BMI The Shelburne Hospital

Quality Report

Queen Alexandra Road, High Wycombe, Bucks. HP11 2TR.
Tel:01494 888700
Website: www.bmihealthcare.co.uk/hospitals/bmi-the-shelburne-hospital

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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 

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Shelburne Hospital opened in August 2000 and is part of BMI Healthcare. The Shelburne Hospital is part of the BMI South Buckinghamshire Hospitals group. The senior management is shared between this hospital and two other services. We inspected one of these services, The Chiltern Hospital at the same time as The Shelburne Hospital.

There is one ward the Shelburne Ward with 26 beds. The operating department consist of three theatres. In outpatients there are five consulting rooms with the additional supporting services. The hospital has a radiology department providing x-rays and ultrasound and a physiotherapy department.

Additional services are provided by the local NHS trust provides which includes pathology, pharmacy, cardiac catheterisation laboratory, Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) Scans.

The executive director, had recently moved from another hospital within the group, was applying to become the registered manager. They were supported by a director of clinical services, a director of operations and a team of heads of departments. There was also a hospital manager based at this site.

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

The announced inspection took place on 26 and 27 July and an unannounced visit on 1 August 2016.

The hospital was rated good for caring and responsive and requires improvement for safe, effective and well-led services.

Our key findings were as follows:

Are services safe at this hospital?

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

- Staff were clear about their responsibilities to report incidents, however the process for the management of reported incidents was not robust and investigations and the sharing of learning did not always take way in a timely way.
- Processes to protect people from harm, such as infection control, the safe handling of medicines and equipment safety checks were being followed. However staff in theatres did not always follow systems and processes to keep patients safe.
- Patients were assessed and action was taken in response to risk. This included the assessment of patients to ensure only patients who the hospital could safely support received treatment.
- Patient records were stored securely . However, medical staff did not always achieve the required minimum standard of documentation in patient records.
- Staff were aware of safeguarding and were clear about their responsibilities to safeguard people at risk. However training to safeguard children was not currently being provided to the level described in the hospitals policy or safeguarding children and young people: roles and competencies for health care staffIntercollegiate document : March 2014.
- In general staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. This was not the case for the operating departmentwhere staffing levels were not always in line with national guidance. Staff in the operating department were also undertaking dual roles without the support of a local hospital policy or risk assessments.

Summary of findings

- The hospital compliance target for mandatory training was 85%. Not all staff were up-to-date with the mandatory training and there were delays in accessing practical based courses.
- There was a good understanding of the principles of the duty of candour, and the need to be open and honest.

Are services effective at this hospital?

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

- Patients' care and treatment was planned and delivered using evidence based guidance.
- Most staff were qualified and had the skills needed to carry out their roles effectively. Some theatre staff were undertaking the role of surgical first assistant without fully completing a recognised competency based course. There was no assurance that staff were competent to undertake the role.
- There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment.
- The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.
- Staff had access to the information needed to assess, plan and deliver care to people in a timely way.
- Consent to care and treatment was obtained in line with legislation and guidance, and staff had an understanding of the principles of the mental capacity act.
- The hospital had systems in place for granting practicing privileges to consultants and when necessary suspended or removed these. However, the process for the biennial reviews was not being effectively managed.
- The hospital routinely collected and submitted data on patient outcomes. Although senior staff discussed this information at regional level, there was no evidence of how the hospital shared and used the information locally to improve outcomes for patients.

Are services caring at this hospital?

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

- Nursing, theatre and medical staff were caring, kind and treated patients with dignity and respect.
- Patients felt they received sufficient information about their planned treatment and were involved in decisions about their care.
- Patients consistently told us they would recommend the service to friends and family.

Are services responsive at this hospital?

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

- The hospital planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service.
- Patients had timely access to initial assessment, diagnosis and urgent treatment at a time to suit them.
- The needs of different people were generally taken into account when planning and delivering services including cultural, language, mental or physical needs. The service had strict selection criteria to ensure only patients whom the hospital had the facilities to care for were referred

Summary of findings

- Discharge arrangements were planned but flexible, and care was provided until patients could be discharged safely.
- The hospital dealt with the majority of complaints promptly, and there was evidence that the complaints were discussed amongst staff. Complaints were used to improve the quality of care.

Are services well-led at this hospital?

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

- There was a corporate vision in place, supported by a hospital business plan. Senior managers were aware of the key risks that may affect them achieving the vision.
- Governance processes were not always effective in monitoring the quality and safety of the service at a local level. Practices were taking place in the operating department that were not reflective of corporate polices or current national guidance.
- Managers and staff did not use the hospital risk register effectively to identify and manage risks within the service and there were no risk register at department level.
- The lack of a consistent and experienced theatre manager to lead and manage the operating department had resulted in no-one taking clear accountability and responsibility for the quality and development of the service. Local leadership was being developed with some department managers being new to the organisation.
- Heads of department found the daily senior team meeting an effective way to share key information with them.
- Staff felt they supported each other well in their teams and this had helped during a number of senior staffing changes at the hospital.
- They valued the changes the new executive director had made, particularly improving the appearance of the hospital and listening to their concerns.

After the inspection the provider was issued with a requirement notice letter, as we had identified potential failings to comply with two regulations relating to good governance and staffing; the detail of which is contained within the report and listed in the must actions at the end of the report. We asked the provider to submit an action plan to show how they would address these concerns and demonstrate how they would reduce the associated risks to patients and staff. The provider submitted a detailed action plan within the agreed timeframe which we felt was sufficient to comply with the requirement notice. A responsible person was allocated to each action, with a date for completion. Compliance with the action plan will be monitored through regular engagement meetings with the provider.

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

Importantly, the provider must:

- The provider must ensure that all staff acting as a surgical first assistant have been assessed as competent for the role. In addition, the evidence of completed competencies and log of cases should be available in accordance with the BMI Healthcare Surgical First Assistance policy.
- The provider must ensure it completes regular reviews of compliance with BMI Healthcare policies, with action taken for areas of non-compliance, including the renewal of practising privileges. .
- The provider must ensure that staffing levels in theatres are in line with current national guidance and the BMI Healthcare policy.

Summary of findings

- The provider must ensure when staff are undertaking a dual role this is supported by a local policy and risk assessment.
- The provider must ensure all theatre staff receive an annual appraisal.
- The provider must ensure there is robust monitoring of the safety and quality of the surgery service at a local level, with risks identified and timely action taken to manage the risks.
- The provider must ensure all medical records are stored securely at all times, including during transport.
- The provider must ensure the hospital risk register reflects the current risks faced by the hospital and in sufficient detail to show how they are monitoring the risks.
- The provider must ensure staff carry out the six-point safety check prior to any radiological scan.
- The provider must ensure there is robust monitoring of the safety and quality of the outpatients and diagnostic imaging service at a local level, with risks identified and timely action taken to manage risks.
- The provider must ensure all staff in the outpatient department complete appropriate training and competency assessment to carry out their role.

In addition the provider should:

- The provider should ensure a trend analysis of all incident reports is completed, with action plans devised as a result.
- The provider should ensure all patient care records are completed in full, by the multidisciplinary staff providing care and treatment.
- The provider should ensure all staff are up-to-date with all of their mandatory training.
- The provider should ensure all staff complete safeguarding children training appropriate to their role.
- The provider should ensure all intravenous fluids are stored securely.
- The provider should ensure there are clear protocols and guidelines for pain management in the outpatient department.
- The provider must ensure all the key recommendations of the Perioperative Care Collaborative Statement on Surgical First Assistants have been considered, with action taken as indicated.
- The provider should ensure there is local monitoring of national guidelines to ensure patients receive care and treatment that reflects current evidenced based practice.
- The provider should ensure patient surgical outcome data is shared and discussed at relevant departmental meetings so changes can be made to practice where necessary.
- The provider should ensure all theatre staff receive an annual appraisal.
- The provider should ensure for all audits there is a clear action plan, with accountability for completion of any actions, by an agreed date.
- The provider should ensure the outpatient department have knowledge of individual consultant competencies.
- The hospital should ensure all outpatient clinics have sufficient numbers of staff to meet patients' needs.
- The hospital should ensure there are appropriate arrangements in place for lone working in the outpatient department during evening clinics.

Summary of findings

- The provider should consider arranging an external review of its theatre service to seek an independent review of the standards of the service.
- The provider should consider displaying information for patients about how to make a formal complaint.
- The provider should consider improving the signage to the hospital car park.
- The provider should ensure there is a robust risk assessment is carried out to assess the risk of carrying out lumbar punctures in the outpatient treatment room.

Professor Sir Mike Richards Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Staff in theatres were not always adhering to systems and processes designed to keep patients safe and to ensure staff were working in accordance with corporate policies and relevant national guidance. Staff acting as a surgical first assistant had not been competency assessed and this additional role was not included in their job description. They were not rostered to complete this role as an additional member of the theatre team. Therefore, theatre staffing was not always in line with national guidance and staff were acting in a dual role without a local policy or risk assessments to support them. Across the service there was limited monitoring of compliance with hospital policies. There were delays in managers investigating incidents and the hospital was significantly behind on some of its clinical reviews for consultants practising privileges. There was insufficient monitoring of the quality and risks of the service at a local level. Concerns identified by senior staff tended to be shared at regional level but this information was not always cascaded back to frontline staff to enable them to develop and improve their service. The hospital wide risk register was not in sufficient detail to provide assurance on how risks were monitored and by whom but there was good use of the corporate clinical quality dashboard. Although audits were completed there were no detailed action plans, showing who was responsible for monitoring areas of non-compliance. The hospital was not compliant with its mandatory training target of 85% for around 55% of the training courses staff needed to complete. Staff found there were sometime delays accessing practical based courses. Also, only 15% of staff in theatres had received an appraisal in the last year. There was a high use of agency staff, across the service, to ensure safe staffing levels due to difficulties with recruitment and retention of staff.

Summary of findings

The hospital collected patient outcome data and submitted this to a number of national databases but the hospital did not use this data locally to keep staff informed about how effective care and treatment had been. Staff involved in the surgery service did not meet as a whole team to discuss outcome data, although the hospital had just introduced a theatre user group who would consider the quality of the service.
However:
We saw staff providing compassionate care and treatment to patients. Nursing, theatre and medical staff were caring, kind and treated patients with dignity and respect. Patients felt they received sufficient information about their planned treatment and were involved in decisions about their care. Patients consistently told us they would recommend the service to friends and family.
Areas we visited were visibly clean and tidy and we saw staff following good infection prevention and control practices.
Patients told us the booking, admission and discharge process had all been prompt and efficient, they felt fully informed at each step in the process. Although, waiting times for surgery for NHS patients did not always achieve the 18-week referral to treatment time indicator.
There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment. Patients' care and treatment was planned and delivered using evidence based guidance. Nursing staff completed risk assessments for patients. In the event that a patient became unwell, there were systems in place for staff to escalate these concerns and refer the patient to another hospital if necessary. The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.
Staff felt they supported each other well in their teams and this had helped during a number of senior staffing changes at the hospital. They valued the changes the new hospital manager and executive director had made.

Summary of findings

Outpatients and diagnostic imaging

Requires improvement 

The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents. Although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any learning quick enough to ensure patient safety. Managers and staff could not accurately describe the trends of incidents or learning in their department and staff did not always receive feedback on incident reports.
There was new management across departments who were still familiarising themselves with the service, departments and hospital. The outpatients department had recently appointed a new manager who had not yet commenced in post and the outpatient manager was acting up as manager in an interim role. At the time of our inspection, managers did not demonstrate an understanding of the risks or clear oversight of the governance processes to monitor the quality standards of the service.
There was no departmental risk register and therefore the hospital could not provide assurance that departments managed key concerns in a timely way. The hospital risk register did not reflect the risks at a department level and was not in sufficient detail to outline how risks were monitored and by whom.
The hospital had a policy and system in place for granting of practising privileges for medical staff wishing to work at the hospital. There was a backlog in completion of the required biennial clinical reviews for 135 medical staff for assurance on local clinical performance. Not all staff completed mandatory training appropriate to their role. Not all staff knew how to recognise a child or adult at risk of abuse. The hospital had not provided safeguarding children level 2 training to some members of staff. Staff in the outpatient department did not always have formal training and competency assessment to carry out specific roles.
The hospital did not always store medical records securely and there was a risk of unauthorised access.

Summary of findings

However, Staff treated patients with dignity and respect and provided emotional support throughout their treatment. Staff helped patients to understand their condition or treatment by giving written information after their treatment and allowing time to ask questions. All patients could request chaperones during their consultation or treatment.

The diagnostic imaging department had access to a Radiation Protection Advisor and Radiation Protection Supervisor. The department displayed radiation hazard signs appropriately and access to controlled areas was secure.

The hospital met the NHS referral to treatment indicator (RTT). All patients commenced treatment within 18 weeks of referral. Patients had a good choice of appointments at times that suited their needs.

Staff valued the new hospital management team and told us they had made a positive impact on the hospital. Staff worked well together across multidisciplinary teams to ensure services met the needs of patients.

Summary of findings

Contents

Requires improvement

Location name here

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to BMI The Shelburne Hospital

The Shelburne Hospital opened in August 2000 and is part of BMI Healthcare. There is one ward the Shelburne Ward with 26 beds. The operating department consist of three theatres. In out patients there are five consulting rooms with the additional supporting services. The hospital has a radiology department providing x-rays and ultrasound and a physiotherapy department.

Additional services are provided by the local NHS trust provides which includes pathology, pharmacy, cardiac catheterisation laboratory, Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) Scans.

The hospital provides a range of services to patients who are self-funded or use private medical insurance. Some treatment was available for NHS funded patients through the NHS e-Referral Service. Services include general surgery, orthopaedics, cosmetic surgery, ophthalmology, gynaecology, urology oncology, physiotherapy and diagnostic imaging. The hospital was not providing services for children and young people.

The executive director, who was new to the hospital, had recently moved from another hospital within the group, was applying to become the registered manager, was supported by a director of nursing and quality, a director of operations and a team of heads of departments.

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

Our inspection team

Our inspection team was led by:

Inspection Manager: Lisa Cook, Care Quality Commission (CQC)

The inspection team of 10 included an inspection manager, four CQC inspectors, an assistant inspector and four specialist advisers, a theatre nurse, outpatients nurse manager, radiographer and a governance lead.

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. We carried out an announced inspection visit on 26-27 July and an unannounced visit on 1 August.

During this comprehensive inspection, we assessed the surgical, medical and outpatients services. We also reviewed the overall governance processes for the hospital and reported on this as part of the well-led domain. We spoke with members of staff and patients, observed patient care, looked at patients' care and treatment records and at hospital policies.

We would like to thank all staff for sharing their views and experiences of the quality of care and treatment at The Shelburne Hospital.

Requires improvement

Surgery

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

Information about the service

The Shelburne Hospital provides elective surgical care to patients aged 18 and over, both NHS and other funded (self-pay or through private medical insurance), as inpatients and day cases. The specialities providing surgery included orthopaedics, plastic surgery, ophthalmology and gynaecology. From April 2015 to March 2016 there were 2,726 admissions for surgery, of which 964 where inpatients and 1,762 day cases. The majority of admitted patients (84%) were other funded. The three most commonly performed procedures were bilateral breast augmentation (183), carpal tunnel release (95) and inguinal hernia repair (95).

The hospital has three operating theatres, two with laminar airflow ventilation systems (a system of circulating filtered air to reduce the risk of airborne contamination). There is a dedicated recovery area. There are 24 patient rooms, all of which are used by both inpatient and day case patients; all are single rooms with en-suite. There are no critical care facilities. In an emergency, the hospital transfers patients to the local NHS Hospital. The Shelburne Hospital is on the same site as this hospital.

The Shelburne Hospital is part of the BMI South Buckinghamshire Hospitals group. The senior management is shared between this hospital and two other services. There are similarities in our findings and the content of both reports due to this and the overall management of the hospitals being the same.

During our inspection, we inspected the operating department and the ward area. We spoke with three patients and 15 members of staff, including theatre and nursing staff, medical staff, allied health professional and administrative staff. We also reviewed three sets of patient records, three personnel files and observed care on the ward, in the operating theatres and in the recovery area. We analysed data provided by the hospital before, during and after the inspection.

Requires improvement

Surgery

Summary of findings

We rated this service as requires improvement because:

- Staff in theatres were not always adhering to systems and processes designed to keep patients safe and to ensure staff were working in accordance with corporate policies and relevant national guidance.
- Staff acting as a surgical first assistant had not been competency assessed and this additional role was not included in their job description. They were not rostered to complete this role as an additional member of the theatre team. Therefore, theatre staffing was not always in line with national guidance and staff were acting in a dual role without a local policy or risk assessments to support them. Across the service there was limited monitoring of compliance with hospital policies.
- There were delays in managers investigating incidents and the hospital was significantly behind on some of its clinical reviews for consultants practising privileges.
- There was insufficient monitoring of the quality and risks of the service at a local level. Concerns identified by senior staff tended to be shared at regional level but this information was not always cascaded back to frontline staff to enable them to develop and improve their service. The hospital wide risk register was not in sufficient detail to provide assurance on how risks were monitored and by whom but there was good use of the corporate clinical quality dashboard. Although audits were completed there were no detailed action plans, showing who was responsible for monitoring areas of non-compliance.
- The hospital was not compliant with its mandatory training target of 85% for around 55% of the training courses staff needed to complete. Staff found there were sometime delays accessing practical based courses. Also, only 15% of staff in theatres had received an appraisal in the last year. There was a high use of agency staff, across the service, to ensure safe staffing levels due to difficulties with recruitment and retention of staff.
- The hospital collected patient outcome data and submitted this to a number of national databases but the hospital did not use this data locally to keep staff informed about how effective care and treatment had been. Staff involved in the surgery service did not meet as a whole team to discuss outcome data, although the hospital had just introduced a theatre user group who would consider the quality of the service.

However:

- We saw staff providing compassionate care and treatment to patients. Nursing, theatre and medical staff were caring, kind and treated patients with dignity and respect. Patients felt they received sufficient information about their planned treatment and were involved in decisions about their care. Patients consistently told us they would recommend the service to friends and family.
- Areas we visited were visibly clean and tidy and we saw staff following good infection prevention and control practices.
- Patients told us the booking, admission and discharge process had all been prompt and efficient, they felt fully informed at each step in the process. Although, waiting times for surgery for NHS patients did not always achieve the 18-week referral to treatment time indicator.
- There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment. Patients' care and treatment was planned and delivered using evidence based guidance. Nursing staff completed risk assessments for patients. In the event that a patient became unwell, there were systems in place for staff to escalate these concerns and refer the patient to another hospital if necessary. The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.

Requires improvement

Surgery

- Staff felt they supported each other well in their teams and this had helped during a number of senior staffing changes at the hospital. They valued the changes the new hospital manager and executive director had made.

Are surgery services safe?

Requires improvement

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

We rated this service as requires improvement for safe because:

- Staffing levels in the operating department were not consistently in line with national guidance, when theatre staff were acting as a surgical first assistant. Staff in the operating department were also undertaking dual roles without the support of a local hospital policy or risk assessments. The roles which staff were undertaking for a session were not included on the rota.
- The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents that staff had reported, although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any learning quick enough to ensure patient safety. Learning from local incidents was shared with frontline staff.
- Staff in theatres did not always follow systems and processes to keep patients safe. We observed on two occasions although staff completed the World Health Organisation (WHO) surgical safety checklist, staff were relaxed in their approach to completing it. The hospital completed observational audits of compliance with the WHO, however, there was no evidence of how they shared the results with frontline staff to enable them to make changes to practice or recognise good practice.
- Not all staff were up-to-date with the mandatory training and there were delays in accessing practical based courses.
- We found staff did not always complete patient records in full. This was also a high level of risk for the hospital following a serious incident, relating to the standard of record keeping.
- On the ward, intravenous fluids were not stored securely and there were concerns about the safe storage of cleaning products but the hospital had addressed this

prior to our unannounced inspection. There were no health and safety risk assessments available to provide assurance the hospital has considered such risks and taken action.

However

- Staff demonstrated a good understanding of duty of candour and gave examples where they had used this to support patients.
- All clinical areas were visibly clean and staff had access to sufficient equipment to provide safe care and treatment. Staff adhered to infection prevention and control practice on the wards and in theatres.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns. Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate. There were appropriate arrangements in place to transfer patients to the local NHS hospital if required.

Incidents

- Staff knew how to and felt confident to report any incidents which occurred. They currently used a paper based reporting system, with incidents uploaded to a central database, by a member of the quality and risk team. The hospital planned to introduce electronic reporting of incidents in October, with training for staff starting in August. There was a current risk of the quality and risk team not uploading information correctly due to being unable to read the hand written forms and they did not actually witness the incident. However, we were told that due to the size of the hospital they would be able to ask the individual directly what the text said.
- At the time of our inspection, there was a delay in closing a total of 105 incidents across this hospital and a second hospital managed by the same team. The quality and risk team had to chase managers at both sites to complete investigations so they could record the outcome and close the incident. The senior management told us they had closed 100 of these by 8 August 2016. The remaining five were within the 20-day timescale for the relevant department to investigate and report on the learning and outcomes. We had concerns the backlog had delayed the hospital applying learning and action, with a potential impact on safe care and treatment for patients.
- Staff told us their manager made them aware of any incidents at their daily team 'huddle' or through the daily information sheet printed and shared with staff after the senior team 'huddle'. The hospital manager told us they were made aware of all incidents at the hospital. Team leaders would discuss any immediate actions at the 'huddle' or share at routine team meetings. The huddle' is a brief meeting of hospital staff to improve communication, cooperative problem solving and focus priorities of the day. Minutes from the medical advisory committee (MAC) meetings showed the hospital presented a summary of the most recent incidents but this did not include the actions taken, to show how the hospital had shared learning with medical staff. There was no evidence of sharing of learning from incidents at other BMI hospitals at departmental level, although senior staff discussed these at their meetings, such as the clinical governance group.
- From April 2015 to March 2016, staff had reported 205 clinical incidents, the majority (94%) were graded as no or low harm with 11 incidents graded as moderate harm but none as severe. One hundred and ninety two incidents occurred in surgery and inpatients.
- There had been one never event during the same period. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. A root cause analysis had been completed, debrief held with staff and learning shared locally and regionally, with an agreed action plan. The root causes were human error and staff not adhering to corporate policy.
- There were no regular mortality and morbidity meetings to discuss unexpected deaths or adverse incidents affecting patients. The hospital told us such cases would be included in the clinical governance and medical advisory meetings as required.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support. Staff gave examples of when they had applied duty of candour and learning because of an incident.

Safety thermometer or equivalent

- The hospital submitted safety thermometer data for NHS patients having surgery at the hospital. The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harm that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. Results for February 2016 to July 2106 showed all patients had received harm free care.

  However, the ward did not display the audit results. It is considered best practice to display the results of the safety thermometer audits as this allows staff, patients and their relatives to see how the wards have performed.

- Staff routinely assessed patients for venous thromboembolism (VTE). The VTE screening rate was 95% or above from April 2016 to March 2016. There had been one incident of hospital acquired VTE or pulmonary embolism over the same period.

Cleanliness, infection control and hygiene

- All clinical areas we visited in theatres and on the ward were visibly clean and tidy. We observed staff following good infection control practices, such as cleaning their hands before and after patient contact and ensuring they were 'bare below the elbow', to minimise the risk and spread of infection to patients. Staff also had access to personal protective equipment such as gloves and aprons, which we observed them using appropriately. There were hand sanitiser points around the hospital for visitors to use, to reduce the spread of infection to patients.

- There was an infection prevention and control (IPC) lead for the hospital and an IPC link for each department. Quarterly IPC meetings took place, with performance in IPC audits such as hand hygiene discussed at these meetings and other areas of concern found at the hospital, such as training for theatre porters to enable them to clean theatres between each case.

- Results from the most recent hand hygiene audit in July 2016 showed 80% compliance for staff on the ward; there had been no audits in the operating department since January 2016 due to insufficient time for the IPC link to complete the audits. The hospital planned to link with the new theatre manager to address this. Learning and actions were shared with staff at the daily 'huddle' and through the IPC local lead. All staff could also access the minutes from the IPC meetings. Staff completed annual IPC mandatory training, at the time of the inspection compliance was 82% against the hospital target of 85%.

- From April 2015 to March 2016, there had been no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) and one case of Methicillin-sensitive Staphylococcus Aureus(MSSA) across the hospital. There had been no incidents of Clostridium difficile and one incident of Escherichia coli (E-Coli). The hospital followed the corporate BMI Healthcare policy 'Methicillin resistant staphylococcus aureus screening and management' (2015), which did not require hospitals to screen all admitted patients for MRSA. Instead, patients were screened depending on their history about previous infection with MRSA, previous admittance to hospital, admittance from a residential home and all NHS patients were screened as part of the contract agreement with clinical commission group. Orthopaedic patients and oncology patients were also screened. Patients with a positive result received treatment prior to the hospital admitting them for surgery.

- The hospital reported there had been no surgical site infections from April 2015 to March 2016.

- The hospital had a contract in place for decontamination and sterilisation of surgical instruments, which took place off-site.

- There were carpets in all of the inpatient rooms, ward areas and main corridors of the hospital. The hospital recognised this was an infection control risk and was in

discussion with the local NHS Trust who owned the building to get these replaced; at the time of the inspection, there was no deadline when this would be achieved and this was not on the hospital risk register. We observed the carpets were clean and staff signed and dated to show carpet-cleaning schedules were complete, including when a deep clean was completed. There was a policy for management of spillages on carpets, with a steam clean taking place.

- In the operating theatre, the patient transfer slide was stored on the floor rather than on the wall, which was an infection control risk. We made staff aware of this and asked them to move the board. Also, there were items on the floor in the ward linen room, meaning staff could not clean properly.

Environment and equipment

- Staff told us there was sufficient equipment for them to care for patients and we saw staff maintained stock levels well for both reusable and single use items. Equipment in general was stored appropriately, with clear labelling in storage rooms.
- Staff understood their responsibility to ensure they segregated and disposed of clinical waste appropriately. Clinical waste bins were clearly labelled and we observed staff kept the rooms used to store clinical waste clean and tidy to minimise infection risk.
- Staff had access to the use of a hoist for transferring patients. The hospital provided disposable slings for individual patient use. Staff received training on the use of equipment as part of the contract held with the supplier. The hospital serviced and tested clinical equipment according to manufacturer's guidance; there were a number of service level agreements in place for servicing of equipment.
- We reviewed the records for daily and weekly checks of the resuscitation trolleys in the operating department and on the ward for the last month and these were complete. There was a list with each trolley to show when items were due to expire, to ensure items were kept in date and ready to use in an emergency. Trolleys had a security tag on them, so it was immediately evident if they had been accessed and the contents potentially tampered with.
- In the operating theatre, we observed electrical cables trailed across the floor, rather than staff using the sockets in the ceiling pendant, this was a trip hazard. We discussed this with staff and they made use of the pendant sockets for the rest of the theatre session.
- On the ward in the dirty utility, we found chlorine based products used for cleaning (tablets and liquid) stored by the sink rather than locked away. There was a potential safety risk as visitors and patients could access the area as they door was kept unlocked due to staff needing frequent access to the area. We made the ward sister aware of this and at our unannounced visit saw the products were stored correctly. We requested health and safety risk assessments for the ward and operating department. The hospital did not provide any; there was therefore no assurance how the hospital were managing any potential risks.
- The ward was accessed from a corridor at the end of the outpatients area. There were no security measures in place, such as buzzer entry or swipe card access, to restrict entry to the ward. We were concerned that some patient rooms were not in sight of the nursing station and the potential vulnerability of patients post-surgery, during the initial recovery period.

Medicines

- The hospital had a service level agreement (SLA) with the local NHS trust for supply of medicines and pharmacy service to the wards, including out of hours cover. Audits of medicine management were the responsibility of the hospital, although the trust pharmacy team completed some audits as part of the SLA.
- During the inspection, we noted two particular concerns. On the ward, staff kept the intravenous fluids in an unlocked store cupboard. The store cupboard was next to patient rooms and potentially accessible to anyone. This was a risk due to the fluids not being stored appropriately and securely. In the anaesthetic room, the medicines fridge was unlocked, to enable staff to have rapid access to medications in an emergency. Staff were unable to find a risk assessment to support this practice, as there was a potential risk of unauthorised access to fridge medications whilst staff were in theatre. However, the most recent medicines

audit action log showed pre-filled syringes were to be ordered for staff to take into theatre to enable staff to lock the fridge when they were not in the anaesthetics room.

- The pharmacy team completed regular audits including missed dose, controlled drugs and medicines reconciliation. The results for the most recent reconciliation audit found staff had not achieved all the standards so a re-audit was planned, there was no date set for this. The team shared audit results at the medicines management meetings held every two months, with managers cascading the information at team meetings, confirmed in the minutes we looked at. The hospital were also linking with the provider of the SLA due to concerns around lack of medicines reconciliation being completed.
- Staff completed the controlled drugs registers in line with current national guidance and the hospital policy. However, in the operating department, the controlled drugs standard operating procedure dated July 2016, contained three staff signatures dated January 2015, there was a lack of assurance staff had read the most recent version. All medicines we checked were in date.
- Staff on the wards told us there was sufficient pharmacy cover provided as part of the SLA.
- Patients told us nursing and medical staff had given clear instructions and advice about any medications they needed to use at home, prior to discharge from the ward. Patients made staff aware of any allergies at their pre-assessment. They recorded this information on the front page of the care pathway so the information was immediately visible to reduce the risk of harm to patients and patients wore a red wristband to make staff aware they had an allergy.

Records

- Patient records were in paper format and these were stored securely on the wards in a lockable trolley. Staff did not raise any concerns about lack of availability of patient records.
- There had been a coroner investigation into an unexpected death of a patient following discharge for the hospital after a surgical procedure just prior to our inspection. They had identified concerns on the standard of record keeping, due to incomplete, inconsistent and conflicting information. The senior management recognised the severity of this and record keeping was the number one risk for the hospital at the time of the inspection. An action plan was being developed at the time of our inspection.
- We reviewed three patient records and found non-medical staff had completed the required information and patient details on every page. In one set of records, the signatures were not clear for the different stages of the World Health Organisation (WHO) checklist and in another, no medical staff had signed the signature page to enable easy identification of who had provided care to the patient. All clinicians looking after the patient had to sign this sheet. There was no discharge plan for one patient and for all three records the care plan and agreed goals were not clear. The standard of record keeping we saw was not in keeping with best practice and systems designed to keep patients safe.
- The hospital patient records audit from July 2016, found compliance of 97%, there had been a gradual improvement each month from January 2016 when compliance was 81%. Current concerns were nursing staff not dating, timing and signing all entries. There was no action plan provided.
- Staff used specific paperwork for each patient which ensured they kept records appropriate to the care pathway being followed. For example, patients admitted for hip surgery had their clinical entries recorded in the 'Primary hip replacement care pathway' documentation.
- The care records contained pre-operative assessments, records from the surgical procedure and anaesthetic, recovery observations, nursing and medical staff notes and discharge checklists and assessments. The records also included multidisciplinary clinical notes, including those from physiotherapists. They raised concerns that there was sometimes insufficient space for them to write their full care plan for a patient in the record for day case patients.
- Theatre staff maintained a comprehensive log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.

Requires improvement

Surgery

Safeguarding

- Safeguarding was part of mandatory training for all staff, the level of training required determined by their clinical role. Staff knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process and how to seek support if they needed to. Flowcharts of the safeguarding process were on display in the ward office and in theatres, including all the relevant local telephone numbers. Staff could access the BMI safeguarding policy on the intranet for reference.
- The policy included what action staff should take if they had concerns a patient had undergone female genital mutilation (FGM).
- Staff told us they completed safeguarding children and vulnerable adults modules in their mandatory training. Hospital records showed 94% of staff had completed level one safeguarding children training and 94% of staff had completed level one safeguarding vulnerable adults training. This met the hospital target of 85%.
- We were told by senior staffin April 2016 BMI introduced training package on their e-learning system, which introduced the different levels of training to bring this in line with the intercollegiate document with the four different levels of training being provided.We were told prior to April 2016 all staff at the hospital were trained using one training module that would have covered the aspects required for level one and level two safeguarding children training.
- Information provided by the hospital indicated that only staff in a management or supervisory role were required to undertake level two safeguarding children and adults training and 67% of staff in this group had completed training. However, the BMI Safeguarding Children policy states that all staff who have some degree of contact with children, young people and/or parent or carers should complete a minimum of level 2 safeguarding training. The policy takes this requirement from the intercollegiate document Safeguarding children and young people: roles and competencies for health care staff (2014). This meant all staff caring for adult patients who have children required level 2 safeguarding children training. The service therefore did not provide its staff with safeguarding training that met the requirements of its own corporate policy.
- All staff had to complete PREVENT (Protecting people at risk of radicalisation) training every three years. At the time of our inspection 91% had completed this training against a target of 85%. The PREVENT strategy requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who are at greater risk of radicalisation.

Mandatory training

- Staff we spoke with told us they were up-to-date with most of the statutory and mandatory training. They sometime had difficulties accessing the practical training courses as they were not all held locally. Staff would value the hospital arranging more local courses.
- Each member of staff was assigned a role-specific mandatory training plan via the online e-learning system used by BMI. This sent reminder emails to staff and their manager when they needed to renew a training module. Staff completed most training electronically but the provider included practical training where appropriate, such as for manual handling and infection prevention and control. Managers gave staff time at work to complete their training or they paid staff to complete online training at home to improve compliance and ensure patient safety.
- As of April 2016, compliance with mandatory training for staff working across the whole hospital was inconsistent. The hospital target was 85% compliance, this had been achieved for 18 of the 39 courses. Courses which were 50% or less compliant included paediatric basic life support (0%) (three staff) and acute illness management for health care assistants (50%).
- The hospital manager recognised compliance with mandatory training was poor and had begun to take action to address this.

Assessing and responding to patient risk

- Staff assessed patients for key risks at their pre-assessment and continued to monitor these before and after their surgery. These included risks about mobility, medical history, skin damage and VTE. Patients had to meet certain criteria before they hospital would accept them for surgery, these minimised the risk of harm to the patient due to lack of appropriate facilities.

Requires improvement

Surgery

- Patients were required to complete a comprehensive preadmission questionnaire to assess if there were any health risks that may compromise their treatment. Nurse discussed the health questionnaires with patients in the pre-admission clinics. If staff identified a patient as being at risk, they discussed these concerns with the patient's consultant, the resident medical officer (RMO) or anaesthetist as appropriate. If a patient appeared to have an abnormal ECG result, the RMO reviewed the results and they arranged a referral to a cardiologist.
- Staff used the National Early Warning System (NEWS) to monitor patients and identify deterioration in their health. This is a series of observations that produce an overall score. An increase in the score would show a deterioration in a patient's condition. A plan was available in each patient's records for staff to follow if the score did increase.
- Nursing staff on the ward had to complete acute illness management training, every three years as part of their mandatory training. As of April 2016, 100% of nurses and 50% of HCAs had completed this training against a target of 85%.
- If a patient's condition deteriorated, service level agreements were in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. Nursing staff and the RMO were aware of the correct process to follow to ensure prompt and timely intervention for a patient who required additional medical treatment.
- Staff had recently completed a training exercise reviewing the pathway and process for transferring a patient to critical care in an emergency, at the NHS hospital which was on the same site. This included action to take if the lifts were out of order. The hospital manager had completed a new pathway document and planned to take this to the next clinical governance meeting for ratification.
- Patients having complex surgery had this performed in the operating theatres at the NHS trust, with the hospital pre booking a bed in critical care. The surgeon was responsible for ensuring there remained a bed free prior to starting surgery, if not the operation was cancelled and rearranged.
- All staff completed adult basic life support, immediate or advanced life support training depending on their role. As of April 2016, 92% of clinical staff had completed adult basic life support training, and 86% of non-clinical staff. Sixty eight percent of staff had completed immediate life support.
- In theatre, staff followed the "Five Steps to Safer Surgery" checklist. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning and end of each theatre list and the World Health Organisation (WHO) surgical safety checklist, which included sign in, time out and sign out. We observed two operations and for both staff said shall we 'do the WHO', rather than defining which stage they were at, although they did complete all stages, with the correct questions asked at each stage. We did not have confidence that staff were fully engaged with the process and recognised the importance of its completion for ensuring patient safety. However, a record of the team brief was kept in theatres, in accordance with best practice.
- The hospital told us they completed monthly observational audits of completion of the WHO surgical safety checklist for 10 patients; this did not include whether the brief and debrief had taken place. The results for January to July 2106, showed 100% compliance. However, when asked two theatre staff were not aware the audit was completed or could remember the results being discussed with them. Minutes from theatre meetings did not include discussion of the WHO audit results. We raised this with senior staff who acknowledged they cascaded the information up but not back to frontline staff. There was no assurance how the hospital were supporting staff to improve the quality of the service and ensure patient safety.
- The hospital arranged simulated cardiac arrest scenarios to assess how staff would respond should a real life cardiac arrest occur. Feedback was given to individuals on their performance and further unannounced scenario sessions planned by management.
- A resident medical officer (RMO) was on site at all times. The RMO was the doctor responsible for the care of the

patients in the absence of the consultant. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest.

Nursing staffing

- We had concerns the staffing levels in theatres did not always meet the Association for Perioperative Practice (AfPP) recommended minimum, although they did meet the corporate policy.
- The AfPP is a national group supporting staff working in the perioperative setting. The guidance from AfPP on 'Staffing for patients in the perioperative setting' (2014) recommends a minimum of one anaesthetic practitioner, two scrub practitioners, one circulating practitioner and one recovery practitioner. The minimum staffing in theatres being five, unless there is only one case, when only one scrub practitioner is needed. However, the corporate BMI Healthcare 'Policy for management of operating sessions for elective scheduled surgery' (2016) referenced the AfPP guidance but their staffing model was not in line with this guidance. The BMI Healthcare staffing model was based on the grade of surgery being performed, using a scale of one to four. The normal staffing for grade two to four operations was three staff; one anaesthetic practitioner, one scrub practitioner and one circulating practitioner. The provider considered recovery practitioner staffing separate to this policy but review of the allocation rotas showed this was planned for appropriately, giving a total of four staff in theatres. The BMI maximum staffing only met the minimum AfPP guidance for grade three/four operations when specific risk assessments had been undertaken to show five staff were needed
- We reviewed the off duty, allocation rota and operating lists for the week of the announced inspection. The allocation rotas were typed and were clear on which role staff would be undertaking for that session and who would be covering if changes had been made to the planned rota. There were normally five staff in theatre but the second scrub practitioner was listed as 'scrub 2/SA', indicating they may act as surgical first assistant. There were therefore occasions when staffing in theatres met the BMI policy but not the AfPP recommended minimum. This was because when staff were acting as a surgical first assistant they needed to be an additional member of the team, requiring there to be a total of six staff in theatres. This was not taking place and was not in line with The Perioperative Care Collaborative Position Statement 'Surgical First Assistant' (2012) that states that a practitioner undertaking the role of the SFA must be an additional member of the team. The BMI Healthcare 'Policy for the provision of surgical first assistants' (2013) also supported this.
- For the 18 planned theatre sessions, there were 14 were staff were listed as 'scrub 2/SA'. We also observed staff acting as surgical first assistant for both of our sessions in the operating theatre on 27 July 2016, when there was only a total of five staff in the operating theatre, rather than six.
- This reduction in staffing meant the scrub practitioner was sometimes also acting as a SFA, meaning they were undertaking two roles at the same time, referred to as dual rolling. We observed this during our session on 27 July. The staffing in theatres for this session was initially as AfPP guidance but one member of staff assisted the surgeon, resulting in them dual rolling. Two theatre staff also told us they dual rolled during breast surgery. This should be supported by a local policy and risk assessment for each situation where staff can dual role to ensure patient safety as recommended in the Perioperative Care Collaborative Position Statement 'Surgical First Assistant' (2012). The corporate 'Policy for management of operating sessions for elective scheduled surgery' (2016) supported this position statement. We discussed our concerns with the director of clinical services who told us theatre staff did not routinely dual role but if they did there should be local policies and risk assessments in place. We looked for these documents on site with staff and requested them after the inspection. The hospital did not provide any policies or risk assessment to support those staff undertaking a dual role. These situations together represented a significant risk to patient safety.
- On the ward, the senior staff used a patient acuity and dependency tool to plan the required level of nurse staffing. This showed the required nursing hours, any unallocated hours were filled using bank or agency staff. The rota was finalised one week in advance, with daily review due to changes in operating lists or patient need.
- There was at times a high use of agency staff due to difficulties with recruitment and retention of staff. From April to June 2016, 14% of planned staffing hours were

covered by agency staff and 1.3% by bank staff. For theatres, 38% of planned staffing hours were covered by bank staff and 44% by agency staff. As of June 2106, there was one vacant posts on the ward and three vacant posts in theatres..

- Evening day case patients sometimes returned late from theatre, after 9pm and some then needed to stay overnight. This created additional pressure for the night staff.
- The hospital manager meet with heads of department on a daily and weekly basis to review staffing, to ensure it met the needs and dependency of patients.

Surgical staffing

- Consultants led and delivered the surgical service at the hospital. Surgeons and anaesthetists were required to be able to attend within 30 minutes drive of the hospital, in case they needed to urgently visit a patient.
- Nursing and theatre staff told us they could contact any consultant, out of hours or when not on-site, if they needed advice about the best care and treatment for a patient. They told us they had a good working relationship with the medical staff, who normally attended the hospital promptly when called in.
- Each consultant was responsible for arranging a colleague who would be on call for any of their patients staying overnight, if the consultant was not available to be contacted by staff.
- There was a resident medical officer (RMO) on-site 24 hours a day. If the RMO had any concerns, they would speak with the consultant responsible for the patient. The RMO also responded to emergency calls and was advanced life support trained. The RMO we spoke with confirmed they were up-to-date with their training.
- Patients told us the consultant and anaesthetist had seen them prior to surgery.

Major incident awareness and training

- The hospital had local and corporate business continuity plans for use in events such as a power failure or adverse weather conditions.
- There was a corporate 'Major Incident' policy for staff to follow should a significant event occur at the hospital or in the local area.
- All staff completed annual fire safety training as part of their mandatory training.

Are surgery services effective?

Requires improvement

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

We rated this service as requires improvement for effective because:

- Some theatre staff were undertaking the role of surgical first assistant without fully completing a recognised competency based course. Assessments of competencies had not taken place and the required evidence for the role was not kept in the operating department in keeping with the corporate surgical first assist policy. There was no register on-site of staff who could perform the surgical first assist role and the role was not listed in their job description. There was no assurance that staff were competent to complete the role and that the department had considered and was adhering to corporate policy and relevant national guidance.
- The hospital had a policy and system in place for granting of practising privileges for medical staff wishing to work at the hospital. There was a backlog in completion of the required biennial clinical reviews for 135 medical staff for assurance on local clinical performance. In addition, the majority of theatre staff had not received an appraisal in the last year.
- The corporate provider policy for surgical first assistants did not refer to the most current national guidance for staffing in theatres, to ensure best practice was being followed.
- The hospital routinely collected and submitted data on patient outcomes. Although senior staff discussed this information at regional level, there was no evidence of how the hospital shared and used the information locally to improve outcomes for patients.

However:

- Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs. Staff could access all the information they needed to provide care for patients. Discharge planning started during the pre-assessment process to ensure the hospital discharged patients with all the support they needed and at the right time.
- Patients told us they had made an informed decision to give consent for surgery. They could access pain-relieving medication as needed post-surgery.
- The hospital had systems in place to ensure they provide care for inpatients seven days a week, including access to on-call theatre and medical staff in an emergency. Planned operations were performed mainly during the week.
- Staff provided care and treatment to patients that took account of nationally recognised evidence based guidance and standards, although reviews of this information did not take place at departmental level.

Evidence-based care and treatment

- Some staff described how they provided care and treatment to patients based on relevant national guidance and standards, such as the National Institute for Health and Care Excellence (NICE). However, although updates to national guidance were an agenda item at clinical governance meetings, there was no evidence of discussions at departmental meetings. There was therefore no assurance that care and treatment was in keeping with the most current recommendations.
- The corporate provider policy on 'Provision of Surgical First Assistants' (2013) referenced Association for Perioperative Practice (AfPP) staffing guidance from 2007, although updated guidance had been issued in 2012 and 2014. The central policy team had not reviewed this policy in view of this more recent guidance and there was a potential risk that services were not following current recommendations.
- Patients received a risk assessment for venous thromboembolism (VTE) prior to surgery in line with NICE (Quality standard 3) 'Venous thromboembolism in adults: reducing the risk in hospitals' with appropriate prophylaxis given to reduce the risk of VTE. The hospital audited compliance with this and the results shared with heads of department.
- The hospital submitted data to Public Health England Surgical Site Infection (SSI) surveillance audit programme, to contribute to national information recorded on SSI but also to enable them to compare nationally their rates of SSI. For the most recent audit period (October-December 2015), the hospital had not reported any surgical site infections following hip and knee replacement surgery.
- The hospital used a number of different care pathways depending on the type of surgery a patient was having, to ensure staff followed a set care pathway that met the needs of each patient.
- Staff in theatres and on the wards told us there had been less time recently to complete audits due to staffing shortages and needing to ensure they met the needs of patients. The hospital planned to train more health care assistants to be able to complete audits. We did though see evidence in minutes from departmental and clinical governance meetings that audit results were discussed.

Pain relief

- Patients commented on the prompt response and action taken by nursing staff when they were experiencing pain. Nursing staff answered call bells quickly and provided medication to help reduce the level of pain.
- Staff asked patients to score their pain using a scale of zero to three. They then documented the result in the patients' care pathway, as part of the National Early Warning System (NEWS) chart along with any action taken to manage the patients' pain. For patients with persistent pain, a patient controlled anaesthesia pump was considered, there was a separate risk booklet for staff to complete to ensure all associated risks were monitored.
- Nursing staff discussed post-operative pain relief with patients as part of their pre-assessment and gave them written information as well to support these discussions.

- The resident medical officer (RMO) could prescribe additional pain relieving medication or if there were significant concerns nursing staff would speak with the patient's consultant.

Nutrition and hydration

- Nursing staff advised patients abut fasting times prior to surgery at pre-assessment. They also completed the malnutrition universal screening tool (MUST) as part of the patient's risk assessments during their pre-assessment. This is used to identify patients at risk of malnutrition. Staff could contact a dietician, from the local NHS trust, for additional advice if needed.
- Specific dietary needs were also recoded at pre-assessment, so the catering team could be informed and provide suitable food for the patient during their stay. A patient told us staff had them supported to make healthy meal choices.
- Staff monitored patients were for post-operative nausea and vomiting. Staff gave anti-sickness medication to patients as needed, which the consultant had written up prior to surgery.

Patient outcomes

- The hospital submitted patient outcome data to a number of national audits, including the National Joint Registry, to enable it to monitor its performance and clinical outcomes against other services. The hospital also audited readmission rates and reported on this data as part of the quality account.
- Patient reported outcome measures (PROMs) were recorded for NHS funded patients having primary knee or hip replacement and hernia repair. Data for April 2014 to March 2015, showed for hip surgery that the adjusted average health gain was within the England average. There were not sufficient knee surgery cases performed for the adjusted average health gain to be calculated. However, results from the PROM surveys used for knee surgery showed the majority of patients reported an improved outcome after surgery.
- Monthly PROMs data was also reported on in the quality account, these enabled patient outcomes at the Shelburne Hospital to be compared to the BMI healthcare average and national average.
- At a corporate level the provider was working with the Private Health Information Network (PHIN). PHIN planned to provide information for the public from April 2017 on 11 key performance measures, so a patient could make an informed choice where to have their care and treatment for providers offering privately funded healthcare.
- From April 2015 to March 2016, there were two unplanned transfers to another hospital, five unplanned readmission within 28 days of surgery and five unplanned returns to theatre. Theatre staff were asked what learning had taken place after these events, they could not describe any learning and seemed surprised this should be considered. Information from the hospital showed all staff had taken appropriate action at the time of the incident. Escalation procedures had been effective in managing the risks to patients. There was though no detailed discussion of these cases at the MAC, clinical governance or departmental meetings.

Competent staff

- We had concerns that staff acting as a surgical first assistant (SFA) were not able to demonstrate competency assessments for this role and some staff had only partially completed the required qualification for the role. This did not meet national guidance or corporate policy. There was no assurance that staff were competent to undertake the role or the hospital was following corporate policy and national guidance to keep staff and patients safe.
- The Perioperative Care Collaborative (PCC) position statement on 'Surgical first assistant' (2012) recommends 'the role of the SFA must be undertaken by someone who has successfully achieved a programme of study that has been benchmarked against nationally recognised competencies underpinning the knowledge and skills required for the role'. In addition, the role of the SFA should be included in the person's job description.
- The BMI 'Policy for the provision of surgical first assistants' (2013) required a register of staff designated to perform the SFA role to be held in the operating department, along with evidence of skills and knowledge assessment. Staff had to complete a recognised training programme, which could be the BMI SFA training course or an externally recognised course.

Staff could act in the role of SFA after completing day one of the four day BMI course. Also, staff were required to keep a log of procedures undertaken to demonstrate on-going competency. Finally, an assessment of competence should take place for staff acting as a SFA.

- The senior nurse told us three staff acted as a SFA during surgery. We reviewed the personnel files for these staff and only one of them had this role listed in their job description. Staff told us they have completed the BMI SFA course.
- There was no register in the operating department of staff who acted in the SFA role and staff were unable to produce evidence of completed competency assessments. Staff told us they had a folder to record their competencies but none were available during the announced or unannounced inspection. No staff had a log of procedures on-site where they acted as SFA but told us they did have a record at home.
- Senior management completed a number of checks prior to granting consultants practising privileges at the hospital. The term 'practising privileges' refers to medical practitioners being granted the right to practice in a hospital. In order to maintain their practising privileges consultant medical staff were required to supply copies of current insurance, a disclosure and barring scheme check, their registration, last appraisal for their main place of work and evidence of completion of the required mandatory training. The hospital were up-to-date with these annual checks but they were behind for the review of clinical performance that took place biennially with the MAC, in keeping with the BMI Healthcare 'Practising privileges policy' (2015). The policy contained a standard agenda that the MAC should adopt which included biennial review of practising privileges. We reviewed the minutes for the last three meetings and these did not contain discussions for medical staff due a biennial review.
- There were a total of 135 medical staff who were due a biennial review, seven reviews were significantly out of date 1 from 2007, three from 2009, one from 2010 and two from 2011. Six of the seven medical staff were undertaking clinical work at the hospital. There was no assurance that the hospital were actively monitoring the local clinical performance of staff who held practising privileges for the hospital. We discussed this with the executive director who was accelerating the reviews, with the aim of being up-to-date by the end of October 2016.
- However, we did see in the minutes from the MAC meetings that the group had reached decisions to grant or stop practicing privileges and appropriate action taken, where the MAC had identified concerns about performance or conduct.
- Staff told us they had received an appraisal within the last year and the hospital supported them financially and gave them the time to complete relevant additional training for their role. The hospital manager had long-term plans to offer set training and development packages to help with retention of staff and offer more career development.
- As of July 2016, 15% of theatre staff and 100% of ward staff had received an appraisal. The appraisal year ran from October to September. In the previous year, only 5% of theatre staff had received an appraisal.

Multidisciplinary working

- Throughout the inspection, our observations of practice, review of records and discussions with staff confirmed good multidisciplinary working between the different teams involved in a patient's care and treatment.
- There was clear communication between staff from different teams, such as theatre staff to ward staff and between the ward staff and physiotherapists. We observed safe and effective handovers of care, between the ward, theatre and recovery staff.
- Nursing, theatre staff and the RMO told us it was easy to contact a consultant if they needed advice. The consultant had overall responsibility for a patient's care.
- The hospital had a number of service level agreements for pathology, pharmacy, cardiac cath lab, chemotherapy and some diagnostic imaging tests. Hospital staff did not raise any concerns about contacting or using these services.
- If a patient needed to be transferred to another hospital, the consultant was responsible for liaising with the hospital and arranging for the transfer.

Requires improvement

Surgery

- Pre-assessment staff told us the liaised with a patient's GP if there were any concerns about tests results or the needed confirmation of any medications the patient was taking. When the hospital discharged a patient, they sent a letter to the patient's GP.
- Physiotherapy staff recorded if they made a referral to social services or other community services as part of the pre-admission discharge planning process.

Seven-day services

- Planned operations took place Monday to Friday, during the day and early evening. There was occasional operating sessions on a Saturday. Theatre staff were on-call should there be any unplanned returns to theatre. Nursing cover was available on the wards, all day, every day, when the hospital was open.
- The RMO was on-call at all times and was based at the hospital, should staff need to escalate concerns about a patient. The RMO told us they were woken at night infrequently and therefore were normally able to rest between midnight and 7am.
- Consultants were required as part of the BMI practising privileges agreement to be contactable by phone and able to attend the hospital within 30 minutes, if they had admitted patients at the hospital. It was their responsibility to arrange appropriate cover if they could not be available and to arrange an anaesthetist if their patient was readmitted to theatre.
- The radiology department provided an on-call service outside of normal working hours and at weekends. Staff could contact the radiologists out of hours to authorise requests and review results but there was no documented on-call arrangements.
- Physiotherapy staff supported effective recovery and rehabilitation by providing sessions to inpatients daily, including at weekends.
- Staff could speak with the trust on-call pharmacist for advice out of hours as needed.

Access to information

- Nursing, theatre and medical staff did not raise any concerns around access to patient records, they told us these were available when they admitted a patient for surgery.
- The use of the patient pathway document enabled different teams to access key information about the patient. Notes were hand written and were accessible to all staff, including agency staff. All the relevant information for each patient such as outpatient clinic letters, surgery records and observational charts were all stored in one file for ease of access.
- A discharge letter was sent to the patients' GP, staff recorded this had been completed in the patient pathway document.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All patients told us they had been able to make an informed decision about surgery, before signing the consent form. The consultant discussed the risks and benefits of surgery with them and these were included on the consent form. The four consent forms we checked confirmed this.
- Relevant staff groups completed consent training as part of their mandatory training. As of March 2016, 96% of required staff had completed this training.
- The results from the last quarterly consent audit, for June 2016, showed 90% compliance. Areas of poor compliance were to be discussed with the relevant staff member, although it did not state who would do this and by when.
- Staff completed Adults at Risk training every two years, which included Mental Capacity Act 2005 and Deprivation of Liberty Safeguards awareness training. Staff we spoke with had an understanding of how this applied to patient consent but told us they implement the training infrequently as the majority of patients had capacity. As of March 2106, 94% of hospital staff had completed this training.
- Nursing staff documented on the front of the patient care pathway if there was a do not attempt resuscitation order in place or an advanced decision to refuse treatment and that they had seen the relevant document. This ensured staff respected the patients' wishes should they collapse and need emergency treatment.

Are surgery services caring?

Requires improvement

Surgery

Good

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

We rated this service as good for caring because:

- All feedback from patients, both verbal and through patient surveys was positive. Patients felt staff took the time to listen to their concerns, provided clear explanations about their care and treatment and on the day of surgery provided care of a high standard. This included treating patients with dignity and respect, and maintaining privacy and confidentiality.
- Patients felt staff treated them as individuals and they, and those close to them, were involved in making decisions about their care. Staff considered patients emotional needs, not just their clinical needs.
- All patients we spoke with would recommend the service to friends and family and this was supported by data collected for the Friends and Family test.

Compassionate care

- All patients we spoke with were pleased with the quality of care they had received. They told us staff had made them feel at ease and had felt comfortable and relaxed prior to having surgery. Staff had spoken to them in a kind manner and treated them with dignity and respect. A patient told us 'staff could not have done more'.
- Staff ensured confidentiality and privacy by knocking before entering a patient's room and kept the door closed while providing care. A patient told us and we observed staff introducing themselves when they met a patient for the first time. Patient names were displayed (initial and last name) on the door of their room and on the whiteboard at the nurse's station, which was visible to patients and visitors. Staff told us they gained verbal consent to display this confidential information; there was also a section in the patient pathway to obtain their consent.
- A patient commented how staff attended to their needs but also ''talked and joked'' with them about 'every day' things, this made their stay in hospital less of a negative experience.
- In the Patient Led Assessment of the Care environment (PLACE) audit for February 2015 to June 2015, the hospital scored above the England average for privacy, dignity and wellbeing, with a score of 91% compared to the England average of 87%.
- We saw notices on display on the wards advising patients to let staff know if they wished for a chaperone.
- The hospital collected Friends and Family test for all patients. This was analysed on a daily, monthly and rolling basis. Data from the previous day was shared at the daily meeting for senior staff.
- Data for April 2016 showed, 99.3% of inpatients would recommend the service to a friend or family member. Data was also analysed by patient category with 99.2% of insured and self-pay recommending the service and 100% of NHS funded patients.
- From April 2015 to April 2016, 94% to 100% of NHS funded patients would recommend the service and between 96%-99% for insured and self-pay patients. The hospital also asked all patients to rate the quality of care, with scores achieving 72% or above for excellent care, the remainder rated their care as very good.

Understanding and involvement of patients and those close to them

- Patients told us all staff had given clear explanations, in sufficient detail for each stage of their care and treatment, from initial consultation through to discharge. They were also given written information to support the discussions that had taken place. Patients valued seeing the physiotherapist during the pre-operative assessment, so they understood the exercise programme they needed to complete after their surgery.
- Staff were clear about the risks and benefits of the planned treatment and patients understood how their recovery would progress. They also had been made aware of any costs they may incur.
- We did not have the opportunity to speak with any carers or family members during our visit. However, with the patients' permission they could attend appointments and be present during their stay in hospital.

- We observed staff explaining any tests or observations to the patient prior to completing them.
- Patients told us they appreciated the time staff spent with them to answer any concerns they had. They had found it helpful seeing the anaesthetist and consultant prior to having surgery.

Emotional support

- Staff in all areas showed sensitivity and support to patients and understood the emotional impact of them having to be admitted for surgery.
- We observed a theatre team providing additional reassurance for a patient who was anxious about their surgery. The patient later told us how much they had appreciated this support.
- The hospital had open visiting hours on the ward so relatives and carers could visit at any time to offer support.
- Patients were able to telephone the ward after discharge, for further help and advice on their return home.

Are surgery services responsive?

Good

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

We rated this service as good for responsive because:

- The hospital and local Clinical Commissioning Groups worked together to plan and deliver surgical services, to meet the needs of local people.
- Admissions were pre-planned so staff could assess patients' needs prior to treatment. This enabled staff to provide care to meet their specific needs, including cultural, language, mental or physical needs.
- The set selection criteria ensured only patients whom the hospital had the facilities to care for were referred. Patients told us the whole process from booking their initial appointment, to being discharged post-surgery was efficient and well organised.
- Discharge arrangements were planned but flexible, and care was provided until patients could be discharged safely.
- The hospital dealt with complaints promptly, and there was evidence that the complaints were discussed amongst staff. Complaints were used to improve the quality of care.

However,

- The hospital did not meet the 18 week referral to treatment time for admitted patients beginning treatment within 18 weeks of referral for NHS patients for six months during April 2015 to March 2016.

Service planning and delivery to meet the needs of local people

- The hospital worked in partnership with local Clinical Commissioning Groups to plan and deliver NHS surgery services, including knee and hip surgery. The hospital participated in the NHS e-Referral Service, allowing local people to receive timely access to treatment. Through this service, NHS patients who require an outpatient appointment or surgical procedure are able to choose both the hospital they attend and the time and date of their treatment.
- The service was registered with various insurance companies, providing access to treatment for patients who had private healthcare insurance. Additionally, patients could opt to pay for treatment themselves. BMI Healthcare had recently introduced a BMI card, allowing patients to spread the cost of their treatment over 12 months.
- The service admission criteria ensured GPs only referred patients whom the hospital had facilities to care for. For patients needing critical care, the hospital had a contract with the trust to use their facilities, with them transferring patients back to the hospital once well enough.
- The service had plans to site ambulatory care in theatres for patients who would not require a full ward admission. Ambulatory care services allow patients to be treated in hospital without the need for an overnight stay. Patients receive timely access to treatment and inpatient beds are released for those who require an overnight stay.

Requires improvement

Surgery

Meeting people's individual needs

- Admissions were pre-planned so staff could assess patient needs prior to treatment. This allowed staff to arrange how to meet patients' specific needs, including their cultural, language, mental or physical needs.
- The hospital did not have a pre-assessment department and patients were referred to BMI The Chiltern Hospital for a pre-assessment appointment. Pre-assessment nurses at The Chiltern Hospital gave patients information leaflets about their planned procedure or treatment during their pre-assessment appointment, or the hospital sent the leaflets to patients with their outpatient appointment letter. The patient information leaflets were written in English but could be provided in other languages or formats.
- The hospital's PLACE score, for the suitability of the environment for a patient living with dementia, was 82%, slightly higher than the England average of 81%. The service had not employed any specialist dementia nurses or a dementia lead, however, staff received mandatory dementia awareness training, as of March 2016, 89% of staff had completed their training. Due to the set admission criteria, the hospital rarely treated patients living with dementia.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. In the assessment for ward food, the hospital scored 80%, significantly below the 93% England average (figures from February to June 2015 assessment). In contrast to these results, patients told us that they were pleased with the quality of the food and that staff were happy to assist patients at mealtimes. Special dietary requirements were recorded at pre-assessment and communicated to the hospital's catering department before the patient arrived.
- All areas of the hospital were accessible for people in a wheelchair or with mobility needs
- In the Patient-Led Assessments of the Care Environment (PLACE) from February to June 2015, the hospital scored 91% for the condition, appearance and maintenance of the wards. This was in keeping with the England average (92%). We spoke with three patients who were happy with the appearance of their room.

Access and flow

- The hospital admitted both private and NHS patients on a planned basis for elective surgery, and staff provided care in a timely manner.
- From April 2015 to March 2016, the hospital admitted 2,726 inpatient and day cases, of which 16% were NHS funded. The hospital monitored the percentage of NHS patients admitted within 18 weeks of referral as part of their quality report submitted to the CCGs. It is expected that 90% of NHS patients are seen within this timescale. The hospital fell below the 90% target for six of the twelve months within the reporting period (April 2015 to March 2016), with compliance ranging from 57% to 79% over these months. The hospital did not explain why they had not achieved the indicator.
- There was no waiting list for private patients requiring surgery. Patients were offered treatment according to their availability, taking into consideration the clinical urgency for the surgery and the need for a 'cooling off' period following consultation.
- The operating department followed a planned programme of activity from Monday to Friday, with Saturday operating sessions available on request. The hospital assigned consultants theatre time on a sessional basis unless there was a clinical necessity to provide an unplanned session, such as a return to theatre.
- The hospital ran a morning, afternoon and evening operating session. The evening session ran from 6pm to 8pm, but was rarely used due to low demand. Key performance indicator data for the first week of August 2016 showed, nine patients had their procedure during the evening session. Low occupancy rates on the ward meant that any day case patient who required an overnight stay could do so and staff recorded the conversion as an incident.
- The pre-assessment nurse at The Chiltern Hospital covered discharge planning during pre-assessment, to determine not only how many days patients would be on the ward but also whether patients were likely to require additional support at home once discharged.

- Consultants, or if unavailable the resident medical officer (RMO), authorised the discharge of patients from the hospital. This meant patients could be discharged out of hours if they wished.
- Staff communicated planned changes to the surgical lists via the administration team. The hospital required consultants to give five days notice of any changes to the list so the hospital could ensure enough staff were working. Senior managers discussed, with consultants who regularly did not comply with this standard.
- From April 2015 to March 2016, the hospital cancelled ten procedures for non-clinical reasons. The hospital could not confirm how many patients were offered another appointment within 28 days of the cancelled appointment. There was no assurance how the hospital assessed if improvements could be made reduce the number of cancellations.

Learning from complaints and concerns

- Staff followed the BMI Healthcare 'Complaints policy' (2015), which provided staff with a clear process to investigate, report and learn from complaints. The policy was up-to-date and based on recommendations made by national reports and enquiries, with a focus on patient safety.
- From April 2015 to March 2016, the hospital directly received 12 complaints, a low figure when compared to other independent hospitals of similar size. Complaint content varied from costings to nursing staff. The Executive Director had overall responsibility for all complaints. The quality and risk manager tracked complaints and assigned each complaint to the relevant head of department for investigation.
- If the hospital received a complaint, the hospital manager aimed to speak directly with the patient to address the concerns promptly. The hospital manager also spoke with patients and asked them how satisfied they were with the nurses, doctors, food and environment. Using this approach the hospital endeavoured to correct any issues the patients had before they developed into complaints.
- Complainants received an acknowledgement of their complaint within two working days. The hospital sent holding letters to inform patients if there was a delay in sending a formal response. The most common delay occurred when information was required from a consultant. The director of clinical services reminded consultants to respond quickly to requests for information at the Medical Advisory Committee (MAC) meetings.
- There were procedures for sharing and learning from complaints across the hospital. Complaints were discussed at the MAC meeting, Clinical Governance meeting, Heads of Department meeting, Executive Team meeting and at the daily communication meeting. Minutes (including patient feedback) from the daily communication meeting were emailed to the wards and theatre departments, as well as being displayed in departments for all staff to access. In response to a complaint about the quality of care and staffing levels after 4pm, the ward reviewed the skill mix and when relevant had more staff on duty for the late shift.
- Patients said they did not know how to make a complaint but would be happy to raise concerns if they had any. We saw comment boxes on the ward for patients to leave feedback cards but did not see specific leaflets on how a patient could make a complaint. The senior staff told us leaflets were available.

Are surgery services well-led?

Requires improvement

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

We rated this service as requires improvement for well-led because:

- Governance processes were not always effective in monitoring the quality and safety of the surgery service at departmental level but this information was monitored by the hospital . Information on performance, risks and incidents was shared with senior staff and regional teams but this information was not consistently shared with frontline staff.
- The hospital manager monitored the key risks to quality and safety, although there were no departmental risk registers in place and the corporate hospital risk register lacked detail.

Requires improvement

Surgery

- Although audits were completed, there no delegated person to ensure any required actions were completed or learning shared with staff. There were no formal written action plans to support completion of outcome from audits.
- Practices were taking place in the operating department that were not reflective of corporate polices or current national guidance. There was no hospital oversight of this. Across the hospital, there was a lack of monitoring of compliance with policies.
- Staff felt unable to raise concerns via the whistleblowing process for fear of being identified.
- There was limited evidence of the monitoring patients outcome data locally to monitor the quality of the surgery service at the hospital.

However:

- There was a corporate vision in place, supported by a hospital business plan. Senior managers were aware of the key risks that may affect them achieving the vision; although, there was no local vision or strategy for the surgical service.
- Staff across the service felt supported by their manager and valued the support of their team particularly during the number of changes in senior management. They had confidence in the new hospital manager, who was visible and staff felt able to raise concerns with them. Heads of department found the daily senior team meeting an effective way to share key information with them.
- The hospital had recently improved how it engaged and sought feedback from staff, also, a new awards scheme had been introduced to recognise the work and commitment from staff. The hospital collected feedback from patients through patient surveys and the hospital manager spoke with inpatients on a daily basis.

Vision and strategy for this core service

- BMI Healthcare had a corporate vision 'to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent healthcare'. Senior managers were aware of this vision and ward staff told us a staff forum was held every two months where the corporate and hospital vision were discussed.
- The new hospital executive director, who had been in post for three weeks, had introduced the '6Cs' as a way of supporting staff to achieve the corporate vision. The '6Cs' help staff to focus on six key areas; care, compassion, competence, communication, courage and commitment. There had not been sufficient time for staff to adopt this new approach but they were aware of it.
- The hospital manager had been in post for five weeks but had identified clear short, medium and long-term aims for the hospital linked to the vision and any challenges to achieving the aims, particularly the financial impact. These included recruitment to vacant posts, focus on initiatives to retain staff, introduction of more specialist services.
- However, there was no local vision for the surgery service, wards or theatres, to show how these services aligned with the corporate vision or to show how they wished to develop.

Governance, risk management and quality measurement

- There were governance systems in place at the hospital but there was not consistent monitoring at departmental level to ensure local management of quality and safety. Practices were taking place in the operating department that were not reflective of BMI Healthcare corporate policies or national guidance, designed to keep patients and staff safe.
- Scrub practitioners were undertaking a dual role without the required risk assessments and policy being in place. This did not follow the corporate 'Policy for management of operating sessions for elective scheduled surgery' (2016). Theatre staff acting as a surgical first assistant were not identified on the rota, were not an additional member of the surgical team and could not provide evidence of completed competencies. This did not follow the recommendations of the Perioperative Care Collaborative (PCC) position statement on 'Surgical first assistant' (2012) or the BMI Healthcare 'Policy for the provision of surgical first assistants' (2013). The hospital could not provide audit evidence to show how it monitored practice against these particular hospital policies. There had been no detailed internal or external review completed of the operating department to

provide assurance of quality and compliance with corporate and national standards. An internal review had been completed but this mainly concentrated on the visual appearance of the department.

- Although the hospital were up-to-date with the administrative checks for consultant practising privileges, they were behind on the biennial review of clinical work for 135 consultants. This did not follow BMI Healthcare 'Practising privileges policy' (2015) and again raised concerns about monitoring compliance with policies.
- The hospital had a local audit programme, with compliance monitored by the hospital manager; who recognised they were accountable for the audits being competed. Whilst the audits identified actions, there was no person listed as being accountable for sharing the results and learning to ensure the information reached relevant staff groups. There were no formal action plans. In the operating department, compliance with the World Health Organisation surgical safety checklist was audited but there was no evidence how the hospital shared the results with staff.
- The hospital also utilised the corporate clinical audit calendar which highlights audits to be completed on a monthly basis. We were told there was also a comprehensive integrated audit programme which incorporates both non-clinical and clinical audits conducted by corporate team specialists. The BMI hospitals quality account provided to us showed some patient outcome data for national reported information were compared organisational wide and with national outcomes. However,there was a lack of information on how the hospital monitored clinical outcomes for patients.
- Senior managers had not given sufficient priority to the investigation and closure of incidents. There were 105 outstanding at the time of our inspection (across the two locations The Chiltern Hospital and The Shelburne Hospital), although the management had since addressed this. Systems and processes to keep patients safe were not being adhered to and prompt action taken to address any risks.
- There was a corporately developed risk management plan and risk register; this listed the top concerns and risks. The hospital manager also kept an additional more detailed quality and risk register for the hospital and had a good knowledge of the current risks affecting the safe delivery of services. They had given each item a risk rating, action owner and completion date, the level or risk was monitored as actions had taken place. They told us they submitted a weekly action plan to the senior team. There were no departmental risk registers in place.
- The hospital manager had begun to build relationships with the different services that the hospital has service level agreements (SLAs) with, particularly the local NHS Trust who provided the critical care, pharmacy, pathology and some diagnostic imaging services. The manager was reviewing the terms of the SLAs and planned to monitor performance of these services to ensure they met the agreed standards.
- There was a governance structure in place. Hospital sub-committees reported to the clinical governance committee and medical advisory committee (MAC), these meetings were all held jointly with The Chiltern Hospital. Senior leaders then reported to the corporate BMI Healthcare regional and national clinical governance structure. Outcomes from the clinical governance meetings were shared at the heads of department meetings; although, minutes from departmental meetings did not show this information always being shared with frontline staff.
- Agendas and minutes for meetings followed a standardised format, with actions listed, who was accountable for the action and by when. We saw from minutes of the clinical governance meetings that staff discussed complaints and incidents, including any learning and trends related to these events. They also discussed audits, policy reviews, updates from clinical committees and any external guidance or new legislation.
- Staff told us they found the daily 'huddle' a useful way of communicating information across the hospital. Senior staff and heads of department discussed daily activity, incidents and complaints at these meetings.
- The hospital had recently set up a theatre user group and defined the terms of reference; the group had not yet held any meetings. Its purpose was to maximise theatre efficiency and consider the quality and standards of the service, reporting to the MAC and

hospital clinical governance committee. This group intended to review the National Safety Standards for Invasive procedures document and develop local policies to deliver safe care for patients.

- The medical advisory committee (MAC) had a role in granting, reviewing and renewing consultants practising privileges. They held meetings once a quarter, with minutes showing they discussed for example, complaints, hospital activity and practising privileges.

Leadership of service

- An executive director had overall accountability for this hospital and two other locations, which were part of the same area group. The hospital manager was responsible for the clinical and operational management of the hospital, escalating concerns as needed.
- Staff raised concerns about the number of changes in senior management during the last 18 months. They felt this had affected the development and management of services at the hospital including the surgery service. They were though positive about the recently appointed executive director and hospital manager, who they felt was visible and took the time to listen to their concerns. Staff were hoping for a period of stability so the hospital could focus on improving the quality of the service they offered to patients.
- There was no theatre manager at the time of the inspection. The previous manager had been in place for about a year so had not made significant changes. Theatre staff did feel well supported by the Director of Clinical Services and able to raise concerns with them.
- Staff told us although the hospital manager was new; they had grasped the current immediate concerns of the hospital and had taken action to address some of the issues.
- Senior staff at the hospital planned their annual leave to avoid them all being away at the same time. Staff knew who to speak with if the hospital manager was not on-site.

Culture within the service

- Staff told us despite all the recent changes, they enjoyed coming to work. They commented on the strong team work and how the positive feedback from patients had helped during all the changes. Staff were flexible in the hours they worked to meet the needs of the service and patients. They felt valued and well supported by the senior staff at the hospital.
- However, staff did raise concerns, particularly in the operating department how the service at times ran to meet the needs of the consultants. This impacted on theatre session start and finish times. Staff would change their hours to ensure patients were seen but felt the hospital management needed to better manage and challenge the performance and approach of some consultants.
- Staff told us they found it difficult to whistleblow due to the small number of staff at the hospital. They felt there was a risk of identification if they raised a concern, even though they could raise this anonymously via an online form or to a central BMI Healthcare email address. Staff did not have confidence in the process and told us they had chosen not to raise concerns.
- The hospital was working towards a more open culture and there was a focus on the needs and experiences of patients and staff.
- There were higher than average staff turnover rates in the operating department, from April 2015 to March 2016, 33% for theatre nursing staff and 17% for other theatre staff. On the wards, turnover averaged 36% for registered nursing staff but was 0% for health care assistants. Sickness rates over the same period were generally low (less than 10%) for staff in the operating department and on the wards. The hospital manager had identified a number of schemes to try and improve staff retention such as additional role specific development training.
- Once a week the hospital held 'Free cake Friday' to encourage staff to meet and acknowledge the work staff had completed that week. This was to help improve staff morale after a challenging 18 months.

Public and staff engagement

- The hospital had recently introduced a number of new schemes to recognise and acknowledge the contribution made by staff and seek their feedback. The hospital also regularly reviewed the feedback received from patients.

Requires improvement

Surgery

- The hospital on a weekly basis awarded the staff member who had best demonstrated the '6Cs', based on nominations from other staff at the hospital. There were also plans to introduce more social events for staff to reward the whole team for their hard work.
- A number of staff commented on the 'open door' policy of the new hospital manager and felt able to raise concerns. The senior management team met with department leads at the daily 'huddle' and monthly managers meetings. The hospital manager planned to attend the first part of each department's monthly team meeting, so staff could raise concerns directly with them.
- Information was cascaded to staff through newsletters, emails and staff noticeboards.
- The results from the 2015 staff survey, showed an engagement score of 46 out of 100 compared with 51 in 2014. The response rate was 55%. The higher the score, the more satisfied staff are who work at that location. Feedback comments from staff were mainly around equity of pay, low morale quality and visibility of the senior leadership and the appearance of the hospital. We asked the hospital for their action plan in response to the staff survey results, they did not provide one. However, the hospital manager had begun to address some of the concerns raised by staff.
- The hospital asked patients for feedback using the Friends and Family test, which they analysed on a daily and rolling month basis. The hospital manager completed a daily walk around, speaking with a few patients each time, asking the same four questions to each patient to get instant feedback on the patient experience and to monitor consistency of the service.
- The hospital also held a monthly customer experience meeting with The Chiltern Hospital. There were no patients as members of the group to seek their views and take action in response to suggestions made, even though the group identified one of its purposes was to 'understand situations from the customer's perspective'.

Innovation, improvement and sustainability

- The senior management had identified key areas for development to either sustain, improve of develop the services they provided for surgery patients.
- The senior management had long-term plans to develop the orthopaedic service to increase the number of referrals and develop their ambulatory care service to reduce the need for patients to stay overnight. In the future, they hoped to run more nurse-led clinics and be more involved with local research projects.
- The hospital had an ongoing refurbishment programme to improve the appearance and was considering a project with local schools to provide new artwork.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at The BMI Shelburne Hospital includes services from 20 different specialities including orthopaedics, dermatology and cardiology. A diagnostic imaging department is also available, which provides x-ray and ultrasound scans. The hospital also provides physiotherapy services to outpatients.

The Shelburne Hospital is part of the BMI South Buckinghamshire Hospitals group. The senior management is shared between this hospital and two other services. There are similarities in our findings and the content of both reports due to this and the overall management of the hospitals being the same.

The outpatients department has five consulting rooms and a treatment room. Consultants lead all clinics with support from registered nurses and health care assistants. The outpatient department held the majority of clinics Monday to Friday including evenings and a small number of clinics on Saturdays. The outpatient department held 5,211 appointments in the reporting period April 2015 to March 2016, 2,168 of these were first attendances and 3,043 were follow up appointments. Patients attending the outpatient department are either NHS funded, self-funded or use private medical insurance. The hospital has recently stopped seeing children under the age of 18. The hospital had recently stopped seeing children under the age of 18.

The diagnostic imaging department has one x-ray room and one ultrasound scanning room.

The physiotherapy department has two treatment rooms and a gym.

During our inspection, we visited the Outpatient department, physiotherapy and diagnostic imaging department. We spoke with six patients and eight staff including nurses, medical staff, healthcare assistants, physiotherapists, radiographers, receptionists and administrators. We observed staff providing patient care, reviewed 12 patient records and analysed data provided by the hospital before and after the inspection.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

We rated this core service as requires improvement because:

- The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents. Although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any learning quick enough to ensure patient safety. Managers and staff could not accurately describe the trends of incidents or learning in their department and staff did not always receive feedback on incident reports.
- There was new management across departments who were still familiarising themselves with the service, departments and hospital. The outpatients department had recently appointed a new manager who had not yet commenced in post and the outpatient manager was acting up as manager in an interim role. At the time of our inspection, managers did not demonstrate an understanding of the risks or clear oversight of the governance processes to monitor the quality standards of the service.
- There was no departmental risk register and therefore the hospital could not provide assurance that departments managed key concerns in a timely way. The hospital risk register did not reflect the risks at a department level and was not in sufficient detail to outline how risks were monitored and by whom.
- The hospital had a policy and system in place for granting of practising privileges for medical staff wishing to work at the hospital. There was a backlog in completion of the required biennial clinical reviews for 135 medical staff for assurance on local clinical performance. Not all staff completed mandatory training appropriate to their role. Not all staff knew how to recognise a child or adult at risk of abuse. The hospital did not provide safeguarding children level 2 training to some members of staff. Staff in the outpatient department did not always have formal training and competency assessment to carry out specific roles.
- The hospital did not always store medical records securely and there was a risk of unauthorised access.

However,

- Staff treated patients with dignity and respect and provided emotional support throughout their treatment. Staff helped patients to understand their condition or treatment by giving written information after their treatment and allowing time to ask questions. All patients could request chaperones during their consultation or treatment.
- The diagnostic imaging department had access to a Radiation Protection Advisor and Radiation Protection Supervisor. The department displayed radiation hazard signs appropriately and access to controlled areas was secure.
- The hospital met the NHS referral to treatment indicator (RTT). All patients commenced treatment within 18 weeks of referral. Patients had a good choice of appointments at times that suited their needs.
- Staff valued the new hospital management team and told us they had made a positive impact on the hospital. Staff worked well together across multidisciplinary teams to ensure services met the needs of patients.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

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

We rated safe as 'requires improvement' because:

- Although we saw posters encouraging staff to 'pause' to complete patient safety checks prior to carrying out a radiological scan, we found staff did not always document they had carried out these checks. An audit of imaging request cards showed staff did not correctly document they had completed the checks in 72 out of 100 patients.
- The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents, although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any learning quick enough to ensure patient safety. Managers and staff could not accurately describe the trends of incidents or learning in their department and staff did not always receive feedback on incident reports.
- Although staff in the diagnostic imaging department followed a process to ensure imaging equipment was working prior to use, there was no documented evidence of this. Resuscitation equipment was available but not always checked on a daily basis.
- There was no oversight of environmental or clinical risk in the outpatient department. The department did not have any risk assessments specific to the department, which could lead to risk not being recognised or appropriately managed.
- Consultant's carried out lumbar punctures in the outpatient's treatment room but staff did not know if the room was a designated clean area to reduce the risk of infection.
- Although staff received adult safeguarding training, staff had not receive safeguarding children training appropriate to their role and did not always have sufficient knowledge on how to recognise a safeguarding concern. The hospital had not updated information for staff about the nominated person for safeguarding.
- The hospital did not always store patient medical records securely. We observed patient records left unattended in the main outpatient corridor, which posed a risk of unauthorised access.
- Although the hospital had met the mandatory training target for most modules, a significant number of staff had not completed practical manual handling training which could pose a risk to staff and patient safety.

However,

- There was a nominated Radiation Protection Supervisor (RPS), who had received appropriate training. Staff had good communication and support from Radiation Protection Adviser (RPA) and a current RPA audit and report.
- The hospital complied with safety measures to monitor staff exposure to radiation such as providing appropriate personal protective equipment and personal dosing badges. The diagnostic imaging department displayed appropriate signage on x-ray doors to prevent people entering.
- We observed the outpatient, diagnostic imaging and physiotherapy department was visibly clean and staff adhered to infection control policies and procedures such as using personal protective equipment and being 'bare below the elbow'.
- The hospital held up-to-date records for all equipment in the physiotherapy, diagnostic imaging and outpatient department. The diagnostic imaging department had a clear process in place for repairing essential equipment such as the x-ray and ultrasound machine.
- All outpatient services had good systems in place to ensure medicines were stored appropriately and securely.
- The hospital had business continuity and major incident plans in place should a significant event occur at the hospital or in the local area. Staff knew what to do in the event of a fire and held regular fire drills.

Incidents

Requires improvement

Outpatients and diagnostic imaging

- Staff knew how to report incidents using the hospital paper based incident reporting system. Incidents were then uploaded to a central database, by a member of the quality and risk team. The hospital planned to introduce electronic reporting of incidents in October, with training for staff starting in August. There was a current risk of the quality and risk team not uploading information correctly due to being unable to read the hand written forms and they did not actually witness the incident.
- At the time of our inspection, there was a delay in closing a total of 105 incidents across this hospital and a second hospital managed by the same team. The quality and risk team had to chase managers to complete investigations so they could record the outcome and close the incident. The senior management told us they had closed 100 of these incidents by 8 August 2016. The remaining five were within the 20-day timescale for the relevant department to investigate and report on the learning and outcomes. We had concerns the backlog had delayed the hospital applying learning and action, with a potential impact on safe care and treatment for patients. Managers could not accurately describe the trends relating to incidents in their department and could not give examples of where learning from incidents had improved clinical practice.
- Departments discussed incidents in a daily communication meeting, but staff could not always describe the learning from these. Staff also told us they did not always receive individual feedback when they had reported an incident.
- The reporting period April 2015 to March 2016, staff reported 10 clinical incidents across all outpatient services. This made up 5% of the hospital's clinical incidents for this period. This was lower than the national average. In the same period, the departments also reported one non-clinical incident, which made up 3% of the hospital's non-clinical incidents.
- In the diagnostic imaging department, staff could discuss their responsibility for reporting incidents under the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER)
- In all outpatient services, staff had an understanding of the principles of duty of candour but some staff had not received training. The outpatient department displayed information for staff about duty of candour (DoC) on the staff notice board. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- All the waiting areas and consulting rooms we visited were visibly clean and tidy.
- Patients and staff had access to hand sanitiser points at reception and in frequent locations across all the outpatient services. This promoted good hand hygiene practice.
- In the outpatient department, each consulting room had a completed cleaning schedule showing staff cleaned rooms on a daily basis.
- A contractor from the local NHS trust carried out legionella testing across all hospital departments. We reviewed legionella water testing records which showed these were complete and up to date.
- In diagnostic imaging, we observed completed cleaning schedules. Radiographers took responsibility for cleaning equipment after each use. Equipment used for invasive procedures are decontaminated in a suitable way.
- Staff in the outpatient department told us they carried out regular infection prevention and control audits. The hospital provided data showing the outpatients department and diagnostic imaging achieved 92% compliance and physiotherapy achieved 100%. Staff could not describe any action taken, or learning from these audits.
- All consulting rooms had sharps bins available for the safe disposal of needles. We observed staff had correctly assembled sharps bins and ensured these were not over filled in line with best practice for health and safety.
- Staff had access to personal protective equipment (PPE) such as gloves and aprons in all outpatient areas to ensure their safety when carrying out procedures.

Requires improvement

Outpatients and diagnostic imaging

- Some consulting rooms had carpeted flooring. The local NHS trust owned the hospital building and the senior management team told us they were working with the trust to replace carpets as this could pose infection risks.
- The outpatient department carried out lumbar punctures in the treatment room, which involves inserting a needle into the spinal canal. Staff did not know if the treatment room was a designated clean area to reduce the risk of infection.. There was no evidence the infection control team had assessed the room for this procedure.
- Staff in all outpatient services adhered to the 'bare below the elbow' guidance, which allowed for thorough hand washing and reduced the spread of infection between patients and staff.
- The hospital provided Infection Prevention and Control (IPC) training for staff depending on their role. The IPC basic awareness training had been completed by 100% of eligible staff, 68% of eligible staff had completed the IPC in healthcare training and 80% of eligible staff had completed the high impact, care bundles and Aseptic Non Touch Technique (ANTT) training.

Environment and equipment

- Equipment across all outpatient services was visibly clean. We observed equipment with labels showing last service and review date. However, in the outpatient department we saw a lung function machine that was managed by an individual consultant. The machine had an up to date service contract but the machine did not display a label to evidence this. All equipment also had an asset number to allow tracking and maintenance of the item.
- Senior staff in the outpatients department did not recognise risks specific environmental and equipment risks within the service. We asked senior staff in the department for risk assessments however they could not provide these.
- Resuscitation equipment was available in the department for use in an emergency. This equipment had a tamper-evident seal in place so staff could clearly see if the emergency equipment had been opened. However, we observed staff had not completed the emergency equipment daily checklist on 19 occasions from March to July 2016. Staff had not recorded if the department was open or closed on these occasions. This posed a risk items could be damaged, missing or expired without staff knowledge.
- Staff in diagnostic imaging followed a process of ensuring all lights displayed correctly on imaging equipment prior to use. However, there was no documented evidence of this and therefore the department could not provide assurance this was completed on a daily basis.
- The hospital accessed a Radiation Protection Advisor (RPA) from an external company who completed equipment safety and paperwork audits. The hospital also had a Radiation Protection Supervisor (RPS) that who responsible for ensuring the diagnostic imaging department was complaint with Ionising Radiations Regulations (1999). All the radiographers we spoke to had knowledge of the RPS and their role.
- Staff in the diagnostic imaging department carried personal dosing badges, which recorded their exposure to radiation. The department monitored this for all staff at three monthly intervals. Staff had access to Personal Protective Equipment (PPE) such as lead coats and aprons. We saw an annual audit of these was completed.
- The diagnostic imaging department displayed radiation hazard signs outside all x-ray rooms.
- Equipment reports for diagnostic imaging had been completed and kept up to date. The department had a clear process in place for repairing essential equipment such as x-ray and ultrasound machines.

Medicines

- Medicines were stored safely across all outpatient services. In the outpatient department, staff kept all medicine cupboards locked and the nurse in charge held the key. Staff kept medicine fridges locked and checked and recorded temperatures daily to ensure medicines were kept at the correct temperature.
- Staff placed medicines required by consultants in clinic in a sealed blue bag and locked them in individual cabinets in the consulting rooms prior to the start of the clinic. The nurse in charge held the key and opened the cabinet when requested.

- Prescription pads were stored securely in the nursing office and signed in and out after each us and the hospital monitored the use of prescriptions by individual consultants.

Records

- The hospital stored patient's medical records at another local BMI site. A driver transferred notes to the hospital for outpatient clinics and staff stored these in the outpatient department until needed for clinic. We observed an occasion where staff left the notes on an open trolley unattended in the outpatients corridor whilst they spoke with another member of staff. This posed a risk of unauthorised access as the trolley was in a patient accessible area. .
- Consultants took responsibility for holding their own patient records in the outpatient department. Staff told us secretaries ensured this information was available in the hospital medical records. All the records we looked at had a detailed record of the consultation, treatment plan and a letter to the patient's GP with this information.
- The hospital's radiological images were stored on a nationally recognised Picture Archiving and Communication System. The hospital also had the same Computerised Radiology Information System as the local acute NHS trust hospital for patient demographic records and radiological reporting. The diagnostic imaging department could also provide and request patient's radiological examinations electronically from other hospitals. Access to these records meant patients who had previously had radiological examinations in the NHS did not need them repeated, and so were not exposed to unnecessary radiation.
- We reviewed the physiotherapy records audit completed in March 2016, which showed the department was compliant with all standards apart from keeping the referrer up to date with the patient's progress and reviewing patients who exceed six sessions. There was no action plan documented on the audit to show how staff planned to address this.

Safeguarding

- Staff told us they completed safeguarding children and adults modules as part of their mandatory training. Hospital records showed 94% of eligible staff had completed level one safeguarding children and vulnerable adults training. This met the hospital target of 85%.
- The BMI policy for safeguarding included what action staff should take if they had concerns a patient had undergone female genital mutilation (FGM).
- We were told by senior staffing April 2016 BMI introduced training package on their e-learning system, which introduced the different levels of training to bring this in line with the intercollegiate document with the four different levels of training being provided. We were told prior to April 2016 all staff at the hospital were trained using one training module that would have covered the aspects required for level one and level two safeguarding children training.
- Information provided by the hospital indicated that only staff in a management or supervisory role were required to undertake level two safeguarding children and adults training and 96% of staff in this group had completed training. However, the BMI Safeguarding Children policy states that all staff who have some degree of contact with children, young people and/or parent or carers should complete a minimum of level 2 safeguarding training. The policy takes this requirement from the Intercollegiate document Safeguarding children and young people: roles and competencies for health care staff (2014). This meant all staff caring for adult patients who have children required level 2 safeguarding children training. The service therefore did not provide its staff with safeguarding training that met the requirements of its own corporate policy.
- The hospital provided a training session on protecting people at risk of radicalisation in line with the government Prevent strategy, 91% of staff had completed this training.
- The hospital had a nominated person for safeguarding children and vulnerable adults and staff were aware of this. The hospital manager also had experience in safeguarding children and told us they supported the nominated person in this role. The manager told us safeguarding concerns would be escalated to them in the first instance and then to the nominated person and local authority if needed.

Outpatients and diagnostic imaging

- Staff in the diagnostic imaging department could not give a clear explanation of how they would recognise a child or adult was at risk of abuse
- We saw the diagnostic imaging department had a notice displaying the names of the nominated person to contact for safeguarding children and vulnerable adult concerns. However, the information on this notice was out of date, displaying the incorrect name of the nominated person.

Mandatory training

- Staff completed a number of mandatory training modules. This included, display screen equipment, infection control, basic life support, Control of Substances Hazardous to Health (COSHH), fire, equality and diversity and safeguarding children and vulnerable adults.
- Staff received training through the BMI online learning package (BMiLearn), face to face and practical sessions. Documentation provided by the hospital showed 89% of staff had completed their mandatory training which met the hospital target of 85%.
- The hospital provided patient moving and handling training, which all clinical staff were required to complete. However, only 58% of all clinical staff had completed this training, against a hospital target of 85%, which could pose risks to patient and staff safety.
- There was a mandatory competency programme in place for staff in the diagnostic imaging department, this included plain film x-ray and ultrasound. We looked at a random sample of staff competencies and these were all completed and in date.

Assessing and responding to patient risk

- Staff in the outpatient, diagnostic imaging and physiotherapy department knew how to recognise and respond to patients who became unwell.
- The hospital employed Resident Medical Officers (RMO) who was on in the hospital at all times. The RMO's were trained in advanced life support and European Paediatric Advanced Life Support (EPALS). They provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would be transferred to the inpatient ward or to the local acute NHS Trust in line with the emergency transfer policy. The hospital had completed scenarios including transferring a patient to the local NHS acute trust.
- Hospital records showed 92% of clinical staff had completed adult basic life support training and 68% of eligible staff had completed adult intermediate life support against a hospital target of 85%.
- Staff in the diagnostic imaging department told us about a six-point check they carried out prior to performing a radiological scan to ensure the correct patient received the correct scan. We saw audit results from May 2016 which highlighted staff did not correctly document they had completed this check for 72% of the 100 records reviewed. A staff member told us they discussed the audit results at a team meeting but records were not available when we visited. We did observe posters encouraging staff to 'pause' to complete checks before performing scans.
- Staff told us about an incident where two patients received the same x-ray twice. During our visit staff could not find any records to show the action taken or learning from these incidents. The hospital provided us with a root cause analysis for one patient, which stated learning should be shared with staff. There was no evidence how staff received learning from this incident.
- Staff could access advice from the Radiation Protection Advisor (RPA) by telephone and email. We saw an example of where this had taken place two weeks prior to our visit and staff told us they received a response within two days.
- There was clear radiation hazard signage outside the x-ray rooms for staff and patients.
- The imaging department had a list of all professionals who had authorisation to request a radiation scan. Nursing staff with authorisation to request a radiation scan had additional training in line with IR(ME)R guidelines. This meant diagnostic imaging staff could ensure all staff making imaging requests had appropriate training and authorisation to do so. Staff told us they felt confident to challenge requests if they felt they were incorrect or inappropriate.

Requires improvement

Outpatients and diagnostic imaging

- Staff in the diagnostic imaging department told us they completed pregnancy checks for all women aged between 16 and 55 prior to any radiation scan. We saw evidence staff had completed these checks during our inspection.
- Staff in the diagnostic imaging department had carried out risk assessments for equipment, which were complete and up to date.

Nursing staffing

- There are no national guidelines for safe staffing levels for the outpatient department. Outpatient and diagnostic imaging managers reported they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner. The outpatient manager told us they did not have a formal system in place to plan staffing.
- At the time of our inspection, the outpatient department sister told us they had three registered nurse vacancies and two health care assistant vacancies across the three sites. Staff in the outpatient department told us nurse-staffing levels were an issue and it was difficult for the outpatient sister to cover three sites. An outpatient manager had been recruited and due to start in September or October 2016. The department relied on bank nurses to cover shifts created by the vacancies.
- In the outpatient department, from May 2015 to February 2016 the use of bank nurses and healthcare assistants was above the average for independent hospitals across the three sites. The rate of bank registered nurses was between 39% and 57% during the reporting period. The rate of bank health care assistants in the outpatient department was between 14% and 17%.
- The outpatient department had one nurse or one nurse and one healthcare assistant on duty for clinics. Staff told us they had concerns over the staffing levels during urodynamic and ophthalmology clinic. They told us the nurse and healthcare assistant were both required to be in urodynamic clinic to assist the consultant and perform tests. However, this meant staff could not assist patients in ophthalmology clinic, despite many of the patients being elderly and potentially visually impaired.
- The diagnostic imaging manager told us they had 12 members of staff including part time and bank staff. At the time of our inspection, the department had one vacancy for a radiographer for 30 hours per week that was covered by the use of bank staff. The manager told us staffing was safe on every shift.
- The physiotherapy department employed 21 permanent members of staff, which equated to 11.7 full time equivalent posts. The hospital had a budget for 12.5 full time equivalent members of staff therefore the service was one part time member of staff short. The hospital employed bank staff to provide cover for the service.
- Staff teams had daily communication meetings to share important updates, such as changes to planned clinics or staffing for the day.

Medical staffing

- There was sufficient consultant staff to cover outpatient clinics, including Saturday. Consultants agreed clinic dates and times directly with the hospital OPD and administration team.
- Staff told us they found medical staff supportive and could seek advice when needed.
- There was a registered medical officer on duty 24 hours a day who provided medical support to the outpatient, physiotherapy and imaging departments.

Major incident awareness and training

- The hospital had local and corporate business continuity plans for use in events such as a power failure or adverse weather conditions.
- There was a corporate 'Major Incident' policy for staff to follow should a significant event occur at the hospital or in the local area.
- Staff told us the hospital organised regular fire drills. During a fire drill, the hospital reception staff handed out radios so staff could communicate in the event of the telephone lines failing.

Are outpatients and diagnostic imaging services effective?

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

Requires improvement

Outpatients and diagnostic imaging

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

- There was good multidisciplinary team working across all departments and provision for patients to access diagnostic imaging and outpatient consultant clinics within the same appointment.
- The hospital participated in some national patient outcome audits such as the patient reported outcome measures programme (PROMS) and recently joined the private health information network (PHIN).
- Staff in diagnostic imaging and physiotherapy department had a clear knowledge of evidence-based treatment such as diagnostic reference levels and good practice on managing hydrotherapy pools. Although the outpatient sister participated in the BMI user group, there was no evidence learning from this group had been used to change clinical practice in the department.
- Staff obtained consent to care and treatment in line with legislation and guidance including the Mental Capacity Act 2005.

However,

- The hospital had a policy and system in place for granting of practising privileges for medical staff wishing to work at the hospital. There was a backlog in completion of the required biennial clinical reviews for 135 medical staff for assurance on local clinical performance.
- Staff in the outpatient department did not always have formal training or competency assessment to carry out specific roles. A nurse in the outpatient department was carrying out tests for patients with bladder and incontinence problems. Although the nurse had observed the procedures being carried out, they did not have formal training or competency assessment.
- In the diagnostic imaging and physiotherapy department, audits had highlighted areas where staff did not always follow policy and guidance. There was no evidence managers tracked progress to improve this or shared learning with staff.

Evidence-based care and treatment

- In diagnostic imaging, staff and managers had a good knowledge of Ionising Radiation Regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The department maintained records of equipment servicing and had access to qualified specialists.
- Although IR(ME)R audits such as image quality and request cards were undertaken in line with national guidelines, Staff could not describe learning or changes in practice from audits. We saw records of these audits, which had clear outcomes, and proposed actions however, there was no evidence the department had put these into practice.
- Local diagnostic reference levels (DRLs) were in use in the imaging department. DRLs ensure a patient does not receive an unnecessarily high dose of radiation. The department audited DRL's regularly and we saw evidence of these during our inspection. Staff displayed DRL's on the wall in each room for guidance.
- The outpatient sister attended the BMI outpatient user group. This group met quarterly to share best practice across the organisation. The outpatient sister could not give examples of how learning from this group led to changes in practice within the department.

Pain relief

- The outpatient department did not have a pain management policy or protocol in place at the time we visited. This posed risks that patient's pain may not be recognised and managed appropriately and in a consistent way. This was particularly important as the service carried out minor operations in the outpatient department.
- The hospital offered some minor procedures where although surgery took place in theatre, all pre and post-operative care was delivered by the outpatient department staff. Consultants told us patients received local anaesthetic and simple pain relief such as paracetamol.
- Staff told us they would call the Resident Medical Officer (RMO) or the patient's consultant if a patient displayed signs of pain before or after a procedure.

Patient outcomes

- The physiotherapy service reported on the patient reported outcome measures programme (PROMs) using

the national quality of life questionnaire (EQ-5D-5L). The results showed that patients received effective treatment as the majority of patient's health outcomes improved.

- The hospital had also recently joined the Private Health Information Network (PHIN). PHIN provide information for the public on 11 key performance measures, so a patient can make an informed choice where to have their care and treatment for providers offering privately funded healthcare. No data was available yet but it expected that all minimum data would be available to the public by April 2017.
- The diagnostic imaging department carries out regular image quality audit, which could also form part of staff performance management if required.
- The diagnostic imaging department did not currently take part in the Imaging Services Accreditation Scheme (ISAS), however the manager told us they had plans to gain accreditation following a trial in another BMI hospital.

Competent staff

- In the reporting period from October 2015 to September 2016, 79% of nurses and health care assistants in the outpatient department had received an appraisal. Appraisal rates for the diagnostic imaging department were not available.
- Diagnostic imaging bank staff, who did not routinely work at the hospital, always worked with an experienced BMI Shelburne Hospital staff member.
- Radiographers had competency assessments for the equipment they used. We observed a selection of these, which were complete and up to date.
- In the outpatient department, nursing staff carried out tests to assess patients with bladder or incontinence problems without formal training or competency assessment. Staff told us a senior nurse had shown them how to perform these tests and authorised them to undertake the clinic. Staff told us they would be starting a formal training course in the future.
- Health care assistants in the outpatient department rotated to work on the ward to gain additional skills. Registered nurses told us they very rarely rotated to work in different wards or other sites.
- Senior management completed a number of checks prior to granting consultants practising privileges at the hospital. The term 'practising privileges' refers to medical practitioners being granted the right to practice in a hospital. In order to maintain their practising privileges consultant medical staff were required to supply copies of current insurance, a disclosure and barring scheme check, their registration, last appraisal for their main place of work and evidence of completion of the required mandatory training. The hospital were up-to-date with these annual checks but they were behind for the review of clinical performance that took place biennially with the Medical Advisory Committee (MAC), in keeping with the BMI Healthcare 'Practising privileges policy' (2015). The policy contained a standard agenda that the MAC should adopt which included biennial review of practising privileges. We reviewed the minutes for the last three meetings and these did not contain discussions for medical staff due a biennial review.
- There were a total of 135 medical staff who were due a biennial review, seven reviews were significantly out of date 1 from 2007, three from 2009, one from 2010 and two from 2011. Six of the seven medical staff were undertaking clinical work at the hospital. There was no assurance that the hospital were actively monitoring the local clinical performance of staff who held practising privileges for the hospital. We discussed this with the executive director who was accelerating the reviews, with the aim of being up-to-date by the end of October 2016 .
- However, we did see in the minutes from the MAC meetings that the group had reached decisions to grant or stop practicing privileges and appropriate action taken, where the MAC had identified concerns about performance or conduct.

Multidisciplinary working

- Staff worked well together to ensure the best care for the patient. Radiographers worked with the physiotherapy team to plan appointments so patients could obtain physiotherapy and x-rays or ultrasounds in the same appointment. This avoided patient having to return for further appointments.

Requires improvement

Outpatients and diagnostic imaging

- Staff told us radiologists had a good working relationship with consultants. Radiologists contacted the patient's consultant directly if they found abnormalities on scans or x-rays.
- The hospital had a Service Level Agreement with the local NHS trust for patients who required emergency treatment that was outside the hospital's expertise.

Seven-day services

- The hospital held the majority of outpatient clinics Monday to Friday, with clinics running until late in the evening. The department worked flexibly, with clinics also held on Saturdays. Patients we spoke to reported good access to appointments and at times which suited their needs.
- The diagnostic imaging department opened Monday to Friday for outpatients. . The diagnostic imaging manager told us they had plans to extend the opening hours to include a Saturday clinic.
- The physiotherapy offered clinics to outpatients Monday to Thursday from 8am to 8pm, Friday 8am until 4.30pm and Saturday 11.30pm until 4.30pm.

Access to information

- Staff spoke positively about the medical records service and told us they had no difficulty in obtaining notes for clinic. Staff told us if a patient booked an appointment at short notice, they would contact medical records and arrange for administrators to fax notes to the hospital. A secure fax was available on site.
- The hospital's radiological images were stored on a nationally recognised Picture Archiving and Communication System and had the same Computerised Radiology Information System as the local acute NHS trust hospital for patient population records and radiological reporting.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging. Results were available for the next appointment or, for certain clinics, during that visit, which enabled prompt discussion with the patient on the findings and treatment plan.
- The hospital had a clear process in place for obtaining notes, including for patients booked at short notice.
- Outpatient consultations within the hospital were consultant-led. All patients attending a clinic had a GP referral letter. The outpatient administration staff monitored this process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards in their mandatory safeguarding vulnerable adults training. Hospital records showed 94% of staff had completed safeguarding vulnerable adult's level one training and 67% of staff had completed safeguarding vulnerable adults level two training.
- The diagnostic imaging department displayed information for staff about the Mental Capacity Act, explaining the five key principles and where to obtain further information if needed.
- Staff received training on consent and 96% of staff had completed this training. Staff sought verbal consent from patients for general x-ray and outpatient procedures carried out. The consultants sought written consent for minor operations.
- Although we looked at a sample of patient records during our inspection, no patients had a minor operation and therefore we were unable to view consent forms. The hospital did not carry out consent audits for patients undergoing minor operations in the outpatients department.

Are outpatients and diagnostic imaging services caring?

Good

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

We rated caring as good because:

- Staff interacted with patients in a friendly and supportive manner, treating them with dignity and respect throughout their treatment or appointment.
- All outpatient services offered patients a chaperone and departments clearly displayed signs in waiting areas and consulting rooms.

Requires improvement

Outpatients and diagnostic imaging

- Patients understood their condition and treatment plan and were given time to ask questions during consultations.
- Staff provided emotional support to patients throughout all outpatient services.

However,

- Patients could overhear conversations at the reception desk in the outpatient waiting area.

Compassionate care

- Staff treated patients with compassion, dignity and respect. We received comments such as, “staff are always on hand very quickly”, “I’ve been in private hospitals before but this is better” and “staff are very helpful and professional”.
- Staff interacted with patients in a friendly and supportive manner. For example, we observed a physiotherapist giving a patient encouragement to achieve their physiotherapy exercises.
- The outpatient department had an open plan reception and waiting area. Patients in the waiting area could overhear conversations taking place at the reception desk. The department did not have a separate room for patients or relatives that wanted to discuss information in private. Staff told us they would use a consulting room or the nurse’s office if a patient wanted to discuss information in private but this would depend on it being available. Consultants held appointments in individual consulting rooms and we observed they kept doors closed during consultations to maintain the patient's privacy.
- The hospital took part in the Friends and Family Test (FTT) which measures how likely patients are to recommend the service to their friends and family. The results for the hospital showed from October 2015 to March 2016, 100% of patients were either ‘likely’ or ‘extremely likely’ to recommend the hospital to their friends and family apart from November 2015 (96%) and January 2016 (94%) when this was slightly lower than the England average of 100%. The response rate was between 63% and 79%, which was significantly higher than the England average of approximately 40%. There was no breakdown of these figures displayed therefore it was not possible to identify the significance of these figures with regard to outpatient services.
- Patient Led Assessments of the Care Environment (PLACE) for February 2016 to June 2016 showed the hospital scored 91% for privacy, dignity and wellbeing, which was higher than the England average of 87%. PLACE audits assess the quality of the patient environment against set criteria.
- All outpatient services displayed signs in the reception area and in consulting rooms offering patients a chaperone.

Understanding and involvement of patients and those close to them

- Staff gave patients clear explanations about their condition and treatment plan. We observed a physiotherapist discussing a patient’s treatment plan with them using language the patient could understand rather than medical terminology. The physiotherapist asked the patient to give a summary of the information they had received to check the patient had a full understanding of information given during the appointment.
- All patients we spoke to told us they had a clear understanding of the next steps in their treatment, for example, if they required another appointment or more tests. Reception staff assisted patients to make follow up appointments and all patients knew how they would receive details of their appointment.

Emotional support

- Staff showed a clear understanding of the importance of providing emotional support to patients. Staff gave us examples of when carers had accompanied patients during their procedure and they had taken additional time to provide reassurance to patients who were anxious.
- Patients had a clear understanding of their condition and proposed treatment plan. Patients told us staff used clear explanations and gave time to ask questions about their treatment. The physiotherapy department gave patients a clear written plan after their appointment.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

Outpatients and diagnostic imaging

Good

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

We rated responsive as good because:

- The hospital planned outpatient services to meet the needs of patients, offering good access to appointments at times that were convenient to them.
- There was evidence of learning and action taken in response to complaints.
- Staff provided additional support to patients living with dementia or disabilities including prioritising them when waiting for clinic appointments.
- Outpatient facilities met the needs of all patients providing ample seating, magazines and access to hot drinks. The outpatient department had made provision for disabled access toilets and baby changing facilities.
- The outpatient waiting areas provided ample seating, magazines and access to hot drinks for all patients.
- The hospital provided text reminders for patients giving details of their appointment.
- Patients had minimal waiting times and staff informed them if there was a delay or cancellation.

However:

- The hospital did not display adequate signs to direct patients to the car park which sometimes resulted in patients parking in the wrong car park a longer walk to the hospital.
- The hospital did not display or provide information to patients on how to make a complaint.

Service planning and delivery to meet the needs of local people

- The outpatient and physiotherapy department planned services around the needs and demands of patients. Appointments were available Monday to Friday including evenings and on Saturdays to accommodate patients with commitments during the working week.
- The diagnostic imaging department offered appointments Monday to Friday but did not offer a weekend service to outpatients. The manager recognised this and told us plans were being developed to offer a weekend service.
- The hospital sent out reminders about appointments by text message. Patients told us they found this helpful.
- We observed staff directing and assisting patients to the department they required.

Access and flow

- Patients made appointments through the national enquiry centre, with the hospital directly, by GP referral or through the consultants own secretary. Patients told us the appointments system was easy to use and they could make appointments at a time that was convenient to them.
- Patients told us they had minimal waiting times, usually attending their appointment within a week of referral. Reception staff told us that they made urgent appointments within two days. We spoke with one patient who was able to book an appointment on the same day.
- The clinics we observed ran to time. Staff told us they would keep patients informed if delays occurred however, there was no formal system to do this.
- The outpatient department did not carry out audits on how long patients had to wait in the department for their consultation. The outpatient sister told us the previous outpatient manager had completed audits but she did not have sufficient time due to clinical duties. This meant that staff would not be able to clearly identify and evidence if a particular clinic consistently had delays.
- The hospital monitored patient who cancelled or did not attend (DNA) their appointment. The DNA rate for diagnostic imaging was 3.8%, for physiotherapy 2%. We requested DNA data for the outpatients department but the hospital did not provide this.
- The cancellation rate for diagnostic imaging was 9.6%, for physiotherapy 7.2%. The hospital did not provide a

breakdown of whether the appointments were cancelled by patients or by the hospital. We requested cancellation rate data for the outpatient department but the hospital did not provide this.

- Patients told us the hospital lacked signage to the car park and many had experienced problems finding the hospital. Patients told us they had parked in the incorrect car park, which resulted in a longer walk to the hospital. Staff also told us availability of car parking could be an issue and at busy periods staff and patients needed to double-park to accommodate all vehicles.
- Patients could access outpatient consultations and diagnostic imaging within the same appointment for example during the urodynamic clinic patients undergo tests, ultrasound and see their consultant with the results.
- The hospital met the NHS RTT indicator. From April 2015 to March 2016 the hospital obtained 100%. The RTT indicator shows the amount of patients accessing treatment within 18 weeks of referral.

Meeting people's individual needs

- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible for example prioritising patients living with dementia or learning disabilities. However, staff told us there were rarely patients who had complex or additional needs.
- The outpatient department did not have a formal system of recording or highlighting patients who have additional needs. One member of staff told us it was possible to place a note on the patient's record but this did not always happen.
- Patient Led Assessments of the Care Environment (PLACE) for February 2015 to June 2015 showed the hospital scored 82% for dementia, which was slightly higher than the England average of 81%.
- The outpatient department had access to equipment for bariatric patients including weighing scales, seating and hoist. This meant the hospital could meet the needs of bariatric patients.
- The outpatient areas were bright and welcoming with ample seating provision. Hot drinks were available in the main outpatient reception for all patients. The hospital provided magazines and free internet in all outpatient areas.
- The hospital provided disabled toilet facilities, which contained an emergency pull cord should patients require urgent assistance.
- The hospital had a hearing loop installed in the main reception to support patients with hearing impairments.
- All written information, including pre-appointment information and signs were in English. These were not available in other formats such as other languages, pictorial or braille. A translator service was available on request.

Learning from complaints and concerns

- We did not see any information about how to make a complaint displayed in the outpatient, physiotherapy and imaging departments and this information was not contained on the BMI Shelburne Hospital website. Patients told us they had not received written information about how to make a complaint and would ask hospital staff for information if they needed it. Senior staff told us leaflets about how to make a complaint were available.
- Staff told us managers shared learning from complaints for example, patients had complained about not understanding all the costs involved in their treatment. At the time of our visit, we saw posters and information cards explaining costs of treatment displayed in all outpatient services.
- A manager in diagnostic imaging told us about a complaint they were dealing with at the time we visited. The manager had spoken directly with the patient, apologised and invited them to a meeting to discuss their concerns.
- Outpatient department staff told us they had access to monthly team meetings where managers discussed key issues and learning from complaints.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

Outpatients and diagnostic imaging

Requires improvement

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

We rated 'well-led' as requires improvement because:

- There was new and interim management across diagnostic imaging, physiotherapy and the outpatients department. Managers were still familiarising themselves with the service and the hospital and did not demonstrate a clear understanding of the risks or oversight of the governance processes to monitor the quality of service. There hospital risk register did not reflect all risks at a department level and there was no clear documentation on how risks were monitored or by whom.
- Although the hospital had completed annual checks of consultants insurance and registration, they were significantly behind with the review of clinical performance. A total of 135 medical staff were due a biennial review, seven of these were significantly out of date.
- The hospital held regular hospital governance meetings and undertook clinical audits. However, there was no evidence that managers shared learning from hospital governance meetings or department audits with staff to ensure clinical practice improved.
- In the outpatient department some aspects of staff management were not always recognised, for example the importance of regular one-to-one meetings and performance management.
- Although the outpatient and diagnostic imaging manager planned to grow their services they did not have a clear vision or strategy for how they would achieve this. There were no clear development or business plans in place to support this.

However:

- Although the executive director and hospital manager had only been in post for four weeks, staff felt they had made a positive impact on the culture of the hospital. Staff knew about the vision and values for the hospital that had been recently implemented by the executive director.
- The hospital had processes in place to share key messages with staff on a daily basis and staff spoke passionately about the care they provided to patients.
- The Medical Advisory Committee (MAC) carried out their roles and functions appropriately.

Vision and strategy

- The BMI corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The registered manager had implemented a local vision for the hospital based on values of care, compassion, competence, communication, courage and commitment.
- The hospital had a strategy to improve and grow some areas of the business including outpatient, diagnostic imaging and physiotherapy. The hospital manager also told us his long-term focus was to build relationships with the local NHS trust, recruitment and retention of staff. The hospital manager had only been in post four weeks when we visited but we saw evidence of progress towards this plan.
- The diagnostic imaging manager told us they had a strategy to grow the service and gave examples, such as opening at the weekend. This had not yet been developed in to a written plan. The outpatient sister told us they wanted to grow the service but had no clear examples of how they would do this. The staff we spoke with during our visit did not have knowledge about the vision and values of the department.

Governance, risk management and quality measurement

- There was a governance structure in place. Hospital sub-committees reported to the clinical governance committee which fed into the medical advisory committee (MAC). Senior leaders then reported to the corporate BMI Healthcare regional and national clinical governance structure. Outcomes from the clinical governance meetings were shared at the heads of department meetings; although, minutes from departmental meetings did not show this information always being shared with frontline staff.

Requires improvement

Outpatients and diagnostic imaging

- The hospital held regular governance and health and safety meetings attended by the senior management team and heads of department. We saw evidence of minutes showing the meetings discussed clinical issues and actions to resolve these. High level governance issues raised in the hospital governance meetings were escalated to the MAC.
- The hospital had a risk register in place, which included actions for senior hospital managers. However, we did not see evidence that department managers used the register as a means of escalating issues. The risk register did not track monitoring of risks and assign it to a specific staff member.
- At the time of our inspection, we had concerns the interim management arrangements were not always effective. This meant that governance procedures to manage the quality and risks to the service were not always in place or followed.
- Staff had access to policies and standard operating procedures for radiological examinations. Local rules (local instructions relating to radiation protection measures for the service) were on display in every x-ray room.
- Staff did not always follow systems and processes to keep patients safe, for example, two patients received a second unnecessary x-ray. There was no evidence from department meeting minutes how any learning and actions had been shared with staff or monitored.
- In the diagnostic imaging and physiotherapy department, audits had highlighted areas where staff did not always follow policy and guidance. There was no evidence that managers tracked progress to improve this or shared learning with staff.
- There were a total of 135 medical staff who were due a biennial review, seven reviews were significantly out of date 1 from 2007, three from 2009, one from 2010 and two from 2011. Six of the seven medical staff carried out clinical work at the hospital. There was no assurance that the hospital actively monitored the local clinical performance of staff who held practising privileges for the hospital. We discussed this with the executive director who was accelerating the reviews, with the aim of being up-to-date by the end of October 2016.
- However, we saw minutes of the Medical Advisory Committee (MAC) meeting, which covered areas of good practice and risk and included outpatients. There was also evidence the MAC had reached decisions to grant or stop practicing privileges and appropriate action taken, where the MAC had identified concerns about performance or conduct.

Leadership of service

- At the time of our visit, the diagnostic imaging and physiotherapy manager were both new in post and still familiarising themselves with the service, departments and hospital. Staff spoke highly of them and felt positive about the changes they would implement.
- In the outpatient department it had been acknowledged that a new manager was required and had been appointed. The outpatient sister was acting up to this role in the interim.However, we did not see evidence of consistent leadership for example recognising the need for one-to-one meetings with staff and performance management. Although staff spoke highly of the outpatient sister and recognised the challenges within her role, staff commented they found the lack of structure in the outpatients department challenging.
- The staff in the outpatient department told us they felt supported by their direct line manager. However, some staff felt there was a lack of clinical support available on a day-to-day basis as the outpatient department sister was not based at the hospital.
- Staff in the diagnostic imaging department told us they felt the recent change in hospital management was positive. Staff felt the new hospital manager had a new way of approaching issues, which was open and refreshing.
- All staff spoke positively about the new executive director. Staff told us they were approachable, and understood the work of each department.
- The outpatient sister and diagnostic imaging manager did not have a clear assessment or plan of how to address the challenges to good quality care in their department.
- Staff and managers across all outpatient services told us they had seen an increase in complaints from patients about charges for treatment. The hospital had

recognised this and displayed posters and leaflets giving information about charges for treatment. All the patient's we spoke to told us they had information about the charges for their treatment.

Culture of service

- Staff spoke passionately about the standard of care they delivered to their patients.
- Although the hospital had undergone a number of senior management changes staff commented this had been a positive change and managers commented they could see positive changes in morale within their teams.
- Staff in the outpatient department told us they could be the only nurse on duty in the department during evening clinics although reception staff were on duty in the department until the last clinic had finished. We saw minutes from the hospital health and safety meeting, which showed the hospital had installed a panic button in the reception area. It was not clear from the minutes of the meeting if the hospital had connected the panic button and if it was working. We asked a nursing and reception staff if the panic button was connected and in working order but they did not know and told us the alarm had not been tested. We were told by senior staff it was tested daily but not recorded.
- The turnover rate for nursing staff in the outpatients department was 40% from April 2015 to March 2016. This was significantly higher than the national average. There was no turnover of healthcare assistants in the outpatients department from April 2015 to March 2016.
- The hospital did not provide any information relating to staff sickness for the outpatient, physiotherapy or diagnostic imaging department.

Staff engagement

- The hospital held a daily communication meeting at 9am to update senior staff on current issues for that day such as complaints, incidents, staffing and workload. Each department then held a department communication meeting to share these messages with staff. All outpatient services had a daily communication meeting board and staff spoke positively about the meetings.
- The hospital identified a 'behaviour of the week' based on the hospital values and encouraged staff to nominate colleagues who had demonstrated this behaviour. Each department displayed this on their communication board. There was an 'Above and Beyond' award scheme in place, whereby patients could nominate a staff member or staff could nominate colleagues for an award. Winners received awards in categories such as outstanding care, innovative thinking, amazing support, true inspiration, brilliant leadership.
- The diagnostic imaging manager had started a weekly communication letter to the team. This highlighted key issues within the department and praised individual staff for positive contributions they had made.
- Diagnostic imaging staff told us they could not attend monthly team meetings as these were held on another local BMI site during clinic hours. This meant they did not always receive updates on key department issues in a timely manner.
- We observed interactions between the hospital manager and staff, which were professional and friendly.
- The hospital manager recognised recruitment and retention of staff was a problem and had implemented strategies to address this. The manager told us he had started a 'free cake Friday' for staff to raise morale and told us about plans to improve the induction and training process for newly qualified staff.
- The hospital manager told us he had plans to implement a board to display staff feedback and action the hospital had taken based on this feedback.
- The hospital also took part in the staff FTT which measures how likely staff are to recommend the hospital to their friends and family. The results showed that 86% of staff were either 'likely' or 'extremely likely' to recommend the hospital to their friends and family. This was higher than the BMI national average of 70%.

Public Engagement

- The hospital took part in the Friends and Family Test (FTT). There was no breakdown of these figures displayed therefore it was not possible to identify the significance of these figures with regard to outpatient services.

Requires improvement

Outpatients and diagnostic imaging

- The hospital manager told he planned to implement a board to display patient feedback and the action the hospital had taken based on this feedback. They told us about a recent initiative to improve food quality introducing patient taste testing sessions.
- The hospital also held a monthly customer experience meeting. There were no patients as members of the group to seek their views and take action in response to suggestions made, even though the group identified one of its purposes was to 'understand situations from the customer's perspective'.

Innovation, improvement and sustainability

- The hospital manager had clear long and short term plans to improve the hospital and we saw evidence of progress towards this plan.
- The hospital manager also had plans to improve the décor of the hospital. We saw evidence they had made some short-term improvements such as placing pictures on the wall to make the patient journey more enjoyable.
- The outpatients department sister and diagnostic imaging manager told us they wanted to grow their services, however, there was no formal plans in place to achieve this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff acting as a surgical first assistant have been assessed as competent for the role. In addition, the evidence of completed competencies and log of cases should be available in accordance with the BMI Healthcare Surgical First Assistance policy.
- The provider must ensure it completes regular reviews of compliance with BMI Healthcare policies, with action taken for areas of non-compliance, including the renewal of practising privileges. .
- The provider must ensure that staffing levels in theatres are in line with current national guidance and the BMI Healthcare policy.
- The provider must ensure when staff are undertaking a dual role this is supported by a local policy and risk assessment.
- The provider must ensure all theatre staff receive an annual appraisal.
- The provider must ensure there is robust monitoring of the safety and quality of the surgery service at a local level, with risks identified and timely action taken to manage the risks.
- The provider must ensure all medical records are stored securely at all times, including during transport.
- The provider must ensure the hospital risk register reflects the current risks faced by the hospital and in sufficient detail to show how they are monitoring the risks.
- The provider must ensure staff carry out the six-point safety check prior to any radiological scan.
- The provider must ensure there is robust monitoring of the safety and quality of the outpatients and diagnostic imaging service at a local level, with risks identified and timely action taken to manage risks.
- The provider must ensure all staff in the outpatient department complete appropriate training and competency assessment to carry out their role.

Action the provider SHOULD take to improve

- The provider should ensure a trend analysis of all incident reports is completed, with action plans devised as a result.
- The provider should ensure all patient care records are completed in full, by the multidisciplinary staff providing care and treatment.
- The provider should ensure all staff are up-to-date with all of their mandatory training.
- The provider should ensure all staff complete safeguarding children training appropriate to their role.
- The provider should ensure all intravenous fluids are stored securely.
- The provider should ensure there are clear protocols and guidelines for pain management in the outpatient department.
- The provider must ensure all the key recommendations of the Perioperative Care Collaborative Statement on Surgical First Assistants have been considered, with action taken as indicated.
- The provider should ensure there is local monitoring of national guidelines to ensure patients receive care and treatment that reflects current evidenced based practice.
- The provider should ensure patient surgical outcome data is shared and discussed at relevant departmental meetings so changes can be made to practice where necessary.
- The provider should ensure all theatre staff receive an annual appraisal.
- The provider should ensure for all audits there is a clear action plan, with accountability for completion of any actions, by an agreed date.

Outstanding practice and areas for improvement

- The provider should ensure the outpatient department have knowledge of individual consultant competencies.
- The hospital should ensure all outpatient clinics have sufficient numbers of staff to meet patients' needs.
- The hospital should ensure there are appropriate arrangements in place for lone working in the outpatient department during evening clinics.
- The provider should consider arranging an external review of its theatre service to seek an independent review of the standards of the service..
- The provider should consider displaying information for patients about how to make a formal complaint.
- The provider should consider improving the signage to the hospital car park.
- The provider should ensure the a robust risk assessment is carried out to assess the risk of carrying out lumbar punctures in the outpatient treatment room.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1)(2)(a)(b)(f) **How the regulation was not being met:** • Practices were taking place in the operating theatres that were not reflective of corporate policies and procedures. Scrub practitioners were undertaking a dual role without a local policy or risk assessments in place to support this. The potential risk to staff and patients was not being assessed or managed. • In diagnostic imaging staff did not routinely complete the 6 point check. There was no action plan to improve compliance and reduce the risk to patient safety. • The required documentation for staff acting as a surgical first assistant was not recorded and kept in the operating department as stated in BMI Healthcare policy. • There were no regular audits to monitor compliance with corporate policies. • Governance processes to assess and monitor service quality and risk were not embedded at a local level. • The hospital risk register was not in sufficient detail to show how risks were being monitored and by whom. It did not contain all the risks for the surgery service and outpatient and diagnostic imaging department. • Patient medical records were not always stored securely and there was a risk of unauthorised access.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1)(2)(a)

How the regulation was not being met:

- The operating department was not always staffed in line with national guidance from the Association for Perioperative Practice or BMI Healthcare policy.
- Staff in the operating department were acting as a surgical assistant without having completed a competency based assessment.
- The majority of theatre staff had not completed an appraisal within the last year.
- Staff in the outpatient department did not always receive formal training and competency assessment to carry out their role.