BMI The Highfield 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?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection of BMI Highfield Hospital on 2 and 3 August 2016. We also carried out an unannounced visit on 18 August 2016 to check the service had implemented improvements from the announced inspection. This was particularly to check that correct numbers of staff were on duty with the appropriate skills to meet the needs of patients and improvements had been made to infection control and environmental issues raised at the announced inspection.

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

Overall, we have rated BMI Highfield Hospital as requiring improvement.

Are services safe at this hospital

- Reviews and investigations following incidents was not always sufficiently thorough and actions were not put in place to prevent the incident recurring. Consequently lessons were not being learned and similar incidents were repeatedly occurring.
- Premises and equipment were not visibly clean in the theatre area and cleaning schedules in theatres were not always completed. This meant the level of cleanliness required for a surgical environment was not being appropriately monitored. Two Department of Health standards for the clinical environment were not met.
- There were no hand washing facilities in the ultrasound room and the chair in this clinical area could not be cleaned following patient consultations.
- We raised these concerns with the executive director at the time of the inspection.
- Immediately following the inspection the hospital arranged a deep clean of the service areas. The areas were appropriately clean at the time of the unannounced inspection.
- Arrangements for the service, maintenance, renewal and replacement of premises and equipment were not adequate in the theatre department. Service records for electronic equipment were not up to date and some equipment was in a state of disrepair.
- We raised these concerns with the executive director at the time of the inspection. Immediately following the inspection the hospital contacted engineers who started the process of servicing and registering each piece of equipment, logging them all onto an asset register with dates of last service and next service due. We received a copy of this register within one week of the inspection ending, with assurance from the hospital that any equipment not up to date with servicing would not be used.
- Staffing levels in theatre did not meet the required standards as set out by the Association for Perioperative Practice (AfPP), the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and in BMI's own staffing policy. This posed a potential risk to patient safety.
- Documentation around the completion of VTE assessments and prophylaxis medication in patient records was inconsistent, despite the hospital reporting 100% completion rates.
- In surgical service despite issues being identified in an audit with the management of controlled drugs, there was no action plan in place and we found they had not been checked the previous day in one area.
- In the outpatient department a medication fridge was being used to store blood products awaiting collection. An additional fridge was in place when we returned for our unannounced inspection.
- Mandatory training figures including adult and child safeguarding courses were lower than the hospital target.
- Completion of the World Health Organisation (WHO) surgical safety checklist was variable also there had been no audit of the use of the World Health Organisation checklist in diagnostic imaging since September 2014.
- Records used in the outpatient department did not contain full details of patients' medical history. This posed a risk that treatment could be unsafe or inappropriate.

Summary of findings

However

- There was good cover by the responsible medical officer (RMO) and consultants.
- Incidents were reported. Staff understood the importance of being open and honest and the duty of candour.
- Medicines were stored securely. Patient group directives were in place and up to date where required.
- Staff knew how to respond to deteriorating patients. Training, systems and processes were in place to ensure risks to patients were minimised.
- Bank workers were used to supplement the establishment and add to the skill mix. Bank workers were inducted to departments appropriately.
- Apart from the theatre area, rooms on the wards were visibly clean and tidy.
- Record keeping was mostly good in the surgical department, with evidence of falls assessments, assessment of pressure areas and assessment of nutritional status in patients' case notes. However, records used in the outpatient department did not contain full details of patients' medical history. This posed a risk that treatment could be unsafe or inappropriate.
- There were processes in place for safeguarding patients and most staff were familiar with these.

Are services effective at this hospital/service

- Local policies and procedures were based on evidence and guidelines produced by Royal Colleges and the National Institute for Health and Care Excellence (NICE).
- Outcomes data indicated that the hospital was performing at a comparable level with other independent hospitals in terms of unplanned returns to theatre, unplanned transfers and unplanned readmissions.
- The hospital operated an enhanced recovery model to improve outcomes for patients following surgery.
- We saw good evidence of pain being assessed and treated accordingly.
- Assessments for nutrition and hydration were being completed and documented.
- There were opportunities for staff to undertake courses and work in different roles which allowed them to develop professionally.
- There were link nurses in place to represent their clinical areas at meetings in particular specialties, eg pathology and resuscitation, and cascade information from the meetings back to their teams.
- Audits of care and discrepancy meetings were in place in the imaging department.
- The diagnostic imaging service was working towards the Imaging Services Accreditation Scheme (ISAS).
- Staff were supported in their personal development and attended both internal and external courses to develop their skills and knowledge.
- There was a BMI policy in place for granting and reviewing the practising privileges of doctors. Consultant files we reviewed contained details of medical revalidation and an up to date appraisal.
- There was good multi-disciplinary working between consultants, nursing staff and allied health professionals.
- Staff we spoke to had an understanding of the need to consider mental capacity when taking consent, but not all staff fully understood the processes required if a patient lacked capacity to consent for themselves.

Are services caring at this hospital/service

- Patients were supported and were involved in planning their treatment and care.
- Patients understood their treatment and, where applicable, were informed of any associated costs prior to treatment.
- Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- Staff were kind, caring and compassionate. They were sensitive in their communications with patients and understood and respected individual needs.
- Staff took steps to promote privacy and dignity. Patients told us they felt staff went above and beyond what was expected of them.

Summary of findings

- Friends and family test results showed that 97.2% of patients would recommend the service to their friends and family.
- The hospital sought feedback from patients about the service using a BMI questionnaire and the NHS friends and family test.
- Staff in the MR department took time to provide emotional reassurance to patients, particularly those who were nervous or claustrophobic. Patients told us staff made them feel at ease.

Are services responsive at this hospital/service

- Services had been planned to meet the needs of local people. There was flexibility in treatment and appointment times and access to a one stop breast clinic.
- The hospital had an admissions policy which detailed criteria for patients who could be safely treated at the hospital.
- Patients' needs were assessed through the use of a range of BMI clinical pathways, which included the use of a pre-operative assessment health questionnaire.
- Patients were kept informed of any delays and patients told us appointments ran to time.
- Overall, the 95% 18-week target for non-admitted patients was met between April 2015 and March 2016. Waiting times for diagnostic imaging were low.
- Individual needs were understood and considered when delivering care and treatment. Adjustments were made to remove barriers to people accessing services. Staff received training in dementia awareness and equality and diversity.
- Staff understood the complaints process and told us learning from complaints was discussed at departmental meetings and at the medical advisory committee.
- An interpreting service was available for patients who did not speak English and staff could access patient information sheets in different languages.
- There was an open visiting policy within the hospital.
- Patients were given opportunities to feedback on the care they received and we saw evidence that patient feedback was acted on.
- Patients agreeing to undergo cosmetic surgery could change their minds and cancel the procedure at any point prior to the commencement of surgery.
- National waiting time indicators for referral to treatment (RTT) were below the 90% indicator for admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 2015 to March 2016).
- Reasons for cancelled operations were not being investigated consistently, so there was no learning or actions in place to prevent the same issues recurring.
- Information about how to complain was not readily available in the departments we visited.

Are services well led at this hospital/service

- Frequent changes to leadership across the theatre departments and change in hospital manager had led to a lack of direction for staff and a need to improve governance systems.
- There was no strategic oversight of incidents so lessons were not always learned from these.
- Communication and sharing of action plans had been identified by the hospital as a problem. Communication meetings (comms cells) were being to improve this.
- A number of senior staff had not seen a risk register at the hospital.
- There was a risk assessment folder on Cedar ward, however this included several expired review dates and some incomplete assessments.
- Clinical governance meetings were not well attended and actions were not completed in a timely way. BMI clinical governance bulletins were not shared with the medical advisory committee.
- Not all consultants who held practicing privileges at the hospital had all the required documentation in place.

However;

Summary of findings

- There was an open culture where staff felt confident to raise concerns if required. Staff spoke positively about their work and their colleagues.
- Leadership in the imaging department was good and staff felt well supported. Work was in progress to ensure the sustainability of the one stop breast clinic and to improve the service by gaining accreditation via the Imaging Services Accreditation Scheme (ISAS).
- 'Comms cell' boards displayed key information about the quality measurement and risk management.
- There was an experienced medical advisory committee (MAC) chair who was able to give examples of how the committee monitored and influenced clinical practice.
- The private healthcare information network (PHIN) had commenced outcome collection and covered hip, knee, hernia and cataract surgery.
- All the staff we spoke with felt supported by their managers, and were positive about their roles and about working at the hospital.

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 	
Outpatients and diagnostic imaging	Good 	

Summary of findings

Contents

Requires improvement

BMI The Highfield Hospital

Services we looked at
Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The Highfield Hospital

BMI Highfield Hospital serves the population of Rochdale, Greater Manchester and surrounding areas. The hospital offers a range of outpatient services to NHS and other funded (insured and self-pay) patients including: cardiology, dermatology, general medicine, rheumatology, respiratory medicine, radiology and physiotherapy. Inpatient and outpatient surgical services include cosmetic surgery, ear, nose and throat surgery, general surgery, gynaecology, ophthalmology, oral and maxillofacial surgery, orthopaedics and urology.

The hospital also provides outpatient services to patients 16 years and above. The on-site facilities include an endoscopy suite, four operating theatres; consulting rooms supported by an imaging department offering x-ray and ultrasound, and inpatient and outpatient physiotherapy services. There are 47 (41 in use) patient bedrooms, all with a nurse-call system, en-suite bathrooms, a television and a telephone.

The hospital was inspected as part of our planned inspection program. This was a comprehensive inspection and we looked at the two core services provided by the hospital: surgery and outpatients and diagnostic imaging.

Our inspection team

Our inspection team was led by:

Inspection Lead: Wendy Dixon, Inspection Manager, Care Quality Commission

The team of six included CQC inspectors and a variety of specialists: a consultant general surgeon and theatre nurse with independent healthcare surgical experience, a radiographer and a governance specialist.

Why we carried out this inspection

The hospital was inspected as part of our planned inspection program. This was a comprehensive inspection and we rated the service. We looked at the two core services provided by the hospital: surgery and outpatients and diagnostic imaging.

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?

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local Clinical Commissioning Group. We carried out an announced inspection visit on 2 and 3 August 2016 and an unannounced inspection on 18 August 2016.

We also spoke with staff individually and in small groups. We talked with patients and staff from the ward, operating department, radiology, physiotherapy and outpatient services. We observed how people were being cared for, talked with patients and reviewed patients' records of personal care and treatment.

Summary of this inspection

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

Information about BMI The Highfield Hospital

- The hospital operates 41 inpatient beds and eight day case beds and is registered for 47 beds.
- There were 6,759 inpatient and day case episodes of care recorded at BMI The Highfield Hospital in the reporting period (April 2015 to March 2016); of these 71% were NHS funded and 29% were other funded.
- 23% of all NHS funded patients and 26% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 34,380 outpatient total attendances in the reporting period (April 2015 to Mar 2016); of these 51% were NHS funded and 49% were other funded.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Surgery

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

Information about the service

We visited BMI The Highfield Hospital in Rochdale as part of our announced inspection on 2 and 3 August 2016 and followed up with an unannounced inspection on 18 August 2016.

BMI The Highfield Hospital in Rochdale is part of BMI Healthcare, the UK's largest provider of independent healthcare. The hospital has four theatres, uses 41 of its 47 registered beds split between two wards, and has eight chairs spread over four rooms for minor procedures. The two wards are Linden ward, 24 single en-suite rooms used by inpatients and day cases, and Cedar ward, 17 single rooms with at least a toilet en-suite used for day case patients only, between 7am and 9pm.

The majority of the medical consultants are from local NHS hospital trusts.

Over £2.5 million has been invested in the hospital over the last two years and a proposal has been submitted for a £1.8 million reconfiguration.

There were 6,420 visits to theatre between 1 April 2015 and 31 March 2016, with the most common procedures including 275 diagnostic colonoscopies and 246 diagnostic endoscopic examinations of the bladder. There were 1,595 inpatient attendances and 5,165 day cases.

Theatre one is open for elective surgery from 8am to 8pm Monday to Friday and on Saturday 8am to 5pm. An on-call theatre team is available 24 hours a day, seven days a week. Types of surgery in this theatre are: breast, colorectal, cosmetic, dermatology, dental, ear, nose and throat, gastroenterology, general, gynaecology, oral/ maxilla facial, pain management, plastic and vascular. Sessions are usually booked on weekdays between 8am and 1pm in the mornings, 1pm up to 5pm - 6pm in the afternoons and 5pm to 8pm in the evenings. On Saturdays the afternoon session finishes at 4pm and there are no evening cases.

Session times are similar for theatres two, three and four where types of surgery undertaken are: breast, bariatric, cardioversion, colorectal, cosmetic, dental, ear, nose and throat, gastroenterology, general, gynaecology, spinal services, ophthalmology, oral/maxilla facial, orthopaedics, plastic, urology and vascular.Theatres two, three and four have laminar flow and laser facilities. At the time of our inspection laser treatments were only undertaken in theatre two.

In exceptional circumstances operating rooms are opened from 7:30am in order to accommodate urgent cases and for procedures recognised to take more time than the allocated session will allow.

There are four rooms in the Forest Suite, each furnished with two reclining chairs, used for procedures requiring only a local anaesthetic such as injections, carpal tunnel, and cataracts. Each room has a small changing area, with access to a communal toilet and shower on the suite. There was also a discharge lounge, where relatives could wait. Patients are admitted in the treatment room, to allow confidentiality.

During this inspection we inspected both wards and all four theatre areas. We spoke with 23 staff including doctors, nurses, health care professionals and managers. We observed a theatre brief, a team brief and held interviews with the deputy theatre manager and the medical advisory committee (MAC) lead. We observed care, looked at records for 11 people, nine prescription charts and spoke with five patients and three relatives.

Requires improvement

Surgery

Summary of findings

Overall we rated this service as requires improvement because:

- We found significant problems with staffing in theatres, and with equipment maintenance, and infection prevention and control. These issues were escalated at the time of our inspection and the new executive director and her team acted on our concerns promptly.
- Incidents were not thoroughly reviewed, so that any remedial actions can be put in place to prevent a recurrence.
- Frequent changes to leadership in theatre and the recent change of the registered manager had led to uncertainty and a lack of direction for staff at the hospital.
- There were no locally developed or observational audits being undertaken. Some corporate checklist audits were being completed, however where standards were not being met there were no action plans in place to improve practice.
- Reasons for cancelled operations were not being investigated consistently, so there was no learning or actions in place to prevent the same issues recurring. This included the lack of a standard operating procedure for consultants confirming their booked theatre slots, and miscommunication with the arrangements for anaesthetists.
- Frequent changes to leadership across the theatre departments and change in the hospital manager had led to a lack of direction for staff.
- There was no strategic oversight of incidents so lessons were not always earned from these. Communication and sharing of action plans had been identified by the hospital as a problem.
- Communication meetings (comms cells) had been introduced to improve this, but at the time of our inspection the comms cell risk information was incomplete and staff were unaware of the top risks.
- Senior staff had not seen a risk register at the hospital.
- There was a risk assessment folder on Cedar ward, however this included several expired review dates and some incomplete assessments.

However,

- There was good evidence of patients being assessed and treated for pain, and nutrition and hydration needs.
- Outcomes data indicated that the hospital was performing at a comparable level with other independent hospitals in terms of unplanned returns to theatre, unplanned transfers and unplanned readmissions.
- Staff were taking the available opportunities to undertake courses and work in different roles which allowed them to develop professionally.
- The service was completing some audit checklists to monitor practice, however we did not see action plans in place where standards were not met.
- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect.
- Patients were supported, and were involved in planning their treatment and care.
- The booking system for patients to be treated was flexible and there was an admissions policy which detailed criteria for patients who could be safely treated at the hospital.
- Patients underwent a thorough pre-operative assessment process prior to admission.
- There was an experienced medical advisory committee (MAC) chair who gave examples of how the committee monitored and influenced clinical practice.
- All the staff we spoke with, at all levels, felt supported by managers, and were positive about their roles and about working at the hospital.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We rated surgical services as 'requires improvement' for safe because:

- Reviews and investigations following incidents were not always sufficiently thorough and actions were not put in place to prevent the incident recurring. Consequently lessons were not being learned and similar incidents were repeatedly occurring.
- Documentation around the completion of VTE assessments and prophylaxis medication in patient records was inconsistent, despite the hospital reporting 100% completion rates.
- Premises and equipment were not all visibly clean and cleaning schedules in theatres were not always completed. This meant the level of cleanliness required for a surgical environment was not being appropriately monitored. Two Department of Health standards for the clinical environment were not met.
- Despite issues being identified in an audit with the management of controlled drugs, there was no action plan in place and we found they had not been checked the previous day in one area.
- Arrangements for the service, maintenance, renewal and replacement of premises and equipment were not adequate. Service records for electronic equipment were not up to date and some equipment was in a state of disrepair.
- Mandatory training rates for staff were not all meeting the BMI targets.
- Completion of the World Health Organisation (WHO) surgical safety checklist was variable.
- Staffing levels in theatre did not meet the required standards as set out by the Association for Perioperative Practice (AfPP), the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and in BMI's own staffing policy. This posed a potential risk to patient safety.

However,

- A new executive director for the hospital had started immediately prior to the announced inspection; they were made aware of the problems we found, and had the capability to ensure action was taken.
- Immediately following the inspection the hospital arranged a deep clean of the service. Areas were appropriately clean at the time of the unannounced inspection.
- The hospital contacted engineers who started the process of servicing and registering each piece of equipment, logging them all onto an asset register with dates of last service and next service due. We received a copy of this register within one week of the inspection ending, with assurance from the hospital that any equipment not up to date with servicing would not be used.
- Rooms on the wards were visibly clean and tidy.
- Record keeping was mostly good, with evidence of falls assessments, assessment of pressure areas and assessment of nutritional status in patients' casenotes.
- There were processes in place for safeguarding patients and most staff were familiar with these.
- All eleven sets of records we reviewed had observations and national early warning scores (NEWS) recorded.
- There was good medical cover by the responsible medical officer (RMO) and consultants.

Incidents

- There was an incident reporting policy in place which included details of how to ensure duty of candour was adhered to. The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.The incident reporting policy used by the hospital set out the principles and requirements of the duty of candour.Staff understood the principles of being open and honest if an incident occurred in the department and duty of candour training was planned for September 2016.
- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses which they did by completing a paper incident form. This was entered onto the electronic system by a member of the administrative staff.
- Following the submission of an incident report one staff member said they received feedback in the form of a discussion about lessons learned in the morning meeting, however two staff members told us they had reported an incident but had received no feedback.

- There had been no never events at the hospital between 1 April 2015 and March 2016.
- There were 472 clinical incidents reported between 1 April 2015 and 31 March 2016, of which 25% (119) occurred in surgery or inpatient services. This was a lower rate of incidents reported when compared with other independent acute providers.
- The medical advisory committee (MAC) minutes from May 2016 recorded that the clinical governance report from 1 January 2016 to 31 March 2016 had been presented. Incidents from this were reviewed and actions or lessons learned noted. The other two sets of MAC minutes that were provided by the hospital (January 2016 meeting and July 2016 meeting) recorded that incidents and lessons learned were discussed but no details were noted.
- We requested the three most recent route cause analysis (RCA) investigation reports completed by the hospital. We received reports from May 2016, August 2015 and May 2015. The most recent report included details of the incident and identified causes. Actions were documented as completed. However the quality of the report provided from August 2015 (a surgical site infection) was poor, with 'N/A' (not applicable) recorded for root causes, lessons learned and recommendations despite the incident involving failures by the hospital. The terms of reference were unclear, the effect on the patient was not completed and no actions were documented as taken.
- The third RCA was from May 2015 and identified wear and tear on equipment as the issue. The only action identified was a discussion around this. No root cause was identified as to how or why equipment that was not fully maintained was in use. Completion of the world health organisation (WHO) surgical safety checklist, including the de-brief section, was also identified as an issue but again, the only action was 'meet to review'.
- The incident log showed a number of incidents between 1 April 2015 and 31 March 2016 where the classification was 'adverse outcome'. We were surprised that none of these had RCA investigations as details provided indicated there were occasions where errors by hospital staff had caused harm to patients. The BMI Healthcare incident policy advised that an RCA should be considered for incidents at all levels.
- During the same period there were 15 cases of unplanned transfer of an inpatient to another hospital, six cases of unplanned readmission within 28 days of discharge and three cases of unplanned return to the operating theatre. We saw details for individual incidents which showed that the circumstances had been discussed between staff and, where applicable, the receiving hospital. We requested information on how the hospital had learned from these, and what steps had been taken to reduce the risk of reoccurrence but this was not received by us.
- There was an area on the communication (comms) cell board in the boardroom for incidents and the "three Cs" (concern, cause and countermeasure). Nothing was reported yet for August at the time of inspection but we looked at the records for July and found six concerns noted. The status of the issues were identified by a symbol to show whether the three Cs were identified and whether a solution had been implemented and the problem eliminated. We asked four staff at senior and junior levels what the three Cs were but they did not know.
- There were no deaths at the hospital between 1 April 2015 and 31 March 2016.

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

- The NHS Safety Thermometer allows teams to measure harm and the proportion of NHS patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE). The data is collected on one day per month.
- At BMI Highfield, safety thermometer data for NHS patients was collected by the acting ward manager who submitted it to the governance department. It was not displayed on the wards. Data was not collected for non NHS patients.
- Safety thermometer data was available for seven of the months during the reporting period from 1 April 2015 to 31 March 2016. No data was available for October 2015 to February 2016 inclusive. The data showed no falls with harm, no new urinary tract infections and no pressure ulcers. All patients included in the sample had undergone a VTE risk assessment. There were no incidents of hospital acquired VTE or pulmonary embolism (PE) during the reporting period from 1 April 2015 to 31 March 2016.
- However, we reviewed 10 sets of inpatient care records and found only seven had a VTE assessment completed

within 24 hours. One had a VTE assessment done outside of the 24 hour period and for two records it was not documented that a VTE assessment had been completed.

Cleanliness, infection control and hygiene

- Some of the rooms we looked in were not visibly clean in all areas. There was thick dust on several of the storage trolleys in the anaesthetic room and store room for theatre two and on the bottom of the anaesthetic machine. Dust was also visible on the storage cabinets and on three trolleys and a storage unit in the recovery area.
- There was no cleaning checklist in theatre one or theatre four for the current week. We looked at checklists for the previous 11 weeks in both theatres and none had been completed in full. We checked on 2 August 2016 and for theatre one the most recent entries were 25 July and 27 July 2016. Staff told us the cleaning schedule should specify when the theatre was not used however there were documented examples of theatre four being cleaned on days when it had been closed, for example 14 July 2016.
- This meant that premises and equipment were not kept clean and cleaning was not done in line with current legislation and guidance, in particular 'premises and equipment should be visibly clean' and 'providers should operate a cleaning schedule appropriate to the care and treatment being delivered' and 'monitor the level of cleanliness'.
- Two embolectomy catheters were out of date (expiring 25 February 2016 and 11 March 2016).
- Other problems with equipment included that some of it was stored on the floor, and several pieces of equipment had tape on it, or sticky residue where tape had been, meaning it could not be cleaned to required standards.
- There were two sinks in the dirty area which was separate to the clean area. Clinical waste in the dirty area was in yellow bags as required, however it was not labelled, despite policy guidelines being attached to the trolley with directions for labelling. The waste should have been labelled with the date, premises, ward or team and a code if intended for incineration.
- Lead aprons in a storage area on the ground floor were visibly dirty. They had stains and debris, such as remnants of sticky tape on them, indicating they had not been recently cleaned.
- Three of the four operating theatres used a laminar flow system, intended to provide a uniform directional flow of air in the operating room with very little turbulence to minimise contamination of the surgical field with airborne microbes. This system is used widely in orthopaedic procedures to try and reduce the opportunity for surgical site infections (SSIs) to occur.
- The hospital reported they had no surgical site infections in the reporting period (1 April 2015 to 31 March 2016) for primary hip arthroplasty, primary knee arthroplasty, other orthopaedic and trauma, spinal, breast, upper GI and colorectal, urological, cardiothoracic, cranial and vascular surgeries. They had one surgical site infection in the same reporting period for gynaecology surgery.
- We observed theatre staff wearing appropriate personal protective equipment (PPE), for example gloves were worn by the anaesthetist, anaesthetic practitioner and other theatre staff.
- We looked in eight rooms on Cedar ward. All were visibly clean and tidy. Bathrooms had a disposable strip over the toilets to indicate they had been sanitised and new cups were wrapped in plastic. Basins had elbow levers, although there was only one basin in the rooms we looked in. It is recommended that a minimum of one clinical hand wash basin is available in each single room, in addition to the general hand wash basin for personal hygiene in the en-suite facility (Health building note 00-09, Infection control in the built environment, Department of Health).
- All surgical patients except for endoscopy were screened for MRSA. There had been no reported cases of MRSA, MSSA, C-difficile or E-Coli between 1 April 2015 and 31 March 2016.
- On Linden suite there were urine samples stored in the same fridge as patients' medication. This was not in line with best practice for infection prevention and control.
- In the patient led assessment of the care environment (PLACE) published in August 2016, the hospital site scored 96.46% which was less (worse) than the organisational average (96.95%) for cleanliness.

Environment and equipment

- We found some problems with the environment and equipment at the hospital. In theatre four there were defects in the walls with paint missing and plaster exposed. There was a gap where the floor was coming away from the wall in theatre one. There was rust on

several pieces of equipment including three trolleys, a pneumatic tourniquet machine and the stacker system. These defects meant the walls and equipment could not be cleaned to required standards.
- Table supports in theatre four had a ripped waterproof covering which left the internal foam exposed.
- We found equipment in theatres did not have labels on indicating that it had been recently serviced, calibrated or safety checked. Staff were unable to provide a register detailing the due dates for these processes and therefore we could not be assured that the equipment was safe to use. Some of the service date labels had not been updated since 2011.
- This meant that premises and equipment were not properly used and maintained. In particular there were not suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises and equipment as required by legislation.
- We raised these concerns with the executive director at the time of the inspection.
- Immediately following the inspection the hospital contacted engineers who started the process of servicing and registering each piece of equipment, logging them all onto an asset register with dates of last service and next service due. We received a copy of this register within one week of the inspection ending, with assurance from the hospital that any equipment not up to date with servicing would not be used.
- There had been previous incidents raised in relation to equipment problems, for example a worn drill bit that had broken off, and a machine that broke in the middle of an operation in April 2016. Had these incidents been adequately investigated, it would have come to light that there was no system in place for monitoring the safety of equipment.
- Similarly, staff at different levels of management were aware there was no current asset register. This was mentioned to us during interviews, and was documented as a risk from previous communication cell meetings on 9 May 2016. The status of the action taken to mitigate the risk was marked as complete.
- There was non-clinical equipment in other areas which was due to be calibrated or PAT checked, including the drugs fridge (due July 2016) on Linden Suite and the televisions in the eight rooms we looked in on Cedar ward where PAT stickers dated back to 2013.
- We observed the anaesthetic machine checks had been completed in the anaesthetic rooms for theatre one and theatre four.
- The resuscitation trolley in the recovery area had completed checks recorded and the emergency drugs we checked were in date.
- On Cedar ward there was equipment at the bedside in the individual rooms for the provision of oxygen. We checked five of the oxygen supplies; four had stickers on indicating they had been recently serviced and calibrated. Two blood pressure cuffs also were also labelled with in date PAT, service and calibration stickers.
- The defibrillation trolley on Cedar ward had a completed and up to date daily check sheet. The drugs and consumables were in date.
- There was carpet on the floor in the patient rooms on Cedar ward. The Department of Health advises that carpet should not be used in clinical areas. (Health Building Note 00-09: Infection control in the built environment, 2013).
- Patient led assessments of the care environment (PLACE) are undertaken by teams of health care providers, and include at least 50 per cent members of the public (known as patient assessors). Results from the most recent PLACE were published in August 2016 using data collected between February and June 2016. The report compared the scores from the hospital site with the scores for the BMI organisation. Areas assessed included communal and ward areas but not theatres.
- The hospital site scored 96.46% which was less (worse) than the organisational average (96.95%) for cleanliness. The hospital site also scored less (65.99%) than the organisational average (78.69%) for dementia friendly environment. However, in all other areas the site scored higher (better) than the organisational average, including for condition, appearance and maintenance.

Medicines

- We reviewed the controlled drugs records in the anaesthetic room for theatre two which were checked and recorded twice daily, as they were in the recovery area. We reviewed the controlled drugs records in the anaesthetic room for theatre one and these had not been checked at the end of the list for the previous day (2 August 2016).
- An audit from March 2016 identified several areas of non-compliance with regard to controlled drugs,

including stock lists (with levels) in cabinets not being dated and adhered to in any of the theatres or on Linden suite, balances not always checked daily when the ward or theatre opened, and the controlled drugs registers and order books not being stored securely. The audit did not have an action plan.

- We looked at a random selection of controlled drugs stored in locked cupboards on Linden suite and all were in date.
- We reviewed nine prescription cards. All prescriptions were signed and dated and all had allergies documented. All were legible. Where medication was omitted or not given, a reason was documented.
- Three of the nine prescription cards we reviewed showed VTE prophylaxis had been given when indicated. For four patients it was not indicated. One patient had no assessment and had not been given prophylaxis and one patient had been given the medication but no elevated risk was identified on the assessment.
- The drug fridge temperatures were recorded daily in the anaesthetic rooms for theatre one and theatre two and Linden suite.
- Staff had bar codes on their ID badges which allowed them to access the fridge where bloods were stored once they had been grouped and cross-matched. If emergency bloods were required they were obtained from an external source.
- Take home medicines were stored in locked cupboard on Linden suite. Unused medication was also locked away and was checked and taken away by pharmacy every day.

Records

- We reviewed 11 sets of care records, ten inpatient records and one day case. All had the name and grade of doctor and/ or nurse clearly documented. All had a diagnosis and management plan documented and all but one had evidence of daily ward round including review with senior clinicians where appropriate.
- We saw good evidence of falls assessments, assessment of pressure areas and assessment of nutritional status.

Safeguarding

- We saw evidence in the MAC minutes for May 2016 that safeguarding issues were discussed and appropriate action taken. Three cases were documented where the hospital had contacted social services to discuss concerns.
- The director of clinical services was the safeguarding lead and had completed level three safeguarding adults training. The acting ward manager was the deputy safeguarding link and each department had a safeguarding champion.
- The deputy theatre manager told us she had completed level two safeguarding training. She was aware of safeguarding issues and provided a recent example of a safeguarding case she had been involved with. Two ward staff we spoke with were also able to give examples of concerns and actions following a recent safeguarding case. They knew how to escalate concerns to their manager, or if out of hours, the manager on call.
- There were flowcharts in the clinical areas with instructions about what to do if staff had concerns or were worried about a child, young person or adult's welfare.
- The hospital training schedule stated that all staff must complete level one adult safeguarding training as part of their mandatory training on the electronic system, BMI learn. All clinical, management or supervisory staff should complete level two, however mandatory training was not up to date in all areas and one member of staff we spoke with had not completed her safeguarding training and was unclear what it meant.
- Ninety-two percent of staff at the hospital had completed level one training which met the hospital target of 90%. Level two training figures were below target at 83%. Level three training had been completed by 100% of relevant staff.
- Although the hospital did not accept patients under the age of 16, staff were expected to complete training in line with intercollegiate guidance on safeguarding children. At the time of our inspection, training figures were below hospital target at 89% for level one and 83% for level two training. All relevant staff had completed level three training.
- The staff we spoke with had not heard of female genital mutilation (FGM) and said they had received no training on this.

Mandatory training

- There was a corporate BMI mandatory training policy in place, with accompanying matrices detailing which training was required for each staff group and at what interval. For example, all staff were required to complete yearly fire safety training, but only clinical staff were required to complete the dementia awareness course.
- The resident medical officers (RMOs) received a BMI induction by the organisation who provided them and a local induction of RMO to RMO was in place. Renewal of their mandatory training was also organised and managed by the provider company and shared with BMI Highfield when completed.
- The BMI target for mandatory training was 90%. Theatre staff were not meeting this target as their compliance was at 85% for completion of mandatory training. Nursing staff compliance was 90% although this was not broken down into different departments.
- Overall the rate of mandatory training for the hospital was 87%. Incentives were in place to encourage staff to update their mandatory training and those who did not were at risk of forfeiting their annual pay rise.

Assessing and responding to patient risk

- Where patients needed a higher level of care, they were transferred to another local BMI hospital where intensive care and high dependency beds were available.
- Between 1 April 2015 and 31 March 2016 there were 15 cases of unplanned transfer of an inpatient to another hospital, and six cases of unplanned readmission within 28 days of discharge. These numbers were not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- The world health organisation (WHO) safe surgery checklist identifies three phases of an operation: before the induction of anaesthesia (sign in), before the incision of the skin (time out) and before the patient leaves the operating room (sign out). In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation.
- We observed preparation for two surgical procedures, both with appropriate handover from a ward nurse to the anaesthetic practitioner. A full check of the patient's details and consent was carried out for both procedures in the anaesthetic rooms.
- We observed a comprehensive team brief in the anaesthetic room for theatre one. This included a full introduction of the team and requirements for the list including an appropriate discussion about the cognitive status of one particular patient.
- The anaesthetist was present during the patient's details check and the pre-op checklist for one patient, but not for the other. For both procedures there was no formal sign in between the anaesthetist, patient and anaesthetic practitioner, ie the boxes were ticked on the form but the questions were not read out loud and it was not an interactive process as it should be, between the patient, anaesthetist and anaesthetic practitioner.
- We observed a theatre check of instruments where the health care assistant (HCA) read through a checklist and the scrub practitioner confirmed. This occurred prior to and following the procedure and did not meet best practice guidelines by the association for perioperative practice (AfPP) which recommends both practitioners must visually check, count aloud and in unison. Swabs and sundries were counted and recorded on a white count board.
- Time out for one operation was a fully interactive process with silent focus observed in line with guidance, but for the other it took place while other preparatory activities were ongoing and there was no silent focus.
- There was no formal process for the two sign outs we observed. There was a full handover by theatre staff to the recovery team.
- We looked at the records for one patient observed in theatre and appropriate risk assessments and care pathways were completed, for example a care pathway had been commenced for the insertion of a urinary catheter.
- Pre-operative marking is required to promote correct site surgery, including operating on the correct side of the patient and/or the correct anatomical location or level. The national patient safety agency (NPSA) and the Royal College of Surgeons (RCS) strongly recommend that the mark should subsequently be checked against reliable documentation to confirm it is (a) correctly located, and (b) still legible. This checking should occur at each transfer of the patient's care and end with a final verification prior to commencement of surgery. All team members should be involved in checking the mark. No pre-operative checklist was completed for one patient we observed.

- One member of theatre staff told us that generally the WHO briefings were good but there were inconsistencies with the process and some teams were better than others. Experienced staff regularly challenged the consultants but they expressed concern that there were a lot of junior staff who may not be as keen to challenge.
- When we returned for the unannounced inspection we observed a further three WHO checklists, one of which was completed appropriately, but two were incomplete.
- Monthly audits showed compliance with the world health organisation (WHO) surgical safety checklist was variable, and dropped to 66% in April 2016. It rose to 99% in May but the July 2016 MAC minutes report it as being only 68%. The minutes suggest this was possibly due to a recording error rather than a lack of compliance as spot checks and observations indicated compliance. Theatre staff had been advised to contact the executive director if a consultant did not comply with the WHO checklist requirements. A WHO checklist compliance checker was to be added to the head of department comm cell although this was not yet in place at the time of our inspection.
- A number of risk assessments were completed as part of the pre-assessment and admission clinical pathway processes. A member of the nursing staff said these worked well and that issues were highlighted for them to be aware of, for example if blood was needed this was highlighted in red. There was a patient alert system and if staff needed to be aware of a particular condition, for example diabetes, an email was sent to the senior staff and put in the ward alert group and handover sheets.
- All eleven sets of records we reviewed had observations and national early warning scores (NEWS) recorded. Of the 10 sets of inpatient care records we reviewed only seven had a VTE assessment completed within 24 hours. One had a VTE assessment done outside of the 24 hour period and for two records it was not documented that a VTE assessment had been completed.
- Patient temperatures were not always recorded, as required, to monitor for surgical site infection (SSI).
- Two units of O negative blood were stored on the ward in case an emergency transfusion was required, in line with accepted practice.

Nursing staffing

- The deputy theatre manager explained there had been changes in the previous three months in the way rotas were planned as there had been four theatre managers in the last four years, all with different ways of working. At the time of our inspection there was an electronic nursing dependency and skill mix tool used to calculate and plan the required numbers of different staff required on each theatre and ward shift, five days in advance. Where specific practitioners were required because they were trained to use particular equipment, this request was sent directly to them and confirmed by email which was described as a more robust process than previous systems.
- The staff numbers were revised on a daily basis by the acting ward manager to accommodate changes to patient numbers and acuity. They generally worked to a ratio of approximately 1:6 qualified nurses to patients although this ratio changed as patients were being admitted and discharged throughout the day and there was always a mix of day cases and inpatients.
- Actual hours worked were entered retrospectively to understand variances from the planned hours and the reasons for these. The tool showed frequent variances in staffing not meeting the required levels and was being adjusted to try and make it more accurate. Two staff members said when there was a flurry of day patients coming and going from theatre at the same time it sometimes meant there were less staff available for inpatients however there was good team working to help each other out and they rarely felt under-staffed.
- The Association for perioperative practice (AfPP) book 'staffing for patients in the perioperative setting' (2014) sets out the staffing recommendations for use in every perioperative environment, including the independent healthcare sector. The BMI policy for management of operating sessions for elective and scheduled surgery reflected these, including the recommendation that two scrub practitioners is the basic requirement for each session, unless patient dependency and/or clinical service demand more or less. Two practitioners are recommended for a list of major surgery unless there is only one case, and for a list of minor surgery that demands a quick throughput or has several cases on it.
- However, we found this recommendation was not being adhered to. When staffing was allocated to the theatre lists there was regularly one scrub practitioner, one surgical first assistant (SFA), one health care assistant (HCA) and one anaesthetic practitioner. This meant on these occasions surgical procedures were not adequately staffed.

- Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed, and the guidance that 'the approach they use must reflect current legislation and guidance where it is available' was not met.
- In 2011 the perioperative care collaborative (PCC) published a position statement in relation to the role of the SFA clarifying that they be an additional member of the surgical team. It stated if the employer considers that a dual role is required, for example in minor surgery, this decision should be endorsed by a policy and should also be based on a risk assessment of each situation to ensure patient safety.
- However, this was not being adhered to. The scrub practitioner was regularly being used in a dual role with the SFA but there was no local or corporate policy setting out under what circumstances this could occur, and there were no risk assessments in place.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend that at all times, at least one member of staff in recovery should be a certified acute (advance) life support (ALS) provider. At BMI Highfield only two theatre staff were ALS trained so there was not an ALS provider on every shift as these staff were not always on duty. However, the registered medical officer (RMO) was on site 24/7,they had completed ALS training and could be called upon if required.
- The use of agency theatre nurses averaged 31% between April 2015 and March 2016 and for operating department practitioners (ODPs) and health care assistants the rate averaged 14%. These were similar to the averages when compared to other independent acute hospitals we hold this type of data for, in the same reporting period.
- On the first day of inspection 50% of the theatre staff were from an agency. The deputy manager said there were eight substantive staff on annual leave at the same time, partly because they were using their leave up as the financial year end for the hospital was in October.
- The hospital acknowledged they have had a reliance on agency staff in theatre and informed us this was due to difficulty with recruitment of permanent and bank staff combined with national shortages of qualified theatre staff.
- The hospital had developed a recruitment plan enabling them to reduce theatre staff vacancies from six to one. Minutes from the medical advisory committee (MAC) meeting in January 2016 documented efforts from all staff to reduce the use of agency staff, including permanent staff taking on more overtime and training recruits from overseas.
- There was an acting ward manager in post, covering the wards and outpatient department. She told us she worked 30 hours but 75% of these were office based. She worked one shift per week on the ward.
- There was an acting ward sister in post, covering the wards and outpatient department She told us her 30 hours were split equally between the ward and the office.
- Ward shifts were worked between 7.30am - 3.30pm (early), 1.30pm - 9.30pm (late) and 9pm - 8am (night). Handovers took place at 7.30am, 1.30pm and 9pm.
- There was one 22.5 hour vacancy which was being advertised at the time of our inspection. Agency staff were not used on the wards. If there was a staff shortage, regular bank staff were used.

Surgical staffing

- Resident registered medical officers (RMOs) were employed to provide medical cover when the consultant was not available. The RMOs were provided by an external company and worked 24 hours, seven days a week for two weeks at a time. They were not permitted to leave the site during these two weeks. It was usually the same two doctors who rotated, with others covering for annual leave.
- The RMO we spoke with said although this rota was challenging it suited him, as it fitted in with his personal circumstances. He had been working in the UK for approximately three months and the RMO he rotated with had worked at the hospital for around two years so there was some continuity with medical cover. When he joined the hospital he spent three days with the other RMO prior to starting and felt fully ready for the work when he began.
- Routine work undertaken by the RMO included venesection, cannulation and prescribing medication. The RMO would be called for any emergencies if the consultant was not on site, and he said on average he got a call during the night about every four or five nights which was manageable.
- The RMO said consultant support was good and it was always clear to him which consultant was responsible for each patient. He felt supported and had never had an issue when ringing a consultant with a query. There

was a list on a noticeboard on Linden ward detailing who was providing cover when consultants were on annual leave. We saw the file used to store consultant contact details including their mobile, home and hospital telephone numbers.

- The RMO provider company reviewed the workload of the RMO by a telephone call every Tuesday.
- RMOs had open access to the director of clinical services and the ward and outpatient managers when they were on site. RMOs also had a 24/ 7 telephone clinical and non-clinical support service with the provider organisation and there was a standby RMO available.
- The RMOs on duty completed ward rounds regularly during the day and were encouraged to highlight any issues or concerns to nurses or the managers on duty.
- When a new RMO started their curriculum vitae (CV) was sent by the provider company to the director of clinical services for review, agreement and sign off prior to them commencing work at the hospital. The CVs included evidence of employment history, references, general medical council (GMC) details along with occupational health information and training including advanced life support certificates. The CVs were filed in RMO electronic files.
- A manager told us there had been a new practice since January 2016 whereby the consultants booked their own anaesthetist. This had not been without problems and there had been occasions when the anaesthetist had not arrived or the consultant had not informed the hospital they were on leave so they had been booked onto the schedule. There was no formal standard operating procedure in place for consultants confirming their theatre slots.
- If consultants did not manage their slots appropriately and one was not filled there were no consequences for the consultant. The practising privileges had a six weeks notice clause in the contract but this was not enforced for an occasional error.

Major incident awareness and training

- There was a business continuity policy in place. This included the requirement that simulation exercises must be undertaken through: a staff communications exercise every six months; a desktop exercise once a year; and a live exercise every three years.
- We asked a manager and two nursing staff if they were aware of a major incident or business continuity plan. They were not, and could not think of any examples as to what they might do in the event of a major incident, even when we provided example scenarios. Two other nursing staff were able to describe how they had to adapt during a flood, for example obtaining linen from another hospital.

Are surgery services effective?

Requires improvement

We rated surgical services as 'good' for effective because:

- Outcomes data indicated that the hospital was performing at a comparable level with other independent hospitals in terms of unplanned returns to theatre, unplanned transfers and unplanned readmissions.
- We saw good evidence of pain being assessed and treated accordingly.
- Assessments for nutrition and hydration were being completed and documented.
- There were opportunities for staff to undertake courses and work in different roles which allowed them to develop professionally.
- There were link nurses in place to represent their clinical areas at meetings in particular specialties, for example pathology and resuscitation, and cascade information from the meetings back to their teams.

However,

- There were no locally developed or observational audits being undertaken. Some corporate checklist audits were being completed, however where standards were not being met there were no action plans in place to improve practice.

Evidence-based care and treatment

- BMI corporate polices based on national institute for health and care excellence (NICE), national and royal college guidelines were available to staff on the intranet. A hard copy of all current policies was available from the director of clinical services office.
- There was an audit calendar which detailed the local audits due each month, with a progress tracker next to them. Regular audits included the WHO checklist, consent and pain management. However, these were mostly simple checklists against what was recorded in

the notes, rather than complete clinical audits including recommendations and action plans. There were no observational audits. Audit was a standing agenda item at the heads of department meetings.

- The BMI corporate monthly clinical governance bulletins set out relevant NICE Guidance, medical device alerts, drug alerts, patient safety alerts and facilities alerts. It also shared learning and best practice from other BMI hospitals.
- At bi-monthly clinical governance committee meetings a clinical governance report was presented that included reporting of healthcare acquired infections. Any new NICE guidance was discussed and forwarded to a relevant member of staff for review.
- We saw copies of some audits, for example a checklist audit completed for ten patient records in March 2016 regarding the consent process. The service had achieved 95% compliance with the required standards. The non-compliance was for not recording patient information provided to the patient but no actions were identified to address this.
- Locally developed clinical audits were not being undertaken. We were told that this was partly because medical staff were fulfilling their appraisal requirements to be involved with audit in their NHS or private operational work.
- The hospital held a breast implant register with records going back approximately 10 years. The register contained patient information, details of the implants used, surgeon, scrub nurse and procedure details.
- There was a 'policy of the month' awareness initiative each month where staff had to sign to confirm that they had read that particular policy.

Pain relief

- Pain relief was discussed with the patient at pre-assessment and pain advice booklets were given to patients for use post operatively. Pain scores were recorded on the national early warning score (NEWS) chart and responded to accordingly. We reviewed eleven care records and found good evidence of pain assessment and timely administration of pain relief.
- Pain scores were recorded along with clinical observations following surgery. When patients had pain control issues the RMO, anaesthetist or consultant were called to reassess patients and amend medication prescription. The pharmacy team supported pain management at ward level.
- All medications given on discharge were included on the discharge letter sent to the patient's GP.

Nutrition and hydration

- We spoke with three qualified members of staff in theatre who were not familiar with fasting guidelines. This meant there was a risk of patients being given the wrong information, or patients undergoing a procedure without having adequately fasted.
- Nutritional state was assessed for each patient on admission using the Malnutrition Screening Tool (MUST). This assessment was repeated post operatively and daily until the patient was ready for discharge. We saw evidence of this in the care records we reviewed.
- We saw evidence in the care records, of the assessment of hydration status and fluid balance charts where appropriate.
- Information provided by the hospital stated that if a patient scored two due to low BMI, had experienced 10% or more weight loss in six months or had had little or no food in the last five days or more, they were referred to the dietician. The dietetic service was outsourced and the dieticians worked for a neighbouring trust. They saw patients either on the day of referral or within one working day.
- Food and fluid intake was monitored using food charts and fluid balance charts. Patients unable to feed themselves were assisted by the nursing team. Additional dietary advice or special requirements were discussed with the patient on arrival to the ward and daily throughout their admission.
- In the most recent PLACE report published in August 2016 the hospital scored higher (better) when compared with the BMI organisational average in all three categories related to food.

Patient outcomes

- The hospital participated in the patient reported outcome measures (PROMS), national joint registry and the AQUA NHS orthopaedic audit. PROMS data were available for patients who had hip, knee and groin surgery. This data indicated the service was similar to national and BMI average scores.

- Local outcome indicators reviewed on a monthly basis included transfers out, returns to theatres, surgical site infection rates, average length of patient stay, day case conversion rates and readmission rates.
- Between 1 April, 2015 and 31 March, 2016 there were 15 cases of unplanned transfer of an inpatient to another hospital, six cases of unplanned readmission within 28 days of discharge and three cases of unplanned return to the operating theatre. These numbers were not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- In the provider information return (PIR) the hospital reported they had one surgical site infection in the same reporting period for gynaecology. This was not followed up adequately, and the RCA was poor quality as described above in 'Incidents'.
- BMI dashboards were in place to monitor performance for quality, safety, health and environment, complaints and information security incidents. However, when we asked a senior manager for clarity around some of the numbers in the dashboard, we were informed that they were incorrect.

Competent staff

- The hospital considered awarding practicing privileges where the applying consultant was licensed, on the specialist general medical council (GMC) register and held a substantive consultant post within the NHS or the defence medical services within the last five years. Applicants were asked to demonstrate relevant clinical experience related to practice. Once this had been established by way of a curriculum vitae (CV) and the submission of any further required evidence the applicant attended for an interview with the executive director (ED).
- The relevant medical advisory committee (MAC) specialism representative reviewed applications to consider the credentials, qualifications, experience, competence, judgement, professional capabilities, knowledge, current fitness to practice, character of and confidence held on the applicant. Recommendations were formulated and passed to the ED prior to the application being granted.
- Practitioners who did not comply with the above but could demonstrate relevant clinical experience over a sustained period applicable to working in the independent sector, including a support network to provide safe cover and care for the patients, had their applications considered.
- The MAC chair said they tried to keep records of appraisals and GMC registrations but it was very difficult to get information from all the consultants. The hospital were notified by the NHS or GMC if there was an issue with clinical work undertaken elsewhere and occasionally the hospital had notified the BMI medical director where there had been an issue at the hospital. The BMI medical director then notified the GMC. However, there was no formal process for this.
- Information provided in the PIR indicated that one consultant had their practising privileges suspended as they had taken a sabbatical from work.
- A new BMI Corporate induction had been introduced in February 2016 and there were local induction processes in place to support RMOs, bank and agency staff.
- In theatre there were a number of practitioners trained at different levels including three scrub practitioners who had also completed the BMI surgical first assistant (SFA) course. The three recovery practitioners had completed an in-house course but did not have an external qualification in anaesthetics. There was a health care assistant (HCA) level three scrub practitioner who was restricted to only scrub for a situation where there was not an open cavity. The practitioners worked at an HCA level while training was ongoing.
- However, there were challenges with skill mix in theatre because some staff could only work in particular specialties, for example they may only be competent and trained to work in recovery, or they may not be able to work in endoscopy.
- New staff nurses and health care assistants had the opportunity to work supernumerary on appointment; the length of time for this was usually around two weeks dependent on factors such as skills, knowledge, experience and confidence. One health care assistant we spoke with described a two week induction, including a week spent with the instrument coordinators learning about all the different surgical equipment and a day spent in materials where all the stock is managed for anaesthetics and theatres.
- Preceptorship was in place alongside appropriate mentorship. The hospital had been audited by two local universities as providing a suitable training environment for students.

- Both qualified and unqualified nursing staff we spoke with said they had opportunities to develop within the organisation. Between them they had completed various different courses including mentorship training at Manchester university, an acute illness management (AIMs) course, phlebotomy and an internal BMI 'airway, breathing, circulation, disability' (ABCD) course. There was flexibility around allowing staff to take time out to attend college, with the opportunity to make time up at weekends.
- Between April and August 2016 nursing staff recalled a minimum of two occasions where a mock cardiac arrest scenario had taken place and the cardiac alarm had been triggered as part of a training exercise. They said this was a good learning experience because they had to take action, not just talk about what they would do in theory. These sessions were overseen by the intermediate life support (ILS) trainer.
- Two theatre staff were trained in advance life support (ALS) but were not always on duty. One member of staff was waiting to attend advanced life support (ALS) training but the courses were full and she was hoping to attend next year.
- There was an 'employee compliance' member of staff responsible for monitoring consultants' revalidations requirements, information commissioner registration and disclosure and barring status. A compliance tracker was in place.
- The hospital told us they had moved from the use of a paper based appraisal to an on online system which had impacted on their ability to demonstrate completion of appraisals as well as on-going appraisal reviews throughout the year. One manager told us they had just started to put a process in place to address this, including providing appraisal training to four senior staff.
- There was an online and telephone BMI service in place to support the full range of human resource enquiries and provide support for managers.

Multidisciplinary working (in relation to this core service only)

- There were daily meetings in the local areas at 8.20am and these fed into the communication meetings, referred to by hospital staff as comm cells, at 10am. Comm cells were held in the boardroom and attended by the heads of departments (HoDs) with representation from a nurse in charge of each area.
- We looked at the comms cell boards in the board room and in theatres. In the board room there was a resource planner showing which comm cell leads, HoDs, were on site. There were key messages to cascade and some safety and governance information, detailed in the relevant areas of this report.
- Each theatre also had a huddle prior to starting their list. There was a communications book where important messages including any actions from the 8.20am brief were noted for all staff to read. Information around new policies, agency staff and any incidents or complaints was also noted in the book which was kept in an area accessible to all staff.
- Shift handover on the ward occurred at 7.30am, 1.30pm and 9pm when the shifts changed. There was also a mid-morning meeting once all the morning admissions had come in, where patients' status and the allocation of beds were updated.
- There were systems in place which facilitated links between the different staffing disciplines as and when required, for example set criteria as to when a referral to a dietician was made. The dietetic service was outsourced and the dieticians worked for a neighbouring trust. They saw patients either on the day of referral or within one working day.
- Physiotherapy services were provided on the hospital site for patients following treatment. This was provided from a third party provider with formal service level agreements in place.
- There were different regular link meetings covering topics including health and safety, blood transfusion, medicines, pathology, resuscitation, medical gases and fire safety. These were either bi-monthly or quarterly. The relevant link nurse, who could be a junior or senior member of staff, fed back to the comm cells and from there information was passed to the wider team. Staff were unclear how often unit meetings were held on the wards.
- Some staff had the opportunity to spend time working in different areas within the hospital, for example two members of the ward staff had gained experience of venepuncture in the pre-operative clinic which they did not get the opportunity to do on the ward. This was described as a positive experience because it enabled staff to gain an understanding of the whole patient journey, from pre-op through to recovery.

- The newly appointed manager had begun to meet with other providers to establish links to share practise and improve communication.

Seven-day services

- It was a requirement of BMI Healthcare's practising privileges policy that consultants who had inpatients at the hospital remained available by telephone and, if required, in person. If a consultant were to be unavailable they were required to arrange appropriate, alternative, named cover. This included remaining in theatre to recover patients and attend the patient on the ward.
- The hospital had a 24/7 physician on-call rota, fulfilled by consultants who were available to review all patients and accept medical admissions on a daily basis. This rota was held by the on-call head of department (HoD) as there was a dedicated medical admission phone carried by the HoD on call 24/7.
- There was no formal arrangement in place to ensure out of hours cover from anaesthetists however there was an informal agreement with consultants to ensure that there was 24/7 cover and support.
- The on site registered medical officer (RMO) was on site 24/7 and would contact a patient's consultant to discuss any concerns.
- The hospital had a pharmacy on-site open from 8.30am to 4.30am on Monday to Friday and from 9am to 5pm on Saturday, depending on the workload.

Access to information

- Information needed to deliver effective care and treatment was available to the relevant staff. We saw evidence of risk assessments, care plans and test results in the patient case notes which were accessible to staff.
- We saw evidence of timely letters to the patients' GPs on discharge.
- Policies and procedures could be accessed by staff on the hospital's intranet pages.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs)

- The Royal College of Surgeons advise that patient's consent be taken prior to surgery ensuring the patient has sufficient time and information to make an informed decision. The specific timing and duration of the discussion should take into account the complexity and risks of the proposed procedure. A patient's consent should not be taken in the anaesthetic room.
- The BMI corporate policy did not specify a time period as to when consent should be obtained, other than that a consent form properly completed and signed, by the responsible clinician and the patient, must be available in the notes prior to the patient leaving their room for surgery or other invasive procedure for which written consent is required.
- Staff referred to a two stage process, with stage one referring to the provision of information prior to admission, and stage two being a written consent form as above.
- All clinical staff who took consent as part of their role completed a consent module as part of their mandatory training. 88% of staff had completed this training. All staff received training on the Mental Capacity Act and deprivation of liberty safeguards (DoLS) as part of the safeguarding vulnerable adults module of mandatory training.
- All 11 patient records we reviewed had signed consent present in the notes. Of these, two had their consent taken prior to admission to hospital, with the other nine having given consent on the day of surgery. Two further records reviewed in theatre showed one patient who had given consent in outpatients prior to admission, and one patient who had given consent on the day of surgery.
- We reviewed a consent form in the anaesthetic room which did not have the patient's ID number documented. This was added by a nurse in our presence. A second consent form we reviewed, completed on the day of the procedure, had not been dated by the patient.
- We asked one of the nursing staff how they would manage a patient with dementia or a patient on a DoLs order. She was able to give good, appropriate examples, detailed later in the responsive section of the report.

Are surgery services caring?

Good

We found surgical services were 'good' for caring because:

Requires improvement

Surgery

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect.
- Patients were supported, and were involved in planning their treatment and care.
- Patients understood their treatment and, where applicable, were informed of any associated costs prior to treatment.
- Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- The hospital sought feedback from patients about the service using a BMI questionnaire and the NHS friends and family test. The results were consistently positive as over 98% of patients said they would recommend the hospital as a good place to go for treatment.

Compassionate care

- We observed staff treating patients with care and compassion. We saw nursing staff interacting with patients, showing them the call bell and providing information about eating, drinking and the discharge process. Staff introduced themselves when speaking with patients.
- We saw staff knocking on patients' doors before entering their room, and being respectful of patients' privacy and dignity.
- Staff asked patients how they were feeling and whether they had any pain. Patients and relatives told us they felt "looked after" by the staff who "made an anxious situation more relaxing".
- There were postcard patient satisfaction questionnaires, as well as a more detailed questionnaire for inpatients, available to patients in their rooms.
- Both negative and positive comments were discussed at daily communication cell meetings. The monthly patient satisfaction report was reviewed at the heads of department (HoDs) meetings and recorded within the clinical governance reports.
- The hospital collected friends and family test data for NHS inpatients. In April 2016, the hospital achieved a response rate of 75%, of which 98% of patients would recommend the hospital. Between October 2015 and March 2016 a satisfaction rate of 99% or 100% was consistently achieved, and response rates rose steadily each month, from 26% in October 2015, to 75% in March 2016.

Understanding and involvement of patients and those close to them

- One patient we spoke with said they had been attending the hospital for several years and the staff had been "brilliant". All patients we spoke with had been given all the information they needed and said they understood everything that was happening.
- Patients told us staff came into their rooms at least hourly to check and they only needed to use the call bells at night. When they did use the bell, staff attended promptly.
- A private patient we spoke with said they could have chosen any hospital, but picked this one because they had been before and like it. Costs had been clearly explained prior to treatment.

Emotional support

- If staff felt a patient needed counselling services they would provide information as to how the patient could access these. There was no specific provision of counselling, however we observed staff behaving in a warm and supportive way.

Are surgery services responsive?

Good

We found surgical services 'good' for responsive because:

- The booking system for patients to be treated was flexible.
- The hospital had an admissions policy which detailed criteria for patients who could be safely treated at the hospital.
- An interpreting service was available for patients who did not speak English and staff could access patient information sheets in different languages.
- There was an open visiting policy within the hospital.
- Patients' needs were assessed though the use of a range of BMI clinical pathways, which included the use of a pre-operative assessment health questionnaire.
- Patients were given opportunities to feedback on the care they received and we saw evidence that patient feedback was acted on.
- Patients agreeing to undergo cosmetic surgery could change their minds and cancel the procedure at any point prior to the commencement of surgery.

- Reasons for cancelled operations were not being investigated consistently, so there was no learning or actions in place to prevent the same issues recurring. This included the lack of a standard operating procedure for consultants confirming their booked theatre slots, and miscommunication with the arrangements for anaesthetists.

Service planning and delivery to meet the needs of local people

- The booking systems were conducive to patient needs in that there was some opportunity for patients to select times and dates for appointments to suit their family and work commitments. NHS patients used the 'choose and book' system, and private patients booked through a national enquiry centre.
- The hospital worked with local NHS commissioning organisations to plan the services needed in local area.
- Every Thursday there was a scheduling meeting attended by the contracts manager, reservations supervisor, a senior member of staff from theatres, operations manager and executive director. The consultants' 'wish list' was discussed and theatre slots were booked in for the following week. The booking list was made available to consultants to promote any empty slots and make best use of theatres.
- National waiting time indicators for referral to treatment (RTT) were below the 90% indicator outlined by NHS England for admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 2015 to March 2016).
- There were 'spot contracts' in place, for example waiting list initiatives for trauma and orthopaedic patients from Tameside and Glossop. NHS patients came in under current spot contracts and for hernias, but there were no NHS cardiology patients.

Access and flow

- In the provider information return (PIR) BMI The Highfield Hospital reported they had cancelled 114 procedures for a non-clinical reason in the last 12 months; of these 92 patients were offered another appointment within 28 days of the cancelled appointment.
- The PIR stated there had been a number of cancellations at different stages in the patient pathway. This included NHS and private patients, and had been highlighted through the incident reports and patient feedback via complaints. The cancellations were for a variety of reasons but these had not been consistently communicated to all areas.
- We saw the list of incidents related to cancelled procedures and noted some common themes, particularly around equipment issues, staffing problems and a breakdown in communication between the consultant, hospital and patient. We asked the deputy theatre manager how these themes were addressed but she told us the incidents were dealt with on a case by case basis and was unable to provide examples of changes to practice resulting from investigation into cancelled procedures.
- As described earlier in the report, there had also been problems with the arrangement whereby the consultants booked their own anaesthetist. There had been occasions when the anaesthetist had not arrived or the consultant had not informed the hospital they were on leave so they had been booked onto the schedule. There was no formal standard operating procedure in place for consultants confirming their theatre slots.
- There were two wards at the hospital, Cedar and Linden. Cedar ward had 17 beds in individual rooms although on the first day of our inspection none of these were in use. Linden ward had a further 41 beds. There was some crossover between the wards in terms of staffing, dependent on the number and status of patients on a given day. This allowed for some flexibility as staff helped with admissions or moved into an area where more support was needed.
- Daily bed meetings were held where admissions and flow were discussed and staff allocated to areas dependent on where they were needed. Day patients were only cared for upstairs on Cedar ward when Linden ward, downstairs, was full.
- The exclusion contract criteria for NHS patients were clearly laid out. These included no patients under the age of 18, no patients with a body mass index (BMI) exceeding 40, no patients with an incapacitating disease that posed a constant threat to life, patients who had previously experienced an adverse reaction to anaesthetics or patients who were undergoing treatment for a mental health condition.
- These exclusions were based on the American Society of Anaesthesiologists (ASA) physical status classification system. ASA level one patients are healthy, non-smoking

with no or minimal alcohol use. ASA level two patients are those with mild diseases only without substantive functional limitations. ASA level three patients have substantive functional limitations with one or more moderate to severe diseases. The hospital did not accept patients with a higher classification than ASA level three and the majority undergoing surgery were ASA level one or level two patients.

- For private patients these criteria did not automatically apply and decisions were made on a case by case basis although there was a minimum age of 16 years.
- Consultants sent booking forms direct to the reservations department who entered the details onto an electronic system and made pre-assessment and MRSA screening appointments.
- There was no specific policy in place which stipulated time scales for a 'cool off' period where cosmetic surgery was booked, but the hospital told us patients could cancel the procedure at any time prior to the commencement of surgery.

Meeting people's individual needs

- Patients' needs were assessed though the use of a range of BMI clinical pathways, which included the use of a pre-operative assessment health questionnaire.
- Staff were aware of how to book an interpreter and regularly did so.
- Where a patient was known to have dementia prior to being booked in to the hospital they would be asked to attend for an assessment with a nurse who decided whether or not the booking was suitable. There were case by case assessments for patients with known risks.
- In the patient led assessment of the care environment (PLACE) published in August 2016, the hospital site scored less (65.99%) than the organisational average (78.69%) for a dementia friendly environment.
- We asked one of the nursing staff how they would manage a patient with dementia or a patient on a DoLs order. They were able to give good, appropriate examples of how these patients were managed including completion of a risk assessment for dementia, caution about using bed rails and nursing in front of the nursing station as doors were not locked. They only had experience of one such patient and they had a carer with them but they knew there was a different process around consent and that extra precautions needed to be taken.
- They also knew that confused patients may be distressed and that certain drugs could cause confusion. A falls assessment would be completed for confused patient who may try to get out of bed. They had completed an online dementia course as part of mandatory training and showed good awareness.
- There was an open visiting policy at the hospital.

Learning from complaints and concerns

- There were 68 complaints in the surgery division between April 2015 and March 216. None of which were referred to the Ombudsman.The hospital used a BMI group wide policy for handling complaints. Patient complaints followed a three-stage process. Stage one involved an investigation and response by the hospital within 20 days. Stage two was a review by BMI's central or regional staff of the complaint and how it had been handled at stage one, also within 20 days. Stage three was an independent investigation by the Independent Sector Complaints Adjudication Service (ISCAS) for fee-paying patients, or the Parliamentary and Health Service Ombudsman (PHSO) for NHS patients.
- However, there was no analysis of the themes of complaints and limited evidence of wider sharing of learning from complaints.
- We saw evidence that the hospital were working to improve their response to complaints. The MAC minutes from January 2016 included a discussion around patients complaining that the cost of extra charges for their treatment was not clear. A completed action from this was to display a list of costs in consulting rooms. We saw these in place.

Are surgery services well-led?

Requires improvement

We rated surgical services as 'requires improvement' for well-led because:

- Frequent changes to leadership across the theatre departments and the change in hospital manager had led to a lack of direction for staff.
- There was no strategic oversight of incidents so lessons were not always learned from these. Communication and sharing of action plans had been identified by the hospital as a problem. Communication meetings

(comms cells) had been introduced to improve this, but at the time of our inspection the comms cell risk information was incomplete and staff were unaware of the top risks.
- Senior staff had not seen a risk register at the hospital.
- There was a risk assessment folder on Cedar ward, however this included several expired review dates and some incomplete assessments.

However;

- The new executive director was working to swiftly address many of the issues identified in the inspection and to make improvements they had already identified.
- There was an experienced medical advisory committee (MAC) chair who was able to give examples of how the committee monitored and influenced clinical practice.
- Private patient reported outcomes collection for the private healthcare information network (PHIN) had commenced and covered hip, knee, hernia and cataract surgery.
- All the staff we spoke with felt supported by managers, and were positive about their roles and about working at the hospital.

Vision and strategy for this this core service

- There was a BMI group corporate vision in place which focused on delivering the best patient experience, best outcomes and being cost effective. The hospital's vision was "to be seen as an important part of the local community, delivering high quality healthcare in innovative ways that benefit the health economy".
- Staff were aware of the BMI vision and had seen it in the newsletter and on posters on the wall.
- The MAC chair and the deputy theatre manager both identified changes to leadership, agency staffing and equipment problems as the three biggest issues in theatres.
- The newly appointed hospital manager had been part of the BMI group for a number of years so was fully aware of the BMI vision and was working with their senior team to look at ways the hospital vision could become embedded throughout the department.

Governance, risk management and quality measurement for this core service

- There were a number of governance sub-committees including medicines, infection prevention and control and resuscitation and critical care that reported to the hospital clinical governance committee. A fire safety group and medical gases group reported to the hospital health and safety and environment committee.
- The medical advisory committee (MAC) was held on a monthly basis We met with the chair who worked at the hospital two half days per week, and one further half day each fortnight. He said when consultants wanted to bring in new procedures they wrote a letter to the MAC where it would be discussed. The MAC members considered the pros and cons of the proposed change including the financial and equipment implications. He provided an example of such a proposal and explained why they had refused it. He acknowledged the minutes taken at MAC meetings were not timely and were not as comprehensive as they should be. Not all discussions were documented.
- The MAC chair said the 'full circle of learning' was only just beginning and that communication was a major problem at the hospital although the heads of departments (HoDs) comm cells were starting to address this..
- Representatives from the different specialities were members of the MAC but did not always attend. The BMI approach was that a member attend the MAC for three years which could be extended to a further two. After that membership was considered on a year by year basis. The chair said if that approach was taken at Highfield there would be no-one on the MAC.
- Information provided by the hospital said an action plan had been put in place to form a restructured governance team that was working towards ensuring a more timely response was made to incidents and complaints, lessons were learned from these and action plans were put in place and shared amongst teams where relevant. These actions included the daily 10am communication meetings, referred to by staff as comm cells. They were attended by the HoDs with representation from a nurse in charge of each area.
- The comms cell board in the boardroom had some items listed for 'risk awareness' but none had a name in the 'who' column or a completed due date.
- We observed a theatre brief held at 8.20am and led by the deputy theatre manager. This was attended by ten members of staff and a number of issues were discussed including problems with equipment,

mandatory training and the current top ten risks which staff told us were discussed daily. However, when asked individually, none of the staff present could articulate what the top ten risks were.

- We looked at the comms cell notice board in theatres which included key messages to cascade. Issues were recorded using the "three cs" which represented concern, cause and countermeasure. Three senior staff we spoke with knew about the three cs but did not know what they stood for.
- One of the risks identified on 9 May, 2016 was that equipment on the asset register was out of date (concern). The cause was recorded as the service agreements, and the countermeasure was described as "out of date service equipment" which had been marked as "problem eliminated". However, as described earlier in the report, this problem had been neither addressed or eliminated at the time of our inspection three months later.
- Other notices on the board were incomplete, including a daily log for planned, actual, cancelled and 'did not attend' (DNA) patients to theatre. This sheet was blank until 18 August, 2016, the day of our unannounced inspection.
- There was a BMI clinical governance bulletin that was discussed at the hospital clinical governance committee. The MAC chair had attended this because the appointed consultant was too busy to attend but said he should not be the representative as he was already chairing the MAC.
- Neither the MAC chair or the ward manager had not seen a risk register at the hospital. We reviewed a risk assessment folder on Cedar ward. Several had expired review dates dating back as far as March 20014. Not all risk assessments had review dates, and some assessments were not fully completed.
- The private healthcare information network (PHIN) has had a legal mandate since April 2015 to work with all hospitals to publish information about specified performance measures for consultants and private hospitals. Private hospitals were required to start submitting data no later than 1 September 2016. BMI Highfield told us BMI Healthcare have worked alongside PHIN for the past two years to be in a state of readiness to submit data by September 2016. Private patient reported outcomes collection had commenced and covered hip, knee, hernia and cataract surgery. This will enable effective comparison with data available from NHS providers to assist with information transparency and, in turn, patient choice.

Leadership / culture of service related to this core service

- The newly appointed hospital manager had recently appointed a number of staff to the senior leadership team. A new theatre manager had also been appointed and was to start in the Autumn.
- All the staff we spoke with were positive about their roles and about working at the hospital. The deputy theatre manager told us her team's strength was that they were dedicated, flexible staff who worked very hard. Sometimes they were "juggling or fire fighting" but they were good at it and at times had come in from annual leave to meet the needs of the service when necessary. They were proud of this.
- This was reiterated by nursing staff on the wards who said that staff always helped each other out, even when work was stressful. There was a culture of collaborative working, with staff supporting each other. When rotas were planned, staff preferences were considered where practicable and there was a system in place for making shift requests when staff had outside commitments.
- Ward staff told us they felt supported by their managers. There was always a senior nurse on duty so someone was always available if staff needed help or advice.
- The executive director and director of clinical services completed monthly leadership walkabouts.
- One concern raised by a member of staff was that there had been "too much change too quickly". The executive director, senior nurse director of operations and theatre manager had all left in the last few months which was unsettling for staff.
- We spoke with one member of staff who felt encouraged to contribute to improvements in the service. She was involved in some activity around dementia care outside of the hospital and had taken some of the suggestions and ideas into work. She was being supported by senior management to pursue this and had positive plans in place to improve dementia care at the hospital.

Public and staff engagement

Requires improvement

Surgery

- The annual staff survey (for the hospital) indicated staff were confident they could raise issues with their line manager without repercussions, and were committed to doing their best for BMI Healthcare.
- Consultant feedback about staff was positive as demonstrated at the May 2016 MAC meeting.
- There were some programmes in place to recognise staff achievements. An award was given to staff who had worked at the hospital for five years and they were treated to a meal for two by the hospital.
- There was an 'above and beyond' recognition scheme in place to reward staff for their actions when they had done something which stood out, or were mentioned by name in the patient surveys for three consecutive months. One staff member we spoke with had received a champagne lunch for two and on another occasion, a glass trophy. At the daily comms cell there was a chart for recording team successes which was then cascaded to relevant teams.
- Staff commendations were followed up with a personal note from the executive director.

Innovation, improvement and sustainability

- A new theatre senior had been recruited as endoscopy lead to develop an endoscopy team and infrastructure towards achievement of JAG accreditation over the next two years.
- An application had been submitted to purchase reporting software and electronic traceability to help in evidencing their effectiveness.

Good

Outpatients and diagnostic imaging

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

Information about the service

BMI The Highfield Hospital provides outpatient consultations and minor surgical procedures. Outpatient clinics cover a wide range of specialities including orthopaedics; general surgery; gynaecology; urology; gastroenterology; ophthalmology and ear, nose and throat. The hospital provides services for patients over the age of 16. The hospital has an outpatient suite with 12 consulting rooms and two treatment rooms, in addition to six consulting rooms in the main hospital building.

The hospital offers a range of diagnostic imaging services. The main hospital building houses plain film x-ray, mammography, and ultrasound. A magnetic resonance imaging (MRI) scanner is located in a separate building in the hospital grounds. A mobile computerised tomography (CT) scanner visits the hospital weekly. The CT scanner is operated by an external provider; however images are reported by radiologists at the hospital.

Between April 2015 and March 2016, there were 14,940 outpatient appointments. The hospital treats both fee-paying patients and accepts NHS appointments where commissioning arrangements were in place for outpatient and diagnostic imaging services.

We carried out an announced inspection at BMI The Highfield Hospital on 2 and 3 August 2016. We also carried out an unannounced inspection on 18 August 2016. We spoke with 11 staff, including nursing staff, doctors, support and administrative staff and allied health professionals. We also spoke with two patients or their relatives who were using the services at the time of our inspection and reviewed 17 sets of patient records.

Summary of findings

We rated outpatients and diagnostic imaging as good overall because:

- Incidents were reported and learning was shared. Risks to patients were assessed and managed safely.
- Care and treatment was provided using evidence based guidelines, backed up by local policies and procedures. Staff were supported to develop their skills and knowledge.
- Staff were kind and caring and took time to provide additional support to nervous patients.
- The hospital met the 18-week target for incomplete pathways and waiting times for diagnostic imaging were low.
- There was a positive and open culture. Staff felt supported by their immediate managers.

However,

- We rated well-led as requires improvement because governance systems were not operating effectively at the hospital. The senior leadership team was new in post at the time of our inspection.
- The medical advisory committee did not receive sufficient information about key issues such as incidents and complaints or learning from these.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- Incidents were reported and learning was shared. Staff understood the importance of being open and honest and the duty of candour.
- Equipment was checked, serviced and maintained correctly. The environment was visibly clean and tidy with completed cleaning schedules and there was sufficient access to personal protective equipment to prevent the spread of infection.
- Medicines were stored securely and managed appropriately. Patient group directives were in place and up to date where required.
- Staff knew how to respond to deteriorating patients. Training, systems and processes were in place to ensure risks to patients were minimised.
- There were no vacancies for nursing or allied health professional staff. Bank workers were used to supplement the establishment and add to the skill mix. Bank workers were inducted to departments appropriately.

However;

- There were no hand washing facilities in the ultrasound room and the chair in this clinical area could not be cleaned following patient consultations. We raised our concerns during the inspection and were told that consultants washed their hands in the room opposite before and after procedures.When we returned we saw that immediate action had been taken in relation to the chair and that it had been replaced.
- A medication fridge was being used to store blood products awaiting collection. When we returned on our unannounced inspection we were told that a second fridge was in place..
- Records used in the outpatient department did not contain full details of patients' medical history. This posed a risk that treatment could be unsafe or inappropriate.
- There had been no audit of the use of the World Health Organisation checklist in diagnostic imaging since September 2014.
- Mandatory training figures including adult and child safeguarding courses were lower than the hospital target.

Incidents

- The hospital used a BMI group-wide incident reporting policy. We reviewed the policy which included guidance on what to report as an incident and how to investigate an incident.
- Incidents were reported on paper report forms and were categorised as clinical and non-clinical. Incidents were logged on an electronic system by a head of department. There had been 353 clinical incidents and 20 non-clinical incidents reported by outpatient and diagnostic imaging services between April 2015 and March 2016.
- Staff could describe the process for reporting incidents and gave examples of incidents they had reported. In the outpatient department, staff told us there were few incidents, but they were able to give us examples of what they may report as an incident how they would report this to their manager. In diagnostic imaging, staff were aware of their responsibility to report radiation incidents to the radiation protection advisor and to CQC.
- Learning from incidents was discussed at 'comms cell' meetings which took place every morning in the outpatient department. We also saw that learning from incidents was displayed on 'comms cell' boards in the areas we inspected.
- Incidents and learning from incidents was discussed at clinical governance committee meetings. We saw evidence in the minutes we reviewed that individual incidents and the number of incidents were discussed each month.
- Staff were aware of a recent incident involving repeated exposure to radiation (where an x-ray examination was completed twice) and we saw that this was discussed in relevant forums and actions were listed. However, actions had not been fully detailed or evidenced on the incident reporting system which meant that there was insufficient monitoring of the progress of this incident and associated actions.

Duty of Candour

- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety

incidents' and provide reasonable support to that person. The incident reporting policy used by the hospital set out the principles and requirements of the duty of candour. Staff understood the principles of being open and honest if an incident occurred in the department and duty of candour training was planned for September 2016.

Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean and tidy. All of the rooms in outpatients we visited had completed cleaning schedules on the doors, which set out daily cleaning tasks to be completed by housekeeping staff. The cleaning schedule in one of the rooms had not been completed and signed on the day of our inspection although we saw the room to be visibly clean and tidy.
- In addition to the daily cleaning schedule, staff in the department cleaned consulting rooms between clinics when they were used by more than one consultant during a day. While the department kept a cleaning rota to record the cleaning between clinics, it had only been completed for one day of the week before the inspection. This meant that the service could not be assured that the consulting rooms were cleaned before each clinic.
- Each of the consulting and treatment rooms had separate bins for clinical and general waste. The rooms also had bins for collecting sharps, which had been changed within the week before the inspection. Staff told us that the curtains in the consulting and treatment rooms were changed every three months; all of the curtains we checked had been changed within the previous month.
- In diagnostic imaging, staff cleaned equipment and surfaces in between patient contacts. Additionally there were procedures for cleaning at the end of the day and a six monthly deep clean scheduled.
- The hospital used a group-wide hand hygiene policy. We reviewed the policy which set out when and how staff should clean their hands. Alcohol hand gel and hand washing instructions were available in a number of places in waiting areas and in every consultation room. There was a poster in the entrance of the outpatients department telling visitors to use hand gel. There was access to personal preventative equipment such as gloves and aprons to prevent the spread of infection.
- The imaging team had an infection prevention and control (IPC) link staff member to lead on IPC issues and audits.
- We saw that there was no hand washing sink in the ultrasound room where patients underwent invasive procedures such as biopsies and fine needle aspiration. Staff told us radiologists washed their hands in the room opposite before and after the procedure. We also noted that the chair in this room could not be wiped down in order to prevent the spread of infection. When we returned on our unannounced inspection we saw that this chair had been replaced.

Environment and equipment

- Resuscitation equipment for adults was available at the bottom of the stairs in the outpatients department. The equipment was in a grab bag which could be quickly transported to the first floor of the building. The bag had been checked in line with hospital procedure and was tagged with a tamperproof seal.
- In the MR department, the resuscitation bag could not be used within the MR scanning room. We saw that this was clearly labelled on the bag and there was a clear procedure in place to move a patient from the scanning room to a safe area.
- We checked the resuscitation equipment in outpatients and in the MR department and saw that it had been checked on each day the departments had been open in line with local policy. The bags were sealed with a numbered tag to enable staff to identify if the bag had been tampered with.
- All equipment we checked had been maintained correctly and was clearly labelled with the date that the next test or service was due. Although physiotherapy at the hospital was offered by an external provider, BMI The Highfield was responsible for maintenance of the equipment and facilities. We saw that all equipment in the physiotherapy department had been serviced and tested within the last six months.
- Daily quality assurance checks were completed on the MRI scanner to ensure the scanner was working correctly.
- Exposure to radiation was audited in the imaging service. Staff wore devices to monitor radiation levels and the results were received fortnightly. Sufficient numbers of lead jackets and thyroid protectors were available to protect staff from radiation and these were

checked bimonthly to ensure the integrity of the protective materials. Access to non-ionising radiation areas was restricted and warning signs were displayed on doors.

- The Patient Led Assessment of the Environment (PLACE) is a measure of the care environment in hospitals which provide NHS care. The assessments see local people visit the hospital and look at different aspects of the care environment. The PLACE score for the hospital between February and June 2015 for privacy, dignity and well-being was 84%, slightly below the England average for independent hospitals which was 87%.
- In the radiology department, there was no single sex changing area. However, there was a policy in place to prevent the changing area being used by both male and female patients at the same time to preserve privacy and dignity as far as possible.

Medicines

- Medicines in the outpatient and imaging departments were stored in locked, secure cabinets. Access to the medicines was restricted to authorised staff only. We reviewed a sample of ten medicines in the outpatient department which were all within the manufacturers use by date.
- Staff told us that the stock of medicines in the outpatients department was checked weekly by a senior nurse, who would re-order any drugs they needed from the hospital pharmacy.
- Medicines which were required to be stored at a lower temperature were stored in a fridge in the outpatients department. We saw evidence that daily temperature checks of the fridge and the ambient room temperature were recorded. While the temperatures were recorded daily, the thermometer was not reset every day and at the time of our inspection the maximum temperature was higher than the maximum it should be. This meant that the service could not guarantee that the temperatures were being stored at the correct temperature. During our site visit we notified the service and a new fridge was placed on order.
- Staff told us that the fridge used for medicines was also used to store blood samples overnight before they were collected by a courier to be sent off-site. The use of the fridge for anything other than storing medicine increased the risk of cross-contamination or infection. During the inspection we notified the service and when we returned on our unannounced inspection an alternative fridge was in place.
- We saw that prescription pads were stored in the medicines cabinet which was securely locked. Prescription sheets were numbered and staff told us that consultants requested access to the cabinet.
- The hospital had a pharmacy on-site open from 8.30am to 4.30am on Monday to Friday and from 9am to 5pm on Saturday depending on the workload.
- Patient group directives (PGDs) were in place in radiology to allow contrast media to be administered by injection. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription.

Records

- The hospital had identified a weakness in the medical record system at the hospital in the provider information return. Some consultants held their own medical record and although they shared key pieces of information for inclusion in the hospital held record, this was not full details of all consultations. This meant that the hospital medical record did not contain the full patient history and posed a risk that key information may be missed during appointments with other consultants at the hospital or as part of the person's inpatient admission. At the time of our inspection, the hospital medical records team were working with the medical secretary team to merge hospital records with consultant held outpatient records. Once this work was completed, the hospital would hold a full medical record for each patient.
- We reviewed 10 sets of the hospital medical record for patients who had had procedures or appointments in the outpatient departments. While all of the records we reviewed were clear, legible and signed, three of the records did not contain the letters sent by the consultant to the patient's GP following a consultation. This meant that there was a risk that someone reviewing the record would not have a full picture of the patient's clinical history.
- We reviewed seven records from the diagnostic imaging department. Records were legible and signed, although they did not always contain justification for the examination on the paper based record.

Good

Outpatients and diagnostic imaging

- In the outpatients department records were stored in locked cabinets in the reception area. Medical records for patients who had visited the hospital before were retrieved from the medical records department ahead of an appointment.
- Images were stored electronically on a picture archiving and communication system (PACS).
- There is a risk that care and treatment may be unsuitable or unsafe if there is not access to a full medical record. Information provided by the hospital showed that 0% of patients were seen without their full medical record being available. However, staff in the outpatient department told us there was no formal monitoring of the numbers of patients whose records were not available at the time of their appointment and therefore there was no formal oversight to identify if this was an issue at The Highfield. They did however tell us it was rare that records were not available for appointments.

Safeguarding

- The hospital used a BMI group-wide policy for the safeguarding of vulnerable adults. We reviewed the policy which set out the types of abuse which staff should be aware of and look out for and what action staff should take, including honor based violence and female genital mutilation (FGM).
- The hospital training schedule stated that all staff must complete level one adult safeguarding training as part of their mandatory training all clinical and management or supervisory staff should complete level two. Ninety-two percent of staff at the hospital had completed level one training which met the hospital target of 90%. Level two training figures were below target at 83%. Level three training had been completed by 100% of relevant staff.
- Although the hospital did not accept patients under the age of 16, staff were expected to complete training in line with intercollegiate guidance on safeguarding children. At the time of our inspection, training figures were below hospital target at 89% for level one and 83% for level two training. All relevant staff had completed level three training.
- Staff understood their responsibilities in relation to safeguarding and gave us examples of safeguarding concerns which they had identified and raised.
- Staff in the imaging department often worked alone in the evenings due to the small size of the service. There was a lone working policy in place and access to the nurse in charge on the ward if required.

Mandatory training

- Nursing staff and health care assistants were required to complete mandatory training modules which were relevant to their role. Mandatory training modules included infection prevention and control, safeguarding, life support and 'Prevent'. Prevent was a special module looking at risk posed to individuals at risk of radicalisation. Training was delivered through a mixture of online learning using the BMI online learning package (BMI Learn) and face-to-face sessions. Each staff member was given a log-in to BMI Learn which assigned the mandatory training specific for their role.
- Consultants were expected to complete mandatory training modules either at their employing NHS trust or at the hospital if they undertook solely private work.
- BMI set a target for 90% of staff to complete the mandatory training for their role. On 1 June 2016 the completion rate for mandatory training across the hospital was lower than this target at 83%.

Assessing and responding to patient risk

- Staff in the outpatients department knew how to respond if patients became unwell. If a patient became unwell they would contact the resident medical officer (RMO), who was on site 24 hours a day. If a patient had a suspected cardiac arrest a bleep was sent to 2222 and the cardiac arrest team would go to the department. During our inspection we saw the bleep system being tested. Staff told us that they would also call 999 at the same time so an emergency ambulance could attend. We saw evidence in the incidents we reviewed that this procedure had been followed appropriately in the outpatient department.
- All nursing staff in the outpatients department had received training in adult immediate life support and acute illness management (AIMS). Two staff were also trained in advanced life support.
- Staff in the diagnostic imaging department asked patients if they were pregnant or if there was a chance they could be pregnant, including confirming the date of the last menstrual period if appropriate.

Good

Outpatients and diagnostic imaging

- Patients listed for an MR scan were given a questionnaire to ensure it was safe to enter the scanner. Additionally, a blood test was taken if patients required a contrast agent during the procedure to reduce the risk to patients who may be at risk from this agent.
- We saw that the imaging department had local rules for the imaging rooms and the mobile x-ray machine, which is in line with Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. This reduced the risk of equipment not being used properly.
- In the MR department, the RMO attended to administer contrast media and remained in the department for an appropriate period of time to monitor for any adverse reaction. MR radiographers were trained in immediate life support and there were always two members of staff present when using any form of contrast media to enable a safe response in the event of an emergency.
- Although waiting times for diagnostic imaging were generally very low, the departments were able to prioritise patients based on clinical need. As there was no static CT scanner on site at the hospital, inpatients or outpatients who required an urgent CT scan were referred to another BMI site within the Greater Manchester area to receive this in a timely way.
- There was a red flag protocol in place for use by reporting radiologists. This protocol was used when there were cancer and unexpected non-cancer findings to ensure results were communicated quickly to the referring consultant.
- Where invasive procedures were used in the imaging department, the World Health Organisation (WHO) safer surgery checklist was used. This included procedures such as fine needle aspirations, arthrograms and biopsies. However, there had been no audit of the use of this checklist since September 2014 and no action place was developed following this despite compliance results being 60% at this time. The imaging lead told us that BMI corporate directive was that an audit should be undertaken monthly from October 2016.The diagnostic imaging service carried out imaging on 16 and 17 year old patients only following completion of a risk assessment.
- There was a radiation protection committee in place at the hospital with a named radiation protection supervisor and an allocated radiation protection advisor.

Nursing staffing

- There was no set guidance for safe staffing levels in the outpatients department. Staffing requirements were planned in line with the number of clinics running and patients attending. Data submitted by the hospital identified that as at 1 April 2016 the outpatients and imaging departments employed four whole time equivalent nurses and 4.8 whole time equivalent health care assistants.
- On a usual day the outpatients department would have one nurse on duty and three health care assistants in the morning with an extra healthcare assistant in the afternoon when the department was busier. As well as the outpatient clinics, staff covered pre assessment clinics which took place in the same building. The staff list was reviewed ahead of the week to identify clinics which may require more staff, so the rota could be amended.
- Bank registered nursing staff had been used in outpatients in only one month between April 2015 and March 2016. The outpatients department used bank health care assistants to supplement the staffing establishment more regularly. Between April 2015 and March 2016, the use of bank health care assistants was generally below the average of other independent acute hospitals at 6.8%. Bank staff undertook a specific departmental induction and e-learning modules which they needed to complete before working within the outpatient department.

Medical staffing

- There were 248 consultants operating under practicing privileges at the hospital.
- The hospital had a registered medical officer (RMO) on site 24 hours a day who could provide medical support to the outpatients and diagnostic imaging departments. The provision of RMOs was outsourced to an external company.

Allied health professional staffing

- The hospital employed six staff in diagnostic imaging including two MR radiographers and two general radiographers. There was also access to three bank radiographers and a bank sonographer to supplement the establishment and add to the skill mix.
- Bank radiography staff were expected to complete a local induction before starting work at the hospital. We saw that these had been completed appropriately.

Good

Outpatients and diagnostic imaging

Major incident awareness and training

- The hospital had business continuity plans to be used in events such as loss of electricity, water or computer systems.
- We saw that the business continuity plans were accessible on the intranet page which staff had access to. Staff told us that a folder containing all of the business continuity plans was usually located in the main reception although at the time of the inspection it was being held by the executive director. Staff were aware of this temporary change.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

- Local policies and procedures were based on evidence and guidelines produced by Royal Colleges and the National Institute for Health and Care Excellence (NICE). Audits of care and discrepancy meetings were completed in the imaging department.
- The diagnostic imaging service was working towards the Imaging Services Accreditation Scheme (ISAS).
- The hospital operated an enhanced recovery model to improve outcomes for patients following surgery.
- Staff were supported in their personal development and attended both internal and external courses to develop their skills and knowledge.
- There was a BMI policy in place for granting and reviewing the practising privileges of doctors. Consultant files we reviewed contained details of medical revalidation and an up to date appraisal.
- There was good multi-disciplinary working between consultants, nursing staff and allied health professionals.

However;

- No registered nurses and only 33% of health care assistants had received an appraisal between October 2015 and June 2016. 75% of staff in the imaging department had received an appraisal.
- Staff we spoke to had an understanding of the need to consider mental capacity when taking consent but not all staff fully understood the processes required if a patient lacked capacity to consent for themselves.

Evidence-based care and treatment

- BMI wide policies and procedures referred to professional guidance and evidence-based care. For example, the chaperone policy referred to professional guidance from the Royal College of Nursing, the hand hygiene policy referred to World Health Organisation guidance and the safeguarding policy referred to national guidance from the Department of Health.
- Policies and procedures were in place locally in the imaging team in line with Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. There were guidelines in place for the use of contrast media and to reduce the risk of contrast induced nephropathy. These guidelines followed evidence-based practice.
- Radiologists working at the hospital followed the Royal College of Radiologists standards for discrepancy meetings. Discrepancy meetings are meetings where radiologists can learn from discrepancies or errors in reporting and improve patient safety.
- Staff in the imaging department used diagnostic reference levels to optimise radiation exposure. Optimisation refers to the lowest dosage of ionising radiation given to achieve the best diagnostic image.
- There was an established audit calendar in the imaging team including of the use the contrast media questionnaire, request forms and a reject image analysis. One in ten image reports were audited for their accuracy and quality. This was a requirement of one of the medical insurance companies whose patients accessed imaging at the hospital.
- Justification for exposure to radiation was not always documented in paper based diagnostic imaging records. In the seven paper records we reviewed, two records did not have a justification for the examination documented.
- The imaging lead told us that dose reference levels for hip and pelvis x-rays were higher than the national average and that further action was required. However, there was no formal action plan in place at the time of our inspection although we saw evidence of planned actions in the minutes of departmental meetings.

Pain relief

Good

Outpatients and diagnostic imaging

- Pain relief was not generally given in the outpatients department, unless it had been prescribed by a consultant.
- Local anaesthetic was administered to patients undergoing certain minor procedures in outpatients or interventional procedures in diagnostic imaging.

Patient outcomes

- The diagnostic imaging service was preparing to start the accreditation process offered by the Imaging Services Accreditation Scheme (ISAS). ISAS acts as a mark of quality and takes approximately 18 months to achieve. The service was working collaboratively with nine other hospitals to prepare for this accreditation.
- A reject image analysis was completed to identify the numbers of images rejected and the reasons that images were rejected with the aim of reducing the need for repeat exposure to radiation. The most recent audit in June 2016 showed that nine out of 314 images were rejected.
- The hospital operated an enhanced recovery model for patients listed for surgery. Enhanced recovery is a programme to improve patient outcomes and recovery following surgery and ensures patients receive evidence based care. This programme commenced in outpatients, preparing patients for surgery and ensuring their recovery was optimised.

Competent staff

- All contracted and bank staff completed a hospital induction before they could work in the outpatient department. This meant that all staff would be familiar with the working environment and local policies before they started work.
- The outpatients department held a record of all of the nursing and health care assistant staff competencies. This meant that managers knew which staff were competent to carry out which procedures. Staff told us that they worked in clinics they had the necessary skills for.
- Registered and unregistered staff told us they were encouraged and supported in their personal development by their managers including attending external courses to develop extended skills.
- There were clear competency based assessments for the use of different imaging modalities in the imaging team. These were completed for all staff members we reviewed.
- Staff in the imaging service told us that opportunities for training and development were good. They were able to access training externally and were also supported to continue further study at university.
- The hospital appraisal calendar ran from October to September. In the previous year 100% of health care assistants in the outpatients department had received an appraisal and 80% of nursing staff in the same period had an appraisal. In the current appraisal year, 100% of nursing staff and healthcare assistants had received an appraisal.
- All eligible staff in diagnostic imaging had received an appraisal during the current appraisal cycle. Staff who had received an appraisal told us the process had been positive and effective.
- There was a BMI policy in place for granting and reviewing the practising privileges of doctors. Practising privileges were only granted to doctors who were licenced, on the specialist General Medical Council register, held a substantive consultant post with the NHS within the past five years and demonstrated relevant clinical experience relating to practice. Where an applicant had not worked in the NHS within the past five years they would need to demonstrate experience in independent practice and a support network.
- The policy said that applications were reviewed by the Medical Advisory Committee with respect of the credentials, qualifications, experience, competence, judgement, professional capabilities, knowledge, and fitness to practice, character and confidence held on the applicant.
- The hospital was required to review practising privileges each year. For a doctor or dentist to retain practising privileges they were expected to demonstrate they complied with certain requirements. These included registration with the General Medical Council, evidence of insurance/indemnity from a medical defence organisation or insurer, and a current performance appraisal.
- We reviewed eight consultant files and saw that all eight contained details of medical revalidation and an up to date appraisal.

Multidisciplinary working

- There was a 'one stop shop' breast clinic at the hospital where patients were able to have mammography or ultrasound as well as seeing the consultant at the same appointment.

Good

Outpatients and diagnostic imaging

- Nursing and healthcare staff said that they worked well with consultants holding clinics in the outpatient department. Radiographers and radiologists told us they had good working relationships.
- Consultants told us that communication with nurses and allied health professionals was good.

Seven-day services

- The outpatients department was open from 8am to 7pm Monday to Friday with extended clinics until 9pm on some evenings. The outpatients department was closed on a Saturday and Sunday
- Standard opening hours at the MR department were Monday to Friday from 9am until 5pm. There was access to the other imaging services at the hospital between 9am and 8pm Monday to Friday with additional urgent access available via an on-call rota 24 hours a day, seven days a week.

Access to information

- All staff had access to a folder on the computer system in the department, so they could access local and group-wide policies and procedures. There was a computer terminal in the nurses' room which could be used to access the system. Staff showed us how to access policies relevant to their work.
- Radiologists were able to access images and report on them at other BMI sites. This allowed for more flexibility when reporting. Additionally, there was an image exchange portal that allowed radiologists to exchange images between the hospital and other local NHS trusts when required, for example if images needed comparing over time.
- Letters were sent to GPs following outpatient consultations informing them of the outcome of the appointment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All clinical staff who took consent as part of their role completed a consent module as part of their mandatory training. 88% of staff had completed this training. All staff received training on the Mental Capacity Act and deprivation of liberty safeguards (DoLS) as part of the safeguarding vulnerable adults' module of mandatory training.
- BMI had a group-wide policy for the gaining of consent before treatment, a procedure or investigation. We reviewed the policy which set out the criteria for requiring written or verbal consent. Most of the procedures carried out in the outpatients and imaging departments only required verbal consent, although we saw evidence of the use of written consent for procedures carried out on outpatients, such as a cystoscopy. Staff told us that consent for minor procedures was discussed and taken by consultants.
- The most recent audit of consent in March 2016 showed 95% compliance with the agreed standards.
- BMI had a group-wide policy which set out a summary of the Mental Capacity Act and Deprivation of Liberty Safeguards and the relevant considerations.
- Staff we spoke to had an understanding of the need to consider mental capacity when taking consent but not all staff fully understood the processes required if a patient lacked capacity to consent for themselves.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff were kind, caring and compassionate. They were sensitive in their communications with patients and understood and respected individual needs.
- Staff took steps to promote privacy and dignity. Patients told us they felt staff went above and beyond what was expected of them.
- Friends and family test results showed that 97.2% of patients would recommend the service to their friends and family.
- Patients told us they were given information about their care and treatment and offered time to ask additional questions. They felt involved in decisions about their care.
- Staff in the MR department took time to provide emotional reassurance to patients, particularly those who were nervous or claustrophobic. Patients told us staff made them feel at ease.

Compassionate care

Good

Outpatients and diagnostic imaging

- We observed staff communicating with patients and their family members in a respectful and considerate manner. Staff greeted patients warmly and compassionately as they greeted them before appointments.
- Patients we spoke with during our inspection spoke very highly of the staff in the outpatient department. Patients told us staff were caring and would go above and beyond what was expected of them.
- We observed that staff took steps to promote patients' dignity. The reception desk for the outpatients department was located far enough away from the seating area so patients' conversations could not be overheard. All clinical activity in the outpatient departments took place in individual consulting rooms or treatment rooms and doors were closed to maintain privacy and confidentiality. We saw that the treatment rooms had 'in use/not in use' signs on the doors. We also observed staff knocking on treatment and consultation rooms before entering.
- The hospital had a group-wide policy for the use of chaperones. We reviewed the policy which explained the consultations where a chaperone would be appropriate and guidance and best practice for using chaperones. We saw posters about chaperones were displayed in the waiting areas and the consultation rooms in the outpatient department. Staff told us chaperones were used for intimate examinations or at the request of patients.
- The outpatient and diagnostic imaging departments collected friends and family test data from NHS, insured and self-paying patients. The friends and family test is a measure of whether someone would recommend the service to their friends and family. In April 2016, 97.2% of people who completed the test said they would recommend the service to friends and family. Response rates for the hospital this month were 78.7%.
- Patients who completed the friends and family test in April 2016 said they would recommend the service to their friends and family because they thought the service was friendly, efficient, professional and caring as well as a number of other reasons.

Understanding and involvement of patients and those close to them

- Patients we spoke to said they were given information about their care and treatment, were involved in the decisions about their care and that their questions were answered.
- Patients were provided with information leaflets about the care and treatment.

Emotional support

- Staff we spoke to understood the emotional impact that care and treatment had on patients and their family members.
- Staff in the MR department told us they valued having time to talk with patients and reassure them. This was confirmed by patients we spoke with who told us that they were made to feel at ease by staff and they were given the support they needed when feeling nervous about the scan.
- A specialist breast care nurse was available in the one stop breast clinic for additional emotional support and information. This nurse was employed on the hospital bank.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Services had been planned to meet the needs of local people. There was flexibility in outpatient appointment times and access to a one stop breast clinic.
- Patients were kept informed of any delays and patients told us appointments ran to time.
- Overall, the 95% 18-week target for non-admitted patients was met between April 2015 and March 2016. Waiting times for diagnostic imaging were low.
- Individual needs were understood and considered when delivering care and treatment. Adjustments were made to remove barriers to people accessing services. Staff received training in dementia awareness and equality and diversity.
- Staff understood the complaints process and told us learning from complaints was discussed at departmental meetings and at the medical advisory committee.

However;

Good

Outpatients and diagnostic imaging

- Information about how to complain was not readily available in the departments we visited. The hospital did not monitor themes of complaints and there was a lack of sharing of learning from complaints.

Service planning and delivery to meet the needs of local people

- The hospital had worked with local commissioners and stakeholders to develop services to meet the needs of people in the Rochdale area. The service offered a wide range of outpatient clinics to meet the needs of the local people. There were outpatient clinics for people over 16 in 19 specialities. Of the specialities offered 55% of appointments were for orthopaedics; 17% for general surgery; 8% for gynaecology; 6% for urology; 3% for ophthalmology and gastroenterology; 2% for ear, nose and throat; and 1% or fewer for the other specialities offered.
- In addition to outpatient appointments the service offered a range of minor procedures which could be carried out without someone needing to be admitted to the hospital as an inpatient. The treatment rooms in the outpatients department carried out minor procedures such as plastering; wound dressing; group and save (collection of blood for patients who may need a blood transfusion); joint injections and minor dermatology; plastics; and ear, nose and throat procedures.
- Outpatient clinics were held between 8am and 7pm, with extended clinics until 9pm on some evenings, giving flexibility for people who worked about when people could attend. The waiting areas in the outpatient department had sufficient seating for the number of consultation rooms. A range of different style of chairs in the meant patients could choose a chair comfortable for them.

Access and flow

- There were 14,940 outpatient attendances between April 2015 and March 2016; of these 51% were NHS funded and 49% were funded by insurance or self-paying patients.
- Overall between April 2015 and March 2016, the hospital had met the England target for incomplete pathways referral to treatment times although the indicator had been missed each month between November 2015 and February 2016. The 95% 18-week standard for non-admitted patients was met each month between April 2015 and March 2016.
- The outpatient department used an electronic system to schedule clinics and track patients from when they had arrived in the department and started the appointment.
- Patients were given flexibility about when they could book appointments. However, patients were limited by what day and time they could have an appointment, if they needed to see a specific consultant. Patients we spoke with were happy about the flexibility offered for their appointments.
- Staff told us they would check the booking system regularly to monitor the time that patients had been waiting. If a patient had to wait more than 10 minutes they would apologise to them and find out when they were likely to be seen. Patients told us that department was efficient and appointments were on time.
- The hospital did not keep a record of clinics which were delayed. Staff told us that if a consultant was consistently late to clinic or did not attend they would raise it with the executive director.
- Staff told us that if a clinic was cancelled, for example if a consultant could not attend, they would try to offer an appointment with a different consultant, from the same speciality.
- If a patient did not attend it was the responsibility of the consultant to decide whether to discharge them or arrange a further appointment. However, staff told us the hospital did not keep a record of patients who did not attend an appointment so was unable to report how frequently this occurred.
- Waiting times for diagnostic imaging were generally low. X-rays were taken on the same day and the average wait for an MR scan was 2.5 days between January and June 2016. Wait times for CT scans and fluoroscopy were longer at 14.1 days for a CT scan and 22.6 days for a fluoroscopic examination. Waiting times for diagnostic testing such as MR and CT scans should be below six weeks to enable patients to commence treatment within 18 weeks of referral.
- We saw that images were reported by consultant radiologists in a timely way. In the seven records we reviewed, five of the images had been reported on the same day as the examination or the next working day.

Meeting people's individual needs

- The hospital used a BMI group-wide equality and diversity policy. We saw that the policy set out the

expectations of staff to ensure patients and staff were not discriminated against and the needs of all patients were met. On 1 June 2016, 90% of staff at the hospital had completed equality and diversity training.

- Staff we spoke with understood the importance of supporting people with additional needs such as dementia or a learning disability and made adjustments where appropriate. However they told us it was infrequent that these patients attended outpatient consultations or for diagnostic imaging at this hospital.
- People living with dementia who had undergone surgery at the hospital were given a questionnaire during the pre-assessment process that was stored in the medical record. This meant that the outpatient department had information about their cognitive impairment, so could meet their needs at the appointment. Dementia awareness training had been completed by 87% of clinical staff.
- Patient-Led Assessments of the Care Environment (PLACE) score for the whole hospital for the period February 2015 to June 2015 for dementia was 79%. This was slightly lower than the national average for independent hospitals which was 81%.
- Patients with reduced mobility were seen in one of the downstairs consultations rooms. There was an agreement in place with a local NHS provider to provide patient transport for NHS patients using the service. Patient transport was arranged in advance by the hospital.
- In the MR department, there was an MR compatible wheelchair and trolley to be used by patients with reduced mobility. The MR scanner was a wide bore scanner which meant that the scanning experience was less confined. Staff reported they had received positive feedback from patients who found standard MR scanners claustrophobic.
- There was access to face to face translation for patients who did not speak English as a first language. Staff knew how to book an interpreter and gave us examples of when they had used the service.
- A one stop breast clinic ran twice a week where patients were able to see a consultant and have a mammogram or ultrasound at the same appointment. This reduced the need for patients to attend multiple appointments and the time frame from symptoms to diagnosis. However, there was only one member of staff trained in mammography at the hospital. If this member of staff was unavailable this meant that patients had to travel to an alternative BMI hospital for their mammogram. The imaging lead had recognised this issue and was attempting to recruit additional bank members of staff trained in mammography.
- There was a water dispenser and hot drinks machine in the waiting area for the outpatient department and in the main reception area, providing refreshments for patients waiting for appointments.
- Newspapers and magazines were available in the waiting area of the outpatients department and in the main reception area, which meant that patients and other visitors could pass the time while waiting for an appointment.
- There were car parking spaces outside of the outpatients department so patients with reduced accessibility did not need to travel far.
- There were information leaflets in the outpatient waiting area giving information about different conditions and services offered by BMI hospitals. Most of the written information, leaflets and signs were only displayed in English although staff had access to leaflets in other languages if required. These were not available in other formats such as pictorial or braille.

Learning from complaints and concerns

- Between December 2015 and April 2016 there were 19 verbal and 22 written complaints about outpatient and diagnostic imaging departments. However, there was no analysis of the themes of complaints and limited evidence of wider sharing of learning from complaints.
- The hospital used a BMI group wide policy for handling complaints. Patient complaints followed a three-stage process. Stage one involved an investigation and response by the hospital within 20 days. Stage two was a review by BMI's central or regional staff of the complaint and how it had been handled at stage one, also within 20 days. Stage three was an independent investigation by the Independent Sector Complaints Adjudication Service (ISCAS) for fee-paying patients, or the Parliamentary and Health Service Ombudsman (PHSO) for NHS patients.
- We did not see any evidence of leaflets or posters in the outpatient area explaining how someone could complain.

Good

Outpatients and diagnostic imaging

- All complaints received about the outpatient and imaging departments were sent to the clinical governance team to be logged on a database. These were then assigned to a relevant member of staff to investigate.
- Complaints were reviewed and discussed at the hospital's medical advisory committee (MAC). We saw evidence in the minutes of the meetings that complaint trends and numbers were discussed but there was limited discussion of the learning from these complaints. Learning from complaints was shared within departments at the 'comms cell', on the 'comms cell' board or at department team meetings.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Clinical governance meetings were not well attended and actions were not completed in a timely way. BMI clinical governance bulletins were not shared with the medical advisory committee.
- The medical advisory committee did not receive sufficient information about key issues such as incidents and complaints or learning from these.
- The leadership in the outpatient department and the hospital executive team were new in post and further action was required to improve governance systems.
- Not all consultants who held practicing privileges at the hospital had all the required documentation in place.

However;

- There was an open culture where staff felt confident to raise concerns if required. Staff spoke positively about their work and their colleagues.
- Leadership in the imaging department was good and staff felt well supported. Work was in progress to ensure the sustainability of the one stop breast clinic and to improve the service by gaining accreditation via the Imaging Services Accreditation Scheme (ISAS).
- 'Comms cell' boards displayed key information about the quality measurement and risk management.

Vision and strategy for this this core service

- A BMI group-wide vision was in place and focussed on delivering the best patient experience, best outcomes and be the most cost effective. The hospital's vision was "to be seen as an important part of the local community, delivering High quality healthcare in innovative ways that benefit the health economy".
- Staff in the outpatients department could not articulate BMI's or the hospital's vision. However, they knew where to look on the intranet to find out more information. Staff in diagnostic imaging had a better awareness of the hospital's vision.
- The management team in the outpatients department, who were also responsible for the surgical ward, had been in place for just over a month before our inspection and were in the process of consolidating practice on the surgical ward before focussing on the outpatient department. This meant that there had not yet been consideration about the plans and strategy for this department.

Governance, risk management and quality measurement for this core service

- There was a defined governance and reporting structure in the hospital which the outpatients department fed into. The management team attended the clinical governance committee and head of department meetings. The leadership at the hospital recognised that further improvement in governance systems was required by ensuring that they 'closed the loop' on governance actions.
- We reviewed minutes of the clinical governance committee meetings for three months in 2016. We noted that the committee was not quorate on any of these meetings and that attendance was poor in general with the previous executive director sending apologies for all three meetings and the pharmacist not attending two of the three meetings. Actions were not closed off in a timely way. For example, at the July 2016 meeting there were still actions in the minutes open from March and September 2015.
- A governance report was prepared bi-monthly. A BMI wide monthly clinical governance bulletin was shared with all staff that included learning from incidents and complaints at other BMI sites along with audit results and updates on clinical guidance from bodies such as NICE and Royal Colleges. This bulletin was also designed

to be shared with consultants and discussed at the medical advisory committee (MAC), however we saw no evidence that this had happened and the MAC chair confirmed this was not discussed at this meeting.

- The hospital leadership team recognised that not all consultants who held practicing privileges at the hospital had all the required documentation in place. However, the executive director told us that there were no consultants working at the hospital in the month of August without the correct documentation and at the time of our inspection the hospital was working to ensure all consultants had provided all necessary documentation.
- The MAC met bi-monthly. There was a radiology representative on the committee who had responsibility for the oversight of practising privileges for radiologists. We noted that the MAC was not always given sufficient information to monitor clinical quality and risk at the hospital. For example, the numbers of incidents and complaints were provided with limited information on themes, analysis and particularly lessons learned
- There was a BMI wide risk management plan and associated hospital risk register in place. Risks were classified as operational, reputational and financial. Risk scores were calculated based on the chance of the event happening and the impact the event would have. Guidance was in place to ensure steps were taken to manage the level of risk appropriately. For example, guidance for risks scoring high and rated as red was to stop the activity until steps could be taken to control and reduce the risk. The risk register reflected high level risks at the hospital and some local facility issues such as the requirement to replacement flooring in the outpatient area.
- There were no locally held risk registers for outpatients and diagnostic imaging. However, the imaging department had identified a number of local risks that were displayed on the comms cell board to ensure all staff were aware of the risks and steps being taken to reduce the risks. These included risks that only one member of staff was trained in mammography and issues with the reliability of the visiting mobile CT scanner. .
- The radiology team held formal bi-annual discrepancy meetings. These meetings were where radiologists discussed any discrepancies in image reporting or errors and an opportunity to improve patient safety and the quality of care.
- The radiation protection advisor produced an annual report on the hospital's compliance with Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- Staff told us that a representative from the outpatients department attended the hospital's 'comms cell' every day. This is a hospital-wide meeting where daily issues such as staffing, incidents or anything else relevant was discussed. The outpatients department had its own 'comms cell' at 7.45am each day where information from the hospital 'comms cell' and the day's activities were discussed.
- We saw 'comms cell' boards displayed in staff areas. These displayed information such as key messages, mandatory training, team success, patient satisfaction, complaints and incidents.
- We saw a 'concern, cause and countermeasure' notice on the 'comm cell board'. Staff told us that they would record any concerns or risks that they had identified in the outpatient or imaging department. These were reviewed as part of the 'comms cell' meetings and could be escalated to the executive team or central 'comms cell' meeting.
- The hospital participated in 'provider visits'. Provider visits were visits from other BMI sites to assess the quality of care provided at the location.

Leadership / culture of service

- The executive director was new to the hospital during the week of our inspection. She was supported by a newly promoted director of clinical services. Staff therefore found it difficult to comment on the new leadership of the hospital. However, staff in the outpatients department told us that the outgoing team had been very visible and approachableThe nursing management team in the outpatients department had been in place for just over a month; however, all staff we spoke with said they were supported by their immediate manager.
- All staff in the outpatients department we spoke with said it was a good place to work. Staff said it was a friendly place to work and that they felt appreciated for the work they did. They told us the outpatients department held a team meeting which took place every six to eight weeks.
- A departmental meeting was held bi-monthly in the imaging service with a formal agenda including standing items such as incidents, audits and

departmental updates. The imaging manager was described as approachable and a good leader. Staff told us they felt valued, appreciated and part of a team. They were confident in raising concerns and reported a positive working environment.

- There were no staff vacancies in the outpatient department at the time of our inspection and there had been no staff turnover between April 2015 and March 2016. There were no vacancies in diagnostic imaging and two staff had left due to retirement during the same time period.
- Sickness absence rates for the outpatient department were generally lower than the average for other similar independent health providers.
- Consultants felt that the aims of the management at the hospital were aligned with those of the medical staff and that there were common values and expectations of a high standard of care.

Public and staff engagement

- Patients were invited to complete a survey by completing a card which asked how likely they were to recommend the service to friends and family (the family and friends test) and given a chance to provide comments on the service. The forms were available in the treatment room in outpatients, although at the time of the inspection they were not available in the main reception.
- There had been a staff survey in 2016 which showed that 67% of staff were proud to work for BMI healthcare. This was a slight reduction from 2014 when 71% of staff reported they were proud to work for BMI healthcare.
- The hospital ran an 'above and beyond' scheme that recognised staff contribution when they had exceeded the expectations of their job role. There was also a reward scheme for long service, the 'pin' awards, including a celebratory dinner hosted by the executive director for staff with over ten years' service. Different coloured pin badges were given to staff to wear on their uniforms depending on length of service.

Innovation, improvement and sustainability

- The diagnostic imaging service recognised a need to have more staff trained in mammography in order to maintain the sustainability of the breast one stop clinic. The hospital was working to develop this service and engaging with local GPs to increase their awareness of this clinic.
- The imaging lead was working with other BMI sites in order to achieve accreditation with Imaging Services Accreditation Scheme (ISAS).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that systems and processes are reviewed so that when issues are identified, steps are taken to address them in a timely manner. Similarly, incidents must be thoroughly reviewed, so that any remedial actions can be put in place to prevent a recurrence.
- The hospital must ensure that premises and equipment are cleaned and monitored in line with current legislation and guidance, to the required standards for a surgical environment and that cleaning schedules in theatres are always completed and monitored.
- The hospital must ensure that arrangements for the service, maintenance, renewal and replacement of premises and equipment are adequate. Service records for electronic equipment must be up to date and some equipment was in a good state of repair.
- The hospital must ensure that staffing levels in theatre meet the required standards as set out by the Association for Perioperative Practice (AfPP), the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and in BMI's own staffing policy.
- The hospital must ensure that accurate, complete and contemporaneous records are kept in respect of each patient including details of outpatient consultations.

Action the provider SHOULD take to improve

- The hospital should ensure that the completion of VTE assessments and prophylaxis medication in patient records is consistent and corresponds with the reported completion rates.
- The hospital should ensure that where issues are identified in audits, action plans are put in place and monitored.
- The hospital should ensure that the World Health Organisation (WHO) surgical safety checklist is consistently completed and the use of the checklist is audited in all relevant departments.
- The hospital should ensure that blood products are stored in a safe and appropriate way.
- The hospital should ensure that risk registers are up to date and that senior staff are aware of current risks in their areas, in order that they can be managed appropriately.
- The hospital should ensure that governance systems and processes are operated effectively, including the operation of the medical advisory committee.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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