating this was being checked.
- The radiographers we spoke with had confidence to challenge an imaging request they were not satisfied with. During our inspection, we saw a radiographer in the outpatient department discussing an x-ray request with one of the consultants.
- The outpatient department used a World Health Organisation (WHO) checklist to provide safer care for patients undergoing minor procedures. We saw evidence in patient's records that this was being completed.
- Patient records included risk assessments such as risk of falls or nutritional assessments. They were completed appropriately in all 10 records we looked at during the inspection. They included GP referral letters or patients medical records from a previous appointment at the hospital.
- Nutritional risk was assessed at pre-operative clinics and advice booklets given to patients. The hospital used the MUST (malnutrition screening tool) and this was seen in the pre-operative assessment records.

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- There was a multidisciplinary meeting within the hospital, known as 'the huddle', designed to discuss and review safety issues. For example, equipment, staffing levels and newly identified risks. This took place every morning, Monday to Friday.

Nursing staffing

- The outpatient department manager was responsible for ensuring that staffing levels were appropriate for the clinics, using professional judgement, speciality clinic requirements and knowledge of previous clinic attendances. Staff and consultants we spoke with said that staffing levels were adequate for the clinics and services that were delivered.
- During our inspection, we observed that staffing levels were adequate to meet the needs of patients, and there was an appropriate skill mix including senior healthcare assistants (HCAs), registered nurses and administration staff.
- We saw that staffing levels were pre-planned on an electronic rota system at least two months in advance.
- Data submitted by the hospital identified that the outpatient department employed 4.8 whole time equivalent (WTE) registered nurses and 2.8 WTE senior healthcare assistants. The outpatient manager told us they had recently employed a senior staff nurse, who would assist in managing the department. There were two registered nurses who worked in the outpatient department, specifically running the pre-assessment clinics.
- The rates of use of bank and agency staff working in the outpatients department were lower than the average of other independent acute hospitals during the reporting period from April 2015 to March 2016. No unfilled agency or bank shifts were reported from January 2016 to March 2016.
- Bank and agency staff were given a formal induction to complete when they started working in the departments we inspected. This induction was guided by a checklist, which included health and safety, mandatory training, BMI Healthcare policies and a local orientation.
- The sickness rates for outpatient nurses, was lower than the average of other independent acute hospitals from April 2015 to March 2016, except for the months of November and December 2015 and February 2016, when rates were higher. This was the same for senior

HCAs, except for November 2015, where the rate was higher. The explanation for this was that was during the winter months, when cold and flu sickness was more prevalent.

- Eight physiotherapists, both full and part time and two hand therapists staffed the physiotherapy department. Staff told us this was enough to meet the demands of the service.
- Staffing levels in the imaging department were determined by the amount and type of booked activity and to support the outpatient clinics. There was an imaging manager, two further radiographers and two part time agency radiographers. One of these was moving into a substantive vacancy in September 2016. There were also two part time radiography assistants.

Medical staffing

- Consultants and radiologists worked under practising privileges with the hospital and attended the outpatient department and imaging department on set days and times. This meant that the managers of departments knew in advance which consultant was attending and were able to allocate staff appropriately to the clinics.
- The patients were provided care by a named consultant. Patients told us they saw their consultant at each appointment.
- Nursing staff told us they felt supported by the consultants while they were on site or if they needed to contact them by telephone.

Major incident awareness and training

- There was a major incident policy in place relating to the services within the hospital available on the intranet. There was also a service contingency plan in place for staff to use in the event of interruption to services, caused by for example, floods, generator failure or IT system failure.

Are outpatients and diagnostic imaging services effective?

We inspected, but did not rate the outpatients & diagnostic imaging services for effectiveness.

We found that:

- The outpatient manager undertook regular multiple quality audits within the department.

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- The imaging department followed best practice guidance by checking radiation levels against national diagnostic reference levels.
- During the inspection, patients' consent was obtained in line with the hospital policy and the Mental Capacity Act (2005).
- Local and hospital policies and guidance we checked, were within review date and based on relevant national or professional guidance.
- Staff had access to the information they needed to deliver effective care and treatment.

Evidence-based care and treatment

- There was evidence of a wide range of local quality audits carried out by the outpatient department manager. These included audits on the completion of patient safety minor procedure checklist, local waiting times in the department and the OPD checklist (which was completed by every member of staff who had an interaction with the patient). The audit activity led to changes in the service. For example, an audit found that a certain clinic would overrun due to the nature of the examinations required. Therefore, the consultant was given longer appointment times for their clinic. A repeat audit to show if this had improved waiting times had not been completed at the time of inspection.
- Staff we spoke with in outpatient and imaging departments had good awareness of local policies. Policies were available to access on the hospital's intranet and were based on professional guidance such as that published by the National Institute of Care and Excellence (NICE) and the royal colleges.
- A monthly hospital bulletin highlighted new guidance to staff.
- The imaging department used diagnostic reference levels (DRLs) to guide radiology practice. The DRLs were displayed on a screen in the x-ray room. DRLs were checked against national audit levels and if they were found to be high, a report would be made to the radiation protection advisor (RPA). During our inspection, we checked the DRLs folder, which contained reports to the RPA in the imaging department.
- The physiotherapy service used a number of BMI group-wide clinical pathways for hand therapy. These documents contained reference to relevant literature and guidance.

- We saw examples of policies referring to professional guidance. For example, the chaperone policy referred to professional guidance from the Royal College of Nursing (Chaperoning: The role of the nurse and the rights of patients, 2002).

Pain relief

- The outpatient department held clinics specifically for pain relief. This provided guidance and treatment for patients with chronic and acute pain issues.
- Pain relief was discussed at pre-operative assessment clinics and advice booklets given to patients. The patient's pain would also be assessed using a pain scale within the national early warning score observation chart.
- Patients could contact the outpatient department directly and speak to a nurse or their consultant if they were experiencing pain after a procedure.
- Consultants were able to provide private prescriptions of pain relief for patients in the outpatient department. Patients could collect medicines from the onsite pharmacy.
- Patients we spoke with during our inspection had not required pain relief during their appointments.

Patient outcomes

- The hospital took part in PROMS (patient reported outcome measures). Results on patient outcomes were compared with other locations within the region and across BMI Healthcare through the corporate clinical dashboard.
- Quality accounts were produced by the hospital on a yearly basis and were shared with the CCG (clinical commissioning group). The hospital had achieved 100% of their CQUINS (commissioning for quality and innovation payment framework) for their financial year from 2015 to 2016.
- The imaging department did not currently participate in the Imaging Services Accreditation Service (ISAS), or improving quality in physiological services (IQIPS).
- The departments conducted monthly infection control hand hygiene audits. The latest audit data for June 2016 showed 100% compliance.

Competent staff

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- Staff were required to receive an appraisal meeting each year. The staff appraisal rate was 94% for registered nursing and radiology staff (August 2016). In addition, 88% of senior health care assistants had an appraisal in the last twelve months.
- New staff were required to complete the BMI corporate and local induction programme. Staff also had competencies to achieve to maintain specific to their job role. We saw staff training records included completed competency assessments.
- The senior radiographer in the imaging department confirmed that the radiographers Health and Care Professions Council (HCPC) registration was checked on recruitment to the hospital and then monitored that had it had been renewed every two years. Radiographers were on a three-month probationary period when they started with the hospital and at the end of this they had an appraisal. They then had another appraisal six months later.
- Physiotherapy staff confirmed that professional registrations were checked by the hospital on recruitment, including training records to ensure competent staff treated patients.
- Consultants had to provide evidence of completing revalidation as part of their practising privileges agreement with the hospital. There were a certain minimum requirements, which a consultant must comply with to maintain their practising privileges. These included registration with the General Medical Council (GMC), evidence of insurance and indemnity from a medical defence organisation or insurer and a current performance appraisal and revalidation certificate.
- The central BMI human resources department send monthly reports on staff's professional registration status to the employee compliance coordinator. This report was reviewed by the employee compliance coordinator and the director of clinical services and sent out to the head of the relevant department to action, as required. Heads of the department were responsible for ensuring that their staff were supported through the revalidation process. Nursing staff we spoke with in the outpatients department said they felt supported through the revalidation process.
- Nursing staff in the outpatients department could access specific training for example, in the use of an electrocardiogram (ECG) machine, bladder scanner,

point of care testing, chaperone training and venepuncture (taking blood samples). Staff told us this allowed them to gain new skills and work confidently in specialist clinics.

- Patients who attended the outpatient clinics and the imaging department told us that they thought staff had the right skills to treat, care and support them.

Multidisciplinary working

- Our observations of practice, review of records and discussion with staff during the inspection, showed that the services worked effectively as a multidisciplinary team (MDT). Staff communicated well with different staff groups in the outpatient and diagnostic imaging departments and with colleagues from different services within the hospital, for example, theatres and physiotherapy.
- One stop clinics were not provided by the outpatients department. This was when different disciplines of staff worked together during the patients' attendance to the clinic. However, staff told us they were able to be flexible and would arrange for the patients to see various members of different specialities during an attendance to the hospital, if this was required.
- After a patient had attended an appointment, administrative staff would print copies of letters to be sent from the hospital to the patient's GP. This ensured relevant information was being shared.
- Patients, who needed local NHS MDT input regarding cancer services, were referred to their local NHS Hospital directly by the consultant.
- The hospital had access to laboratory support from specialist off site companies for pathology. Histopathology samples were sent to the local NHS hospital laboratory under a service level agreement.

Seven-day services

- The outpatient department was open Monday to Friday 8am to 8pm and Saturdays 8am to 1pm. Staff confirmed that additional clinics were held on request from the consultant.
- The imaging department was open Monday to Friday 8am to 6pm. After 6pm, there was an on call service until 9am the following morning. There was also a weekend on call service from Friday evening until Monday morning. Radiographers took it in turns to cover on call shifts.

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- The physiotherapy department was open Monday to Friday 8am to 5pm, for appointments for both the physiotherapy team and the hand therapist, with additional hand therapy services some evenings and weekends.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment. They demonstrated how to access policies and procedures on the hospital's intranet.
- Inpatient records were kept on site and then archived in a secure store, which could be accessed for outpatient appointments.
- Consultants could access patient's NHS scans and x-rays via an online system. This system was the picture archive communication system (PACS), which stored and allowed image sharing, radiation dose information and patient reports. This could be accessed on a computer that had the system installed.
- The diagnostic images were reported on in a 48 hour time frame and results were sent to the patient's GP, or referring consultant. Analysis and reporting took place in a dedicated reporting room where data could be entered onto (PACS).
- Staff could access pathology results electronically and the external pathology provider would also send paper copies to the consultant.
- Each clinic room had a computer where staff could access test results and images.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff across both departments had completed training in Mental Capacity Act (2005) and Deprivation of Liberty safeguards (DoLS) as part of their safeguarding adults level two training. At the time of inspection, compliance was at 100%. Compliance with consent training was 98%.
- Staff we spoke with were able to describe the relevant consent and decision making requirements relating to the Mental Capacity Act 2005 (MCA) and DoLS to protect patients. Staff had signed that they had read the policy in the department.
- Consent for procedures was obtained from patients as per hospital guidelines. We checked five consent forms during the inspection and found they were completed as per guidelines.

- Gaining consent from patients for care and treatment was managed by individual consultants.
- We saw during the inspection, that verbal consent was gained from patients as a minimum prior to any procedure, such as venepuncture and diagnostic tests.
- The outpatient department had a MCA folder, which contained relevant guidelines and policies, for example 'best Interests' meetings.
- In the outpatient department monthly meetings minutes, we saw that staff would discuss scenarios relating to MCA.

Are outpatients and diagnostic imaging services caring?

Good 

We rated outpatients and diagnostic imaging services as good for being caring because:

- Patients were unanimously complimentary about the care they had received in the departments. This was also reflected in the positive feedback in patient satisfaction surveys.
- Patients told us that they felt that they were part of the decision making process regarding their treatment plan. We saw that staff provided an unhurried approach and treated patients with respect.
- Patient's privacy and dignity was maintained at all times during our inspection.

Compassionate care

- We observed staff being polite and friendly towards patients and relatives during the inspection.
- The six patients and two relatives who we spoke with were unanimously complimentary of the staff and the hospital.
- We observed staff interacting with patients in a professional and compassionate manner in clinics and in the waiting area.
- Patients told us and we saw that staff were kind, respectful and always introduced themselves.
- We observed the receptionists being kind, courteous and helpful. We asked reception staff how they maintained patient confidentiality at the front desk and they told us no sensitive information was discussed at the booking in stage.

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- Patients told us that their privacy and dignity was always maintained.
- Staff and patients told us that patients undergoing an examination would be asked if they needed a chaperone.
- Patient satisfaction survey results, which included both NHS and privately funded patients, were displayed in the main outpatient department waiting room. The results from October 2015 to March 2016 showed that 99% to 100% of patients would recommend the hospital to family and friends. This result was similar to the England average. The response rates were also similar to the England average during the same reporting period, except from January to March 2016, which were slightly lower.

Understanding and involvement of patients and those close to them

- Patients and the relatives we spoke with told us their treatment was discussed in detail and in a manner they were able to understand. They felt they were given time if they needed to ask further questions.
- All the patients we spoke with said they felt that they were part of the decision making process regarding their treatment plan.
- Patients were given the opportunity to be accompanied by a friend or relative during consultations.

Emotional support

- Staff we spoke with had an understanding of the emotional impact care and treatment could have on patients. Staff told us that information was provided to support patients prior to and after their appointment, including information regarding pricing tariffs.
- A consultant told us they would ask for a member of the nursing staff to be present when delivering bad news to patients.
- Patients would be given information about counselling services should they need them. These were private services or through other providers.

Are outpatients and diagnostic imaging services responsive?

Good 

We rated outpatients and diagnostic imaging services as good for being responsive because:

- There were short waiting times from referral being made to treatment being provided. Between 99%-100% of NHS funded patients began treatment within 18 weeks of referral (April 2015 to March 2016).
- Patients had short waiting times in departments prior to consultations or appointments.
- There was clear signposting to the departments and staff available to provide advice and assistance at the reception areas.

However, we also found:

- Complaints had been made regarding the departments, including poor communication of fees and consultant's attitude. However, we saw that efficient action and response had been taken to address these issues.

Service planning and delivery to meet the needs of local people

- There were clear signs to direct patients to the outpatient and imaging departments. We found the reception desk was staffed at all times during our inspection. This meant there were staff available to answer any queries and to assist with directions if needed.
- Some of the consultation rooms in the outpatient department were used for specific specialities with dedicated equipment, for example ear nose and throat, and ophthalmology. This meant that consultants would be able to work in an appropriately equipped room and staff could be arranged to support and deliver this service.
- Clinic room doors in the outpatient department had signs, which staff changed to indicate if the room was free, or engaged. This helped to maintain patient's privacy and dignity.
- The senior radiographer in the imaging department described how staffing was flexible so the department could provide a service for patients. They also booked time slots appropriate to the length of the test required.

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- Outpatient clinics were held at weekends and evenings to provide a flexible service.
- Patients and staff told us that there was always available parking in the hospital car park.
- Seating was available in the outpatient areas and this was appropriate for the number of patients attending the clinics.
- Magazines for waiting patients were available on request and there was a hot drinks machine available for patients and their relatives to use.
- Food and drink from the hospital's restaurant was available for patients on request. After minor procedures, patients would be given snacks and refreshments free of charge.
- The outpatients department did not provide official 'hot clinics', which were same day, or next day appointments. However, they maintained that they were able to be flexible and provide urgent appointments depending on patient's requests.
- Results from the imaging department were sent to the referrer via hard copy and images were available to view on the hospital computer system. Any urgent requests or images of concerns were telephoned to the referrer for immediate attention. A consultant we spoke with confirmed this process happened. We saw that the picture archive communication system (PACS) was available on computers in each consulting room.
- Posters were displayed in each of the waiting areas in the outpatient and imaging departments, advising patients to inform the reception staff if they were not seen within 20 minutes of their appointment time. Staff told us they would inform the patients of any delays. Patients we spoke with said they had a minimal wait for their consultation on arrival to the hospital. The head of the outpatient department carried out a weekly audit of waiting times. We saw evidence of this and action plans in place for a specific clinic noted to be frequently running behind.

Access and flow

- Referral to treatment time (RRT) was the term used to describe the period from when an appropriate referral for treatment was made and the date of the initial consultation or treatment occurred. The Department of Health stated for NHS patients that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral. The service met the RTT times target from April 2015 to March 2016, with between 99%-100% of NHS funded patients beginning treatment within 18 weeks of referral being made.
- Patients we spoke with felt that the booking system for appointments was good. A patient told us they were seen at the hospital within days of being referred by their GP.
- NHS funded patients were given the option to book their appointment via the NHS patient booking website. This allowed them to choose a time that was convenient to them or they could contact the outpatient booking team directly. Staff in the booking team contacted patients if an urgent referral was received.
- The percentage of patients that did not attend (DNA) their outpatient clinic appointments was on average 5%, which was better than the England average of 7% of all other providers. The hospital told us that no formal audit of DNA appointments took place. However, they routinely logged details of the patients who DNA. Staff would contact the patients that DNA and provide the option to rebook the appointment. However, if more than one appointment was missed the hospital would write to the patient's GP and record this.

Meeting people's individual needs

- Data provided by the hospital for July 2016, showed that 98% of staff in outpatient, imaging and physiotherapy departments had completed their equality and diversity training.
- Appointments in the imaging department were booked according to the estimated time the imaging would take. However, if a person living with dementia or a learning disability required an appointment, the booking staff would inform reception and nursing staff. Administrative staff told us they would arrange longer appointment times and patients could visit the department prior to the appointment. Staff told us they would encourage carers and relatives to stay with person living with dementia or a learning disability during appointments.
- A member of the outpatient team would telephone patients in advance if there was to be a planned change of consultant for their appointment.
- We saw in monthly meeting minutes that the outpatient manager would discuss scenarios relating to the needs of patients living with dementia.

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- In the imaging department, a carer or a relative would be invited into the imaging room if the patient agreed and it would help to keep them calm and comfortable. If this happened, there was a specific section on the imaging request form for the carer or relative to sign, to declare they were not pregnant and understood the risk of receiving a small dose of radiation. They would also be provided with a protective lead apron.
- The departments we inspected could accommodate patients who used wheelchairs. We found there was sufficient space to manoeuvre and position wheelchair in a safe manner.
- Staff told us that interpreter services were available for patients. The booking team would identify this as a need in advance and inform the manager of the department. Staff gave inspectors examples of when and how they had used this service.
- Patients had access to a variety of information leaflets in the outpatient department and imaging department, these included information about medical conditions and services available. The leaflets were printed in English. However, staff told us they could be printed in a variety of languages if required.
- Patients told us that they were informed of fees for their consultation before their appointment and sent leaflets regarding this. This meant that patients received information in relation to costs to enable them to make a decision. This had been improved following complaints received regarding communicating about fees.
- There were signs in the departments informing patients that chaperones were available if required. Patient could choose a male or female chaperone according to their preference.
- Patients we spoke with were satisfied with the service. However, they also knew how to raise a concern or complaint if they needed to.
- There had been 10 complaints received regarding outpatient and imaging departments from January 2016 to July 2016. The complaints mainly related to communication regarding fees and consultant's attitude. We found the hospital had taken immediate action to resolve both of these concerns. Letters of apology for the miscommunication and correct information about fees had been sent to the complainants.
- We saw from meeting minutes that complaints and complaint themes were discussed at department level with staff.

Are outpatients and diagnostic imaging services well-led?

Good 

We rated outpatients and diagnostic imaging services as good for being well-led because:

- Staff were aware of the corporate vision and strategy of the BMI group.
- Risk assessments had already been completed for all areas of concern that we found during the inspection. This meant that managers were aware of the areas of risk in their departments.
- We found that staff morale in both departments was good and local leadership was supportive.
- Daily 'huddle' meetings were used as a forum to alert risks to the senior management team.
- The departments sought feedback from patients who used the services and were proud of the positive satisfaction survey scores.

However, we also found:

- There were plans for refurbishment areas of non-compliance with infection control standards such as flooring. However, timescales for this were not clear.

Vision and strategy for this core service

Learning from complaints and concerns

- There was an up-to-date complaint procedure policy on the hospital's intranet. This set out the various stages of complaints and the timescales for responses. Staff we spoke with understood the complaints procedure and would try to address any concerns at the time they were raised.
- We found copies of an information leaflet, which provided guidance on how to raise concerns and outlined the complaints procedure in the waiting areas for both outpatient and imaging departments.

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- Staff were aware of the overall corporate vision and strategy, which was 'Serious about health. Passionate about care.' They also knew about the six themes of the corporate clinical strategy.
- In both outpatient and imaging departments, the corporate values were displayed, which included being open and honest.
- Staff told us of the plans for refurbishment of the hospital to ensure appropriate flooring and handwashing facilities. We noted the refurbishment plans did not include a date when they would be take place.

Governance, risk management and quality measurement for this core service

- The hospital had a risk management policy in place. This provided guidance to staff in assessing and responding to risks, including guidance on how risks were to be graded and how to escalate issues. There was a risk register, which contained some relevant issues for the departments. However, this document was set at a corporate rather than a local level. Both the outpatients and imaging departments relied on their risk assessments to prioritise and organise local risks.
- The outpatient and imaging department completed annual risk assessments. The managers of both departments had a clear understanding of all risks to their services. These included areas of infection control noncompliance such as the minor procedures room sink and the decontamination of naso-endoscopes, which we identified during the inspection. We saw that these were reviewed regularly and that plans were being actioned. Each risk assessment included control measures and an identified owner. We found that managers of the individual departments had a good awareness of issues that posed a risk in their areas.
- The head of each department attended monthly meetings with the executive director and director of clinical services. We saw that agenda items included risk register updates, new corporate policies and significant complaints. This information was then shared to staff via email and the heads of department would print out the relevant information for their own staff and display on notice boards.
- A representative from the outpatient and imaging departments attended a daily 'huddle' meeting with the executive director and director of clinical services. This meeting was to discuss staffing and activity for that day,

and any issues or gaps which could be resolved by the team within the meeting, incidents and near misses from the previous day and to make staff aware of any unusual activity that was happening in the hospital, for example maintenance in clinical areas. We saw that messages from the huddle meetings were cascaded to staff at departmental level on the same day. We also saw messages from departments were passed to the 'huddle' and written on the 'huddle' board.

Leadership / culture of service

- The outpatient and imaging departments were each led by a head of department. These managers reported to the director of clinical services. We saw strong leadership, commitment and support from the senior management team within the hospital. Staff told us the senior managers were supportive and approachable.
- Managers of the departments told us they had autonomy to make decisions and were proud of their staff.
- Staff throughout the departments told us they felt supported, respected and valued by their immediate line managers and they were visible and approachable.
- We saw that the nursing, imaging, physiotherapy and administration teams communicated well and supported each other.
- Staff told us since the appointment of the outpatient manager in particular, the department's culture and morale had improved under their leadership. We found staff were enthusiastic and proud to work within the outpatient department.
- The head of the outpatient and imaging departments, described an environment in which any mistakes in patients care or treatment would be investigated and that they supported staff to meet the duty of candour regulation.

Public and staff engagement

- The views and experiences of patients were sought through completion of a survey. The survey questions were open to allow people to express themselves. Patients were encouraged to complete the patient satisfaction survey during or after their visit to outpatients, imaging and the physiotherapy department. Posters were displayed on walls also asking patients to complete the cards. There were collection boxes at each reception desk or they could be returned by post. The results of the surveys were

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analysed by an independent third party and communicated back to the hospital for learning and action. The heads of department would share the survey results with the staff in their monthly department meetings. The results of the survey showed from October 2015 to March 2016 that 99% to 100% of patients, friends and relatives would recommend the service. The outpatient department manager told us, they had scored 100% for June and July 2016. The staff were proud of the positive feedback and scores from the survey.

- Staff were invited to attend monthly department meetings, which was a forum to raise any issues and receive updates. These were on a variety of topics, including the business strategy and financial matters. The outpatient and imaging departments had good attendance to their monthly department meetings. This was the main strategy for staff engagement for these areas. Staff told us that they were encouraged by their line managers to report incidents and raise concerns.
- The manager of outpatient department had made an 'open door' policy for so staff could raise concerns.
- Staff received the BMI corporate group clinical governance and quality and risk bulletins on a monthly basis via email. These included, drug and patient safety alerts, duty of candour examples and NICE guideline updates. These bulletins were also available in a folder in the 'huddle' room.

Innovation, improvement and sustainability

- The hospital had recently installed an anti-gravity treadmill for the physiotherapy department. This used innovative technology to reduce weight going through the body, allowing patients to work on the treadmill without full weight bearing on lower body injuries or following surgery. At the time of inspection, this was the only anti-gravity treadmill available in Worcestershire.
- The outpatient department manager saw that there was a need to employ another senior nurse for the department. This would allow the manager to focus on quality and improvement, while the senior nurse could carry out the day-to-day running of the area. A business case was developed, which was approved. During the inspection, we were told that the post had been successfully recruited to.
- The imaging department had recently started using patient group directives. This allowed the radiographers to prescribe and administer a range of medicines to enhance images being taken. This improved the efficiency of the service because prior to this, radiologists would have to prescribe and give the medicines, which could result in delays for the patient.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

Action the hospital **MUST** take to improve

- Implement procedures to ensure that invasive equipment (naso-endoscopes) are decontaminated in line with national guidance.
- Ensure that all members of clinical staff work within infection prevention and control guidelines.
- Ensure that all staff consistently participate and complete the five steps to safer surgery checklist.

Action the provider **SHOULD** take to improve

Action the hospital **SHOULD** take to improve

- Ensure the safe management of medicines complies with hospital policy and guidelines. This includes the procedure for managing the medicine keys within the ward area.
- Ensure all consultants practising privileges are reviewed in line with company policy.
- Ensure that sinks and taps which conform to Health Building Note 00-10 Part C Sanitary Assemblies are available in clinical areas to allow correct hand hygiene practice.
- Ensure carpets in clinical areas are replaced with flooring that meets the requirements of Health Building Note (HBN) 00-09: Infection control in the built environment.

Requirement notices

Action we have told the provider to take

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

Regulated activity

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

The provider did not ensure that care and treatment was provided in a safe way for service users.

The provider did not have effective systems in place to ensure all equipment used for providing care and treatment was correctly used and decontaminated in line with national guidance.

Poor practice in assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated was observed.

The provider did not ensure that all staff consistently participated and completed the five steps to safer surgery checklist in order to reduce risks to patients receiving care and treatment.