BMI The South Cheshire 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 South Cheshire Private Hospital, Crewe is an independent hospital, based in a semi-rural location on the site of a large NHS Hospital in Crewe, is easily accessible, with free on site car parking and is part of BMI Healthcare. The hospital is registered to provide the following regulated activities:

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

The hospital director is the registered manager, supported by a senior management team. The hospital director also managed another BMI Healthcare hospital at the time of the inspection.

This inspection was carried out as part of our on going programme of comprehensive independent health care inspections. We inspected the hospital on 6 and 7 September 2016 as an announced visit. During the inspection there were scheduled surgical procedures and outpatient clinics taking place and also radiological investigations. On 21 September 2016 we also carried out an unannounced inspection when there were surgical procedures, radiological investigations and outpatient clinics taking place.

We inspected the core services of surgery and outpatients and diagnostics (OPD) at the hospital.

Are services safe at this hospital

- Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There was one 'never event' in 12 months prior to the inspection, which occurred in theatres. Improvement actions were identified during the root cause analysis (RCA) investigation; however, staff told us that the details of this never event were not circulated effectively to staff to enable learning and prevent recurrence.
- There were 250 clinical incidents in the reporting period April 2015 to March 2016.
- Out of 250 clinical incidents, 95% occurred in surgery or inpatients and 1% in other services. The remaining 4% of all clinical incidents occurred in outpatients and diagnostic services.
- The hospital followed a reporting policy where incidents were categorised into clinical or non-clinical and were reported on colour coded incident forms, pink for clinical and blue for non-clinical, however, not all staff were aware of how to report an incident. Some told us that it was quite difficult to do. A list of what could be reported as an incident was available on the ward. This could be quite limiting as the codes were mandated per area, however, we were told that free text was allowed. Incidents were recorded in a paper format, and then submitted to the Quality and Risk Manager for inputting into the electronic system. We did not see any formal action tracking following incidents during the inspection. We were told that a new system that would enable staff to report incidents electronically was to be introduced this year.
- We found limited evidence of analysis and learning from incident reporting. All incidents reported were presented to the Medical Advisory Committee along with a brief description of some incidents (2-3 sentences).The main types of incidents that were discussed were 'day case to inpatients' and 'cancelled operations'.No examples of learning or actions could be found within the minutes.We were told that there was discussion and challenge at the meetings but it was acknowledged that the minutes did not reflect this.

Summary of findings

- The hospital had a system to identify and safeguard the needs of vulnerable adults, children and young people. Staff were aware of their responsibilities and the correct procedures to follow if a patient was at risk.
- Systems were in place to protect people from the risk of healthcare related infections. There were no reported healthcare related infections at the hospital in the period April 2015 to March 2016 and there were no reported incidents of acquired venous thromboembolism or pulmonary embolism in the same period.
- The environment was generally visibly clean and tidy; we saw that cleaning rotas were in place and that these were audited regularly. Action plans were in place, if necessary and were reviewed regularly.
- The hospital generally performed similar to the England average in the person-led assessment of the care environment (PLACE) audits for 2016 for questions related to the safe domain.
- Records were stored securely and generally contained relevant information; however Nursing staff in outpatients had very limited or no information regarding patient's requirements who attended the outpatient department for follow up nursing care. Patient records were sent to medical records following a procedure performed in the outpatients department or discharge from the wards. In addition there were no individual patient records for patients attending for follow up review and treatment. We observed an A4 book which staff had documented care given for each patient at every visit. The information was limited with no evaluation, plan of care or reasons for treatment. On our return to the hospital for the unannounced inspection, the hospital had implemented a new process, in place of the 'A4 book', but it was too soon to judge its impact and effectiveness.
- Medicines were stored securely and there were processes in place to ensure they remained suitable for use. There were pharmacy audits and controlled drugs audits completed.
- Staffing levels were planned and implemented to ensure that there was sufficient staff on duty to provide safe care. This included the resident medical officer (RMO) cover.
- The use of agency staff and bank nurses working in inpatient departments was below the average when compared with independent hospitals we hold this type of data for in the reporting period of April 2015 to March 2016.

Are services effective at this hospital

- The hospital had a 'Corporate Audit' document which listed the monthly audits undertaken. These were the same audits each month and enabled comparison of compliance. Compliance was generally high, with the exception of falls, which was at 52% in January 2016. We requested the action plan for the fall audit. On discussion we were told that there wasn't an action plan in place but were shown the data collection pro-forma and where the hospital believes errors had occurred in the data collection process. The Quality and Risk Manager explained that there were a few areas where improvements could be made in practice but that the main improvements required were in accurate initial data collection.
- During our visit we spoke with two consultant surgeons about clinical audits and we were told that there would be limited evidence of clinical audits on this site. It was explained that as the majority of the doctors at this hospital also work at the NHS Trust co-located on the same site, the NHS cases were all included in the audits conducted at the NHS Trust. This was discussed with hospital management team who confirmed that this is an area for improvement within the audit programme.
- The service bench marked themselves corporately with other BMI services. The service planned to participate in the Private Healthcare Information Network (PHIN) which at the time of our inspection had not yet started.
- There were poor appraisal rates across surgical wards, theatres and outpatients. Staff we spoke with felt that appraisals were beneficial and wanted regular appraisals. Some staff said they had not had an appraisal for at least two years. They were happy that these had been started up again and those whom had had an appraisal recently stated this was a positive move. Organisational data showed that 33% of theatre staff and 40% of ward staff had

received an annual appraisal in the 12 months, up to September 2016. In outpatients Information provided by the hospital showed that 66% of of health care assistants (HCA) had received their appraisal at the time of inspection. The nursing sister told us since the Director of Clinical Services had been employed there was a focus on performing appraisals. At the time of the inspection we asked for the most up to date appraisal rates, but were not provided with them. At a later date we were shown appraisal rates for the time period requested.

- There were local policies and procedures in place and we saw evidence that departments followed relevant guidelines. The hospital kept their practices up to date and current by ensuring they were consistent with latest guidance such as those from the National Institute of Health and Care Excellence (NICE) and the relevant Royal Colleges'.
- Nutrition and hydration was assessed, information on fasting for surgery was provided; however, the letters we checked did not reflect the latest guidance which resulted in some patients fasting for longer periods than necessary.
- There was a comprehensive induction programme in place for new staff.
- The hospital was generally performing similar to, or better than the England average, for outcomes in relation to knee and hip replacements for the period of April 2014 to March 2016.
- Staff were observed working in partnership with a range of staff from other teams and disciplines including allied health professional, consultants and administration staff.
- The hospital had policies and procedures in place for consent, mental capacity and deprivation of liberty safeguards. Consent was sought prior to any treatment and patients were required to sign consent forms, which were then confirmed on the day that patients attended the hospital. We saw evidence that where a patient lacked capacity to make a decision, decisions about care and treatment were made by relevant professionals within a multidisciplinary team setting. Input was sought from the patient, their family and their representatives. Such decisions were made in the best interests of the patient and were documented and recorded appropriately

Are services caring at this hospital

- Patients we spoke to were positive about staff and said they were kind, considerate and treated them with dignity and respect.
- Without exception, every patient we asked spoke very highly of staff and were very positive about the way they had been treated by the service. They felt very strongly that staff were exceptionally caring and considerate of their needs.
- We observed staff being attentive and caring to patients during the inspection.
- The NHS friends and family test (FFT) is a survey, which asks NHS patients whether they would recommend the service they have used to their friends and family. From April 2015 to March 2016, hospital wide, 100% of NHS patients would recommend the service to their family or friends, the response rates were above the England average of 49.9%.
- The hospital performed well in the Person-Led Assessment of the Care Environment (PLACE) audits. The results for privacy and dignity at the hospital were 86% in June 2016 which was better than the England average of 83%.

Are services responsive at this hospital

- Information provided regarding waiting times for treatment for NHS patients, also known as referral to treatment times (RTT) showed that from April 2015 to March 2016, on average 92% of patients referred to the BMI South Cheshire private hospital were admitted for treatment within 18 weeks of referral.

Summary of findings

- The hospitals performance in the Person-Led Assessment of the Care Environment (PLACE) audits for 2016 in relation to responsiveness was mixed. The hospital performed better than the England average for privacy, dignity and wellbeing. However, they performed significantly below the England average for dementia.
- Signage around the inpatients ward was not dementia friendly, in that signage was not in both written and pictorial form. However, the inpatient ward had done a lot of work on trying to improve the environment for people living with dementia and had established a designated dementia friendly room.
- There was no cosmetic surgery specialist nurse in post therefore there was a lack of formal assurance that issues such as psychological assessment of patients seeking cosmetic surgery and enforcement of the two week 'cooling off period' were being achieved.
- The hospital received very few complaints. We were provided with a tracker detailing ten complaints to date this financial year (at the time of the inspection). All of the complaints had been acknowledged on the day of receipt. Only 50% of the complaints on the tracker had been closed. The oldest open complaint was from 3.5 months ago; a holding letter had been sent one month after receipt. The hospital followed the corporate complaints policy which was a three stage process; if the complainant was not satisfied at stage one, which was at hospital level, the complainant had the right to escalate as per policy, to stage two, which was investigated by a senior director within BMI Healthcare. These complaints tended to be around financial issues as opposed to patient safety or experience issues.
- Meeting minutes we reviewed indicated that complaints were discussed at the Senior Management Team (SMT) meeting. They were also discussed through the clinical governance and medical advisory committee (MAC) meetings.

Are services well led at this hospital

- Staff were aware of the BMI Health vision, values, and strategy.
- The Risk Management Policy and Procedure was a new document issued in August 2016.
- There was a risk register in place at the time of the inspection. The risk register was a generic document provided by the corporate team and risk was rated by the hospital staff. Additional information, such as 'actions to be taken', could be added to the document to localise some of the risks. We reviewed the risk register and found that local risks were added by inserting a sentence in bold, for example 'Use of aged Diathermy Machines'. We saw five local risks had been added all relating to equipment. The risk descriptions were poor and did not clearly articulate the condition, cause and consequence of the risk. Staff were not aware of the risk register, key risks included or how to have a risk included on the risk register. Actions were listed for each risk. However, there was no timescale or lead for each action (an overall lead for each risk was allocated). This did not appear to be a live document identifying and managing risks proactively. The Quality and Risk Manager did tell us that a new online system, which would capture incidents and have a comprehensive risk register module, was due to be implemented in October 2016.
- The hospital had a Clinical Governance Committee. We looked at the minutes from January, April & June 2016. They did not demonstrate any robust challenge or discussion around key clinical governance issues. The minutes read as being very process rather than outcome driven. For example, evidence was recorded that a root cause analysis (RCA) was being undertaken or had been completed but there was no record of the findings or improvement actions. Actions within the minutes were given a status of 'New,' 'Ongoing' or 'Closed'. There were no timescales allocated and no monitoring system to ensure that actions were responded to on a risk basis and in a timely way. The Clinical Governance Committee minutes referred to the risk register, as in stating that the first draft had been completed, but there was no discussion of any actual risks, no debates about risk ratings and no updates on actions taken to mitigate any risks.We discussed this with the hospital management team who acknowledged that an area for improvement is bringing to life the governance systems as opposed to managing processes.

Summary of findings

- The management team included the Medical Advisory Committee (MAC) Chair.
- There was a formal process for when new procedures or techniques were introduced / approved. The hospital dealt with this through practicing privileges interviews and new procedures were then escalated to the MAC for approval but BMI were planning introduce a new formalised system and flowchart to indicated the process for considering and approving new procedures.
- We observed some non-adherence to the sign in stage within the World Health organization (WHO) checklist and National Patient Safety Agency (NPSA) five steps to safer surgery process, yet the management audit had been recorded as compliant. After the inspection we wrote to the hospital concerning this matter and received assurance that all theatre staff had been briefed with our findings and saw evidence of communication to consultant surgeons and anaesthetists, highlighting the importance of the WHO checklist process. We were informed that the hospital would be reviewing their processes to ensure that compliance and completion of the 'WHO' checklist is adhered to for all surgical procedures.
- The hospital undertook a BMI staff survey on an annual basis. We were provided with the hospitals results from the 2016 survey, comparing results to the 2014 survey. There were a number of areas that staff experience deteriorated. Only 51% of staff were 'likely' or 'extremely likely' to recommend BMI Healthcare to friends and family as a place to work. This was a 13.9% reduction from 2014.All areas of the survey under 'Our Purpose' (vision, goals, communication of these, objectives etc.) had deteriorated since 2014, as had all areas under 'My views of BMI Healthcare' (proud to work for, recommend as an employer, valued etc.).Of those surveyed, 68% said that they were likely to be working for BMI Healthcare in 12 months' time. In terms of the way changes are made, only 27% reported that changes were introduced effectively. Staff told us that morale was low and this was also reported in the survey with only 28% reporting that morale was good.
- The leadership team were making efforts to improve the engagement with staff to improve morale. Various initiatives such as the staff forum and newsletter was in place to encourage place to improve engagement with staff both locally and nationally. The recently recruited Director of Clinical services had focused on improving governance, quality and leadership within the outpatient department with addressing training and appraisals, which staff agreed had improved.

We identified some areas of poor practice where the provider must make improvements;

Hospital-wide

- The hospital must improve its clinical governance and risk management processes to provide greater assurance that actions are being monitored to ensure timely attention to matters.
- The hospital must improve the incident reporting process to enable all staff to submit reports and enable all manner of incidents to be reported. There should be an effective system of circulating information and learning about incidents so that all staff remain aware of issues.
- The hospital must improve communication to ensure people who use the services, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service. In particular, meetings need to be better attended with important information shared and distributed accordingly.
- The hospital must ensure staff are appropriately supported and have access to an annual appraisal.
- The hospital must ensure that there is an effective process for clinical staff to receive supervision.
- The hospital must address issues with patient records to ensure that there are contemporaneous medical records for each service user, which include all relevant pre and post-operative information.

Summary of findings

In surgery

- The hospital must ensure that clinical waste from theatres is labelled in line with guidance issued by Association for Perioperative Practice (AFPP) in 2015 'Standards and Recommendations for Safe Perioperative Practice'.

There were also areas we feel the provider should make improvements;

In surgery

- The service should ensure they demonstrate progress towards implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) and Local safety standards for invasive procedures (LocSSIPs).
- The hospital should take step to improve signage to make it more dementia friendly.
- The service should optimise the fasting periods for patients prior to surgery in keeping with best practice guidance.
- The ward should consider removal of carpets in all clinical areas for infection prevention purposes.
- Managers should become familiar with contingency and business continuity plans for their departments.

In outpatients and diagnostic imaging

- The hospital should ensure staff are trained appropriately in relation to record keeping.
- The hospital should consider implementing a pain tool for use within the outpatient department.
- The hospital should consider ways to measure patient outcomes to identify areas for improvement.
- The hospital should store sharps equipment for example cannulas and needles within a locked cupboard/drawer.
- The hospital should increase patient engagement.
- The hospital should improve the environment to make it dementia friendly.
- The hospital should consider ways to improve support to those patients with learning difficulties or additional needs.

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	There was limited assurance in the effectiveness of the incident reporting system. Clinical waste from theatres was not labelled with patient identifiable data contrary to best practice. Staffing in theatres did not always comply with Association for Perioperative Practice (AFPP) standards. Managers had not implemented some key policies in theatres. The majority of staff had not had an annual appraisal for the last year. There was limited assurance in clinical governance procedures. However, the service had positive performance outcome measures, low levels of healthcare related infections. The hospital had good NHS friends and family test results. There were good levels of mandatory training and opportunities for further development. There was an effective and robust pre-admission process. The service had very good access to the services and facilities at the local NHS acute hospital (co-located on site).
Outpatients and diagnostic imaging	Requires improvement	The incident reporting system was limited and not accessible to all staff. Staff had minimal understanding of what incidents should be reported and the numbers of incidents reported were low which could suggest there was under reporting of incidents across the service. Outpatient staff had limited access to patient information prior to appointments which meant that they couldn't always plan for any additional requirement for patients and there was no structure in place to meet the needs of patients who required additional support. Staff did not have access to formal clinical supervision and not all staff had received their annual appraisal. There was limited assurance in clinical governance procedures and not all senior managers were visible. Staff morale was low at times with some staff not feeling valued. However, compliance with internal safety measures such as medicines management audits and mandatory training met the hospitals targets.

Summary of findings

Staff were caring and worked well as a team. There were staff vacancies but staff were flexible in their working patterns to support the needs of the service and patient requests. Service planning and development was patient focussed and flexible with referral to treat waiting times mostly meeting the national standards.

Summary of findings

Contents

Requires improvement

BMI South Cheshire Private Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The South Cheshire Hospital

BMI The South Cheshire Private Hospital, Crewe an independent acute hospital, which opened in 1989 and is part of a group of 59 hospitals within BMI Healthcare, which is a not for profit healthcare provider.

The hospital is located in Crewe, in a semi-rural location, with good access by road and has free on site car parking. The hospital has a ward area with 32 inpatient and day-case beds.

Our inspection team

The team that inspected the service comprised of an Inspection Manager, two CQC inspectors, specialist advisors including an operating theatres manager, a consultant plastic, reconstructive and hand surgeon, an antenatal day services manager and a manager with experience in governance and healthcare management.

How we carried out this inspection

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

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

The inspection was carried out as part of our ongoing programme of comprehensive independent health care inspections.

The hospital provided us with information and data before the inspection and we also used information from patients and the public including patient survey data and feedback from patients who had received treatment at the hospital. We looked at information from Healthwatch and from the commissioners of the services. Some data was available nationally including friends and family data.

During the announced inspection on the 6 and 7 September 2016 and the unannounced inspection on 21 September 2016 we spoke with a range of staff including senior managers, nurses, consultants, allied health professionals, administrators and health care assistants who worked at the hospital.

We spoke with patients and relatives who were attending the hospital at the time of our inspection. We gathered feedback from questionnaires and received comments from people who contacted us to tell us about their experiences. We also reviewed patient records.

We viewed policies and standard operating procedures. We observed care and treatment, reviewed performance and assessed information about the hospital and the different departments. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

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	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Requires improvement

Surgery

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

Information about the service

The BMI South Cheshire private hospital is set in the grounds of an acute NHS general hospital and has internal access to many of the hospitals facilities and services through a series of service level agreements.

The hospital has 32 inpatient beds and two operating theatres, it undertakes a range of surgical procedures including orthopaedics, gynaecology, dermatology, general surgery, gastroenterology, endoscopy, neurology, ophthalmology, pain management, rheumatology and urology, plastic and cosmetic, ear, nose and throat and oral surgeries.

The surgery department undertook 2,675 procedures from April 2015 to March 2016; of these 62% were NHS funded and 38% were self-funded or insurance funded.

As part of the inspection, we inspected the surgical inpatients and surgical day cases wards areas, the operating theatres, the recovery areas and the pre-operative assessment clinic.

We spoke with 11 patients and carers and looked at 18 patient care records. We spoke with 14 staff of different grades including nurses, doctors, allied health professionals, support workers, managers and administrators. We gathered feedback from questionnaires and received comments from people who contacted us to tell us about their experiences. We observed care and treatment, reviewed performance by checking policies, documentation and other evidence and assessed the care provided on the surgery wards and in operating theatres areas. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

Summary of findings

We rated surgery services as 'Requires Improvement' overall. This is because;

- The incident reporting system did not enable the hospital to capture all relevant incidents due to its limited nature.
- Staff did not always receive information and feedback regarding incidents, there was limited assurance of learning from incidents and never events.
- The service followed the World Health Organization (WHO) checklist and 5 steps to safer surgery, but some elements of the sign in stage were not completed fully.
- There were carpets in some clinical areas which was contrary to infection control best principles.
- Clinical waste from theatres was not labelled with patient identifiable data which was contrary to best practice.
- Staffing in theatres was compliant with BMI policy, but this did not always meet Association for Perioperative Practice (AFPP) minimum staffing requirements.
- The service had not taken any steps towards meeting the National Safety Standards for Invasive Procedures (NatSSIPs) and Local safety standards for invasive procedures (LocSSIPs).

Requires improvement

Surgery

- Records did not always contain information about initial consultations and background details as these were retained by consultants.
- The service had very low rates of staff who had received an annual appraisal.
- Target dates and monitoring of actions from clinical governance and medical advisory committee meetings were not evident. There was limited assurance that issues were being dealt with in a timely way.

However, we also found:

- Staffing levels were satisfactory with no shifts going unfilled in the period January to March 2016. Safeguarding and mandatory training levels were satisfactory.
- Patient Recorded Outcome Measures (PROMS) data showed positive outcomes that were similar to, or better than the England average.
- Staff demonstrated a kind, caring and attentive manner towards their patients. Patient felt they had been treated very well and that staff did everything they could to make their stay as pleasant as possible.
- Staff protected the privacy and dignity of their patients when providing care and treatment.
- Patients were kept informed and involved in the care and treatment. This service received good friends and family test results; which were better than the England average.
- The service attended to the requirements of patients with individual and complex needs. Reasonable adjustments were made to enable access to the service for patients living with dementia, learning disabilities and mental health problems.

Are surgery services safe?

Requires improvement

We rated surgery services as 'Requires Improvement' for safe. This was because:

- The incident reporting system did not enable the hospital to capture all relevant incidents due to its limited nature. There was uncertainty over who was authorised to report incidents and what type of incidents could be reported.
- Staff did not always receive information and feedback regarding incidents, there was limited assurance of learning from incidents and never events.
- The service followed the World Health Organization (WHO) checklist and 5 steps to safer surgery, but some elements of the sign in stage were not completed fully.
- There were carpets in some clinical areas which was contrary to infection control best principles.
- Clinical waste from theatres was not labelled with patient identifiable data which was contrary to best practice.
- Staffing in theatres was compliant with BMI policy, but this did not always meet Association for Perioperative Practice (AfPP) minimum staffing requirements.
- Records did not always contain information about initial consultations and background details as these were retained by consultants.

However, we also found:

- Staff were knowledgeable about the duty of candour processes and had evidence that these had been put into practice appropriately.
- The service used key performance indicators and safety thermometer information to assess their own performance and indicate areas for improvement.
- Staffing levels were satisfactory with no shifts going unfilled in the period January to March 2016.
- Safeguarding and mandatory training levels were satisfactory. Staff were knowledgeable about their safeguarding responsibilities.

Requires improvement

Surgery

Incidents

- 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The department had one never event during the reporting period April 2015 to March 2016. This involved the administration of local anaesthetic to the wrong site. An investigation was undertaken, the details were notified to CQC and an action plan was completed appropriately. However, it seems that the details of this never event were not circulated effectively to staff to enable learning and prevent recurrence. When asked three theatres staff were unsure about the never event that had occurred and could not identify learning or changes implemented thereafter.
- There were 250 incidents reported within the hospital from April 2015 to March 2016; 238 (95%) were within the surgery service; 112 resulted in no harm, 131 resulted in low harm and seven resulted in moderate harm.
- During our inspection we saw limited evidence that the process of reporting incidents, analysis, feedback and sharing of learning from incidents was wholly effective. The numbers of incidents reported were small, not all staff were aware of how to report an incident and some told us that they found it quite a difficult process. We were told that all staff irrespective of grade were encouraged to report incidents and near misses, however from our discussions with some staff, they were unclear of their role within the reporting framework as they believed they were not authorised to do so.
- The main types of surgical incidents recorded were day cases which reverted to inpatients and cancelled operations. Incidents were presented to the Medical Advisory Committee (MAC) along with a brief description, but we saw no examples of learning or actions taken detailed within the minutes of the meeting.
- Furthermore, we saw that action tracking following incidents did not have time scales attached and found that when incidents were reported, the reporter did not always get feedback about outcomes.
- We saw evidence that learning was identified and circulated from other BMI hospitals in corporate clinical bulletins but staff we spoke to were not always familiar with lessons learnt or changes implemented following incidents.
- BMI healthcare have a corporate policy in place for incident reporting, whilst it appears the service was following this policy, it was very broad and did not provide specific instructions on the manual recording and form completion.
- Staff in the department reported incidents manually in two incident reporting books. The use of each book was determined by the type of incident which occurred and categorised into clinical or non-clinical incidents. These were reported on colour coded incident forms, pink for clinical and blue for non-clinical, a pink book was kept on the department and there was one blue book, which was used by the whole hospital, this was kept in theatres. This system stated the nature and types of incidents that could be reported and provided a coded template of about 30 different incidents. We felt this limited the scope of incidents that might be reported and the range of potential issues that could be learned from. For example, we were told about an incident in which a planned operation had to be cancelled as the specific needs of the patient could not be met and further planning was needed. We were told this was not reported as an incident as it did not fit into the incident framework. We were told by managers that an 'other' option was allowed and that free text could be added. However, this option did not appear familiar to staff making reports.
- We were therefore not assured that the incident reporting system was an effective one. There was some acknowledgement that learning from incidents could be improved and a new electronic reporting system was being implemented which would hopefully resolve the issues identified and capture all incidents. However, this new process would also necessitate a change in the culture of incident reporting to ensure that staff were aware of which incidents should be reported and that it was not limited to the list used previously.

- Mortality and morbidity were discussed at the medical advisory committee meetings along with other clinical issues. This information was circulated to clinical staff as appropriate through minutes of meetings and newsletters.
- 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 were aware of the duty of candour procedures and the process to follow. We saw evidence that the correct procedures had been followed following harm to a patient. Patients were involved in discussions and investigations, were kept updated and received apologies for the harm caused.

Safety thermometer

- The service used safety thermometer information to benchmark themselves against other BMI hospitals and to assist in measuring improvements in the quality of the care they provided. A league table was produced centrally and circulated to show rankings.
- The hospital participated in the safety thermometer dashboard scheme. This showed that the hospital reported no falls with harm and no pressure ulcers for the year September 2015 to August 2016. They reported 100% compliance with venous thromboembolism (VTE) assessments and 100% harm free care for the same period.
- The wards posted some elements of safety thermometer information on the patient notice board displayed on the wards. They provided staffing numbers, patient satisfaction rates, staff uniforms and dementia information.

Cleanliness, infection control and hygiene

- During our inspection we found the theatres and recovery areas visibly clean and tidy. We saw that cleaning rotas were in place and that these were audited regularly.
- We found the wards to be clean and tidy however there were carpets in some of the patient's rooms and in the corridors. The use of carpets in clinical areas is not in keeping with infection control best practices due to difficulties in cleaning and sanitising carpets. The managers were aware of this issue and some of the rooms had been refurbished with vinyl flooring. There were plans to replace the remaining carpets with more suitable flooring in the future. In the meantime we saw that a risk assessment was in place to mitigate some of the recognised issues.
- The service reported zero cases of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium difficile infection (CDI) and Escherichia coli (e coli) infections during the reporting period April 2015 and August 2016.
- Infection control audits were completed monthly and identified actions were compiled and monitored by the infection control lead and heads of departments.
- We observed staff working in the wards and theatres to be compliant with 'bare below the elbow' policies and BMI uniform policy. We saw the appropriate use of personal protective equipment (PPE) such as gowns, aprons and gloves.
- There was adequate access to hand gels on entry to clinical areas and also at the point of care, we observed staff adhering to hand hygiene procedures. The service undertook monthly hand hygiene audits and results were 100% from January 2016 to July 2016.
- Although there were no patients under isolation precautions at the time of our visit we were satisfied that staff knew and followed correct procedures should there be a patient who had an infection and required such precautions. There were policies in place and staff were knowledgeable about the procedures.
- In the ward areas we observed staff following infection control best practice in relation to waste management, disposal of sharps, contaminated waste and laundry. However, the service was not labelling theatres waste in line with best practice produced by the Association for Perioperative Practice (AFPP) in 2015 'Standards and Recommendations for Safe Perioperative Practice'.
- Patient-led assessments of the care environment (PLACE) is a system for assessing the quality of the patient environment, undertaken by patients and the public. Scores for the BMI South Cheshire for cleanliness at June 2016 were 97%, which was similar to the England average of 98%.

- The service took precautions to reduce the risk of surgical site infections during and following surgery and staff told us they monitored their own compliance with such precautions. They achieved 100% compliance with skin preparation, prophylactic antibiotic administration, promotion of normothermia and glucose control, they were 90% compliant with supplemental oxygen.

Environment and equipment

- There were systems in place for equipment servicing, testing and maintenance. An asset register was kept and updated as appropriate. The manager kept a record of when equipment required servicing and ensured these were up to date. A sample of equipment checked on inspection was found to be up to date.
- We found that the ward clinical areas and theatre block were well maintained, free from clutter and provided a suitable environment for treating and caring for patients.
- Waste and clinical specimens on the wards were disposed of appropriately were handled and disposed of safely, this included safe sorting, storage, labelling and handling. However, the service was not labelling theatres waste in line with best practice produced by the Association for Perioperative Practice (AFPP) in 2015 'Standards and Recommendations for Safe Perioperative Practice'.
- The hospital used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates. The service had arrangements for the sterilisation of reusable instruments, some on site and some contracted out. We saw that this process was efficient and effective.
- Records indicated that resuscitation equipment was checked in line with hospital policy; trolleys they were locked, equipment was in date and records were kept of the unique seal reference numbers.
- We observed that theatres staff checked equipment including anaesthetic equipment and followed the correct processes.
- Condition, appearance and maintenance of the environment in the patient led assessments of the care environment (PLACE) assessments scored 89% at June 2016, which was lower than the England average of 93%.
- Hoists were available on the wards; records indicated these were serviced and maintained appropriately and instructions for use were attached on a laminated card.
- Other equipment, such as commodes were found to be visibly clean and maintained appropriately.
- We found that systems were in place for the traceability of various components and implants, such as joints and breast implants. We saw that this information was safely recorded on patients' notes we reviewed and submitted to databases where appropriate. Copies were also given to patients where appropriate.
- We saw that consumables and other equipment with traceability stickers were recorded in patients operating notes for future cross-reference if needed.

Medicines

- We found that medicines, including controlled drugs and intravenous (IV) fluids were stored safely and securely; they were in date and were readily available for use. Doors into rooms storing medicines had keypad access with codes that were changed periodically.
- We saw that there were processes in place to ensure that medicines remained suitable for use. Medicines requiring cool storage were stored appropriately and records indicated that refrigerators were being checked daily to ensure they were maintained at the correct temperature. Records also indicated that room temperatures where medicines were stored were being checked appropriately. Staff were aware of action to follow if room or refrigerator temperatures were found to be out of range and a laminated flow chart was posted next to the thermometer to advice of action to take.
- We observed records which confirmed staff completed daily checks on controlled drugs stocks to ensure medicines were reconciled correctly. During the inspection we also checked a random selection of controlled drugs on the wards and found the stock balances correlated with the registers. We also saw that the controlled drugs book confirmed that two staff members had signed for controlled drugs.
- Drugs administration trolleys were locked with key code access and chained to the wall in the clinical room when not in use.

- Emergency medicines and resuscitation equipment for both adults and children was stored appropriately, readily accessible and records indicated they were checked regularly.
- All the care records we looked at on our inspection included documentation of allergy status and details of the procedure with medicines administered.
- A pharmacist was available through an agreement with the NHS acute hospital (co-located on site). A routine service was provided during core hours and outside of this period the service had access to an out of hour's pharmacy service who provided an on call service for emergencies.
- The service completed periodic audits on medicines, the last medicines management audit in May 2016 found 90% compliance, the missed drug dose audit in July 2016 found 100% compliance and a controlled drugs audit in June 2016 found 92% compliance. We saw that the service took steps to improve shortfalls identified in such audits through action plans.

Records

- As part of our inspection, we reviewed the medical and nursing records of 18 patients. We found them to be accurate and legible. However, we found that the notes made by consultants during previous clinic records were not generally included in the records, they were recorded in the consultants own separate records, which was not kept with the BMI records and not directly available to staff on the ward or in theatre. This was an issue identified by BMI locally during documentation audits and recognised nationally by the organisation. A review was currently underway and there were plans to change the patient records system to improve the continuity of records.
- We found the pre-operative documentation process to be robust, comprehensive and complete.
- Patients' records contained important information such as patients' allergies, operation notes, post-operative care, observation charts and emergency contact details.
- We saw that patients' notes contained the relevant risk assessments and that care plans and pathways were completed thoroughly in nursing notes.

Safeguarding

- The hospital's Quality and Risk manager was the designated lead for safeguarding.
- The staff we spoke with were aware of their responsibilities regarding safeguarding of patients and the correct procedures to follow; they could describe how to access the BMI policy on the corporate intranet and who to speak to for advice.
- Information provided by the hospital showed that 95% of staff on the wards were up to date with training on safeguarding vulnerable adults and safeguarding children and young people; 96.5% of staff in theatres were up to date with training on safeguarding vulnerable adults and safeguarding children and young people. In addition, 100% of the ten designated staff in the hospital had received level 2 training in the safeguarding of children and young persons, and one member of staff was trained to Level 3. The new director of clinical services was booked onto a course shortly after our visit.
- The safeguarding policy included some guidance for staff on female genital mutilation (FGM) and when asked, staff were familiar with this issue.

Mandatory training

- Training classed as mandatory were those subjects which were considered the most important, such as basic life support, safeguarding patients and moving and handling.
- Mandatory training was kept updated by attendance on training courses or by training done remotely on a computer.
- Data provided by the hospital showed that 96.4% of staff on the wards and 94.8% of staff in theatres were up to date with mandatory training requirements. The hospital target was 90%.

Assessing and responding to patient risk

- Patients' surgical risk was assessed at pre-operative clinic. Any potential risks were investigated and highlighted. Those at greater risk were referred to an anaesthetist for further assessment and advice and if appropriate, sent for further tests such as echocardiogram and lung function tests. For some

patients', their surgical risk was too great and it was not possible to accommodate them at this service. Such patients were referred back to the local acute NHS hospital or GP service.

- The service adopted a version of the national early warning system (NEWS) to identify sick and deteriorating patients who required closer attention. The patient's observations and vital signs produced a score, the higher the score the more urgent or sick the patient was. The score triggered certain actions to take to prevent or identify further deterioration and risk. We saw these were recorded in the patients' medical records.
- Risks such as falls, nutrition, pressure ulcer and venous thromboembolism were assessed and reviewed periodically for each inpatient and these were documented appropriately in patients' medical records.
- In an emergency situation, an outreach team from the NHS acute hospital (co-located on site) and emergency 'bleep holders' attended to treat the patient quickly. A service level agreement was in place and the hospital had aligned its emergency equipment with that in the co-located NHS acute hospital.
- We observed that the operating theatres used the National Patient Safety Agency (NPSA) 'five steps to safer surgery' and the completion of the World Health Organization (WHO) checklist. However, during our observations we saw that the 'sign in' stage was not completed as per the WHO checklist. Three of the questions were not answered and the process was not undertaken as an interactive process with all team members and the patient. We found that the theatres teams recorded that this had been done on their check sheet even though we saw it had not. There appeared to be a misunderstanding over the sign in step and what this entailed. After the inspection we wrote to the hospital concerning this matter and received assurance that all theatre staff had been briefed with our findings and saw evidence of communication to consultant surgeons and anaesthetists, highlighting the importance of the WHO checklist process. We were informed that the hospital would be reviewing their processes to ensure that compliance and completion of the 'WHO' checklist is adhered to for all surgical procedures.
- The hospital followed the BMI Health care corporate policy relating to resuscitation, which was based and referenced against the National UK Resuscitation Council Requirements.
- Following discharge, patients were provided with a phone number for the ward, which was accessible 24 hours a day. They could phone for advice if they had any questions or concerns following their discharge.

Nursing staffing

- The surgical wards used an acuity tool to assess the dependency of patients they were expecting and treating to determine nurse staffing levels. This was done five days in advance, when managers were aware of which patients were being admitted. Staffing was reviewed on an ongoing basis and any needs escalated where additional staff could be sought.
- Theatres based their staffing on BMI theatre staffing policy; this allowed that for minor procedures to use a surgical first assistant and just one scrub nurse. We saw a list go ahead which scheduled one minor procedure and two major procedures with only one scrub nurse rather than two. Therefore, we were not assured that staffing levels in theatres always met the recommendations of the Association for Perioperative Practice (AFPP).
- The service reported that there were zero unfilled staff shifts for the reporting period from January to March 2016.
- Handovers were undertaken in the nursing office on the surgical wards. We saw that all relevant patients' details, status and plans were passed to the incoming shift. In theatres, we saw that team briefings were conducted to handover all relevant information to the team.
- The surgical wards had a lower than average use of bank and agency staff than that reported by other surgical wards at independent hospitals during the period April 2015 to March 2016. The wards' use of agency staff was around 5%, staff were predominantly BMI 'bank' staff.
- Theatres had a higher than average use of bank and agency staff than that reported by other theatres at independent hospitals during the period April 2015 to March 2016. Theatres use of agency staff was around 20%. Theatre used BMI bank staff and external agency

staff through block bookings and ad hoc bookings. Theatres had three whole time equivalent vacancies which they were trying to recruit to at the time of the inspection.

- In theatres; nurse staffing vacancies were around 4% on average between April 2015 and March 2016, this was lower than other similar hospitals we hold data for. Operating department practitioners and care assistant vacancies in theatres were around 11% on average for the same period; this was higher than the average for other similar hospitals we hold data for.
- On the inpatients wards; nurse staffing vacancies were around 5% on average between April 2015 and March 2016, this was lower than other similar hospitals we hold data for. Health care assistant vacancies were around 2% on average for the same period, this was also lower than other similar hospitals we hold data for.
- Staff sickness for nurses in theatre was generally below the average rate for other similar locations, but was higher for operating department practitioners and health care assistants.
- Staff sickness for nurses and health care assistants on the surgical wards were lower than the average rate for other similar locations.
- Skill mix was maintained by managers who reviewed staffing levels and mix on a regular basis.

Surgical staffing

- A resident medical officer (RMO) was on site for 24 hours a day, seven days a week. They would attend to the immediate medical and surgical needs of patients on the wards.
- We were told that outgoing RMOs handed over to the next RMO highlighting patient risks and areas of concern.
- The hospital tried to use the same RMOs regularly who were block booked, however during our visit we saw that an RMO was on their first assignment at the hospital. We saw that the induction procedures were comprehensive and thorough and that all relevant checks were available.
- Consultants with practising privileges undertook surgical procedures at the hospital. They maintained responsibility for the post-operative and follow up care of their own patients and were available for advice and instructions by telephone for nursing and medical staff.
- In most circumstances, other than very minor day surgery procedures, the consultant reviewed their patients post-operatively.
- Consultants had good links with the NHS acute hospital (co-located on site) and could facilitate additional services and facilities for patients as called for.

Major incident awareness and training

- Training on fire and bomb procedures were updated annually as part of the hospital's mandatory training package.
- Fire and bomb drills were undertaken periodically and evacuation procedures tested.
- There were business continuity plans in place on a corporate level for all BMI hospitals. However, ward and theatre managers stated they were unfamiliar with these and stated they would implement individualised responses to any incidents that occurred, such as staffing shortages, power cuts and equipment failure.

Are surgery services effective?

Good

We rated surgery services as 'Good' for effective. This was because:

- There was attention paid to the nutrition and hydration needs of patients.
- Policies were in place for the management of surgical patients which were based on best practice guidance and relevant National Institute for Health and Care Excellence (NICE) clinical guidelines. Policies were readily accessible by staff.
- The service provided good attention to the pain needs of patients and had access to a specialist pain team.
- Patient Recorded Outcome Measures (PROMS) data showed positive outcomes that were similar or better than the England average.

- Staff were trained and experienced to carry out their role effectively.
- The service demonstrated an effective approach to multidisciplinary working.
- The service had adequate access to the key resources they required out of hours such as access to pharmacy, diagnostics provision and consultant input.
- Staff had access to the information they required to undertake their role successfully and knew how to access that information.

However we also found that:

- Some best practice guidance was not implemented or there was no assurance process that this was being implemented.
- Some patients were instructed to fast longer than necessary prior to their surgical procedure.
- The service had very low rates of staff who had received an annual appraisal.
- There was no cosmetic surgery specialist nurse in post to monitor cooling off periods and psychological assessments of patients undergoing cosmetic surgery.

Evidence-based care and treatment

- The service generally followed relevant National Institute for Health and Care Excellence (NICE) guidelines and evidence based guidance in their care and treatment of patients.
- The service used BMI corporate policies and procedures that had been developed based on NICE and professional bodies guidance. These were reviewed and amended centrally to reflect any changes in advice and guidance.
- We saw that the service adhered to local clinical policies and followed established integrated care pathways for certain procedures such as knee and hip surgery.
- The service provided some enhanced recovery pathways in orthopaedic surgery procedures.
- The service followed NICE guidance CG45 regarding preoperative tests for elective surgery, we saw this was undertaken through a comprehensive preoperative assessment process.
- The service complied with NICE guidance QS49 regarding prevention of surgical site infections. They also audited their compliance with these procedures which shows good compliance results.
- The service had not complied with guidance issued in the patient safety alert in September 2015, advising NHS funded care providers to take steps to implement procedures and practice in line with the National Safety Standards for Invasive Procedures (NatSSIPs).
- The departments were familiar with the guidance 'Professional Standards for Cosmetic Practice' and 'Good Medical Practice in Cosmetic Surgery'. However they did not have a cosmetic surgery lead nurse in post and therefore, there was a lack of formal assurance that issues such as psychological assessment of patients seeking cosmetic surgery and enforcement of the two week 'cooling off period' were being achieved.
- Care was provided in line with NICE guidance CG50 concerning recognising and responding to deterioration of patients.
- The service did not care for critically ill patients, if this occurred; patients were transferred to the critical care units at the acute NHS hospital (co-located on site).
- The hospital followed the BMI corporate audit calendar programme and submitted outcome data centrally. They appeared regularly in the top 10 within 'league tables' produced corporately.

Pain relief

- We saw that patients were asked and assessed for pain pre-operatively and any issues were provided for as appropriate.
- Patients we spoke with reported that the service was very good at alleviating pain following their surgery. This was supported by documentation we saw and testimony of the staff we spoke with. Patients were asked about their pain regularly and appropriate analgesia administered without delay.
- Pain was recorded within the 'NEWS' observations chart through a pain scoring system. We saw that these charts were completed appropriately.
- The service had access to dedicated pain team from the acute NHS hospital (co-located on site) and via an on-call anaesthetist out of hours.

- Pain management audits were part of the corporate calendar of audits completed by the hospital.

Nutrition and hydration

- All the patients we spoke with felt the food provided was both appealing and nutritious. They said the choice was good and hot food was still warm.
- Patient-led assessments of the care environment (PLACE) regarding ward food was 89% which was slightly lower than the England average of 91%.
- The patient records we checked included all appropriate assessments of nutritional requirements and fluid and food charts were completed regularly where required.
- Surgical wards had access to a dietician through an arrangement with the local acute NHS hospital. Those patients who were highlighted to be at risk of dehydration or could be referred for input from the dietician.
- Similarly, surgical wards had access to the diabetes specialist nurse from the acute NHS trust hospital through a service level agreement. Staff showed us the process they would follow for both these referrals.
- We saw that patients were prescribed medication to prevent and treat nausea following surgery.
- Diabetic patients were allocated the first slot on theatre lists where possible and were monitored closely prior to and following surgery.
- We found that the times that patients were required to fast and refrain from drinking before surgery was inconsistent. Current best practice from the Association of Anaesthetists of Great Britain and Ireland (AAGBI) states that fasting periods should be six hours for foods and two hours for clear fluids. We felt that letters sent out with patients appointments were unclear and this resulted in some patients fasting for longer than necessary periods. The service was trying to improve this and had started to stagger admittance times so that patients who were later on the theatres list could come into hospital later and their fasting periods were adjusted as appropriate. However, this was only done for a selection of patients and the letters did not state the patient could take clear fluid up to two hours before their operation.

Patient outcomes

- Information provided by the hospital showed that 2,675 surgical procedures took place at the hospital from April 2015 to March 2016. Of those, 18% (491) were inpatients and 82% (2,184) were day cases. These were made up of private self-paying and insured patients (38%) and NHS funded patients (62%).
- The service participated in patient reported outcome measures (PROMS), national joint registry, and surgical site infections reporting. They also participated in the 'corporate audit tracker' and local audit programmes including medical records, safeguarding, pain management, consent and falls.
- Patient Reported Outcome Measures (PROMS) data for knee replacement surgery at March 2015 showed similar or better than England average outcomes were reported by patients.
- PROMS data for hip replacements at March 2015 showed similar or better than England average outcomes were reported by patients.
- PROMS data for hernia repairs at March 2015 were similar to the England average.
- The service benchmarked themselves corporately with other BMI services. The service planned to participate in the Private Healthcare Information Network (PHIN) which at the time of our inspection had not yet started.
- The hospital had 10 surgical site infections in the period April 2015 to April 2016; there were two in knee replacement procedures, three in upper gastro intestinal and colorectal procedures, four in urological procedures and one in a gynaecological procedure. These were investigated for trends and investigated as appropriate. There were zero infections in their hip replacement procedures and other orthopaedic procedures and zero in breast procedures.
- The service reported information to the national joint registry database regarding performance for joint operations. They were prepared to submit data to the breast implant database when this became active.

Competent Staff

- New staff completed a comprehensive induction programme before being able to work independently.

This included corporate and local induction procedures where new staff were given information about the organisation's practices and principles as well as clinical mandatory training and job specific training.

- Revalidation of nurses and operating department practitioners was supported by the service and the organisation. Training sessions and focus groups had been established to support each other through the process and BMI had provided input and training on how to maintain portfolios and evidence.
- The revalidation and checking of doctors with practices privileges were undertaken to ensure they had the qualifications, competence, skills and experience necessary for the work to be performed by them. We saw evidence that this occurred during our visit.
- Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. Organisational data showed that 33% of the theatre staff and 40% of ward staff had received an annual appraisal in the 12 months to September 2016. Further data provided by the hospital showed that some surgery staff had not received an appraisal since 2010.

Multidisciplinary working

- Staff were observed to be working well with internal partners from other teams and a range of disciplines including allied health professionals, surgeons and administration staff. Staff told us there were good working relationships and a supportive collaborative culture.
- The service had formed good external working partnerships in particular with the local acute NHS hospital (co-located on site). They had various service level agreements in place which assisted the service to run more effectively. We saw colleagues from the NHS hospital on the ward during our visit to exchange information about a patient and the system seemed to work very well.
- The outreach and emergency response team that attended emergencies at the hospital were the local acute team who had an arrangement to assist in emergencies and with the transfer and care of patients who needed more intensive intervention.
- Physiotherapy and occupational therapy services were obtained through a service level agreement with a third party provider. Managers, staff and patients reported that this was a good service and that therapists were available daily on the ward. They also provided input and consultation to orthopaedic patients at the pre-operative assessment clinic.

Seven-day services

- Staff told us that all patients were reviewed by the resident medical officer (RMO) daily. Consultants visited their own patients on a daily basis and were available for advice by telephone if required.
- The service had access to laboratories and pathology outside of normal working hours and at weekends via the arrangements with the local acute NHS hospital (co-located on site). We were advised that the turnaround for these tests were prompt and no problems were reported.
- There was access to pharmacy via an on call system out of hours and at weekends through the arrangements with the local acute NHS hospital (co-located on site).
- Physiotherapists were available and on site for physiotherapy consultations and treatments at weekends.
- Imaging and diagnostics such as x-ray, computerised tomography (CT) and magnetic resonance imaging (MRI) were available out of hours through arrangements with the local acute NHS hospital (co-located on site).

Access to information

- Staff had access to the organisations intranet and the co-located local acute NHS hospital's intranet to obtain information. They could access BMI policies and procedures and e-learning, they could also refer to NHS policies and request specialist services from the NHS hospital (co-located on site), such as electronic referral for dietician, pain team and specialist nurse input.
- Staff could also access external reference sources such as NICE guidelines and professional guidance.
- We saw that staff had access to electronic or paper based documentation of patient information such as laboratory results, appointment records, x-rays and past medical history.

- Important information was displayed on notice boards such as safety alerts, minutes of meetings and key messages; these were found in staff areas to help keep staff up to date with current issues.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Surgical staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff recognised the importance of informed verbal and written consent before providing care or treatment and took steps to ensure it was within the patient's capacity to consent.
- Records indicated that consent was obtained on the day of the procedure in most cases but sometimes it was during the outpatient consultation. Best practice suggests it is better to gain consent at a time prior to the date of the procedure to enable the patient a period of reflection and the opportunity to change their minds.
- We saw evidence that where a patient lacked capacity to make a decision, decisions about care and treatment were made by relevant professionals within a multidisciplinary team setting. Input was sought from the patient, their family and their representatives. Such decisions were made in the best interests of the patient and were documented and recorded appropriately.
- Staff received training on, and were familiar with the Mental Capacity Act (2005) and the deprivation of liberty safeguards (DOLs). They showed good insight and identification of those whose liberty may be impacted and took steps to ensure these were highlighted.
- The service had access to input and advice from a designated safeguarding lead nurse who was able to provide advice and guidance to staff, patients and their representatives.
- We were advised that the service had never had cause to apply for a deprivation of liberty authorisation, but upon speaking with staff we were satisfied that they understood the process required.
- The service had a corporate policy in place regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), however at the time of inspection we did not see any patients with a DNACPR in place, therefore were unable to check if the policy was being followed or if documentation was completed appropriately.

Are surgery services caring?

Good

We rated surgery as 'Good' for Caring. This is because;

- Staff demonstrated a kind, caring and attentive manner towards their patients. Patient felt they had been treated very well and that staff did everything they could to make their stay as pleasant as possible.
- Staff communicated in a compassionate and supportive manner with patients and took time to listen to their needs; answering their questions and addressing any issues in a timely and considerate way.
- Staff protected the privacy and dignity of their patients when providing care and treatment.
- Patients and relatives were involved in decisions about their care and treatment and were given time to ask questions and have them answered fully.
- Patients told they were kept informed and involved in the care and treatment they received and any instructions and communication was clear and unambiguous.
- This service received good friends and family test results; which were better than the England average.

Compassionate care

- Without exception, every patient we asked spoke very highly of staff and were very positive about the way they had been treated by the service. They felt very strongly that staff were exceptionally caring and considerate of their needs.
- Patients said they had been treated with care dignity and respect and that their privacy had been preserved throughout their stay.
- Throughout our inspection, we witnessed positive and caring interactions between staff and patients. We saw that staff introduced themselves and asked permission before carrying out any patient care. We saw that staff explained processes and procedures fully in a way that patients could understand and answered any questions they may have had.

Requires improvement

Surgery

- We saw that if a patient needed anything they were attended to very quickly and this was supported by the comments made by patients who said that staff constantly checked with them if they needed anything and were attentive in anticipating what they might require.
- Patients made comments such as "I felt in very good hands" and "it was a great privilege, I feel very lucky to have been treated here".
- The NHS friends and family test (FFT) is a survey which asks patients whether they would recommend the NHS service they have used to their friends and family. The FFT results for October 2015 to March 2016 showed that 100% of patients would recommend surgical services. The response rate for the survey was on average 48% for this period which was much higher than the England average.
- Patient-Led Assessments of the Care Environment (PLACE) assessments for privacy and dignity at the hospital were 86% in June 2016 which was better than the England average of 83%.
- The hospital undertook their own internal patient satisfaction surveys and feedback given was very positive. The hospital has been rated amongst the top quarter of BMI hospital from March 2016 and September 2016 based on those surveys.

Understanding and involvement of patients and those close to them

- The patients we spoke with told us they felt members of staff were attentive and listened to what they had to say. Patients said they felt they had sufficient time to ask questions and have their questions answered by staff of all grades including consultants.
- Patients said they received clear information about their care prior to during and after their treatment in a way they understood and which enabled them to make informed choices about treatment options. This is supported by what we saw during our visit.
- Patient and relatives told us they felt included in the decision making process, had a say in their care and could contribute to planning and delivery of their treatment.
- We saw that staff acted upon the individual preferences that were expressed to them and these were communicated sensitively to other departments in the patient's journey. We saw that records were updated to include individual preferences.

Emotional support

- During our visit, we observed emotional support being provided by staff of all grades, who spoke with patients and relatives in a comforting and supportive way. This took place with nervous patients awaiting their surgery, those who returned from theatre in discomfort and routinely with patients on the ward.
- Patients told us they felt well supported through each stage of their surgical treatment, they were given enough time to have their questions and concerns answered and were supported to make decisions about their care and treatment.
- Clinical nurse specialists were available through the service level agreements in place with the local acute NHS hospital (co-located on site). There was a range of specialisms which could be called upon such as stoma, cardiac, diabetes, pain and learning disabilities and they could be requested to support patients as necessary.
- Counselling services were available if required through an arrangement with the local acute NHS hospital (co-located on site).
- The chaplaincy and spiritual services were also available for spiritual, religious or pastoral support to those of all faiths and beliefs, this was arranged through an agreement with the local acute NHS hospital (co-located on site) to utilise their services.

Are surgery services responsive?

Good

We rated surgery services as 'Good' for Responsive. This is because;

- Surgery was planned and delivered to offer an alternative to care at an NHS hospital, which met the needs of those patients.
- Treatment was provided in suitable premises with appropriate facilities for surgical procedures.

Requires improvement

Surgery

- Access to treatment was good and 94% of patients referred were treated within 18 weeks.
- Flow through the service was good, with few delayed discharges and cancellations of procedure. The service always had beds available to patients being admitted and very rarely reached capacity of occupied beds.
- The service attended to the requirements of patients with individual and complex needs. Reasonable adjustments were made to enable access to the service for patients living with dementia, learning disabilities and mental health problems.
- Complaints were handled and responded to appropriately and the feedback was used to improve the service provided to patients.

However, we also found:

- Signage in the communal areas of the hospital was not dementia friendly.

Service planning and delivery to meet the needs of local people

- The hospital was available as a 'choose and book' option for certain consultations and procedures through NHS funding. Patient could choose to have their surgery undertaken at BMI South Cheshire rather than an acute NHS hospital provided they fulfilled the admission criteria.
- Private patients could buy 'all inclusive' surgical packages at a set price for their complete treatment or could pay for itemised treatments.
- The facilities provided for the delivery of surgical services at the hospital were appropriate for the services that were planned and delivered. The two theatres and ward areas were well equipped and well planned to deliver surgical care appropriately.
- The areas we inspected were compliant with same-sex accommodation guidelines, we observed that males were cared for in separate areas to females and the hospital has reported no breaches to this policy.
- The service was able to cope well during their busiest periods, as all admissions were pre-planned and there were always beds available and sufficient staff on duty.

Access and flow

- Patients were admitted to surgical services through a number of routes; through their GP via the 'choose and book' process, via referral from the local acute NHS hospital, through private healthcare insurance and through self-referral and payments.
- Patients undergoing procedures where admitted for pre-planned elective surgery as an inpatient or day case patient.
- Information provided from April 2015 to March 2016 showed that 94% of patients referred to the hospital were admitted for treatment within 18 weeks of referral, this figure was better than England averages.
- Patients were admitted to their rooms prior to their surgery where they were made comfortable and allowed to settle in. They had their observations taken, admission processes completed before being called for their procedure.
- Seven patients were readmitted to hospital within 28 days of their discharge following surgery at this hospital between April 2015 and March 2016. This was not considered high when compared to other similar hospitals we hold this type of data for.
- Eight patients were transferred out of the hospital between April 2015 and March 2016. These were all cases which were transferred to the local acute NHS hospital (co-located on site) for patients who needed more intensive care following their surgery. The service had an agreement with the critical care unit and outreach teams to care for such patients.
- There was one unplanned return to theatre between April 2015 and March 2016.
- Patients were discharged by nurses following a discharge checklist, if they were stable and met predefined parameters, they were discharged. Arrangements were made to see the consultant for follow up appointments as an outpatient.
- The discharge procedure involved advising patients on medication, recuperation and what to expect. Physiotherapists and occupational therapists taught patients techniques for managing at home and provided equipment as required. Patients we spoke

with stated the process was thorough and they understood the information provided. From our observations we were satisfied that the process was comprehensive and effective.

- The service supplied computerised discharge letters, a copy of which was sent to the patient's GP, a copy to the patient and a copy retained in the patient's records.
- If necessary the service was able to arrange district nursing services for patients upon discharge. Procedures were in place to request domiciliary visits for those unable to return to the hospital for dressings. Procedures were in place for referrals and assessments by social services and intermediate care facilities.
- There was sufficient and free car parking facilities for patients to be dropped off and picked up and this was only a short walk away from the department.
- Signage and directions were clear and helpful. Reception staff were attentive and helpful in showing patients where they needed to be.
- During the pre-operative assessment, patient's surgical risk was assessed. In some cases those deemed higher risk were advised that it was not appropriate for them to have their surgical procedure At BMI South Cheshire, as they might require more intensive care and treatment post operatively.
- Patient who required more intensive care where this was not anticipated before their surgery were transferred to the local acute NHS hospital (co-located on site).
- Patients with certain medical conditions were excluded from receiving treatment at the hospital. For example, patients with an American Society of Anaesthesiologists (ASA) physical status score of 4. The majority of patients admitted to the hospital had an ASA score of 1 or 2 which indicated that they were generally healthy or suffered from only mild systemic disease.
- Patients with complex pre-existing medical conditions or a body mass index (BMI) of greater than 40 were also excluded from undergoing treatment at the hospital.
- The service cancelled 17 operations between April 2015 and March 2016, of those 15 (88%) had their operations rearranged within 28 days.

Meeting people's individual needs

- Patient-Led Assessments of the Care Environment (PLACE) assessments for dementia care at June 2016 were 64% which was lower than the England average of 80%.
- Signage around the inpatients ward was not dementia friendly, in that signage was not in both written and pictorial form. However, the inpatient ward had done a lot of work on trying to improve the environment for people living with dementia and had established a designated dementia friendly room. This room had been refurbished and equipped with equipment and décor that was dementia friendly. They had produced a bright and informative information and resource board with useful information and had appointed a dementia champion.
- We saw evidence that the needs of patients living with dementia, learning disabilities and mental health issues were assessed in the pre-operative screening and assessment of patients prior to admission. These needs were built into an individualised care plan prior to admission and reasonable adjustments were made.
- The wards and some patient rooms were wheelchair friendly with wide doors for access and room to manoeuvre a wheelchair in bathroom areas.
- The pre-operative assessment of patients prior to surgery highlighted their individual needs, these were used to plan the admission and any additional equipment or adaptations required.
- The service had access to interpreters and telephone interpretation services for those whose first language was not English

Learning from complaints and concerns

- Staff were familiar with how to enable patients to make a complaint and how to escalate complaints; information regarding complaints was shared in clinical governance reports.
- Four complaints were received between April 2015 and March 2016. These complaints were reviewed and were found to have been investigated and responded to appropriately and in the appropriate time frames.
- Zero complaints had been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period.

Requires improvement

Surgery

- How to complain and feedback forms were placed around the ward and admission areas to enable patients to feedback their experiences.

Are surgery services well-led?

Requires improvement

We rated surgery as 'Requires Improvement' for 'Well-led'. This is because:

- We were not assured that important information and feedback regarding incidents and never events were appropriately shared with staff to enable learning and prevent recurrence.
- Quarterly medical advisory committee (MAC) meetings were held within the hospital but attendance at the committee meetings was not always as good as it might be, as the inpatient ward, operating theatres and consultants were not represented regularly. There appeared to be no formal tracking of actions between the quarterly meetings with no deadlines monitored.
- Theatres had not acted upon some key changes in operational practice and there had been a failure to implement two key pieces of guidance.
- Although a Clinical Governance Report was produced on a monthly basis with an overview of numbers of complaints, incident and infections, there were no trends or learning points identified from them and it was unclear if this information was being used to improve practices.
- Target dates and monitoring of actions from clinical governance and medical advisory committee meetings were not evident. There was limited assurance that issues were being dealt with in a timely way.
- Managers did not have a robust system for ensuring all staff had an annual appraisal, rates of staff who had received an appraisal was low, some had not received an appraisal for several years.
- There was an element of dissatisfaction amongst some staff in theatres.
- The last staff survey prior to the inspection found that there were issues with staff morale and staff satisfaction. Only 51% of staff were 'likely' or 'extremely likely' to recommend BMI healthcare to friends and family as a place to work, which was significantly lower than previous results.

However we also found:

- The leadership team were making efforts to improve the engagement with staff to improve morale. Various initiatives such as the staff forum and newsletter was in place to encourage place to improve engagement with staff.
- The service engaged with patients to seek their views on their experience and what could be done differently.
- The service completed relevant key performance indicators and commissioning for quality and innovation (CQUINs) measurements.

Vision and strategy for this service

- BMI healthcare had a strategy called '2020 vision', this aimed that they would become the largest network of acute care hospitals, delivering the best possible outcomes and experience and quality service for patients and to be financially successful. The BMI corporate strap line is 'Serious about health. Passionate about care'. This was seen on literature and the corporate website.
- Staff we spoke with were familiar and advocates of the BMI corporate vision which was 'commitment is to quality and value, providing facilities for advanced surgical procedures together with friendly, professional care'.
- BMI sought to be the provider of choice for private health care by building on four core themes of safety, clinical effectiveness, patient experience and quality assurance. They sought to provide staff with the platform to consistently deliver quality care to patients.
- Locally, senior managers told us that the strategy for BMI South Cheshire Private Hospital was to increase the numbers of consultants with practising privileges and to increase the surgical procedures on offer at the hospital. The hospital was also keen to expand cosmetic surgery provision. They also wanted to develop the day surgery services and ambulatory care service to make the patient journey more streamlined and efficient.

Requires improvement

Surgery

Governance, risk management and quality measurement

- The hospital had a risk register in place and managers updated this accordingly. However, the description, cause and consequence of the risk was not documented clearly. Actions were listed for each risk but there was no target date for completion; this meant it was not clear whether all risks were being managed as effectively as possible. We did not see a clear mechanism and evidence of learning from incidents and never events.
- Heads of departments did not have their own departmental risk registers, but were managing their own risks using individual risk assessments for each identified risk for example the surgical ward had a risk assessment for the carpets in clinical areas and reviewed and updated these regularly.
- A 'comm cell' meeting took place every morning, this was a meeting of key members of staff from each department, it allowed for communication of key issues, regarding patients, procedures and operational issues.
- Heads of department, practising consultants and key staff members attended monthly clinical governance committee meetings. We reviewed several sets of minutes from such meetings, dated between November 2015 and June 2016. We noted there was a detailed agenda, which included a range of subjects, related to governance such as quality and safety, incidents, complaints, audit results, key performance indicators and performance dashboard results, these minutes were circulated and available for review. However, the minutes did not demonstrate any robust challenge or discussion around key clinical governance issues. The minutes read as being very process rather than outcome driven. For example, evidence was recorded that a root cause analysis (RCA) was being undertaken or had been completed but there was no record of the findings or improvement actions. We saw from the minutes that although each action had a responsible person assigned, they were given a status of 'new,' 'ongoing' or 'closed'. There were no timescales allocated and no monitoring system to ensure that actions were responded to on a risk basis and in in a timely way.
- A Clinical Governance Report was produced on a monthly basis. This provided an overview of numbers of complaints, complaints performance, numbers of incidents, types of incidents, mandatory training compliance, infection control outcomes, patient satisfaction survey responses, monthly audit results, visits, suspensions and service developments.In the three months that we reviewed (May, June and July 2016) all stated 'no trends identified' and there were no service developments.'Learning Points' were also blank in all three reports. It was unclear if this information was being used to improve practices.
- Quarterly medical advisory committee (MAC) meetings were attended by senior managers and consultants. Attendance at the committee meetings appeared unsatisfactory as the inpatient ward and surgery were not represented in the November, February or May committees. There appeared to be no formal tracking of actions between the quarterly meetings with no deadlines monitored. Furthermore, we saw no mention of issues raised from the Clinical Governance Committee or BMI Clinical Governance Bulletins.
- We found the manager was unfamiliar with and therefore unable to demonstrate any progress towards establishing procedures and practice in line with the National Safety Standards for Invasive Procedures (NatSSIPs) and had not started to implement their own local safety standards for invasive procedures (LocSSIPs). This was contrary to the national patient safety alert of September 2015 for all services undertaking NHS funded care, including private hospitals, which directed that all services should be able to demonstrate progress that they have made with implementation by 14 September 2016.

Leadership of service

- We found that there were clear lines of management responsibility and accountability within the surgical wards.
- The surgical wards were led by a visible, experienced, enthusiastic and well respected leader. They were passionate and knowledgeable about the issues within their department and were taking steps to seek improvements in the service to improve quality and service to patients.

Requires improvement

Surgery

- We found that there were some issues with management in the operating theatres. We found a lack of awareness of some recommendations, which led to them not being followed such as the labelling of clinical waste, implementation of NatSSIPs and LocSSIPs.
- We observed some non-adherence to the sign in stage within the World Health organization (WHO) checklist and National Patient Safety Agency (NPSA) five steps to safer surgery process, yet the management audit had been recorded as compliant. We felt there was some uncertainty and inconsistency with this process in theatres.
- There appeared to be failing in communication within theatres, when asked about their 'never event' incident, some staff stated there had not been one and others were unclear about the circumstances of the event. This indicated some failings in communicating important information to staff to enable learning and prevention of future similar incidents.
- The surgical wards and theatres had poor appraisal rates, some staff said they had not had an appraisal for at least two years and data provided by the hospital showed that some staff in surgery had not received an appraisal since 2010. Staff and managers we spoke with stated that annual appraisals had fell by the wayside for the last few years, but with the arrival of the arrival of the new director of clinical services came new impetus to reinstate them as a priority. The service had started working their way through them and some staff had received their first appraisal for a number of years. Staff felt positive about this and felt that appraisals were beneficial to their development, staff were happy that these had been started up again and those whom had had an appraisal recently stated this was a positive move.

Culture within the service

- Staff on the surgical wards reported that they were happy in their role and felt supported by their team and managers.
- Most staff in theatres stated they felt settled and happy in their role and confident to express their views. Others had mixed feelings about their role and felt apathetic about speaking out as they felt nothing would be done.
- Staff we spoke with felt that the arrival of the new hospital director of clinical services had brought about positive changes, but they accepted this was 'a work in progress'. They were optimistic of the future and believed things were changing for the better.
- Staff we spoke with told us if they witnessed poor practice they would have no hesitation to raise their concerns and we saw evidence that staff had raised concerns in the past. This was indicative of a no blame culture and we were satisfied that openness was encouraged.
- On the surgical wards the rates of sickness for nurses and healthcare assistants were low and below that reported in other similar hospitals. The rates of sickness for nurses in theatres was also low, but for operating department practitioners and healthcare assistants, this was high compared to other similar hospitals.
- Staff turnover was similar to or better when compared to surgical services at other similar hospitals that we hold this type of data for.

Public and Staff engagement

- An annual staff survey was conducted across the hospital, findings were analysed to determine staff opinion and satisfaction. The last staff survey prior to the inspection found that there were issues with staff morale and staff satisfaction. The survey found 51% of staff were 'likely' or 'extremely likely' to recommend BMI healthcare to friends and family as a place to work, which was significantly lower than previous results. The hospital had taken steps to try to improve this through reinstating staff appraisals, introducing a staff recognition scheme to highlight good performance and contributions to patient care and daily walk arounds by managers to improve managers' visibility. Staff we spoke with believed that morale had improved with the appointment of a new director of clinical services.
- Monthly departmental staff meetings were conducted on the surgical ward and in theatres, important issues were relayed and minutes were taken of these meetings.
- Staff told us that their managers were supportive of them as individuals, both in terms of their personal and domestic situations and their professional development. They said that managers were flexible and accommodating and were fair and even-handed.

Requires improvement

Surgery

- Staff sought and encouraged feedback from patients and their carers who visited the wards. They provided two types of feedback surveys to solicit the views of patients and feedback of their experiences of the hospital. We saw the use of a patient satisfaction questionnaire and for NHS patients the Friends and Family Test in use. Patient feedback cards were available in the waiting areas, at the nurses' station and posters were clearly displayed to inform patients.
- Monthly group meetings took place to agree operational priorities.
- An annual away day was undertaken to review performance and agree the strategy for the next year.
- Staff forums were undertaken by the executive director who provided input into various subject areas and advised staff on local and national projects.
- A weekly newsletter was produced to highlight key corporate issues and local information.

Innovation, improvement and sustainability

- The endoscopy services were working towards a new external system for decontamination which would enable them to obtain Joint Advisory Group (JAG) accreditation. This would enable expansion and development of the service.
- The new director of clinical services was reviewing processes and procedures to improve quality assurance and governance processes for the hospital. This had already started and improvements had already been seen prior to our visit.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

BMI The South Cheshire Hospital provides outpatient and diagnostic imaging services to NHS and other funded (insured and self-pay) patients from around Cheshire.

The hospital treats adults and previously treated children over the age of three. However, since April 2016, children and young people over the age of 16 attend the outpatients department for consultation only.

The outpatient department consists of 10 consulting rooms and two treatment rooms hosting a number of different specialities including orthopaedics, ophthalmology, gynaecology, cardiology, oncology and cosmetic surgery. In addition the hospital has a plain x-ray room which was managed by the neighbouring NHS hospital via a service level agreement.

The hospital worked closely with an NHS hospital which was co-located on the same site and accessible via a corridor. Service level agreements were in place for clinical services including imaging, pathology, histology and pharmacy with the neighbouring NHS trust and physiotherapy was also outsourced to another provider and a result we did not inspect these services.

In 2015, there was 12,330 out-patient attendances with the greatest number of attendees in

Orthopaedics (30.9%), general surgery (17.22%) and ear nose and throat (11.7%).

During the inspection, we visited the outpatient department and we spoke with 12 members of staff including medical, nursing, administrative staff and managers. We had the opportunity to meet four patients and their family members and we observed care and patient interactions. We reviewed 16 patient records.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

We rated BMI The South Cheshire Hospital outpatients as 'Requires Improvement' overall. This is because;

- The incident reporting system was not accessible to all staff and did not enable the capture of all relevant incidents due to its limited nature. Not all staff were clear regarding the identification of an incident and there was low levels of incidents reported which may suggest the potential of under reporting across the department.
- Staff did not always have access to patient information prior to their appointment which meant that they couldn't always plan for any additional requirement for patients.
- There was no formal process in place to meet the needs of patients who required additional support.
- Clinical Governance systems and processes were not robust and we were not assured that actions were taken or reviewed within a timely manner.
- Information regarding the performance of the service were not always discussed or shared with the staff working within the department.
- Staff morale had improved but was low at times and not all staff felt valued although senior managers had plans in place to increase staff engagement and morale.
- Not all senior managers were visible in the department.
- There was limited engagement with patients and therefore it was difficult to measure the impact of the service provided and identify and implement any improvements that could be achieved.

However;

- Staffing levels were acceptable although the service was reliant on bank staff.
- Staff were aware of their roles and responsibilities in regards to safeguarding. Staff were up to date with mandatory training, including safeguarding.
- Evidence-based practice, national guidelines and best practice standards supported patient care, which was delivered by skilled and competent practitioners.
- Staff interactions were kind, compassionate and genuine. Patients acknowledged they were fully informed and the quality of the care they received was good.
- The hospital performed above the England average for patients beginning treatment within 18 weeks and for non-admitted patients beginning treatment within 18 weeks in the reporting period.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated the Safe for Outpatients and Diagnostic Imaging as 'Requires Improvement'. This is because;

- The incident reporting system was not accessible to all staff and did not enable the capture of all relevant incidents due to its limited nature.
- Not all staff were clear regarding the identification of an incident and there was low levels of incidents reported which may suggest the potential of under reporting across the department.
- Nursing staff had limited access to patient information prior to attendance and there were no individual patient records for those patients returning for follow up care.
- Medical staff did not complete their name, designation and signature consistently in patient records or when completing care pathways

However;

- Compliance with required mandatory training for all staff was above the hospital target of 90%.
- Staffing levels were acceptable although the service was reliant on bank staff.

Incidents

- Incidents were reported via a paper system which was submitted to the Quality and Risk Manager for inputting onto the electronic system. However, no incident forms were available within outpatients area which meant staff had to go to another part of the hospital in order to report an incident. This reporting system was limited to a coded template of around 30 different incidents that could be reported. This meant that anything outside the scope of the pre-determined list could not be reported and therefore this reduced the range of potential issues that could be learned from.
- Staff were aware of their responsibilities to report incidents although some felt only incidents that resulted in a consequence required reporting. One staff member told us they didn't know the process to report an incident and would escalate concerns to the nurse in charge. Reporting incidents was limited to trained staff with the expectation that untrained staff relayed information to the nurse in charge to report, all staff were unclear as to why this process was in place.
- Between April 2015 and March 2016 there were four clinical and four non-clinical incidents reported from outpatient services. We were concerned that due to the small amount of incidents reported, along with lack of understanding by some staff of what incidents to report and the difficulties in accessing and reporting incidents, that there is the potential for incidents to be under reported across the department. Data regarding these incidents has been requested from the hospital, however we had not received this at the time of report writing.
- Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Between April 2015 and March 2016 there were no never events reported in outpatients services.
- Records indicated that incidents were discussed at the medical advisory committee (MAC) meetings. Some staff told us incidents were discussed at team meetings and gave us a recent example of a change in the environment following an incident. We have requested copies of the last three team meetings from the provider to confirm if they were discussed but this was not provided.
- There were no expected or unexpected deaths reported from April 2015 to March 2016. Mortality and morbidity cases were discussed at the MAC meetings.
- Staff we spoke to had an understanding of duty of candour. 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.

Cleanliness, infection control and hygiene

Requires improvement

Outpatients and diagnostic imaging

- The hospital reported zero cases of Methicillin-resistant Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium Difficile infection (CDI) and Escherichia coli (e coli) infections from April 2015 to August 2016.
- All patient areas that we visited were visibly clean and clutter-free. All equipment was also observed to be visibly clean.
- An audit of infection control prevention and management in November 2015 showed the outpatients department overall score was 95.1%. The shortfall was due to cleaning schedules not being displayed. On the week of our inspection a cleaning check list had been introduced and was visible in each of the consulting rooms we looked at. The housekeeper cleaning schedules were extensive and fully completed.
- The services were included in the Patient-led assessment of the care environment (PLACE) audit from February to June 2016. Overall, the hospital scored below the England average for cleanliness (97% compared to 98%) and for condition appearance and maintenance (89% compared to 93%). The director of clinical services told us an action plan had been implemented. We have requested this from the provider but had not been received at the time of writing the report.
- Separate hand washing basins, hand wash and hand gel dispensers were available in the departments and patient areas. Hand gel was available for patients, visitors and staff to use at the entrance and in the waiting room and we observed staff, patients and relatives using hand gel and washing their hands.
- Staff told us they regularly participated in hand hygiene audits and we requested a copy of the hand hygiene audits undertaken in the last 3 months. We received data for a hand hygiene environment audit performed in May 2016 which showed 90.7% compliance. An action plan was implemented which included ordering of domestic waste bins and commencing observational hand hygiene audits in September 2016.
- We noted that there were material covered chairs in the waiting area and in the consulting rooms; the nurse in charge told us these were hoovered and cleaned by domestic staff and if there were any were soiled they would be disposed of straight away. All chairs we observed were visibly clean and dry to touch.

Environment and equipment

- There were systems in place for equipment servicing, testing and maintenance. Records indicated the equipment we inspected had been serviced and had undergone safety testing to ensure electrical safety.
- Resuscitation equipment, including defibrillator, oxygen and suction was readily accessible and available in outpatients. The resuscitation trolley was locked with tamper seals in place. Emergency drugs were available and found to be within the expiry date. Records indicated that checks of the equipment had been completed on a regular basis. The resuscitation trolley and location of contents were the same as the neighbouring trust which ensured all staff were familiar with equipment and location of contents used during emergencies.
- The x-ray room was managed by staff from the neighbouring hospital.
- The department had appropriate arrangements for the safe handling and disposal of clinical waste and sharps.We observed that the disposal of sharps, such as needle sticks followed good practice guidance. All sharps containers we observed were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use.
- We saw that equipment; including cannulas and needles were stored in an unlocked drawer in a treatment room which was accessible to the public. We raised this with staff during the inspection who said they would address it.
- The nurse in charge told us on occasions clinics were cancelled due to the cystoscope equipment failing and we were told that the cystoscopes were old and required replacing. The issue of cystoscopes were on the risk register and it stated that new ones would be provided from October 2016.

Medicines

Requires improvement

Outpatients and diagnostic imaging

- We saw that medicines in the departments were stored in locked cupboards and monitored appropriately. No controlled drugs were stored in the department.
- We checked a range of medicines and all were found to be in date, indicating that there were good stock management systems in place. A service level agreement was in place with a neighbouring hospital pharmacy department who re-stocked and checked medications.
- The outpatients department achieved 100% compliance in an audit of medicines management carried out in February, May and August 2016.
- Medicines requiring storage at temperatures below eight degrees Celsius were appropriately stored in a fridge. Records indicated that fridge temperatures were checked daily and on occasions when the temperature exceeded eight degrees Celsius, staff told us they had either reset the fridge or redistributed the contents. However, it was unclear if a further check of the fridge temperature had taken place within two hours as per guidelines as it was not documented; there was no specific area on the checklist, and the nurse in charge told us they would update the checklist so this could be reflected. The guidelines did not make reference to when staff should notify the pharmacists if temperatures were out of range.

Records

- Patients' full set of medical records were not kept at the hospital and senior managers told us they recognised the difficulties associated with not keeping a full medical record on site for all patients and we were told this was going to be reviewed.
- Patients' medical records that were completed by BMI South Cheshire staff were kept on site and were readily accessible however this did not include the consultation records completed in outpatients as these were the responsibility of the consultant. Consultant's with practising privileges were responsible for these records and were able to take these off-site in accordance with the standard set by the Information Commissioner which included the transferring and storage of records.
- Prior to a patient's appointment, patients' consultation records were either sent over in a secure blue bag by the consultant's secretary or the consultant would bring them to the clinic. Those records that required storage were stored in a locked cupboard in the nursing office.
- At the time of inspection, we saw patient personal or identifiable information and hospital records managed safely and securely.
- Data provided by the hospital confirmed that during the previous three months all patients attending their outpatient appointment were seen with relevant medical records.
- Nursing staff had very limited or no information regarding patient's requirements who attended the outpatient department for follow up nursing care as patient records were sent to medical records following a procedure performed in the outpatients department or discharge from the wards.
- In addition there were no individual patient records for patients attending for follow up review and treatment in the outpatient department and we observed an A4 book which staff had documented care given for each patient at every visit. The information was limited with no evaluation, plan of care or reasons for treatment. Each input was signed but it was not always clear by who or designation. This was brought to the attention of senior management and on our unannounced inspection we observed that a new process had been implemented, where the patients' records were requested the day before the appointment so staff would have access to patient information. Also this allowed for staff to be fully aware and review the plan of care, in addition to being able to document care and treatment given thus maintaining consistency and continuity of care and record keeping.
- We viewed seven consultation records and saw these contained all the relevant information, including test results, discussion around treatment risks, outcomes. All entries were legible and dated however not all were signed although there was a copy of a typed letter following each consultation signed by the doctor which was for the attention of the GP.
- We reviewed nine records which were completed for patients who underwent an invasive procedure in outpatients and we found these were legible and

generally of a good standard with risks, consent and discharge checklists clearly documented. However we noted that medical staff had not completed the section on the front page which assisted in identifying the signatures of staff within the document by each member of staff writing their name, designation and signature. In addition the signature at the end of the forms was illegible and therefore it was not clear who had performed the procedure.

Safeguarding

- The hospital had reported no safeguarding concerns between April 2015 and March 2016.
- The Quality and Risk manager was the designated lead for safeguarding at the hospital and had completed Level 3 safeguarding training.
- Compliance with safeguarding training was good; seven out of eight clinical staff were compliant with safeguarding adults and children level 1 and level 2, whilst eight out of ten non-clinical staff were compliant with safeguarding adults and children level 1.
- Safeguarding policies were in place which included child sexual exploitation and female genital mutilation. Staff were aware of the safeguarding policies and procedures and how to access them. Staff were aware of their roles and responsibilities in relation to safeguarding and could describe what types of concerns they would report and the process for doing so. We observed a flow chart in the main office with instructions for staff to follow if they had safeguarding concerns.

Mandatory training

- Staff were able to fulfil mandatory training requirements by completing on-line modules and by attending face-to-face training. Staff had the opportunity to complete on-line modules in their own time and were reimbursed for time taken to complete the training.
- The senior nurse lead told us they received an email to highlight when staff were due or overdue specific training, which then assisted them in reminding staff and managing mandatory training compliance.
- Mandatory training records provided by the hospital at the time of our inspection showed that the overall mandatory training compliance within the department was 93.5%. The hospital target was 90%.

Assessing and responding to patient risk

- There were reliable systems, processes and practices in place to assist in keeping patients safe.
- The hospital had a resuscitation policy for both adults and children. We were told that all trained staff had completed immediate life support (ILS) training. However data
- provided showed that in July 2016, 78% of staff across the hospital had completed the training.
- If a patient became unwell, staff told us that there was usually a doctor within the department who could be contacted. If not, they would contact the doctor on call on the ward.
- In an emergency situation, an outreach team from a neighbouring the NHS hospital (co located on site) could be contacted along with the 'emergency bleep holders' and would attend to treat the patient quickly.
- All rooms were fitted with an emergency alarm should staff require immediate assistance. Alarm systems were checked monthly.

Nursing staffing

- The outpatient department had a dedicated team of registered nurses, healthcare assistants and administration staff, who provided clinic cover five days a week, between 8am to 8pm.
- The nurse in charge worked 20 hours a week and managed general outpatients and two part-time staff nurses and two health care assistants (HCA). The senior nurse lead told us that two members of staff had recently left and the service now used regular bank staff to cover clinics. We were told there were no issues in booking additional staff and the staff within the department were flexible.
- No staffing tool was used to determine staffing levels within the outpatient department however the sister in charge told us BMI were looking into implementing one in the near future.

Requires improvement

Outpatients and diagnostic imaging

- Recent data regarding sickness levels, turnover, and vacancies was requested however at the time of writing the report this had not been received.
- Staff in the outpatients department confirmed workload was variable depending upon the number of clinics and the number of patients attending. The sister told us each clinic would have one registered nurse and a HCA; however, they had a good knowledge of consultants' and clinic needs and booked extra staff accordingly. We reviewed off duty records, which confirmed this.
- Staff all confirmed midweek evenings to be busier, however, the sister ensured staffing was always appropriate to meet patient and consultant needs. All staff we spoke to felt the staffing levels were safe however some staff expressed that they felt on occasions more staff were needed.
- Staff told us that details regarding daily lists and delegated duties were discussed at staff handover every day.

Medical staffing

- All patients were referred to a named consultant or could choose a consultant they wished to see. There were 94 clinicians with practising privileges at the hospital, with most being employed in the neighbouring trust. The Medical Advisory Committee (MAC) had oversight of arrangements for consultants.
- The hospital utilised two resident medical officers (RMOs) on a regular basis. A RMO was available 24 hours a day, seven days a week and further support was available from a standby RMO if required.

Major incident awareness and training

- The hospital had a business continuity policy, which detailed roles, responsibilities and contact numbers, along with escalation procedures covering a number of potential internal incidents, such as fire and loss of power, including mains electricity. It also highlighted potential external incidents, which may affect service provision, such as adverse weather conditions. Staff we spoke with were aware of the policy.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the Effective domain as we are not confident we are currently collecting enough information to rate this domain in Outpatients and Diagnostics. Positively, we saw that;

- Staff appraisals had increased over the past 12 months however figures were still low for health care assistants.
- Staff didn't have access to formal clinical supervision across the service.
- There was no evidence of multidisciplinary working within the department. Patients did not have access to specialist nurses within the department although we were told there were plans for a breast care nurse.
- The service was not available seven days a week although patients could access later appointments up to 8pm on weekdays.

However;

- Staff were aware of the National Institute for Health and Care Excellence (NICE) guidelines and policies based on NICE guidelines were in use in the outpatients department.
- Staff were skilled and competent for their role.
- Staff demonstrated awareness and understanding around consent and mental capacity.

Evidence-based care and treatment

- Staff provided care and treatment in line with evidence-based practice. The service used BMI corporate policies, procedures and pathways that had been developed based on National Institute for Health and Care Excellence (NICE) guidelines and professional bodies guidance. We were told these were reviewed and amended centrally to adhere to any changes in advice and guidance.
- Ambulatory care pathways were not yet embedded in the department however the director of clinical services told us there were plans to implement this at the end of September 2016.

- Staff had easy access to all the hospital policies and procedures using the department computers. All staff were aware of where policies and procedures were stored.

Pain relief

- There was no pain tool used to assess pain levels. However we observed in the patient's records that patients were asked and pain levels were reviewed. Staff explained to us how they recognised when a patient was exhibiting signs and symptoms associated with pain.
- Patients were offered local anaesthetic for minor procedures performed within the outpatients department.

Nutrition and hydration

- Patients had access to hot and cold drinks in the main waiting area at a minimal cost.
- Staff had access to a kitchen to prepare drinks for patients who had undergone minor procedures within the department. Staff told us they had energy drinks for diabetic patients who had a low blood sugar.

Patient outcomes

- Patient outcomes were monitored across the hospital including follow up calls post discharge and friends and family test.

Competent staff

- Information provided by the hospital showed that 100% of nurses and 66% of health care assistants (HCA) in outpatients had received their appraisal at the time of inspection which was an improvement from the previous year where 16% of nursing staff had completed them and no HCA's had received an appraisal. The nursing sister told us since the director of clinical services had been employed there was a focus on performing appraisals.
- Staff told us there was no formal system in place for clinical supervision. However, nurses told us that they were able to speak to their manager at any time. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.
- All new staff completed a corporate and local induction on commencing work at the hospital.
- All staff had required qualifications validated prior to commencing work at the hospital and thereafter upon revalidation or re-registration. Nursing staff told us there had been sessions to support them throughout the revalidation process.
- Staff completed specific competencies to deliver care within the outpatient's service, including venepuncture and chaperoning.
- We reviewed staff personal files, which included a new starter checklist and competencies, which were detailed with evidence of on-going review.
- Health care assistants were trained up to assist consultants with equipment and support patients in procedures, such as flexible cystoscopy.

Multidisciplinary working

- A range of clinical and non-clinical staff worked as a team in the outpatients department.
- There were no specialist nurses within the outpatients department; however, a senior manager told us there were plans to employ a breast specialist nurse and cosmetic surgery specialist nurse.
- During our inspection we observed staff working well together and staff told us they had a good relationship with most consultants although they worked in different ways which they accommodated. However there were no multidisciplinary team meetings held in the department.
- Staff told us there were team meetings for nursing and health care assistants, although these were not on a regular basis and had been cancelled due to staffing issues. We were told minutes from the meetings were emailed out to all staff.We have requested a copy of the minutes from the last three team meetings; however, we had not received these at the time of writing the report.

Requires improvement

Outpatients and diagnostic imaging

- Staff told us the hospital had strong working relationships with clinical colleagues from the other services and the neighbouring NHS trust. During our inspection we observed efficient team working with physiotherapy staff and outpatient staff.

Seven-day services

- Outpatients and diagnostic imaging services were routinely available from Monday to Friday with later appointments available up to 8pm on weekdays.
- Out of hours patients had access to the hospital wards if they required post-operative care or advice.

Access to information

- During our inspection we saw no evidence that staff had access to specific patient information prior to attendance and administrative and nursing staff told us they did not have access to information including reason for attendance other than the patient's demographic details. Reception staff told us they relied on the secretaries to share additional information regarding any specific needs the patient may have. This meant that staff could not plan for patients who required additional needs for example a quiet room. However the hospital told us that information was accessible on the GP referral letters for NHS patients but not always for private patients.
- Post-operative patients who required follow up in the department were either referred verbally over the phone or a referral form was sent over. We viewed one referral and found the information to be sufficient. The consultant would bring the patients records over or they would be sent prior to attendance.
- Staff had access to the organisations intranet including e-learning, BMI policies and guidelines and staff told us these were readily accessible.
- The hospital had electronic access to diagnostic and pathology results. Consultants told us it was their responsibility to review all results and put a hard copy in the patients' records. We observed this in the patient records we reviewed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training around Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), which had recently been included with training in adult safeguarding.
- Staff demonstrated a basic awareness and understanding of the principles of MCA and DoLS and told us they would contact the safeguarding team if they had any concerns.
- Staff confirmed it was primarily the consultant's role in assessing capacity to consent, however, they recognised the importance of verbal and implied consent and if they had concerns about a patient's ability to decide on treatment options then this would be highlighted to the consultant, the nurse in charge and the hospital safeguarding lead. Consent training was mandatory and all relevant staff we spoke to had completed the training.
- Staff confirmed care was provided solely according to patient need, in their best interests and with their informed consent. This was evident in the patient's records we reviewed.

Are outpatients and diagnostic imaging services caring?

Good

We rated Caring as 'Good'. This is because:

- Patients were treated with respect, dignity and compassion. Patients described positive experiences at the hospital and would recommend the service to friends and family.
- In the Patient Led assessment of the Care Environment (PLACE) assessments at the hospital for privacy, dignity and wellbeing scored 86% which was better than the England average of 83%.
- We observed staff at all levels communicating with patients and their families in a respectful and considerate manner.
- Patients were involved in discussions about care and were informed about treatment options.

Compassionate care

Requires improvement

Outpatients and diagnostic imaging

- Patients were respected and their privacy and dignity was maintained. Patients had access to private changing areas and a dressing gown. All consulting rooms used signage to confirm if a room was 'in-use'. We observed staff at all levels communicating with patients and their families in a respectful and considerate manner.
- Patient Led assessment of the Care Environment (PLACE) findings at the hospital supported this with patients rating satisfaction with privacy, dignity and wellbeing to be 86%, which was above the England average of 83%.
- We spoke with four patients, including family members, about the care they received at the hospital. All were positive about the service they had received and felt they had been treated with kindness and respect, with one patient saying staff are 'always polite and friendly' and one patient stated they were 'absolutely' treated with kindness and respect.
- The NHS Friends and Family test (FFT) is a survey which asks patients whether they would recommend the NHS service they have used to their friends and family. The FFT results for October 2015 to March 2016 showed that 100% of patients would recommend surgical services. The response rate for the survey was on average 48% for this period, which was much higher than the England average. All four patients we spoke to during our inspection told us they would recommend the service to others.

Understanding and involvement of patients and those close to them

- Staff told us that no patient would undergo any test or procedure without being fully informed, supported and being made aware of the risks and intended benefits. In addition, private patients were advised about all possible costs and payment options available.
- All the patients we spoke to told us they felt involved with their care and fully informed regarding treatment options.
  Where patients were required to complete admission documents, staff made themselves available to assist with any queries or concerns regarding the content.
- The service offered and provided a chaperone service to patients in line with hospital policy, in particular when intimate examinations were necessary, or if patients were anxious or requested additional support. There was male and female staff available to chaperone patients. We observed a register for September 2016, which recorded whether chaperones were offered, accepted, declined or not required.
- A member of staff told us they would ensure they were available to chaperone a particularly anxious patient who attended the department on a regular basis to help alleviate any further stress or anxiety.

Emotional support

- Staff spoke with compassion and genuine warmth about their patients and all strived to ensure the patients' needs were addressed.

Are outpatients and diagnostic imaging services responsive?

Good

We rated Responsive as 'Good'. This is because;

- The hospital referral to treatment times within 18 weeks were above average, ensuring patients received access to treatment in a timely way.
- Flexibility within the service allowed for unplanned minor surgery to be performed on the same day as their appointment.
- Patients had access to nurse led phlebotomy 'drop in 'clinics throughout the day.
- Translation services were available and staff knew how to obtain this service for patients if required.

However;

- There was a lack of a formal structure to meet the needs of patients who required additional support due to particular special needs or patients living with learning disabilities.
- Information leaflets for patients and their relatives were not available in different languages or formats.

Service planning and delivery to meet the needs of local people

Requires improvement

Outpatients and diagnostic imaging

- The hospital provided independent healthcare for insured, self-funded and NHS referred patients who were referred via the 'choose and book' system. All patients were offered a choice of preferred consultant, an appointment time to suit and for self-funding patients, options on payments methods via the BMI card.
- The hospital was licensed to treat adults along with children over the age of three. However, since April 2016, children and young people over the age of 16 attend the outpatients department for consultation only.
- The hospital had service level agreements with a neighbouring hospital to provide emergency assistance, pathology services, and pharmacy services and carry out x-ray imaging, magnetic resonance imaging (MRI) and computerised tomography (CT).
- Directions within the hospital were clear. However, signage at the main entrance to the outpatients department stated 'consulting suites' and not outpatients. During our inspection we came across two patients who had got lost on their way to their appointment.
- The outpatient department comprised of one reception, two waiting areas, two treatment rooms, ten consulting rooms each used by different specialities. All areas were bright, well furnished, decorated and appropriate for the service. Wheelchairs were available on request for patients attending clinic appointments.
- The reception area was open-plan and at times were not helpful if patients wished to raise concerns or discuss personal health or financial matters; however, private rooms for such discussions were available. During our inspection we observed reception staff discreetly and professionally discussing personal information with patients over the telephone and maintained confidentiality at all times.
- The hospital provided free parking directly outside the hospital however this was on the same site as another hospital. Reception staff told us they would give patients a permit to display in their car window.
- The hospital offered consultant led clinics for a full range of specialities, including cosmetic surgery, orthopaedics, gastroenterology and gynaecology.
- Patients who required bloods to be taken could access a nurse led phlebotomy drop in clinic from 8am until 4.15pm, Monday to Friday. Staff told us completed blood request forms would be stored in the department and were readily accessible for when the patient attended.

Access and flow

- Referrals were received from a variety of professionals including GP, opticians and consultant to consultant. Appointments for the majority of consultants were managed by the outpatient coordinator.
- The hospital allocated appointments based on clinical need and not ability to pay. All patients received their consultation and access to treatment options quickly. Staff confirmed there was no cap on appointment numbers and no minimum number of patients required for a clinic to run. This allowed patients to access clinic in a timely manner and avoided cancellations.
- The hospital were above the England average for patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 2015 to March 16), except for December 2015 and January 2016.
- In addition the hospital were above the England average for non-admitted patients beginning treatment within 18 weeks of referral from April 2015 to March 2016.
- Private patients who did not attend their appointment were followed up by the consultant and NHS patients would automatically be sent a further appointment out in the post.
- From April 2015 to March 2016, there were 12,329 outpatient attendances; 5,496 were first attenders and 6,833 were follow-up visits. In addition 220 children under the age of 17 attended outpatients.
- Of the 12,329 appointments, 5,123 were adult NHS funded patients (2,347 first appointment and 2,776 follow up) and 7,206 were classified as 'other funded' (3,149 first attenders and 4,057 follow-up).
- Across the hospital, the top three speciality clinics by volume of attendances were orthopaedics, general surgery and ear nose and throat which made up over 59% of all attendances.

Requires improvement

Outpatients and diagnostic imaging

- Data provided by the hospital showed that from October 2015 to October 2016 there had been 254 flexible cystoscopy procedures and 24 prostate biopsy procedures undertaken in the outpatient department.
- The hospital did not formally advertise waiting times in waiting areas however; reception and nursing staff monitored these and told us they would apologise and inform patients if clinics were running late and if they were not happy to wait would offer to book an alternative appointment. During our inspection no clinics were running late.
- Unplanned basic minor operations, for example removal of lumps under local anaesthetic, were performed if there was appropriate staffing within the department. This meant that patients would not be required to return on another date.

Meeting people's individual needs

- There was no formal structure to address those patients with additional needs. However, staff told us they responded on an individual basis and recognised when certain patients might require additional support during the appointment such as those with who were anxious or had a disability.
- Staff told us patients living with a learning disability or dementia had access to a quiet room to use while waiting for their appointment which gave the option of a less stressful environment than the main waiting area.
- The hospital dementia rating in the Patient Led Assessments of the Care Environment (PLACE) audit from February 2016 to June 2016 was lower than England average (64% compared to 80%).
- The hospital had a dementia lead that was going to participate in the BMI national group to share learning & best practice within the company. Dementia friendly training was available to staff with the expectation that 100% of all staff would become a dementia friend. Data provided by the hospital showed that 60% of staff across all services the hospital had completed dementia friendly training.
- The reception area had audio induction loop systems to assist those with hearing difficulties. However, reception staff told us this was never needed, as patients tended to have digital hearing aids.
- In the waiting areas there was a television, radio and reading materials for patients and their family. In addition, information leaflets were available and visible; however, these were not available in any other language than English or in different formats, for example with large print.
- Waiting areas were comfortable and spacious with plentiful seating and toilets were accessible to all areas.
- Patients who required follow up for wound care were offered an appointment at the clinic and if dressings were required at the weekend, they were directed to the ward. If patients struggled to return to the hospital, they were directed to their own GP for further care.
- Patients requiring medication to take at home were given a choice as to whether to take their prescription with them to use at any pharmacy or take medication straight home from the hospital. Staff arranged for a porter to collect their medication from the neighbouring hospital pharmacy department.
- Translation services were available for patients whose first language was not English and for patients who required British Sign Language interpreters. Staff told us the secretaries would usually make aware if a patient required translation services prior to the appointment and staff were familiar with the process for organising translation via telephone or face to face. Once booked, this would show up on the electronic booking system.

Learning from complaints and concerns

- The hospital had a complaints policy and staff told us they received training in the complaints procedure as part of induction to the hospital.
- The hospital executive director was responsible for the management of complaints supported by senior managers.
- In the main waiting area there were 'Please tell us....' leaflets displayed inviting patients to raise any issues and also advising how to make a complaint.
- The service received one complaint from July 2015 to July 2016, which was regarding a delay in blood test results. This was ongoing at the time of inspection.

Requires improvement

Outpatients and diagnostic imaging

- Staff described how they always endeavoured to resolve patient concerns informally in the first instance, but would escalate to senior staff if necessary. Staff were aware of the hospital policy.
- Complaints were discussed at the daily 'communication cells' meeting and we reviewed minutes of heads of department meetings where complaints were discussed.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated Well-led as 'Requires Improvement'. This is because;

- Clinical Governance systems and processes were not robust and we were not assured that actions were taken or reviewed within a timely manner.
- Information regarding the performance of the service were not always discussed or shared with the staff working within the department.
- Staff morale had improved but was low at times and not all staff felt valued although senior managers had plans in place to increase staff engagement and morale.
- Not all senior managers were visible in the department.
- There was limited engagement with patients and therefore it was difficult to measure the impact of the service provided and identify and implement any improvements that could be achieved.

However;

- Staff were aware of the vision and plans for the hospital and felt proud this reflected their practice.
- Senior managers had clear visions and plans for the future and were passionate about their approach to improvement.
- Staff worked well together felt supported by each other and some managers and felt safe to raise issues.

Vision and strategy for this this core service

- The strategy for BMI healthcare was the '2020 vision' which aimed at being the largest network of acute care hospitals delivering the best possible outcomes and experience and quality service for patients and to be financially successful. The corporate strap line 'Serious about health. Passionate about care' was visible on literature and the corporate website.
- Senior managers told us the vision for the outpatient service was to increase pathways, increase cosmetic surgery and recruit specialist nurses into the department
- Locally, senior managers told us that the strategy for BMI South Cheshire Private Hospital was to increase the numbers of consultants with practising privileges and to increase the surgical procedures on offer at the hospital. The hospital was also keen to expand cosmetic surgery provision.
- Staff we spoke to were aware and of the vision and expectations to deliver high quality care and felt they represented what they were trying to achieve in the service.

Governance, risk management and quality measurement for this core service

- Quality and performance were monitored across the hospital through a dashboard. We requested this information from the hospital however; at the time of writing this report no information has been received.
- Senior managers and line managers attended monthly clinical governance meetings, which discussed governance, quality and safety performance. Quarterly medical advisory committee meetings were attended by senior managers and consultants. We reviewed minutes from four meetings and saw that clinical governance issues including clinical incidents and audits were discussed. On review of all the minutes we saw that each action had a responsible person assigned, however, there were no timescales documented therefore we are not assured these actions were monitored or responded to in a timely manner.
- There was a corporate risk register which managers at the hospital added local risks to. We reviewed the register and noted local risks were added in bold but the description, cause and consequence of the risk were not

documented clearly. Actions were listed for each risk, however there was no target date for completion; this meant it was not clear whether all risks were being managed as effectively as possible.

- The Quality and Risk Manager told us a new online system which would capture incidents and have a comprehensive risk register module was due to be implemented in October 2016.The manager thought this module would improve risk management, as it could address the issues identified, such as date the risk was identified, cause and consequence of the risk, and inherent and target risk ratings.
- The nurse in charge of outpatients did not have an awareness of how all performance was monitored, for example they were not aware as to why there had been a decline in performance in relation to referral to treatment times in December 2015 and January 2016. This did not assure us that all information was shared with staff.

Leadership / culture of service

- Staff reported that although they knew who the senior managers were, only a few of them were visible and would visit the department thus they felt they were approachable.
- A 'communication cell' meeting took place every morning at the hospital where issues such as staffing and incidents were discussed.
- Staff we spoke to were aware of the whistleblowing policy and how to access it.
- Staff told us that although morale had improved since a new director of clinical services was appointed; it was low at times. In the 2016 hospital staff survey just 28% reported morale as good.
- The recently recruited director of clinical services had focused on improving governance, quality and leadership within the outpatient department with addressing training and appraisals, which staff agreed had improved.
- The hospital recognised staff who had gone 'the extra mile' and all members of staff had the opportunity to nominate a colleague for a 'above and beyond' staff award which were displayed in the staff dining room.
- Staff expressed there was a great deal of respect for one another and commented positively about the support and commitment of each other and the sister. All staff felt very proud to how they as a team work and supported each other with the current staffing issues.

Public and staff engagement

- Public engagement within the service was limited to the hospital friends and family test (FFT) which meant that there was no way of measuring patient satisfaction directly to the department. Senior managers told us that once a manager was recruited this would be looked at.
- Senior managers told us that they engaged with patients through the FFT, which was then disseminated to staff in the team meetings. However we are not assured that staff had information shared regularly as we were told meetings were not held regularly with some being cancelled. We have requested a copy of the last three sets of minutes from the meetings however these had not been received at the time of writing the report.
- Not all staff felt valued however staff we spoke with felt comfortable in raising concerns directly with their line manager and in group settings and felt that the nurse in charge actively asked them for feedback.
- An annual staff survey was conducted across the hospital. The results of the 2016 survey showed a deterioration in staff morale and satisfaction with 51% of staff reporting they were 'likely' or ' extremely likely' to recommend BMI healthcare to friends and family as a place to work, this was a 13.9% reduction in the survey performed in 2014. The hospital has responded to this by introducing a staff recognition scheme to highlight good performance and contributions to patient care. The introduction of daily walk around by managers aimed to improve managers' visibility. In addition senior managers told us there were plans to improve staff engagement.
- **Innovation, improvement and sustainability**

  The new director of clinical services was focussed on staffing and leadership within the outpatient department and had plans in place to recruit a full time manager specifically for the outpatient department with the current sister to focus on supporting and leading staff with day to day duties. We were told in place of the

registered nurse vacancies that there were going to increase health care staff who would have training opportunities to develop their role and skills further to support the trained staff for example in performing electrocardiogram's (ECG's).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Hospital-wide

- The hospital must improve its clinical governance and risk management processes to provide greater assurance that actions are being monitored to ensure timely attention to matters.
- The hospital must improve the incident reporting process to enable all staff to submit reports and enable all manner of incidents to be reported. There should be an effective system of circulating information and learning about incidents so that all staff remain aware of issues.
- The hospital must improve communication to ensure people who use the services, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service. In particular, meetings need to be better attended with important information shared and distributed accordingly.
- The hospital must ensure staff are appropriately supported and have access to an annual appraisal.
- The hospital must ensure that there is an effective process for clinical staff to receive supervision.
- The hospital must address issues with patient records to ensure that there are contemporaneous medical records for each service user, which include all relevant pre and post-operative information.

In surgery

- The hospital must ensure that clinical waste from theatres is labelled in line with guidance issued by Association for Perioperative Practice (AFPP) in 2015 'Standards and Recommendations for Safe Perioperative Practice'.

Action the provider SHOULD take to improve

In surgery

- The service should ensure they demonstrate progress towards implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) and Local safety standards for invasive procedures (LocSSIPs).
- The hospital should take step to improve signage to make it more dementia friendly.
- The service should optimise the fasting periods for patients prior to surgery in keeping with best practice guidance.
- The ward should consider removal of carpets in all clinical areas for infection prevention purposes.

In outpatients and diagnostic imaging

- The hospital should ensure staff are trained appropriately in relation to record keeping.
- The hospital should consider implementing a pain tool for use within the outpatient department.
- The hospital should consider ways to measure patient outcomes to identify areas for improvement.
- The hospital should store sharps equipment for example cannulas and needles within a locked cupboard/drawer.
- The hospital should increase patient engagement.
- The hospital should improve the environment to make it dementia friendly.
- The hospital should consider ways to improve support to those patients with learning difficulties or additional needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing HSCA 2008 (Regulated Activities) Regulations 2014, Regulations Sec 18 (2) (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform **How the regulation was not being met**: Some staff said they had not had an appraisal for at least two years. Organisational data showed that 33% of the theatre staff and 40% of ward staff received an annual appraisal in the 12 months to September 2016. In outpatients Information provided by the hospital showed that 66% of outpatient health care assistants (HCA) had received their appraisal at the time of inspection which was an improvement from the previous year where 16% of nursing staff had completed them and no HCAs had received an appraisal. Further data provided by the hospital showed that some staff in surgery and outpatients had not received an appraisal since 2010. HSCA 2008 (Regulated Activities) Regulations 2014, Regulations Sec 18 (2) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance HSCA 2008 (Regulated Activities) Regulations 2014, Regulations Sec 17 (2) (a) (c)

This section is primarily information for the provider

Requirement notices

Assess, monitor and improve the quality and safety of the services provided in the carrying on the regulated activity (including the quality of the experience of service users in receiving those services.

Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment.

How the regulation was not being met:

As part of the inspection, we looked at the governance structure. We looked at how the hospital mitigated risks. Within the hospital risk register, the risk descriptions were poor and did not clearly articulate the condition, cause and consequence of the risk. Staff were not aware of what risks were currently on the risk register. Staff told us that the details of a never event were not circulated effectively to staff to enable learning and prevent recurrence.

The hospital's process for records did not ensure that complete and contemporaneous records were available. This is because: Nursing staff in outpatients had very limited or no information regarding patient's requirements who attended the outpatient department for follow up nursing care. Patient records were sent to medical records and there were no individual patient records for patients attending for follow up review and treatment. We observed an A4 book which staff had documented care given for each patient at every visit. The information was limited with no evaluation, plan of care or reasons for treatment. On our return to the hospital for the unannounced inspection, the hospital had implemented a new process, in place of the 'A4 book', but it was too soon to judge its impact and effectiveness.

In surgery we found that the notes made by consultants during previous clinic records were not generally included in the records.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulations Sec 17 (2) (a) (c)